COUNCIL OF GOVERNORS

Report on Proceedings of High-Level Consultative Forum on Health Policy and Legislative Barriers

December 2021

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DECEMBER 2021

FOREWORD FROM THE CHAIRMAN, COUNCIL OF GOVERNORS (CoG)

Pursuant to the Constitution of Kenya 2010 (CoK), the greater part of delivery of health services is assigned to County Governments. As the country gears towards nine (9) years of implementing devolution, and also as the term of the second-generation County Governments nears expiry in August 2022, this becomes an opportune time to reflect on the experiences of the devolved health sector. The State of Devolution Addresses (SODAs) delivered by the CoG every year reveal that significant milestones have been achieved in County health services. However, this is one sector that has attracted both praise and criticism in probably equal measure owing to the fact that the right to quality, affordable and accessible healthcare services continue to receive high demand from the citizens.

One of the most notable challenges that plague the County Governments in delivery of health services is the policy and legislative environment that the sector operates in. The Audit of Laws Report developed by CoG in 2019 showed that there are still a myriad of policies, laws and regulations that were passed pre and post 2010 and are still not aligned to the constitutional tenets on devolved governance. Consequently, implementing the County health services function continues to be faced with institutional, procedural, financial and regulatory weaknesses, a phenomenon that poses a great threat to health service delivery.

CoG plays the critical role of coordinating County health sector issues with the National Government and amongst County Governments. All health sector related matters that are of interest to County Governments are handled by the CoG Health Committee with the support of the Directorate of Health Services. The caucuses of the County Executive Committee Members (CECMs) for Health, Chief Officers, Directors and county health teams have also proved useful in consolidating the voice of the County Governments on matters related to the health sector. CoG has been working closely with the National Government and non-state actors, who also play a critical role in delivery of health services, through established intergovernmental forums in a bid to strengthen the policy and legislative environment for the sector.

To illustrate, most recently a section of Governors and CECMs for Health from 34 Counties participated in a joint forum with USAID and its Implementing Partners under the banner of "*Deepening the partnerships between USAID and county governments through the Kenya Health Partnerships for Quality Services Initiative (KHPQS).* The forum discussed the project's focus, strategic shifts, and anticipated outcomes. The meeting also focused on how to strengthen partnerships and collaboration between USAID implementing partners and County Governments in the implementation of these activities including alignment to County priorities and building self-reliance through co-creation and co-funding of activities in light of diminishing donor funding. A key recommendation of the forum was the need to undertake policy and legislative reforms that facilitate establishment of strong and resilient County health systems. Such anticipated reforms

would target the following thematic areas: health care financing; supply chain management systems; County health institutions, structures, systems and processes; and service delivery readiness and preparedness.

CoG with the support of USAID held a two-day forum in December 2021 to address this recommendation. This was achieved through detailed reviews of the policy and legislative barriers based on policy briefs and position papers prepared by the Team of Health Experts (ToE) for consideration, deliberation, adoption, and future implementation by both levels of government through intergovernmental forums.

My desire is that all the resolutions agreed on in these two engagements mentioned above will be implemented with the aim of strengthening health service delivery in all Counties.

H.E. Hon. Martin Wambora, EGH

Chairman, Council of Governors

ACKNOWLEDGEMENT FROM THE CHAIRPERSON, CoG HEALTH COMMITEE

On behalf of the CoG Health Committee, I wish to acknowledge and sincerely thank all the delegates who attended the High-Level Forum on health sector policy and legislation. The success of the event was attributed to their active participation and provision of great inputs that shaped the delivery of sessions and the joint communique.

I appreciate the participation of Excellency Governors, and particularly the Chair of the CoG H.E. Martin Wambora for his leadership. Additionally, the stewardship of various thematic sessions by members of the Health Committee was incredible. I appreciate the Cabinet Secretary of Health, Sen. Mutahi Kagwe for gracing the forum and delivering an insightful keynote address.

The forum benefited significantly from the contributions of leadership of the County Assemblies Forum, the Commission on Revenue Allocation, and Kenya Medical Supplies Authority. Similarly, we applaud the participation and inputs from the CECMs for Health Health led by Hon. Joseph Mbai. I also wish to thank other officials from the Ministry of Health and various County Departments of Health for their participation.

We remain grateful to the Mission Director for USAID Mark Meassick and his team for the continued support to the CoG in strengthening its capacity for improved delivery of its mandate. The technical support through the ToE and the financial support towards the convening of the forum has been positively impactful.

Finally, I applaud the efforts of the CoG Secretariat under the leadership of Mary Mwiti, the Chief Executive Officer who relentlessly supported the planning and delivery of the event. This kind of collaboration is encouraged and I hope that the synergy between government and development partners in the health sector is maintained.

H.E. Prof. Anyang' Nyong'o, EGH

Chairperson, CoG Health Committee

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CAF	County Assemblies Forum
CECM	County Executive Committee Member
CIC	Commission for the Implementation of the Constitution
CIDP	County Integrated Development Plan
CoG	Council of County Governors
CoK	Constitution of Kenya 2010
CRA	Commission on Revenue Allocation
CRF	County Revenue Fund
EBS	Event Based Surveillance
FIF	Facility Improvement Fund
FY	Financial Year
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HPT	Health Products and Technologies
IBEC	Intergovernmental Budget and Economic Council
IGR	Intergovernmental Relations
IGRTC	Intergovernmental Relations Technical Committee
KHFS	Kenya Health Financing Strategy
KLRC	Kenya Law Reform Commission
KEMSA	Kenya Medical Supplies Authority
KPMDC	Kenya Medical Practitioners and Dentist Council
LMIS	Logistic Management Information System
MES	Managed Equipment Services
MoH	Ministry of Health
MTC	Medicines and Therapeutics Committee
NHIF	National Hospital Insurance Fund
PFM	Public Finance Management
PPP	Public Private Partnership
SER	Social Economic Rights
TA	Transition Authority
UHC	Universal Health Coverage
USAID	United States Agency for International Development
USG	United States Government


Council of Governors
Kenya

EXECUTIVE SUMMARY

The Kenya Health Policy (2014-2030) provides the overall policy direction for health in Kenya with an overarching goal of attaining the highest standard of health in a manner responsive to the needs of the Kenya population. Progressive achievement of this goal is premised on successful delivery of health services under devolved governance that has been in place since adoption of the CoK and subsequent establishment of County Governments in 2013.

Notable achievements have been registered by County Governments, in partnership with National Government and other stakeholders, in improving access to quality health care services through strengthened health systems. These successes cut across all health systems – increased budgetary allocations for health from an average of 21.1% in FY 2014/15 to 27% in FY 2020/21, indicating a significant increase of 5.9% including health commodities; increased staffing capacity; additional health facilities and equipment; application of information technology in various service delivery aspects; and strengthened institutional infrastructure. Nevertheless, there are critical challenges that continue to slow the pace of these achievements for greater impact in the UHC journey. A critical area of concern is the policy and legislative environment.

The need for an enabling legal and institutional framework in the health sector cannot be sufficiently underscored. On this premise and owing to its mandate of considering matters of common interest to the County Governments, CoG monitors policies emanating from the National Government and laws generated by Parliament and undertakes detailed reviews and analyses to ensure compliance with the devolution principles anchored in the CoK. In doing so, CoG has been working closely with National Government and non-state actors to achieve this goal. Continuous reviews have revealed persistent policy and legislative barriers that hinder effective and sustainable delivery of health services by County Governments. CoG, having identified the urgent need for a structured and focused dialogue with stakeholders on the health policy and legislative frameworks, convened a consultative forum with support of USAID in December 2021 in a bid to build consensus on key priority areas. The platform brought together Governors, CECMs for Health, representatives from MoH, Parliament, CAF, CRA and USAID.

Consultations that were undertaken through both presentations and plenary discussions facilitated interrogation of policy and legislative issues affecting achievement of health outcomes, with a focus on sustainable health care financing; supply chain management systems; County institutions, structures, systems, and processes; and service delivery readiness and preparedness. To address the prevailing gaps regarding policies and laws that are not aligned to the CoK, and which stifle implementation of devolved health services, the forum agreed to prioritize comprehensive review of health policies and legislations, and then undertake a coordinated reform process.

On health financing, the forum noted the need to revisit NHIF reforms with a view to adequately re-defining and standardizing the existing benefit packages, expressly mandating enrolments and contributions, and aligning governance structures for greater accountability. The meeting acknowledged the ongoing efforts geared at increasing financial resources to the health sector through ring-fencing of health facilities' funding and refocusing partnerships with development partners for greater impact and sustainability. The need to pass FIF legislation at the County level was noted as being urgent. Further, the forum agreed to carry out coordinated transition of development partners' financing to ensure continuity of support especially regarding commodity security, human resources for health and capacity building efforts. Appreciating

the need to accelerate implementation of output-based financing, the need for increasing allocation of funding to primary healthcare was noted.

Regarding improving health commodities security, the forum highlighted the need to address the existing policy and legislative gaps affecting demand and supply planning. The meeting resolved to ensure that the UHC benefits package adequately defines the HPT aspects and HPT budgets at County level are ring fenced for predictability. In dealing with rising costs of HPT, County Governments will be expected to strengthen HPT transparency through improving accountability in procurement, utilization of market surveys, promoting use of generics and biosimilars, and preferential procurement opportunities. Further, County Governments will be expected to enhance local production of HPT through effective collaborations with local research and training institutions and private firms.

Revitalization of governance structures for HPT – including MTCs and County HPT units – at County level will be effected through appropriate revisions to the County Health Services Act. Further, County Governments need to expressly clarify functions regarding the regulation of County pharmacies and ensure that they are in conformity with the national legislations. To strengthen demand and supply planning, County Governments should increase investments in electronic LMIS that assures end to end visibility of health commodities and the related data. On the quality front, County Governments will be expected to establish mechanisms that facilitate for information sharing with the regulators.

Appreciating that there are still glaring overlaps and duplication of roles in implementing the health functions (even those assigned exclusively to the County Governments), complete unbundling of functions in the health sector was agreed as a priority for improved accountability and delivery of health services. This exercise should include, but not limited to, existing national referral facilities, KEMSA, NHIF and training functions. At the County level, governance structures that support further decentralization and accountability of resources at health facilities and community health units need to be established and adequately funded. The health sector intergovernmental forum will also be strengthened to enable it to efficiently and expeditiously resolve teething issues in the health sector. In this journey, there should be renewed focus on utilization of joint committees in stewarding origination, discussions and consensus building on health legislations and policies to protect functions and powers of both levels of government. Further, the critical roles of the National Treasury and the National Assembly in IGR should be appreciated and optimized.

The forum agreed that County Governments, in collaboration with the National Government, will realign their health budget allocations to truly reflect the importance of preventive health care all the way to community level, taking into cognizance the collaboration and contribution of other health related sectors such as education, water and agriculture. Noting the numerous lessons learned from the COVID-19 pandemic response, the meeting also agreed to prioritize strengthening of Emergency Preparedness and Readiness of County Health Systems through increasing budgets for emergency health, increasing coordination between Counties and National Government actors in disaster management and reviewing the Public Health Act Cap 242. Additionally, County Governments need to invest in County Disease Surveillance, reporting and response through rolling out event-based surveillance, enhancing data for decision making at all levels - community level, health facility and management levels – and initiating administrative and policy reviews to enhance routine reporting by private health facilities and community health units.

The key resolutions emerging from the forum were captured and articulated in the communique below. The immediate next step will involve development of a detailed action plan with specific interventions and responsibility assignments to support implementation of agreed actions.

COMMUNIQUE

COMMUNIQUE' OF THE HIGH-LEVEL CONSULTATIVE MEETING OF COUNCIL OF GOVERNORS HELD ON 15th AND 16th DECEMBER 2021

The Council of Governors (CoG) convened a two-day High-Level Consultative Forum with an overall theme 'Reflections on Policy and Legislative Experiences for Accelerated Delivery of the Universal Health Coverage agenda at County Level' at Whitesands Hotel, Mombasa County.

The forum brought together Governors, Council Executive Committee Members for Health, Chief Officer of Health, Ministry of Health, National Assembly, Senate, County Assemblies Forum (CAF), Commission for Revenue Allocation (CRA) and Kenya Medical Supplies Authority (KEMSA). The forum interrogated policy and legislative barriers that have created hindrances in implementation of devolved Health services with a view of coming up with ways to address them.

Acknowledging that devolution, by all accounts, has proven to be an economic, social, and political advancement game changer for our people, and that gains made need to be sustained and accelerated through cordial partnerships and engagement led by both county governments and national government,

The following resolutions were arrived at:

1. (a) County Governments and the national government will jointly undertake a coordinated and comprehensive review of the existing health policies and legislation, starting with;
    - NHIF Act,
    - Kenya Medical Supplies Authority (KEMSA) Act, 2013 and;
    - Pharmacy and Poisons Act, in the next six months to align these to the requirements of the devolved governance system.

    (b) Having reviewed various laws and policies that are problematic in institutionalizing and financing devolution, through a clear division of functions between the national and county governments, the meeting resolved that the CoG, County Assemblies, National assembly, and Senate jointly work together to streamline all these laws and policies to be fully aligned to devolution or, where repugnant, be repealed.
    (Actors: CoG, Ministry of Health, Office of the Attorney General, Kenya Law Reform, National Assembly and Senate).

2. County Governments shall enhance their capacity for analysis and utilization of county generated data to track progressive realization of Article 43 of the Constitution and inform the review of County Integrated Development Plans (CIDPs) and annual budgetary allocations.
(Actors: County Governments, Ministry of Health)

3. County Governments will engage the National Government to restructure the budget making process, to enable adequate and timely participation of county governments in the generation of the National Budget Policy Statement and sharing of the equitable revenue.
(Actors: CoG, County Governments, Parliament, National Treasury, Commission of Revenue Allocation)

4. County Governments will, in the next budget cycle, adopt the Model law for Facility Improvement Funds to ring-fence funds for health services.
(Actors: CoG, County Governments)

5. Both levels of government will support the enforcement of National Hospital Insurance Funds reforms in the following areas;

- beneficiary management,
- Benefits management,
- Healthcare providers management,
- digital transformation, organizational transformation, and,
- positioning NHIF as a strategic purchaser in line with the Kenya Health Financing strategy.

(Actors: CoG, National and County Governments)

6. In view of the amendments to the NHIF (Amendment) Bill that were approved recently, expunging the provision requiring every Kenyan above 18 years to contribute to the fund, CoG to engage the National Assembly to reconsider recommendation No 7 and 11 to allow for mandatory contributions. (Actors: CoG, National Assembly, Senate)

7. The County Governments will undertake a rapid assessment of county health fiscal spaces to inform health finance transitions discourse. (Actors: CoG, County Governments)

8. County Governments will engage the National Government on the implementation of county-led financial protection schemes and pursue consolidation and expansion of existing risk pooling schemes towards equitable access to health services and efficiency enhancement. (Actors: CoG, National Government, County Governments)

9. County Governments will, in the next budget cycle, increase budget allocations for both Health Products and Technologies and supply chain systems strengthening activities and make provision in the current budget cycle, to fast-track settlement of outstanding debts to Kenya Medical Supplies Authority (KEMSA). (Actors: CoG, County Governments, KEMSA)

10. County Governments, leveraging on the strength of the regional blocs and in close collaboration with local research institutions, Technical Vocational Educational and Training (TVET) Institutions and private firms, shall utilize the applicable preferential procurement provisions to spur both local production and local procurement of Health Products and Technologies. (Actors: County Governments)

11. County Governments will strengthen the Logistics Management Information System for health commodities supply chain through implementation of integrated systems that assure end to end visibility of products to support demand and supply planning. (Actors: CoG, County Governments, National Government (MoH)

12. County Governments shall review their county legislations to support enforcement functions in respect to county pharmacies through strengthened HPT governance at county level and establish elaborate mechanism to support coordinated information sharing with the Health Products and Technologies regulator(s) (Actors: County governments, Regulator(s) including Pharmacy and Poisons Board and Kenya Bureau Standards).

13. Recognizing the critical role of the following institutions in Intergovernmental Relations - National Cabinet, National Treasury, Ministry of Devolution - County Governments will engage the National Government to restructure processes of approval of health policies and legislation to ensure compliance with the Constitution and devolved system. (Actors: CoG, Intergovernmental Relations Technical Committee and Summit)

14. County Governments and National Government shall engage parliament to resolve conflicts between the two houses

of parliament in legislative processes and support harmonized and efficient review of health laws and policies.
(Actors: CoG, County Governments, Parliament)

15. The County governments will ensure that, on an annual basis and in collaboration with the Ministry of Health, a database of doctors undergoing postgraduate studies is submitted to the Ministry of Health, and the National Treasury, through MOH, to make provision in every budgeting cycle for the payment of Personnel Emoluments for those doctors to the Counties.
(Actors: CoG, MoH, IGRTC and Summit)

16. County Governments to strengthen Emergency Preparedness and Readiness of their Health Systems, increase budgetary allocation to emergency health, ensure effective coordination between Counties and National Government actors in disaster management, and review of the Public Health Act Cap 242 to clearly unbundle the disaster management functions between the two levels of government.
(Actors: CoG, County Governments, Ministry of Health, Parliament)

17. County Governments to increase budget allocations to preventive health services and improve outcome measurement of preventive health services by strengthening collaboration with Agriculture, Education, Environment, and other relevant sectors.
(Actors: CoG, County Governments, Ministry of Health)

18. County Governments Commit to strengthen County Disease Surveillance, Reporting and Response through rolling out Event Based Surveillance, enhancing data for decision making at all levels and initiating administrative and policy reviews to enhance routine reporting by Private health facilities and community health units.
(Actors: CoG, County Governments, Ministry of Health)

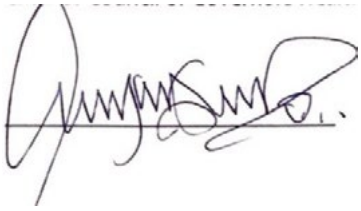
19. County Governments shall scale up and sustain COVID-19 Pandemic Response efforts. In particular, Counties will accelerate COVID-19 Vaccination at county levels to meet agreed targets; and in collaboration with National Government review, enhance and enforce access protocols and guidelines to public areas.

20. All those present at this forum reaffirm their commitment to the achievement of Universal Health Coverage.

This can only be achieved through strong partnerships amongst:

- county governments
- national ministries, department, and agencies
- private sector,
- development partners.

Signed
H.E. Prof. Anyang' Nyong'o, EGH
Chair of Council of Governors Health Committee



H.E. Martin Wambora, EGH
Chair of Council of Governors

INTRODUCTION

Background of the CoG

County Governments were established in 2013 after the first general election in the post-2010 constitutional dispensation. The CoK assigned functions and powers to both levels of government and went further to entrench intergovernmental relations (IGR) to enable governments at either level to cooperate, consult, coordinate and collaborate in the delivery of services. To facilitate implementation of the devolved system of governance, several statutes have been enacted, including: the County Governments Act (CGA), the Intergovernmental Relations Act (IGRA), the Urban Areas and Cities Act (UACA) and the Public Finance Management Act (PFMA).

The IGRA created institutions that would actualize the practice of IGR. One of such bodies is the Council of Governors (CoG), established by section 19 of the IGRA. The mandate of the CoG is canvassed in Section 20 of the IGRA as a forum for, among others:

a.) consultation amongst County Governments;
b.) sharing of information on the performance of the Counties in the execution of their functions with the objective of learning and promotion of best practice and where necessary, initiating preventive or corrective action;
c.) considering matters of common interest to County Governments;
d.) facilitating capacity building for governors; and
e.) receiving reports and monitoring the implementation of inter-county agreements on inter-county projects.

The CoG therefore plays a coordinating and facilitative role amongst the forty-seven (47) County Governments on matters of policy, legislation, administrative actions and general sector development in the Counties. This is usually achieved through various sector committees, Health being among them. Arising from its statutory mandate to share information and promote learning amongst Counties, CoG established the Maarifa Center- a hub that hosts best practices emerging from County performance of functions and knowledge products developed by the CoG Committees.

Background of the High-level Forum

In 2019, during the sixth (6th) Annual Devolution Conference in Kirinyaga County, the President H.E. Uhuru Kenyatta launched the *Report on the Audit of National and County Policy and Legislation*, a collaborative initiative of the CoG and the KLRC. This report analysed the national policy and legal frameworks for seven (7) sectors[1], health being one of them and further delved into a review of policies and laws in ten (10) Counties[2] for each of the identified sectors. The report covered the period before the promulgation of the CoK and after- examining to what extent the national and County body of policy and law in the seven (7) sectors was aligned to the CoK and the principles and objects of the devolved system of governance. This audit revealed that the health sector was and is still being governed by policies and laws that do not respect the constitutional design envisaged for devolution.

Additionally, on 31st August, 2020, the CoG convened the virtual COVID-19 conference to reflect on the government's COVID-19 response efforts, challenges and recommend strategic policy measures that could be adopted by both levels of government in readiness for future pandemics.

1 These sectors are: Health; Agriculture; Trade and Investment; Physical Planning; Urban Development; Natural Resource Management; and Public Finance Management. The overall report and the sector reports can be accessed at the Maarifa Centre- https://maarifa.cog.go.ke/

2 These Counties are: Nairobi, Nyeri, Makueni, Kisii, Kisumu, Mombasa, Turkana, Vihiga, Lamu and Wajir.

One of the resolutions captured in the Joint Communique that culminated from the conference discussions was: "*the Public Health Act to be reviewed with a view to aligning it with the current constitutional dispensation*". Whether in conferences and stakeholder meetings or through submissions before Parliamentary Committees or by participation in intergovernmental spaces, CoG has continued to advocate for County positions in the development and implementation of policies and laws. This is a key priority area and can be traced in CoG's Strategic Plan (2017-2022).

As devolution gets into its ninth (9th) year of existence, CoG finds it imperative that the efforts towards policy and legislative reform be accelerated to facilitate realization of the intended objectives of devolution as enumerated in Article 174 of the CoK. CoG recognizes the importance of strengthening the institutional, legal and administrative environment of the health sector since this will influence the effectiveness and resilience of health systems and their intended outcomes. The reviews documented in reports and memoranda and deliberations in CoG and CECMs for Health meetings and intergovernmental sector forums informed the need to convene, with the support of USAID, the '*High-Level Consultative Forum on Health Policy and Legislative Barriers*' from 14th to 16th December 2021 at Sarova Whitesands Hotel in Mombasa County.

The forum was guided by an overall theme '***Reflections on Policy and Legislative Experiences for Accelerated Delivery of the UHC Agenda at County Level***' and paid particular attention to sustainable health care financing; supply chain management systems; County institutions, structures, systems, and processes; and service delivery readiness and preparedness.

This meeting brought together Governors, CECMs for Health, Chief Officers of Health, County Attorneys, representatives from MoH, Parliament (the National Assembly and Senate), CAF, KEMSA, IGRTC, CRA and USAID.

Objectives and Expected Outputs of the Forum

The objectives of the forum were to:

- Examine the policy and legislative barriers facing the devolved health sector in Kenya;
- Discuss solutions and countermeasures to address the health policy and legislative barriers; and
- Develop an action plan for implementation of the prioritized health policies and legislative reforms.

At the end of the forum, a summary of key issues and resolutions with attendant interventions /actions was developed. Commitment to implementation was also articulated in a Communique summarizing key resolutions and this was signed by the Chair of the CoG and the Chair of the CoG's Health Committee.

Format and Structure of the Forum

The meeting was characterized by individual presentations and plenary discussions that led to in-depth interrogation of health sector policy and legislative barriers and identification of countermeasures. The two-day forum comprised six key sessions – opening remarks from key speakers; a landscape analysis of health policy and legislative environment; Sustainable Financing for Universal Health Coverage (UHC); Health commodities security; Institutional and structural issues in health policy and legislation; County Health Service Delivery Readiness and Preparedness; and a final session on action planning. The program is included in Appendix 2.

This report summarizes the proceedings of the High-Level Consultative Forum, capturing the key highlights from the various thematic sessions. The annex section contains the speeches, the program, and the list of participants. The report is structured in chapters related to each of the thematic areas canvassed in the meeting. Each chapter includes: a summary of the presentation made with respect to each topic; key issues raised in plenary; the recommendations made therein; and the respective policy briefs that informed the session.

CHAPTER ONE

OPENING SESSION OF THE HIGH-LEVEL FORUM

Opening Remarks

The Chair of the CoG Health Committee and Governor of Kisumu County, H.E. Prof. Anyang' Nyong'o in his introductory remarks noted that Kenya has achieved significant progress in key health indicators especially those for maternal and child health (MCH) and reversing the burden of communicable diseases such as HIV/AIDS. He also acknowledged investments in health systems including infrastructure and human resources have increased. On the other hand, he highlighted the urgency to address the strain presented by the increasing burden of non-communicable diseases – cancers, diabetes, cardiovascular diseases, injuries – and negative effects of climate change to the County health sector. Governor Nyong'o whilst appreciating the fact that County Governments continue to invest over 30% of their funding in healthcare, reiterated the need to not only scale up investments but realign both policy and investments to prioritize preventive health, research and training to enhance the outcomes of health care delivery.

Figure 1: H.E Hon. Anyang Nyong'o, Chair of COG Health Committee, giving the opening remarks

Figure 2: USAID/KEA Mission Director, Mr. Mark Meassick giving remarks during the meeting

In his remarks, USAID/KEA Mission Director **Mark Meassick**, highlighted the need to strengthen and refocus partnerships in health at the County level and build on extensive experiences garnered over the past 20 years between the Kenyan and USG. He noted that USG continues to be the largest external funder to the health sector. Similarly, he acknowledged the various County led health financing initiatives undertaken by County Governments such as Makueni, Kakamega, Isiolo, Kitui, Nakuru, Mombasa and Kiambu, and called for interrogation of the experiences and lessons learned as the country embarks on ongoing reforms of the NHIF towards UHC. Further, Mr. Meassick appreciated the current efforts by both national and County Governments in response to the COVID-19pandemic. While lauding these efforts particularly regarding vaccination, he reiterated the commitment by the USG to continue with the collaboration especially in vaccination in view of the recent spike of infections.

Figure 3: Hon. Ndegwa Wahome - Chair of the County Assemblies Forum (CAF) delivering his opening remarks

The Chair of CAF - **Hon. Ndegwa Wahome** acknowledged the need for County executive and legislative arms (as well as Senate) to work more closely in addressing the low health budget allocations. Further, he called for policy and legislative interventions to optimize the potential of regional blocs especially in relation to development and production of vaccines and drugs as well as sharing of specialized health services, leveraging on the unique strengths of individual Counties. On the governance front, Hon. Wahome called for increased representation of County Governments in the NHIF and KEMSA boards to improve accountability.

In his remarks, **Senator Dr. Mbito Michael Malinga,** Chair of Senate Departmental Committee on Health shared updates on the progress made by the Senate in terms of legislative interventions to strengthen policy and legislative environment for health service delivery in advancement of the requirements of Article 96 of the CoK. Amongst the key legislations that the Senate has considered are: NHIF Amendment Bill 2021, Emergency Health Services Bill, Amendments to the of the Public Finance Management Act to ring fence heath funds (facility improvement funds including NHIF reimbursements); KEMSA Act Amendment Bill that seeks to give greater autonomy to County Governments to ensure health commodity security; Pandemic Response and Management Bill 2020, which seeks to provide a legal framework with a coordinated response to pandemics; Disaster Risk Management Bill 2021, which seeks to establish the National Disaster Risk Management Authority and County Risk Management Committees to provide a legal framework for the coordination of disaster risk management activity; and the Health Act Amendment Bill 2020, which seeks to provide a framework for the recruitment and transfer of health workers.

Dr. Mbito called for deeper engagement not only between the Senate and National Assembly but also with the County Governments, in development of harmonized policies and legislations that promote equity and access to health while reducing duplication, maximizing efficiencies, and ensuring prudent use of scarce resources.

Figure 4: Senator Dr. Mbito Michael Malinga, Chair of Senate Departmental Committee

Figure 5: Hon. Dr. James Nyikal, speaking on behalf of the Chairperson of the National Assembly Committee of Health

Hon. Dr. James Nyikal, who spoke on behalf of the Chairperson of the National Assembly Committee of Health observed that there is need for further decentralization of national health budgets to Counties in line with the functions assigned by the CoK. He highlighted that the National Assembly Health Committee was reviewing the NHIF Amendment Bill and hopefully pooling of existing multiple funds would be addressed. Additionally, he indicated that the committee was also exploring mechanisms for reducing healthcare costs including those for health commodities and professional fees, in consultation with stakeholders. This area will necessitate policy and legislative interventions after extensive interrogation.

The Cabinet Secretary for Health, **Sen. Mutahi Kagwe** applauded the CoG for convening the forum and noted that it was a great step in ensuring that the health sector policy and legislative environment supports the modalities in which health services are covered, funded, managed, and delivered, in consonance with the UHC agenda spearheaded by the president.

He acknowledged that there some current laws and regulations, developed before the adoption of the CoK - such as the Public Health Act, NHIF Act, Mental Health Act, Malaria Prevention Act, and the HIV/AIDS Prevention and Control Act – that do not fully conform to the CoK and devolved governance system.

Further, he observed that there are also gaps and inefficiencies in the regulation of health professionals across aspects such as training, registration, licensing, and practice. Despite the existence of several legislations and government agencies for professional regulation, some health cadres are not covered, negatively impacting on the quality of their training and practice. An allied health professionals' regulatory body has been proposed to cater to the health cadres which are not regulated, including radiographers, biomedical engineers, dental technologists, optometrists, emergency medical technicians, orthopedic technologists, morticians, and medical social workers, among others.

Figure 6: H.E Hon. Martin Wambora (COG Chair) and Sen. Mutahi Kagwe (Cabinet Secretary for Health) having a light moment

Sen. Kagwe noted that there are also aspects of the PFM Act, 2012 that require review to facilitate ring fencing of health funds at the County level, with the support of County legislations. On the HPT front, he observed that there was urgency to review the KEMSA Act to allow for national referral facilities and County Governments to procure from other suppliers. The Cabinet Secretary reiterated the need for County Governments to work closely with the MoH in review of policies and legislations, while ensuring that the process is guided by evidence and takes into consideration the dynamic environment. In conclusion, he called for sustained efforts in COVID-19 pandemic response, particularly regarding ramping up vaccination programs to meet agreed targets.

H.E. Martin Wambora, the Chair of CoG noted with appreciation, the investments made by County Governments in enhancing access to quality health services against the backdrop of changing epidemiological burden, emerging pandemics and increased demands for citizen participation and accountability. He observed that the forum was timely as Counties continued to face legislative and policy challenges that stifle progressive attainment of UHC. The Chair asked participants to hold candid discussions, piggyback on the work already undertaken by the CoG in terms of developing briefs to guide engagements and build consensus on the key issues and countermeasures. He reiterated the need to address the legal framework necessary to operationalize Article 189(2) of the Constitution concerning joint committees and joint authorities; issue of costs of training of post graduate medical specialists; and gaps in funding for emergency preparedness and response. Finally, as he officially opened the forum, he requested County Governments to scale up efforts in the COVID-19 response including increasing outreaches and strengthening of restriction measures guided by data on the new infections.

CHAPTER TWO

SESSION 1: HEALTH POLICIES AND LEGISLATIONS UNDER DEVOLVED HEALTH CONTEXT: Success and Challenges

Introduction

Following the adoption of the CoK and the devolved system, several policies and legislations have been adopted and enacted both at the national and County levels of government to facilitate performance of the health function. The introduction of the devolved system with national health policy assigned to the National Government, policy making activities have increased leading to policies in areas that hitherto operated without any policy framework. For example, the development and adoption of the Kenya Health Policy 2014-2030 though with some aspects that are not fully aligned to the CoK can be said to be a relative success in this regard.

More recently, the development of the Policy on Donation, Transfusion and Transplant of Human Derived Products, and the Intergovernmental Blood Service Coordination Framework spearheaded by the Kenya National Blood Transfusion Service through a very extensive consultative process with County Governments, the CoG and other stakeholders has been an illustrative demonstration of a good cooperative and consultative process of policy and legislation making; hence a relative success. The comprehensive Amendment Bill of the Mental Health Act which has been spearheaded by Senator Sylvia Kasanga is also a demonstration of how a comprehensive amendment that seeks to fully align the law to the CoK and the devolved system can look like.

Despite the successes discussed above, there have also been numerous challenges which due to various reasons identified and discussed in the High-level Forum, have been encountered with respect to formulation and implementation of policies and legislations.

Session discussions

This session focused on the examination of the successes devolution has made in the health sector and the challenges that are being encountered, from the perspective of policies and legislations, with a view to setting the stage for proposals on how best to address the challenges.

The presentation on health policies and legislations under devolved health context was delivered by **H.E. Prof Anyang' Nyong'o,** Governor of Kisumu County, after which the discussant for the session, lawyer **Wachira Maina** delivered a presentation on the constitutional basis for health. While the presenter focused on the identification of the successes made in the devolution of health services and the challenges experienced in health policies and legislations; the discussant introduced new dimensions to policy and legislation making such as the human rights perspectives that should inform health policies and legislations.

Figure 7: Wachira Maina, a constitutional lawyer, delivering a presentation on the constitutional basis for health

The session identified and highlighted the following key issues:

1. The key successes and achievements in the devolution of health were identified as increased investment in health infrastructural development; increased staffing in health facilities; and improved utilization of information technology in delivery of health services.
2. Policy and legislative challenges that out to be urgently addressed were noted as follows:

    i. incomplete process of transition from the unitary to the devolved system which has enabled the old order of policies and legislations that are not in conformity with the CoK and the devolved system to continue in existence;
    ii. inadequate alignment of post-2010 policies and legislations to the CoK and the devolved system;
    iii. lack of or inadequate operationalization of the system of cooperative devolved government which has resulted in the process of policy formulation and legislation making to be dominated by the National Government;
    iv. lack of clarity in the assignment of functions and unfinished unbundling and transfer of functions and powers which has led to encroachment of the functions of County Governments; and
    v. contradictions and gaps in health policies and legislations which have hindered efficient delivery of health services in the devolved context.

3. In addition, the process of formulation of policies and legislation making should recognize new dimensions such as the factors that drive health policy in Kenya. These include issues of class which drive access to and use of health facilities; geographical factors which have denied people who live in marginalized locations or regions access to adequate and efficient health services; and institutional factors which force politicians and government officials to invest more in easily demonstrable brick and mortar tangible projects as opposed to investment in health services that may produce high impact in the lives of the citizens. There is a tendency for policies to prioritize investments that produce short-term results rather than focusing on long-term goals that have higher impacts such as reduction of infant mortality rates.
4. There is the need for the national and County Governments to translate, through policy and law, the rights enshrined in Article 43 of the CoK. The right accorded to every Kenyan to enjoy the highest standard of healthcare is the foundation for prioritizing affordable, quality and accessible health services.
5. There is need to sufficiently use socio economic data when formulating health policies and interventions that are consistent with the CoK. The high cost of healthcare which should be openly and critically discussed, was identified as a major challenge. It was recommended that legislators should actualize the right to emergency healthcare at any facility for every Kenyan as provided in Article 43 of the CoK and ensure that facilities do not exceed the stipulated charges for services regardless of their location.

Figure 8: Hon. Ruweida Mohamed, Lamu County Women Representative contributes to the discussions

Recommendations

Considering the matters discussed above, the following recommendations and way forward should be considered:

1. County Governments should engage the National Government and agree to re-engineer cooperative devolved government and intergovernmental relations to embrace the pursuit of joint policy and legislative solutions in the health sector, undertaken through joint committees and joint authorities.
2. The CoG should coordinate with the President through the Summit and secure his consent to restructure the process of cabinet approval of draft policies and draft legislations to require--
   a. Disclosure by the relevant ministry on whether the policy or legislation was originated jointly by the national and County Governments.
   b. The involvement of the Ministry of Devolution in the development of the draft policy or legislation to confirm whether the policy or legislation concerns County Governments and coordinate the involvement of County Governments in its development.
   c. A statement by the relevant ministry on whether the Ministry of Devolution was involved in the development of the policy or legislation.
   d. A statement of the Ministry of Devolution to confirm its involvement in the development of the policy or legislation.
3. The CoG should engage the President through the Summit on the need to restructure the Ministry of Devolution into a ministry of Devolution, Justice and Constitutional affairs or Devolution, Justice and Constitution Implementation Affairs to take over the functions of the defunct CIC, and also focus its mandate on coordination of the national and County Governments; coordination of intergovernmental relations; and ensuring strict compliance to the constitutional mandates of the two levels of government, especially in the process of development of policies and legislations.
4. The CoG should coordinate with the President through the Summit and establish a Joint Committee to review the Public Finance Management Act leading to Amendments that aim to establish the National Treasury as an independent state organ that serves both levels of government in a neutral manner.
5. The CoG should engage the President through the Summit on the need to engage the Speakers; Majority; and Minority Leaders of the two houses of Parliament regarding the need to amend the Standing Orders of the two houses of Parliament to--
   a. Conclusively resolve the persistent conflicts between the two houses over the interpretation and application of Article 110 of the CoK regarding the role of the Senate in the legislative process.
   b. Establish a Joint Committee of the two houses charged with the responsibility of determining and advising the Speakers on whether a Bill concerns County Governments and reviewing and harmonising bills introduced in the two houses of Parliament to avoid multiple piecemeal Amendment Bills.
   c. Require each Bill to disclose whether it was originated jointly by the national and County Governments.
6. The CoG and the National Government should take the necessary steps to implement sections 54 and 114 of the County Government Act.
7. The CoG should engage the President through the Summit and establish a joint committee of the National Government, County Governments, IGRTC and the Ministry of Devolution to review the Intergovernmental Relations Act and all the previously proposed amendments and generate amendments that streamline intergovernmental relations including amendments to establish a separate CoG Secretariat that is legally recognized and funded by the Exchequer.

8. The CoG should engage the MoH and the National Treasury to find agreement on how best the National Government can take over the payment of Personnel Emoluments of County Governments' health workers when they are on further studies and working in the National Teaching and Referral health facilities.

9. The County Governments should coordinate with the National Government through the Summit and form a joint committee working with the IGRTC, to undertake a thorough unbundling and transfer of functions in all the devolved sectors leading to the enactment of a Functions and Powers Act.

POLICY BRIEF

POLICY BRIEF 001: HEALTH POLICIES AND LEGISLATIONS UNDER DEVOLVED HEALTH CONTEXT: Successes and Challenges

Introduction

Since the adoption of the devolved system of government with health as one of the major devolved sectors, many reforms in the Kenyan health sector have been undertaken through policies and legislations at both the national and county levels of government. No doubt, there are some areas in which success has been registered in terms of policies and legislations.

AREAS OF RELATIVE SUCCESS IN HEALTH POLICY AND LEGISLATIONS

Following the adoption of the constitution and the devolved system, several policies and legislations have been adopted and enacted both at the national and county levels of government which evidence relative success in the delivery of health services. The introduction of the devolved system with national health policy assigned to the national government, policy making activities have increased leading to policies in areas that hitherto operated without any policy framework. For example, the development and adoption of the Kenya Health Policy 2014-2030 though with some aspects that are not fully aligned to the constitution can be said to be a relative success in this regard. More recently, the development of the Policy on Donation, Transfusion and Transplant of Human Derived Products, and the Intergovernmental Blood Service Coordination Framework spearheaded by the Kenya National Blood Transfusion Service through a very extensive consultative process with county governments, the Council of Governors and other stakeholders has been an illustrative demonstration of a good cooperative and consultative process of policy and legislation making; hence a relative success. The comprehensive Amendment Bill of the Mental Health Act which has been spearheaded by Senator Sylvia Kasanga is also a demonstration of how a comprehensive amendment that seeks to fully align the law to the constitution and the devolved system can look like.

Despite the successes discussed above, there have also been numerous challenges which due to various reasons identified and discussed in the following sections, have been encountered with respect to formulation and implementation of policies and legislations.

Anchorage of the Devolved System in a Supreme Constitution

A major challenge in the formulation and implementation of policies and legislations is the fact that the Kenyan devolution is anchored in a supreme constitution adopted in 2010 against a background of a highly centralised and unitary system of government that was supported by policies and legislations founded in the unitary system. The constitution establishes and protects two levels of government—the national and county; assigns and protects exclusive and concurrent functions of the two levels of government; and provides for a protected system of sharing of resources to enable the performance of the functions. For these reasons, the policies and legislations that underpin the devolved system both pre-and-post the constitution, ought to be in conformity with the constitutional provisions, both in substance and the process of their making. A major implication of the adoption of devolution through a supreme constitution was the need to comprehensively review all the existing health policies, legislations, strategies, and institutions to ensure their compliance with the constitution and the devolved system including the functional assignment by the constitution to the two levels of government.

Incomplete transition from the unitary to the devolved system

The adoption of the constitution was followed by a two phased transition period that ended in 2016 and aimed at establishing enabling institutions, policies, and legislations to align the health system among other devolved sectors, to the constitution and the devolved system of government. The transition process was overseen by the Commission on Implementation of the Constitution (CIC), established under the Constitution and a statutory Transition Authority (TA), established under the Transition to Devolved Government Act, both of which had responsibility to ensure that the draft policies and legislations were in conformity with the constitution. The terms of both CIC and TA expired before the completion of the transition process thereby leaving an institutional vacuum in the process of development of enabling policies and legislations. While the constitution identified certain enabling laws and required them to be enacted within specified timelines, many policies and legislations as well as institutions from the old unitary constitutional order have remained in place and in the statute books, thereby posing challenges, and raising barriers to efficient and effective health service delivery. For example, the 2009 HIV and AIDS Policy has not been comprehensively reviewed to align it to the devolved system, while the 2007 National Reproductive health Policy remains operational since the process of developing a new reproductive health policy remains incomplete. Similarly, legislations from the old unitary constitutional order such as the HIV/AIDS Prevention and Control Act of 2006; the Pharmacy and Poisons Act; the Public Health Act; the Mental Health Act Cap 248; the Anatomy Act Cap 249; the Narcotic Drugs and Psychotropic Substances Act of 1994; the Kenya Medical Training College Act Cap 261; the Human Tissues Act Cap 252; the Malaria Prevention Act Cap 246; and the National Hospital Insurance Act of 1998 have not been comprehensively and conclusively reviewed to align them to the constitution and the devolved system of government.

Inadequate alignment of post-constitution policies and legislations to the constitution and the devolved system

Since the adoption of the constitution in 2010 and the election of the pioneer county governments in 2013, many policies and legislations have been developed which are inadequately aligned to the constitution and the devolved system of government. Many of these policies and laws encroach upon the functions and powers of county governments and assign them to the national government either directly or indirectly through entities or state corporations of national government. For example, although the following policies were adopted after the promulgation of the constitution, they have various aspects that fall short of proper alignment with the constitution and the devolved system of government: The Kenya Health Policy 2014-2030; Kenya National eHealth Policy 2016-2030; Health Information Systems Policy; The National Food and Nutrition Security Policy; The Kenya Mental Health Policy 2015-2030; Health Sector Strategic and Investment Plan 2013-2017; Tobacco Control and Prevention Strategy: Towards Tobacco Free Kenya 2012-2017; Kenya National Strategy for the Prevention and Control of Non-Communicable Disease 2015-2020; The National Cancer Control Strategy 2017-2022; and Kenya Health Sector Referral Strategy 2014-2018. Likewise, the following legislations enacted after the promulgation of the constitution fail to fully align themselves to the constitution and the devolved system of government: The Health Act of 2017; the Kenya Medical Supplies Authority Act of 2013; the Public health Officers (Training, Registration and Licensing) Act of 2013; the National Authority for the Campaign Against Alcohol and Drugs Abuse Act of 2012; The Alcoholic Drinks Control Act of 2012; Counsellors and Psychologists Act of 2014; the Health Records and Information Managers

Act of 2016; and the Clinical Officers (Training, Registration and Licensing) Act of 2017. While some of these legislations encroach upon the functions of county governments, others do not recognize any role for county governments, yet they deal with areas that the constitution has devolved to county governments. For example, many of them establish entities such as management boards in which county governments do not play any role. Various factors discussed in the following subsections account for this state of affairs of continued development of post-constitution policies and legislations that are not fully aligned to the constitution and the devolved system.

Lack of or inadequate operationalization of cooperative devolved government

The inadequacy in alignment of post-constitution policies and legislations to the constitution and the devolved system of government has been occasioned by various reasons relating to operationalization of cooperative devolved government. First, some policies and legislations were developed before the pioneer county governments were elected in 2013, whose input could therefore not be sought. Secondly, even after the first county governments were elected, some policies and legislations were developed at a time when these governments were still struggling with the transition challenges of establishment of the initial county structures and institutions; unbundling and transfer of functions and powers; and taking over from the defunct local authorities and so they could not meaningfully engage in the scrutiny of the policies and legislations then under development. Thirdly, the devolved system of government was new to all players including the national government officials who needed time and learning to internalise and understand the system especially the concept of cooperative devolved government and its operationalization. Fourthly, after the expiry of the term of both the CIC and the TA, the institutional vacuum created left the Council of Governors without the useful support it was receiving from these defunct institutions in terms of scrutiny of draft policies and legislations for compliance with the constitution. Fifthly, even where county governments were involved, the cooperation has been inadequate as it is limited to consultation which at times would not be meaningful given the short notices given to COG that would deny it ample opportunity to coordinate the 47 county governments in coming up with a common position. Details regarding the understanding and operationalization of cooperative devolved governments are discussed in the fourth session where recommendations and calls for action in this respect are made.

Lack of clarity in functional assignment and unfinished unbundling and transfer of functions

A major cause of non-alignment and inadequate alignment of policies and legislations to the constitution and the devolved system of government has been the lack of clarity in the assignment of functions and powers and the need for such clarity through unbundling and transfer of functions. The constitution assigns functions to the two levels of government through two lists set out in the Fourth Schedule with some functions being exclusive while others are described as concurrent. First, the development of policies and legislations started before the unbundling and transfer of functions to clarify the content of the functions and separate the exclusive functions from the concurrent was undertaken or even started. Notably, CIC was established and started its work even before the TA was established, yet it is the TA that bore the responsibility of unbundling and transfer of functions. Secondly, since the expiry of the term of the TA with unfinished unbundling and transfer of functions, policies and legislations have continued to be developed without the necessary

clarity that functional assignment would bring on board in ensuring that the policies and legislations are in conformity with the constitution and the devolved system including functional assignment. Thirdly, even though the Intergovernmental Relations Technical Committee (IGRTC) took over the unfinished business of the TA as provided by the IGR Act, the IGRTC has not completed this assignment and policies and legislations have continued to be developed without clarity of functional assignment. Because of these reasons, both national and county governments have continued to develop and implement policies and legislations without the benefit of clarity in functional assignment. Once again details on this issue are discussed in the fourth session and comprehensive recommendations on the way forward are made.

Lack of capacity at both national and county governments

Another cause of non-alignment and/or inadequate alignment of policies and legislations to the constitution and the devolved system of government has been the lack of adequate capacity at the COG Secretariat. Although the COG is an important intergovernmental relations organisation with a mandate to coordinate the 47 county governments in cooperating with the national government and plays a critical role in representing the position of the county governments on various issues, the COG's Secretariat is not established by legislation. The failure to legally establish and recognize the COG Secretariate with entitlement to funding from the exchequer has denied the COG the capacity to effectively scrutinise draft policies and legislation to make meaningful contribution.

Contradictions and gaps in health policies and legislations

Apart from lack of and or inadequate cooperation between national and county governments, there have also been lack of inter-sectoral coordination among various devolved sectors even at the national level. This has resulted in contradictions in various health policies and legislations made at the national level of government as well as areas of gaps in policy and legislation leaving certain areas without policy and legal frameworks to govern them. For example, while the Health Act of 2017 makes provision for some matters governed by the Public Health Act; the Pharmacy and Poisons Act; and the Kenya Medical and Supplies Authority Act, these other Acts remained in force unamended and with provisions that may appear contradictory or duplicative of what the Health Act provides. On the other hand, some counties have gaps in their policies and legislations having not legislated for certain matters. For instance, while a few counties have enacted laws to ring fence Facility Improvement Funds to ensure the availability of financial resources for delivery of health services, many others are yet to take steps in this regard.

Conclusion

Given the challenges discussed above and in the context of the country's prioritisation of Universal Health Coverage, policy and legislation making or comprehensive review should prioritise and focus on policies and legislations in the following areas: Sustainable financing for Universal Health Coverage (UHC) including NHIF reforms which are extensively discussed in session two and recommendations made; Health Commodities security including financing, local production, governance and accountability in the devolved context which are discussed in session three and recommendations made; and county health service delivery readiness and preparedness including COVID 19 response which are discussed in session five and recommendations made. In focusing on these areas lessons must be drawn from the experiences and challenges identified and discussed above and in session four which focuses on the understanding and operationalization of cooperative government and intergovernmental relations; and the role of unbundling and transfer of functions and powers in ensuring the policies and legislations comply with the constitution and the devolved system of government.

PRESENTATION BY H.E. PROF ANYANG' NYONG'O, GOVERNOR OF KISUMU COUNTY

Health policies and legislations under devolved health context: Successes and Challenges

By

H.E. Prof Anyang' Nyong'o, EGH Chair, COG Health Committee and Governor of Kisumu County

Presented at a Council of Governors Consultative Meeting on 'Reflections on Policy and Legislative Experiences for Accelerated Delivery of the UHC Agenda at the County Level', held between 14th and 16th December 2021 at Sarova Whitesands, Mombasa

Successes in the policy and legislation areas

- The adoption of devolution of health has been followed by many reforms undertaken through national and county policies and legislations.
- Success has been registered with—
  - several policies and legislations being adopted and or enacted by both national and county governments; and
  - increased policy making activities by both national and county governments witnessed, leading to policies in areas that hitherto operated without policy frameworks.

Challenges in the policy and legislation arena

- For various reasons, County governments have experienced many challenges regarding formulation and implementation of policies and legislations.
- The Kenyan devolution was adopted through a supreme constitution against a background of a highly centralized and unitary system supported by unitary policies and legislations.
- This necessitated the need for comprehensive review of all pre-and post constitution policies, legislations, strategies and institutions to align to ensure compliance with the constitution and the devolved system.

Incomplete transition from the unitary to the devolved system

- The transition from the unitary to the devolved system which was overseen by the Commission on Implementation of the Constitution (CIC) and a statutory Transition Authority (TA), both of which had responsibility to ensure that the draft policies and legislations were in conformity with the constitution remains incomplete.
- The terms of both CIC and TA expired before the completion of the transition process thereby leaving an institutional vacuum in the process of development of enabling policies and legislations with many policies and legislations having not been comprehensively reviewed as required.

Inadequate alignment of post-constitution policies and legislations to the constitution and the devolved system (1)

- Many policies and legislations have also been developed which are inadequately aligned to the constitution and the devolved system of government.
- These policies and laws encroach upon the functions and powers of county governments by assigning them to the national government directly or indirectly to entities or state corporations of national government.

Lack of or inadequate operationalization of cooperative devolved government (1)

- Various factors relating to operationalization of cooperative devolved government occasion the inadequacy in alignment of post-constitution policies and legislations to the constitution and the devolved system of government.

1) Some policies and legislations were developed before the pioneer county governments were elected in 2013, whose input could therefore not be sought.

Lack of or inadequate operationalization of cooperative devolved government (2)

2) Other policies and legislations were developed at a time when the first county governments were still struggling with the transition challenges of—

   a) establishment of the initial county structures and institutions;
   b) unbundling and transfer of functions and powers; and
   c) taking over from the defunct local authorities and could not meaningfully engage in the scrutiny of the policies and legislations then under development.

Lack of or inadequate operationalization of cooperative devolved government (3)

3) The devolved system of government was new to all players including the national government officials who needed time and learning to internalize and understand the system especially the concept of cooperative devolved government and its operationalization.

4) After the expiry of the term of both the CIC and the TA, the institutional vacuum created left the Council of Governors without the useful support it was receiving from these defunct institutions in terms of scrutiny of draft policies and legislations for compliance with the constitution.

Lack of or inadequate operationalization of cooperative devolved government (4)

5) Even where county governments were involved, the cooperation has been inadequate as it is limited to consultation which at times would not be meaningful given the short notices given to COG that would deny it amble opportunity to coordinate the 47 county governments in coming up with a common position.

Lack of clarity in assignment of functions and unfinished unbundling and transfer of functions (1)

- The constitution assigns functions to the two levels of government through two lists set out in the Fourth Schedule.
- It recognizes that some functions are exclusive, others are concurrent, and yet others are residual without clarifying which functions falls into which category.
- This lack of clarity is a major cause of non-alignment and inadequate alignment of policies and legislations to the constitution and the devolved system of government.

Lack of clarity in assignment of functions and unfinished unbundling and transfer of functions (2)

- Hence the need for such clarity through unbundling and transfer of functions.
- The problem is that—
  1) The development of policies and legislations started before the unbundling and transfer of functions to clarify the content of the functions and separate the exclusive functions from the concurrent ones, was undertaken or even started.
     - Notably, CIC was established and started its work even before the TA was established, yet it is the TA that bore the responsibility of unbundling and transfer of functions.

Lack of clarity in assignment of functions and unfinished unbundling and transfer of functions (3)

2) Since the expiry of the term of the TA—with unfinished unbundling and transfer of functions, policies and legislations have continued to be developed without the necessary clarity that functional assignment would bring on board to ensure that the policies and legislations are in conformity with the constitution and the devolved system including functional assignment.
3) Even though the Intergovernmental Relations Technical Committee (IGRTC) took over the unfinished business of the TA as provided by the IGR Act, the IGRTC has not completed this assignment and policies and legislations have continued to be developed without clarity on functional assignment.

Lack of capacity at the COG

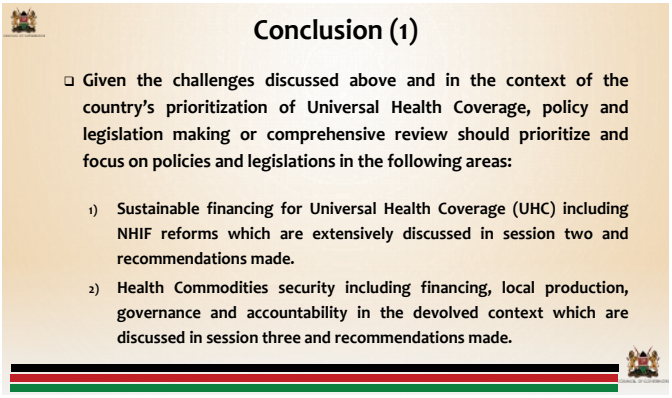
- Although the COG is an important intergovernmental relations institution with mandate to coordinate the 47 county governments in cooperating with national government and plays a critical role in representing the position of the county governments on various issues, the COG's Secretariate is not established by legislation.
- The failure to legally establish and recognize the COG Secretariate with entitlement to funding from the exchequer has denied the COG an opportunity to establish a permanent Secretariat that has capacity to effectively scrutinize draft policies and legislation to make meaningful contribution.
- COG mostly relies on support by Development Partners to hire short term technical Assistants to work in the Secretariat.

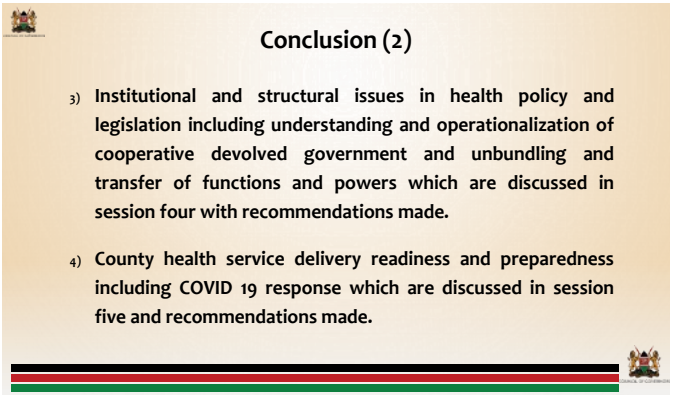
Contradictions and gaps in health policies and legislations (1)

- In addition to lack of and or inadequate cooperation between national and county governments—
  - There has also been lack of inter-sectoral coordination among various devolved sectors even at the national level.
  - This has resulted into contradictions in various health policies and legislations made at the national level of government
  - There have also been gaps in policy and legislation leaving certain areas without policy and legal frameworks to govern them.

Contradictions and gaps in health policies and legislations (2)

- For example, while the Health Act of 2017 makes provision for some matters governed by the Public Health Act;
  - the Pharmacy and Poisons Act; and
  - the Kenya Medical and Supplies Authority Act,
  - these other Acts remained in force unamended and with provisions that may appear contradictory or duplicative of what the Health Act provides.
- On the other hand, many counties have gaps in their policies and legislations having not legislated for certain matters.





BIOGRAPHIES

H.E Prof. Peter Anyang' Nyong'o, EGH
Governor - Kisumu County.

Prof. Peter Anyang' Nyong'o is the current Governor of Kisumu County. Having been involved in the struggle against authoritarian rule in Kenya throughout his academic career, he was amongst the leaders who made a breakthrough into multiple-party politics in 1992. He was then elected to Parliament in that year and has served in various capacities since then including as the Minister for Planning and National Development (2003-05) and Minister for Medical Services (2008-2013), and Senator of Kisumu County (2013 - 2017).

Wachira Maina
Constitutional Lawyer

Wachira Maina is a renowned constitutional lawyer with extensive experience in providing advisory services to governments and multi-lateral agencies and in developing and evaluating governance and constitutional and legal reform programmes in Sub-Sahara Africa, SSA. He has been a Consultant for many agencies and governments including the World Bank, UNDP, the Government of Tanzania, the Government of Malawi, the Government of Rwanda, CIDA and the International Institute for Democracy and Electoral Assistance, IDEA. Wachira Maina was twice nominated for the Rebok Human Rights Award in the early 1990s for his work as editor of the Nairobi Law Monthly and in 1996 was named in Time Magazine's Global 100 future leaders. He was a Ford Foundation Fellow at Columbia Law School.

CHAPTER THREE

SESSION 2: SUSTAINABLE FINANCING FOR UNIVERSAL HEALTH COVERAGE (UHC) - NHIF REFORMS, TRANSITION ARRANGEMENTS, AND ALIGNMENT TO THE DEVOLVED SYSTEM OF GOVERNMENT

Introduction

UHC means that every Kenyan can access health services without facing financial burden. Of notable importance is that these services are not for free and therefore come at a cost. Consequently, delivering UHC requires the reorganization and re-engineering of our country's health systems with a keen focus on financing. Both levels of government need to develop sustainable financing mechanisms that can manoeuvre the delicate balance of delivering UHC and cushioning beneficiaries from high costs associated with health care. The session therefore looked at health financing in a devolved system of governance and discussed how best County Governments can shift resources towards an output based financed health system that will mitigate the huge financial risk facing Kenyan citizens as they continue to seek health care services.

Figure 9: Dr. Mohammed Kuti chairing the session on Health Financing

Session discussions

The session was chaired by **H.E. Hon. Dr. Mohammed Kuti**, EGH, Governor Isiolo County and a presentation delivered by **Dr. Owino Wasunna,** a health financing expert. After the presentation, the initial feedback was provided by the session's discussant, **Hon. Dr. James Nyikal**, MP.

The Session Chair did note in his opening that a good health financing system is one able to raise adequate funds that guarantee equitable access to affordable and quality health services. While pointing out that healthcare financing, alongside human resource, commodities, and infrastructure, are the main factors in the achievement of UHC, he observed that Counties have taken various measures to finance healthcare including use of own source revenue and creation of Facility Improvement Funds. Some Counties, such as Isiolo, have partnered with NGOs in raising resources for health service delivery. Another avenue that could be explored is PPPs.

Noting that County health services is a devolved function and thus County Governments have more leeway in making autonomous decisions on resource mobilization, allocation, spending and management, the session presenter in his presentation focused on the following three aspects of Health financing, - how to mobilize resources, pool resources and purchase healthcare services. He noted that the provision and use of health services have implications on key health indicators such as access, efficiency, equity, quality, and financial protection which all depend on adequate and sustainable financing. Giving an illustrative example of how Counties have increased investments in health financing from 21.1% in FY 2014/15 to 27% in FY 2020/21, indicating a significant increase of 5.9%, the presenter noted that the growth in equitable share has not kept pace with the growth in tax revenue, nominal growth of GDP, or inflation.

Notably, Counties continue to face the following challenges: insufficient funding, inefficiencies, human resource for health and commodity stock outs, poor service delivery and weak public finance management. To address these challenges, it is proposed that Counties need to enhance their domestic resource mobilization strategies by increasing government budgetary allocation to health, fast track the ongoing NHIF reforms, facilitate advocacy forums with County Assemblies on rationale for increased funding for health, seal loopholes for leakage of County resource revenue collections and unlock the untapped potential of private sector in health financing.

While noting the importance of adequate and sustainable financing for health, the session discussant reiterated the need for IBEC to undertake the Counties' health expenditure needs assessments and take them to the Senate and the National Assembly to build a compelling case for Counties need for increased funding. It was further noted that the budget making process should be done simultaneously to allow for the County Governments to look through their CIDPs and make their needs known and captured in the National Budget Policy Statement (BPS) early enough.

Further, Counties can get into negotiations with partners and donors and get their monies directly. Participants were informed that a Bill had been passed by the National Assembly and submitted to the Senate, proposing that Counties get into agreements with partners independently as an alternative means of raising resources for health. Noting that several Counties such as Laikipia, Kisumu, and Makueni were working on ways to buy insurance for indigents, the discussant emphasized the need to have a clear structure of identifying and taking care of indigents. Pooling of resources and having a well-defined benefits package coupled with all the proposed reforms for NHIF need to be prioritized.

Figure 10: CoG CEO Ms. Mary Mwiti, USAID/KEA Mission Director Mark Meassick and Hon. Dr. James Nyikal, MP having a side chat

Recommendations

1. County Governments to enhance their capacity for analysis and utilization of County generated data to track progressive realization of Article 43 of the CoK and inform the review of CIDPs and annual budgetary allocations.

2. County Governments to engage the National Government to restructure the budget making process, to enable adequate and timely participation of County Governments in the generation of the National Budget Policy Statement and sharing of the equitable revenue.

3. County Governments to adopt the Model law for Facility Improvement Funds to ring-fence funds for health services.

4. Both National Government and County Governments to support the enforcement of NHIF reforms with the sole aim of positioning NHIF as a Strategic purchaser in line with the Kenya Health Financing Strategy in the following areas.
   i. beneficiary management
   ii. benefits management
   iii. healthcare providers' management
   iv. digital transformation, organizational transformation.

5. County Governments to engage the National Government on the implementation of County-led financial protection schemes and pursue consolidation and expansion of existing risk pooling schemes towards equitable access to health services and efficiency enhancement.

6. In view of the amendments to the NHIF (Amendment) Bill of 2022, that were approved recently, expunging the provision requiring every Kenyan above 18 years to contribute to the fund, CoG to engage the National Assembly to reconsider recommendation No 7 and 11 to allow also for mandatory contributions. Ensure NHIF reforms are guided by KHFS; disseminate KHFS to key stakeholders, notably, Senate, CECMs for Health, Parliamentary Health Committees and Counties.

7. County Governments to undertake a rapid assessment of County health fiscal spaces to inform engagements on transitioning out donor dependent programs to government programs and budgets.

8. National and County Governments to take care of the poor and vulnerable for sustainability of UHC and, enforce mandatory social health insurance; increase budgetary allocations for health and strategic programs (HIV/AIDS, TB, FP/RMNCAH) while ensuring efficient use of the available and future resources; HIV commodities are included in the EMS and, HIV/TB care treatment services incorporated in the essential benefit package towards sustainability.

9. County Governments to deliberately shift from input to results-based financing; obtain seamless health finance transition starting with commodities security, human resources for health, supervision and capacity building; increase allocations to primary health care and, pre-payment schemes; and ring-fence funds for health guided by the new Facility Improvement Funds (FIF) Guidelines and accompanying Model law.

POLICY BRIEF

POLICY BRIEF 002: SUSTAINABLE FINANCING FOR UNIVERSAL HEALTH COVERAGE (UHC) IN KENYA: Policy Priorities for the county governments

Background and context

Healthcare financing relates to the mobilization, accumulation, and allocation of money to cover the health needs of the people, individually and collectively. Ideally, a good health financing system should be able to play a key role in achieving universal health coverage (UHC) by raising adequate funds for health in ways that ensure people can use needed services and are protected from the financial risk associated with having to pay for health services [1]. This policy brief explores how the counties can obtain adequate and sustainable health financing and advocate for equitable and effective health care financing to obtain better health outcomes. The recommendations are meant to guide counties in ensuring that health budgets are better aligned with Government of Kenya and County commitments and that the health sector receives enough funds to deliver quality healthcare services.

KEY POLICY ISSUES

As counties continue to allocate more resources for health, health care costs continue to create a huge financial risk to the citizens making the need to protect the more than 1 million Kenyan households from being impoverished as a result of catastrophic health expenditures challenging. Given that health is a devolved function, it requires that counties offer practical solutions to aggressively attack the crushing burden of health care costs. Issues of concern are as follows: -

Inadequate investments in health by national and county governments

Overall, the total government budget allocated to health as a percentage of total for both national and county increased to 11.5% in FY 2020/2021 up from 7.8% in FY 2012/2013. In absolute terms, the combined health budget allocation was Ksh 217 billion in 2019/20, nearly three times compared to pre-devolution (FY 2013/14). County health budgetary allocations almost doubled in nominal terms between 14/15 FY and 2020/21 and, as a proportion of total county government expenditures, grew by 5.3%. Even then, most counties still fall below the recommended 30% allocation as recommended by the 2012 Public Financial management Act (PFMA). Only **20 counties**[3] have an allocation of 30% or more to health in FY 2020/2021. Despite the increases in budget allocations, on average counties are spending between 70-75 percent of their recurrent health budgets on personnel emoluments leaving insignificant amounts for other equally important inputs thus compromising on quality and access.

The growth in equitable shares in absolute terms, has not kept pace with the growth in national tax revenues and nominal gross domestic product (GDP)

Despite the equitable share revenue/transfers by the national treasury to the counties increasing from Ksh. 190 billion in 2014/15 to Ksh. 370 billion (2021/22), the rate of growth of the equitable share has been on a decline except for 2021/22 and, largely, lower than the growth of national tax revenues and nominal gross domestic product (GDP). Similarly, it has not kept pace with population and inflation growth, eroding the capacity of county governments to deliver consistent level of services on a per-capita basis.

3 These include: Baringo, Elgeyo Marakwet, Embu, Homa bay, Kericho, Kisii, Kiambu, Kilifi, Kisumu, Lamu, Kirinyaga, Murang'a, Makueni, Meru, Nakuru, Nandi, Narok, Nyamira, Nyeri and Tharaka Nithi

Late disbursement of the equitable share of revenue by the national treasury to the counties

In as much as the Public Financial Management Act (PFMA) provides for the disbursement of the equitable share revenue by the National Treasury to the counties by the 15th day of every month, these funds are often disbursed late, with occasioned extension of the cut-off date of closure of the Financial Year (FY). Also, Facility Improvement Funds (FIF) raised and transferred to the County Revenue Fund (CRF) as per PFMA regulations are more often been reallocated to other activities rather than being ploughed back to the facilities to improve on service delivery.

High reliance on development partners assistance adversely affecting sustainability

With the country obtaining a lower-middle income country status in 2014, donor financial support to the health sector that currently stands at 18% of health budget (NHA 2016-2019) with donors contributing as much as 69% for HIV is set to decline and, both levels of government anticipated to take on increased responsibility for funding the sector.

Fragmented and disjointed government support in the health care delivery system leading to inefficiencies

With multiple funding flows risk pooling remains fragmented, compromising financial risk protection. The fragmentation in the sector is alarming with separate funding pools such as the numerous individual county government and/or corporate institutions negotiated enhanced schemes with the insurer; promising, yet non-insurance based county health financing initiative such as Makueni care, pools for identified vulnerable groups such as pregnant mothers under Linda Mama, Health insurance subsidy schemes for the elderly, people living with severe disability and the indigents, and Edu-afya program for school going children; independent, strategic programs that have persisted with little or no effort to consolidate them into the UHC health insurance benefit package, including the management of COVID-19 treatment; and, coupled with the ongoing parallel input financing for the health sector. The schemes are small and fragmented with wide gaps in the levels of benefit packages for scheme members and with different provider payment rates for similar services which are not linked to quality improvement. Fragmentation brings about inefficiencies in utilization of limited public resources as seen in the high administrative costs of NHIF (17% in 2018) against an average 4.7% for reviewed health insurance schemes in 58 countries (HEFREP report); but also, inequities as experienced by county governments who provide healthcare to these covered, partially covered, and uncovered groups.

Glaring gaps in public financial management

For many counties, there is – lack of clear interlinkage of 10 – year planning frameworks to the 5 – year County Integrated Development Plans (CIDPs) to annual Medium Term Expenditure Framework (MTEF) budgeting processes; lack of evidenced based budgeting in health sector; non – compliance in budget execution due to limited capacity; weak human resource enforcement and, limited capacity among county assemblies to scrutinize budget execution processes; and lack of operational public participation operational legislation and, citizen engagement in planning and budgeting cycle and, operational audit function at the County.

Limited financial protection

There exists inequities in the health financing system especially in the absence of a strong social financial protection system. About 21.4% of sick Kenyans do not seek healthcare due to high costs. Still, while the proportion of Kenyans with health insurance increased from 17% (2013) to 20% (2018)[4], health insurance mobilizes only 5% of current health expenditure pointing to low depth of coverage.[5]

4 Ministry of Health. 2014 & 2018 Kenya household expenditure and utilization survey. Nairobi, Kenya 2014 & 2018.

5 Barasa EW, Maina T, Ravishankar N. Assessing the impoverishing effects, and factors associated with the incidence of catastrophic health care payments in Kenya. International journal for equity in health. 2017;16(1):1-14.

In general, health insurance coverage rates remain low in Kenya (19.9%)[6] with wide disparities between rural (12%) and urban (27%) areas and income quintiles (42% highest income quintiles and 2.9% lowest quintile). Limited financial risk protection leads to high OOPs expenditures (5 percent of Kenyans incur catastrophic expenditures from OOPs due to health care costs) thus, limiting access to essential health care services especially by the poor and vulnerable groups. Worse still, out of pocket payments (OOP) remain high (27.7 per cent of total county health expenditure and 7.1% of Kenyans incur catastrophic health payments.[7] As part of financial protection, the government operates a health insurance subsidy program for the poorest covering both inpatient and outpatient care in public and private health facilities. To date, the NHIF scheme covers 920,325 indigent and vulnerable households of the targeted 1 million households across the country. The dismal competitiveness of the NHIF, is due to weak regulatory and enforcement environment coupled with a parallel input financing system. To-date, no policy document has clearly addressed a clear pathway on how County Governments can reorganize resources in the shift towards an output based financed health system.

OPPORTUNITIES TO OBTAIN SUSTAINABLE FINANCING FOR UNIVERSAL HEALTH COVERAGE

Moving forward, the county governments should place emphasis on mobilizing additional domestic resources for the health sector as well as increasing efficient and effective allocation and use of health budgets to safeguard the health system and to maximize on the health outcomes. The following proposals are provided for consideration: -

County negotiations with the Treasury/MOH/NHIF for increased funding and timely disbursements

As the third-generation formula prioritizes health -- determined by number of primary health care visits to Level 2 and 3 facilities and number of in-patient days in level 4 and 5 hospitals, the counties need to take advantage of this opportunity to undertake advocacy with the national government to increase allocations to county governments through annual negotiation on the division of revenue process.

Consolidate and expand existing financial risk pooling schemes: NHIF reforms should be guided by the Kenya health financing strategy. Senate's failure to assent to mandatory NHIF enrollment which would have brought over KES. 120 billion to NHIF notwithstanding, this proposal remains the most feasible and sustainable strategy to attain UHC. Additionally, counties need to negotiate with the government (MOH / Treasury) for targeted subsidies to be earmarked towards UHC to cover indigents.

Ringfence health funds: The COG has been developing a Model Law aligned with 2021 PFMA (Section 109 (2) read together with Section 116, to create county special purpose accounts (CSPA) to protect health funds from diversion to non-health sectors. This Law which is to be annexed to the *Facility Improvement Funds (FIF) and Health Facilities Management Committee (HFMC) Guidelines for Health Facilities,* provides clarity on sources of funds to be ring fenced for health services and key actors, procedures and accounting procedures and processes. On finalization, the counties need to support its implementation to improve the financial flow of health funds to the health facilities.

Increase county health budgetary allocations: Counties could consider increasing their health budgetary allocations by 10% annually while also ensuring efficient use of the resources, allocating at least 5% of the yearly budgets to strategic programs, depending on county disease burden. An assessment of county fiscal space will be critical to inform county resource mobilization strategies. To increase Own Source Revenue (OSR) that currently stands at 10 per cent, the counties should adopt more efficient/low-cost tax collection systems guided

6 The Kenya Integrated Household Budget Survey 2015, KNBS, 2018
7 Ministry of Health. 2018 Kenya household health expenditure and utilization survey. Nairobi, Kenya2018.

by the fiscal assessments; re-evaluate properties after every 10 years and, enhance staff capacities in tax administration. Deliberate efforts should also be taken to increase the population covered by insurance or any other pre-payment schemes.

Obtain seamless transition of donor programs: To ensure sustainability of the vertical programs including HIV, TB, Immunizations, and malaria which are overly dependent on donor-support, county governments should progressively make provisions for these programs in their annual budgets (i.e. HRH and supervisions). This is in addition to an increased commitment at the national level as guided by the Kenya Health Finance Transition Road Map.[8]

Enhance technical and allocative efficiency: The developments in the health fiscal space call for more prudent use of the limited public health sector resources to ensure better value for money in the context of health finance transition period and to deliver on the UHC agenda. To obtain this objective, this brief calls for: *Streamlining flow of funding to the counties through responsive pooling arrangements:* In line with the health financing strategy, Policy actions to reduce fragmentation of the existing health financing landscape will entail (i) restructuring and consolidating current public budgets and health insurance to align to the pooling arrangements, (ii) consolidation of budgetary allocations at both national and county levels. Kenya health finance strategy[9] proposes the creation of four major risk pools, namely, Social Health Insurance Fund - County Health Funds (CHFs), National Health Fund (NHF) and, complementary private health insurance. Virtual pooling of the fragmented health pooling schemes will also be required to harmonize the benefit packages, consolidate and expand existing pools to maximize on efficiency gains. Mandatory NHIF enrollment which will bring over KES. 120 billion to NHIF remains the most feasible and sustainable strategy to attain UHC. Additionally, counties need to negotiate with the national government (MOH / Treasury) for targeted subsidies to be earmarked towards UHC to cover indigents.*Establishment of county health planning units (CHPU) to enhance health planning, budgeting and programming:* Building on lessons learned from such counties as Kisumu, Makueni, Mombasa and Kitui, counties need to establish CHPU as a framework for coordinating planning and budgeting functions of the county health department and interface with the county treasury.

Strengthen the purchasing function: The counties need to work with NHIF and MOH to establish a minimum benefit package entitled to beneficiaries. The package should be oriented towards preventive and primary health care and, be provided through the provider care networks (PCNs) to enhance efficiency and referral care systems. Payment mechanisms also need to change from passive to strategic purchasing of health services pegged on quality of services offered that include a standard benefit package and harmonization of provider payment rates for the package (i.e a standard fee regime which does not discriminate between private, FBO and public health facilities.) in addition to reviewing and/or expanding the definition of health providers to include private chemists, diagnostic services, X-ray, lab etc.

Leverage on private sector support through public-private sector partnership (PPP): The counties through the Council of Governors (COG) should increasingly support enactment of laws and instruments that support increased and efficient private sector participation in health financing. Options to this end include collaborating with Treasury to channel funds from environmental impact assessments infrastructure development towards health sector priorities (eg. up to 2% of all capital (infrastructure) projects and, providing fiscal and monetary policy incentives (such as tax breaks and low interest financing) to manufacturers producing quality assured products in the respective counties. Both levels of government can also ring-fence at least 10% of health sector budgets to be implemented by non-state actors to deliver and improve quality of health services within difficult and hard to reach areas; maintain infrastructure and equipment; implement critical prevention and care interventions for key and vulnerable populations, among others.

8 Ministry of Health, Kenya Health Sector Transition Roadmap: In the Context of Universal Health Coverage Sustainability Financing 2022-2030, September 2021 (Draft).
9 Ministry of Health, 2021. Kenya Health Financing Strategy 2020–2030, Republic of Kenya, July

Need to ensure Social Health Protection for vulnerable groups as per the Constitution: Financial protection schemes at both levels of government need to be progressively consolidated to enhance efficiency without losing entitlements). Kisumu, for instance, implements health solidarity cover dubbed MARWA that covers to 41,800 households (approx. 136,000 lives) – indigents under NHIF Super Cover on a partner/county matching contribution. MARWA, which is semi-autonomous and administered by NHIF, acts as the aggregator, enabler and innovator of the social health insurance for the county, bringing in critical players in the UHC ecosystem. In addition to the Government's health insurance subsidy program, the counties need to consolidate and expand the schemes and ensure that the benefits packages are harmonized, and payment rates standardized across facilities (private, FBO, public).

Strengthen Public Financial Management: This will be through (i) development of Health Sectoral Plans and, integration of Sectoral Plans with County Integrated Development Plans (CIDPs), (ii) budget execution specifically in procurement, reporting and performance management and, (iii) supporting system reviews on budget execution systems. There is also a need to limit the growth in the proportion of wages as a per cent of recurrent expenditure that crowds out much-needed resources for key and priority health inputs. Guidelines by the Senate recommends 50-60 percent, while PFMA (35 percent). Lastly, at least 30 percent of county governments' budgets should go to development expenditures as per 2012 PFMA guidelines.

Promote evidence-based decision making: Counties need to invest in technical and operational efficiency analyses for more effective decision making aligned with the PFMA and, to enhance the ability of the public health facilities to deliver quality and affordable healthcare services. Priority areas could include costing, budget absorption, payroll cleansing and staff rationalization analysis, performance-based financing.

Conclusion

This Policy brief recognizes that, success of the county governments to obtain sustainable financing for UHC will depend on a multitude of factors that need to be addressed in addition to the proposed health financing reforms. Further, comprehensive, and integrated health care financing initiatives through the support COG will be required as well as close partnership and coordination with the other actors including National Treasury and Ministry of Health.

CALL FOR ACTION BY THE KEY ACTORS

1. **Senate:** Review of the recommendation No 7 and 11 allowing voluntary contributions under the Senate report on the NHIF Act (amendment) Bill 2021.
2. **National assembly and the Senate:** Consider COG memorandum on 2021 NHIF Act amendment Bill that calls for separation NHIF functions and, advocate for implementation of county led financial protection schemes.
3. **Parliament and Senate (health committees):** Legislate for mandatory enrollment to risk pooling schemes for sustainability of UHC roll out- including consolidation and expansion of existing risk pooling schemes towards equitable access to health services and efficiency enhancement.
4. **National Ministry of Health**: Ensure NHIF reforms are guided by KHFS; disseminate KHFS to key stakeholders, notably, Senate, CECs health, Parliamentary Health Committees, counties.
5. **National and County Governments**: Take care of the poor and vulnerable for sustainability of UHC and, enforce mandatory social health insurance; ensure health finance reforms are aligned with the Kenya Health Financing Strategy (KHFS); increase budgetary allocations for health and strategic programs (HIV/AIDS, TB,FP/RMNCAH)while ensuring efficient use of the available and future resources; HIV commodities are included in the EMS and, HIV/

TB care treatment services incorporated in the essential benefit package towards sustainability; NHIF reforms-separate pooling and purchasing functions in line with KHFS.

6. **COG/Counties**: Deliberate shift from input to results-based financing; obtain seamless health finance transition starting with commodities security, HRH, supervision and capacity building; increase allocations to primary health care and, pre-payment schemes; ring-fence funds for health guided by the new Facility Improvement Funds (FIF) Guidelines and accompanying Model law and undertake rapid assessment of county health fiscal spaces to inform health finance transition

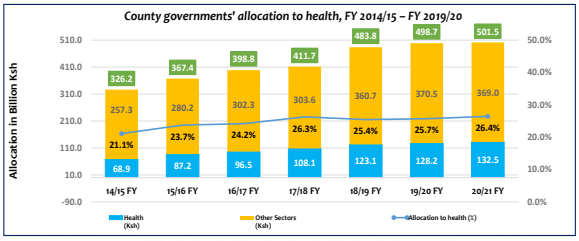
PRESENTATION BY DR. OWINO WASUNNA, A HEALTH FINANCING EXPERT

SUSTAINABLE FINANCING FOR UNIVERSAL HEALTH COVERAGE (UHC) IN KENYA: POLICY PRIORITIES FOR THE COUNTY GOVERNMENTS

DR. WASUNNA OWINO

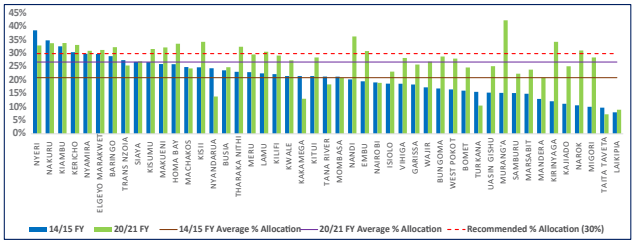
HEALTH FINANCING EXPERT

Increased investments in health financing by counties



Significant increase (5.3%) in the county health budgetary allocations between 14/15 FY and 2020/21

Increased county health budgetary allocations



Average county health budgetary allocation increased from 21% (2014/15) to 27% (2020/21). In 2021, 20 counties allocated 30% or more to health in 2020/2021 FY compared to only 6 in 14/15 FY.

Significant challenges in county health financing…1

- Insufficient national and county government health sector funding accompanied by high poverty (16%), declining donor funding and, adverse impacts of covid 19
- Inefficiencies in the health system have resulted in the wastage of resources especially in public sector health facilities (30 percent).
  - Fragmented and disjointed government support in the health care delivery system
- Poor quality of health services is significant in public sector facilities.

Significant challenges in county health financing…2

- Lack of equity in access to affordable and high-quality health services continues despite policies that support equity across the health sector.
  - Limited Financial Protection
- Cost of health care (affordability) is beyond a significant proportion of the population
- High reliance on donor support for vertical programs

Significant challenges in county health financing…3

In public financial management (PFM), there is:-

- Late disbursement of equitable share revenue by the national treasury
- Inability to effectively ring-fence health funds
- Weak linkage between county sectoral plans and CIDPs and MTEF process
- Non –compliance in budget execution, choking county health budgets
- Weak social accountability mechanism including weak citizen participation
- Lack of interoperability between the available tools for monitoring health

Opportunities to obtain sustainable financing for universal health coverage... 1

1. Enhance domestic resource mobilization
   - Increase Government/National Treasury budgetary allocations to counties beyond the current 15%
   - Mandatory NHIF payments Kes 6,000 , though opposed by Senate

2. Evidence based advocacy with MCAs to increase county health budgetary allocations especially for < 30% as recommended by PFMA

Opportunities to obtain sustainable financing for universal health coverage... 2

3. Increase Counties' Own Source Revenue - Efficient/low-cost tax collection systems; Property re-evaluation after every 10 years; Enhance capacity in tax administration

4. Unlock potential of private sector funding for health – workable PPP

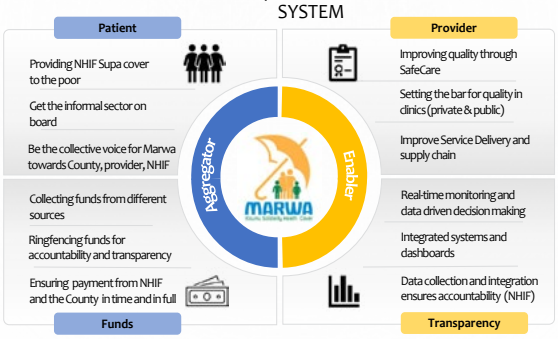
5. Shift towards output-based financing as opposed to an input-based model

Government Health Insurance Subsidy Program

- Financial risk protection to Kenya's poorest by providing them with a health insurance subsidy covering both inpatient and outpatient care in public and private health facilities
- The government has set aside ksh.6 billion to provide health insurance to the first cohort of 1 million indigent and vulnerable households across the country.

NHIF HAS received and uploaded total 1,201,835 indigent data from the counties, out of which Only 837,837 Were Registered. Bulk Of The Registered Data From Counties Was Rejected And To Date, Nhif has received 134,213 indigent data which THEY are currently working on.

THE MARWA MODEL | STRENGTHENING THE EXISTING SYSTEM



Priorities for National and County Transition

HRH	• Transition of contacted IP service delivery staff to county govt. payroll
Supervision	• Transition of supervision to county staff
Capacity building	• Transition of Training & mentorship to county staff
Health Commodities	• Transitioning of the procurement and management of commodities to Government
Financing	• Transition from donor funded programs to sustainable domestic funding

World Bank – Transforming Health Systems for Universal Care project and DANIDA programs

- The programs channeled resources for the delivery of high priority health services, offering important lessons for improving performance-based financing for health within counties
- Sustainability of funding for health, a concern, as it is now critical for counties to put in place mechanisms to safeguard financing for health at county level as funding are not assured beyond the life of the projects
- Transparency in fund allocation and disbursement to build confidence among stakeholders is a key lesson learnt by counties from the way the projects were managed
- Encouraging strategic purchasing at county level

Call for Action

COG/Counties:

- Shift from input to results based financing
- Obtain seamless health finance transition starting with commodities security, HRH, supervision and capacity building
- Increase allocations to primary health care and, pre-payment schemes
- Ring-fence funds for health guided by the new Facility Improvement Funds (FIF) Guidelines and accompanying Model law and
- Undertake rapid assessment of county health fiscal spaces to inform health finance transitions

Call for Action... 3

National and County Governments:

- Take care of the poor for UHC sustainability of UHC and, enforce mandatory social health insurance
- Ensure health finance reforms are aligned with the Kenya Health Financing Strategy (KHFS); increase budgetary allocations to strategic programs e.g HIV/AIDS, FP/RMNCAH
- Consolidate and expand existing risk pooling schemes towards equitable access to health services and efficiency enhancement.

Call for Action... 4

National Ministry of Health:

- Ensure NHIF reforms are guided by KHFS;
- Disseminate KHFS to key stakeholders, notably, Senate, Parliamentary Health Committees, Counties.

Senate:

- Review of the recommendation No 7 and 11 allowing voluntary contributions under the Senate report on the NHIF Act (amendment) Bill 2021.

CONCLUSION

The success of the county governments in obtaining sustainable health financing for UHC will depend on a multitude of factors that need to be addressed in addition to the proposed health financing reforms. Comprehensive and integrated health care financing initiatives through the support COG will be required as well as close partnership and coordination with the other actors including national treasury and MOH. Of top policy priority is the timely disbursements of the equitable share revenue by the National Treasury, that the counties rely on 81%.

BIOGRAPHIES

H.E. Hon. Dr. Mohammed Kuti, EGH
Governor - Isiolo County

H.E Mohammed Abdi Kuti is the current Governor of Isiolo County from August 23, 2017. He has a B.Sc. Medicine and B.Sc. Surgery from the University of Nairobi. Prior to this, he served as the Senator for Isiolo county for one term. H.E Kuti previously represented Isiolo North Constituency in the National Assembly of Kenya for 10 years. He also held the positions of Minister for Youth Affairs in 2005 and Minister for Livestock from 2008 - 2013.

Dr. Pius Wasunna Owino,
Health Financing Expert

Dr. Wasunna Owino is a seasoned leader of international health projects in Africa. He has a Ph.D., Health Economics, University of Sussex, an MA, Economics, University of Nairobi and a BED Arts, University of Nairobi. He has spent over 16 years providing technical vision, managerial oversight and technical assistance to donor and government-funded health projects in health financing and policy. He combines solid analytical skills with special expertise resulting in strategies and approaches that yield results relevant for spearheading programmatic technical strategies.

Hon. Dr. James W. Nyikal, MBCHB, MMED CBS
Member of National Assembly, Member of National Assembly Committee on Health

Hon. Dr James Wambura Nyikal is a distinguished Paediatrician/neonatologistas who currently serves as a member of the Kenyan National Assembly representing Seme Constituency. He has a Bachelor of Medicine and Surgery from the University of Nairobi; a Masters degree in Paediatrics and Child Health - Monash Medical Centre, Melbourne Australia; and a Fellowship in New Born Medicine - Monash Medical Centre, Melbourne Australia. In the assembly, he also serves as a member of the National Assembly Committee on Health. Previously, Dr. Nyikal served as the Permanent Secretary Ministry of Gender, Children and Social Development (MGCSD) in October 2008 and occupied the position until he was elected to the Kenyan Parliament.

CHAPTER FOUR

SESSION 3: HEALTH COMMODITIES SECURITY: FINANCING, LOCAL PRODUCTION, GOVERNANCE, AND ACCOUNTABILITY IN THE DEVOLVED CONTEXT

Introduction

Citizens in Kenya have high expectations that health commodities, be it drugs, vaccines, medical supplies such as masks, sanitizers, and even devices for administering drugs like injection syringes, cannulas and catheters, are available at an affordable cost when needed. Delivering this promise requires a properly functional health supply chain. The responsiveness of the supply chain results from an effective interplay of products, information, human resource, and technology that ensures products are delivered from source to the point of use and that there is flow of information on needs, consumption for planning and key decisions in procurement and distribution. County Governments are still far from achieving HPT security with product availability still at 44%, order fill rates for tracer HPT at 73%, HPT budgetary allocations against requirements at 43%, and level of local production still suboptimal. Further, inadequate visibility of health commodities in the supply chain, and prevailing gaps in policy and regulatory environment continue to negatively impact accountability too.

Session discussions

This session was chaired by **H.E Salim Mvurya**, Governor, Kwale County. The session's presentation was delivered by **Dr. Joseph Murega**, CECM for Health, Kiambu County with initial feedback before the session plenary provided by **Prof. Gilbert Kokwaro**, Director, Institute of Healthcare Management, Strathmore University. The session interrogated critical policy and legislative barriers that stifle County Governments from availing quality assured, affordable HPT and provided some action points towards improving the implementation of HPT policies and legislation. The key highlights from the session are highlighted below.

Access to affordable and quality HPT is a useful pointer to the responsiveness of a health system. Despite the gradual improvement of the health supply chain, there are challenges that impede the achievement of desired health supply chain outcomes and addressing these bottlenecks requires policy and legislative interventions.

There has been inadequate allocation of funds by both national and County Governments to HPT and related systems. The allocated funds are also not availed on a timely basis for timely procurement of commodities thus stifling supply planning and resulting in stock outs. Financing is also affected by the high prices of commodities in the local market.

Both demand and supply planning for HPT has been affected by sub-optimal investment and use of HPT information management systems. There are persistent challenges with the availability, timeliness, quality, and visibility of HPT data, leading to negative implications on data for decision making. There is also low use of local production opportunities for sustainable outcomes.

Figure 11: Dr. Joseph Murega, County Executive Committee Member for Health, Kiambu County making a presentation on Health commodities security

There was acknowledgment that there are imminent accountability deficits along the supply chain and across core functions. Even though HPT supply chain is underfunded, there are high inefficiencies arising from accountability deficits experienced on the little investment available.

Attempts to address legislative and policy gaps have often been through reactive and piece-meal amendments of legislations and policies. A single regulatory body for HPT, envisaged under the Health Act, 2017, is yet to be established. There are various health sector bills (including those on provision of preventive and treatment services) that mandate County Governments to provide relevant, quality, and affordable HPT, but whose implementation arrangements lack clarity. Further, County legislations are yet to provide specific and elaborate sections on HPT that address the aspects of governance, management, and enforcement.

Finally, there was appreciation that the COVID-19 pandemic has both exposed our underbelly in terms of inadequacies in supply chain responsiveness, but also provided critical lessons on opportunities available for local production of essential commodities across the entire spectrum of HPT – including medicines, medical supplies, vaccines, laboratory reagents, medical diagnostics.

Recommendations

1. Firstly, there is urgent need to review the current HPT legislations, particularly the KEMSA Act, 2013; Pharmacy and Poisons Act, and County Health Services Acts to address gaps in regulatory aspects touching on procurement, distribution, and rational use.
2. Secondly, there is need to develop an elaborate accountability framework for HPT that clarifies the roles of HPT governance structures at the County level, provides for adequate representation of County Governments in regional and national HPT institutions and provides for adequate rewards and sanctions. Further, transparency should be strengthened to support planning and HPT decision-making as well as facilitate driving down healthcare costs.
3. Thirdly, there is need to align health financing allocations for HPT to the County health priorities through appropriate analysis, quantification and monitoring. This is critical in reducing wastages, expiries, and stock outs.
4. Fourthly, County Governments, individually and through regional blocks, should initiate programs for strengthening capacity for local prodution of HPT in close collaboration with the County technical and vocational training centers, and the private sector.
5. Fifthly, County Governments should demand for increased accountability from KEMSA through structured reforms of KEMSA to a joint entity of both national and County Governments, and at the same time support continued operations of KEMSA through prompt settlement of outstanding debts.

Figure 12: Prof. Gilbert Kokwaro making his presentation

POLICY BRIEFS

POLICY BRIEF 003: TOWARDS A HARMONISED HEALTH PRODUCTS AND TECHNOLOGIES (HPT) LOGISTICS MANAGEMENT INFORMATION SYSTEM (LMIS)

Introduction

The prevailing status of the LMIS for Health Products and Technologies (HPT) is characterised by systematic lapses in recording, collation, analysis and reporting of health commodities data, that hamper provision of continuous information required for demand and supply management. These also have implications on focus of national and county governments on market shaping through improved local production of HPT. Continued investments aimed at strengthening use of information technology in HPT supply chain are too fragmented, verticalized by programs, and largely driven by partners with no clear sustainability arrangements. Strategic investment in an elaborate e-LMIS will not only help address management of health commodities data, but also contribute to optimal use of the already stretched staff capacity. Adoption of end-to-end supply chain visibility platforms of by counties[10] to supplement the current tools for capturing consumption and stock status data, through provision of real time data, and facilitate consolidation, analysis, management of exceptions and provide alerts for prompt supply chain decisions is a top priority.

Moving forward, county governments should develop and adopt a standard policy on the use of e-LMIS, incorporate e-LMIS in the County Health legislation with requirements for reporting by facilities, and jointly invest in a suitable e-LMIS that is interoperable with other health systems as well as county core information systems.

REFLECTIONS ON LMIS STATUS

Strengthening the Supply Chain System for Health Products and Technologies is a priority of the Health Sector in a bid to ensuring that essential health commodities are accessible and affordable to the population. As such the flow, encompassing products, service, and information, from producers to the end users must be effectively managed to meet both supply and demand side needs. A logistical management information system (LMIS), whether paper based or electronic, provides the essential link across the various levels of the supply chain system through collection, aggregation, analysis, validation, and display of data that facilitates logistical decisions and performance of supply chain roles. Such roles include but are not limited to quantification, supply planning, warehousing, distribution, and inventory management.

The LMIS for health commodities has been facilitating county governments in making decisions on rational order management, redistributions, managing inventory as well as managing expiries. The systems have been more elaborately established for the health commodities covered under the vertically run health priority programs, that are managed by the national Ministry of Health (MOH), such as HIV commodities, Malaria commodities, TB drugs and related supplies, Family Planning commodities, and vaccines. These have supported close monitoring of availability of health commodities at the points of service as well as the central stores.

These systems have also aided in demand forecasting for health products through provision of consumption data. However, current experiences with the application of the LMIS reveals that there are persistent challenges with availability, timeliness, quality, and visibility of health commodities data across the supply chain, that continue to hamper the effectiveness and efficiency of the health supply chain system. Furthermore, attempts to

10 Five counties are already considering adoption of end-to-end visibility systems - Busia, Kilifi, Makueni, Tharaka-Nithi and Vihiga

address these challenges have been characterised by fragmentation and unsustainable interventions. The extent of integration of the LMIS components with other systems has also been limited.

Commodity stock status tracking on aspects such as stock levels, expiries, months of stocks available, consumption for the last period (month or quarter), and request for the subsequent period is based on manual reports from facilities, summarised by the county health management teams (CHMTs) and keyed into the Kenya Health Information System (KHIS). The fragmented applications applied at this level have contributed to inefficiency and inconsistencies during aggregation of data.

There are notable gaps in integration of the various systems especially the KHIS and the KEMSA LMIS that limit data sharing, provision of early warning signals and order rationalisation, generation of real time monthly reports and end to end visibility of commodities data in the supply chain. Notable progress has been made regarding program commodities especially malaria and HIV products where the KEMSA LMIS linkages with KHIS supports order management through provision of commodity stock status at facilities, national stores and in the pipeline, and has alerts for overstocking, understocking based on estimated monthly consumption data. Since stock levels at county health facilities are not visible as most of the records are manual and limitations in ICT infrastructure exist, the accuracy of inventory levels reported is compromised. This situation is exacerbated by the human resource constraints at most facilities especially Level 2 and 3 facilities that are manned by very few workers. The sheer number of manual records required to be filled at the health facility has been reported as a disincentive. Unfortunately, the ripple effect of inaccurate and incomplete reports in the health sector's ability to manage demand and supply of HPT is not adequately appreciated at the individual facility level.

There is lack of harmonisation of the IT Systems and inadequate linkages for interoperability of the IT infrastructure limits the county health supply chain ability to support visibility of products in the last mile since most of HPT functions are managed manually or using standalone systems at the facility level.

Towards improving access, sharing and analysis of data, the Ministry of Health has developed various policies and guidelines including the Kenya Health Information Systems Interoperability Framework (KHISIF) that focuses on interoperability of health information systems. There is also an appreciation that the existing platforms may be too diverse to achieve the level of interoperability expected and there is a current initiative led by the Ministries of Health and ICT to develop a national Electronic Medical Records (EMR) system that will ultimately have modules for HPT management. The extent to which the system will meet the urgent LMIS functional gaps of counties is yet to be clarified.

END TO END VISIBILITY PLATFORM

The fragmented approach towards strengthening of the e-LMIS for HPT has resulted in inefficiencies in data collection, data aggregation, analysis and reporting on HPT. There is need for good data visibility, based on routinely and accurately updated records and timely reporting for guiding decision making and the ultimate improvement in performance of the health supply chain through increased product availability. It is notable that reporting[11] by counties on commodities has improved overtime, but the timeliness and quality of data remains suboptimal thus hampering the use of data in key decisions such as quantification, resupply, and redistribution.

11 Facility reporting rates in KHIS range from 80% to 100%

Recommendations

To address the current gaps, county governments should:

1. County governments should invest (provide budgets) individually or jointly in systems that assure end-to end visibility of HPT. Owing to the scale of required investment, county governments need detailed and phased implementation plan spanning three-to-five-year period.
2. To ensure the chosen system(s) are responsive, county governments should undertake a comprehensive mapping of the existing systems including ICT infrastructure, internet connectivity, application of mobiles as well as the capacity for use by the health workers.
3. Reorganise the county Health Products and Technologies HPT function/units to effectively manage the logistical aspects of all categories of HPT under one roof.

POLICY BRIEF 004: INADEQUACIES IN THE REGULATION OF HEALTH PRODUCTS AND TECHNOLOGIES: A time for County Governments to Act

Introduction

Regulation of Health Products and Technologies (HPT) plays a key role in safeguarding the public from harm associated with the use of health products. Quality assurance for both pharmaceuticals and the entire spectrum of public health consumables, including food and food products-remains a major concern in the sector. The Kenya Health Policy 2014-2030 and the Health Act 2017 seek to forestall this challenge by comprehensively addressing regulation through an autonomous, harmonised, national regulatory framework that brings on board human drugs, vaccines, blood and its products, diagnostics, medical devices and technologies, animal and veterinary drugs, food products, tobacco products, cosmetics, and emerging health technologies. A draft Bill[12] currently in parliament seeks to establish a single regulatory body for HPT.

Key policy and regulatory concerns for County Governments

Currently, the regulation of HPT is governed under several legislations and policies. The overarching policy is the Kenya National Pharmaceutical Policy while the overarching legislation is the Pharmacy and Poisons Act, Cap 244. These are complemented by legislations and policies of standards, industrialisation, industrial property, public procurement and prevention and treatment of various diseases. These legislations have provided direction to county governments in various aspects of the HPT supply chain. Despite efforts to strengthen the HPT regulatory environment, there are gaps in the implementation and/or enforcement of existing policies. Amendments to existing health policies have not considered effecting the principles and objects of devolved government in respect to assigned functions according to the Fourth schedule of the Constitution[13] with no requisite enforcement responsibilities extended to the county government to implement sector policies. There is need to enforce clear policies to safeguard consumer interests and enhance the involvement of county governments providing guidance for instance on the level of government that is suited to control different aspects of HPT regulation in respect to quality.

HPT regulatory environment

The Ministry of Health has put in place several HPT specific guidelines to support implementation of the Kenya National pharmaceutical Policy 2012. These include strategy,[14] essential lists, forecasting and quantification handbook, and guidelines for the establishment of medicines and therapeutic committees (MTCs). They complement the efforts of the Pharmacy and Poisons Board (PPB) and other regulatory agencies.

The Board,[15] regulates the manufacture and trade in drugs and poisons to ensure quality of health products and technologies (HPT) in the country. However, there are gaps in HPT regulation which are yet to be addressed such as intensifying internal and cross-border quality control of HPT, enforcement of pharmaceutical procurement, and pharmaceutical care services such as polypharmacy, inappropriate use of antibiotics resulting in ineffective treatment and increased risk of drug resistance and cost of health care; lack of enforcement on the use of the standard treatments and clinical guidelines towards rational drug use, curbing antimicrobial resistance, or managing promotional activities by drug companies- areas that county governments are best effectively placed for enforcement.

12 Kenya Food and Drugs Authority Bill, 2019
13 The constitution of Kenya 2010
14 The Kenya Health Supply Chain strategy 2020-2025
15 Pharmacy and Poisons Board established by the Pharmacy and Poisons Act (PPA) CAP 244

Constitutional oversight role of County Governments on pharmacies

The fourth schedule of the constitution of Kenya 2010, Part 2. 2(a), assigns 'county health facilities and pharmacies' to counties. This role may be interpreted to include oversight of all health facilities including retail pharmacies. However, this is yet to be operationalized and has not been considered under the Kenya Food and Drugs Authority Bill, 2019.

Additionally, the Bill does not provide for the representation of counties in the governance of the proposed authority, despite provisions under schedule 1V of the Constitution of Kenya being specific on some regulatory roles for food establishments, veterinary outlets, and pharmacies in the counties. While county governments in the quest to strengthen governance structures have established HPT Units for comprehensive HPT management at County level, few have made requisite legislations to effectively give mandate to the Units.

Legislations at the County level on HPT

County governments legislations such as County Health Acts, do not specifically address functions such as the regulation of county health facilities and pharmacies. Where supervisory roles or quality audit structures have been identified, this has been on county health facilities, necessitating an understanding on whether county facilities encompass retail pharmacies.

Effective regulation should reflect on both quality and cost of health products

Quality of HPT: The quality of HPT in Kenya is important for the achievement of highest attainable quality healthcare for all. The PPB regulates the trade in pharmaceuticals and related products through registration of medicines, medical devices, licensing for import/export and pharmaceutical facilities and regulation of trade in medical products and health technologies.

Quality monitoring interventions by the Board in collaboration with other quality oversight bodies point to a reliably good quality HPT with products that meet quality specifications, an indication that the existing regulatory and quality assurance systems are effective. However, there are exceptions with incidences of sub-standard and counterfeit medicines, weak investments in HPT storage infrastructure, gaps in the regulation and post market surveillance for nutrition products, medical devices, and non-pharmaceuticals and lack of clear feedback mechanism to support information sharing.

Cost of HPT: Prices of health commodities remain a key driver of the cost of healthcare. However, there is a gap in the implementation and enforcement of past policies that have always encouraged cost awareness[16] for HPT in the sector and proposed interventions for controlling drug prices in Kenya.[17]

County governments are best positioned to invest in data systems and operational research towards health technology to inform the costing of health products, medical devices, diagnostics, and medical equipment. Such investments are critical in informing decisions such as reimbursement of essential medicines under the UHC benefit package.

Recommendations

The following actions are necessary to strengthen the regulatory environment of HPT:

- Comprehensive legislative review of national and of County Health Services Acts to entrench the principles and objects of devolved government in relation to county government oversight role on pharmacies that puts in place a national legislation (including within Draft KFDA Bill where possible) that clarifies the oversight role of county governments.
- Immediate actions by county governments to address illegal outlets and quality concerns.

16 The Kenya Drug Policy 1994
17 The Kenya National Pharmaceutical Policy 2012

The PPB (and other regulators) inspectorate should ensure compliance with laws and regulations on HPT through mechanisms that ensure joint inspections of pharmacies with county representation.

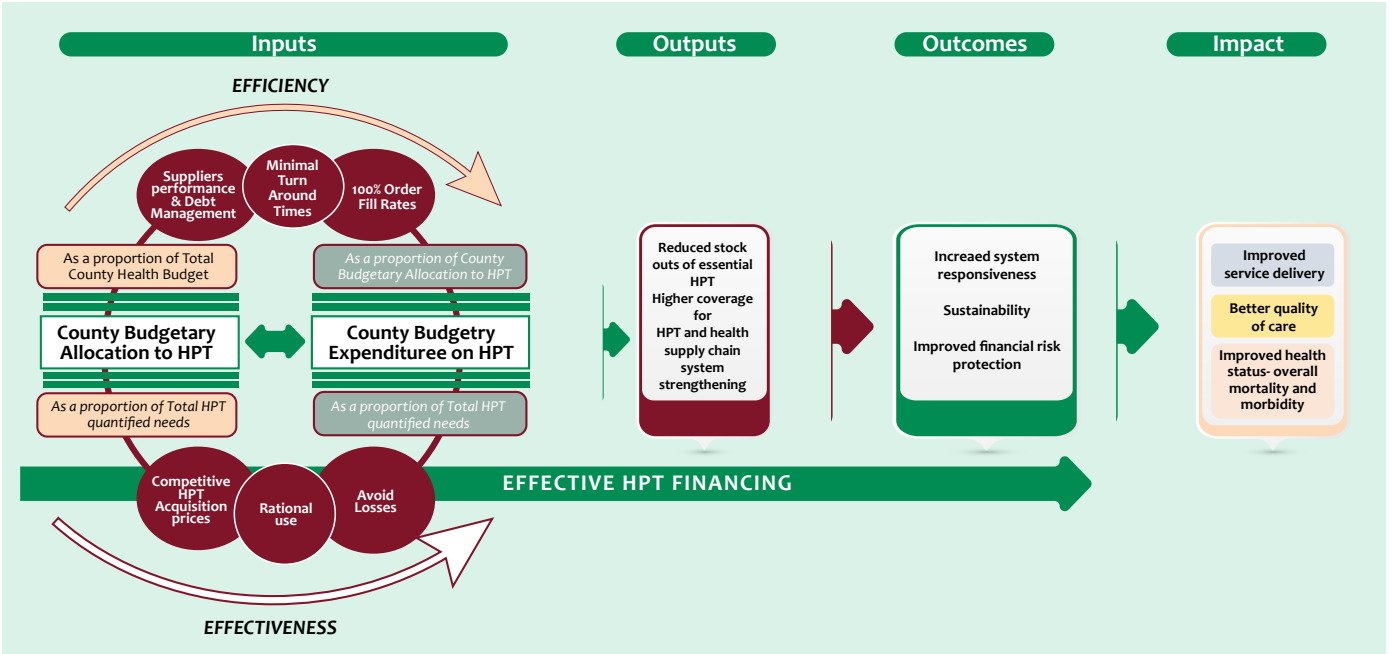
- Establishment of mechanisms and forums to facilitate timely information sharing between the regulator and county governments on HPT quality monitoring data generated by the testing laboratories for use in decision making especially in the supplier pre-qualification and monitoring systems.
- County governments to strengthen HPT institutional mechanisms at County Health Departments for effective regulation, implementation, and enforcement of HPT policies at the county level through county specific legislations on HPT Units/Directorates with clear mandates.
- Establish clear collaboration mechanism for national and county governments to manage and regulate the cost of HPT including ensuring that the UHC insurance benefit package reimburses the cost of HPT for sustainability.
- County governments to promote the essential medicines concept as a cost-effective intervention for maintaining HPT costs and enforce compliance in both public and private facilities.

POLICY BRIEF 005: STRENGTHENING ACCOUNTABILITY FOR HPT THROUGH HPT UNITS

Introduction

The health sector has embraced various mechanisms geared at promoting accountability in the health supply chain including: data quality audits undertaken by departments of health, inventory reviews by health departments and implementation partners, audits by the office of the Auditor General (OAG), compliance reviews by the Public Procurement Regulatory Authority(PPRA), performance reviews by county governments and national ministries, compliance reviews by professional regulatory bodies, and reviews under the performance contracting and staff performance appraisal systems. These initiatives have not only facilitated identification and resolution of challenges in the health supply chain, but also informing design of HPT supply chain capacity building.

Despite these contributions, there are accountability deficits that still need to be addressed such as: noncompliance with procurement procedures, leakages of HPT, avoidable stock outs and expiries and inaccurate reports. The cost of undertaking reviews, especially audits and investigations, in cases of accountability deficits is also prohibitive. There is a need to review the legislation dealing with HPT to entrench suitable rewards and sanctions for unethical practices. Similarly, an elaborate accountability framework that incorporates citizen participation in the health supply chain and repositions the county health products and technologies units as an integral unit for management of HPT at county level is necessary. Further, there is urgency to review the KEMSA Act, 2013 to recognise and provide for joint accountability of KEMSA to both national and county governments.



Aligning the financial allocations for HPT to optimize it contributions to national health prioritie, goals and target

ACCOUNTABILITY DEFICITS AND MANIFESTATIONS

There is acknowledgement by stakeholders that the county health supply chain is underfunded to deliver its mandate. On the other hand, there are several common issues across the supply chain that indicate that available resources have yet to be optimally applied.

On the regulation front, there is good quality assurance of HPT in the market as evidenced by the high pass rates achieved in market surveillance testing. However, market surveillance for medical supplies and medical devices is inconsistent, and illegal establishments providing HPTs still exist. There is also ineffective coordination between HPT regulatory agencies particularly Kenya Bureau of Standards (KEBS) and Pharmacy and Poisons Board (PPB) contributing to lapses in quality assurance of medical supplies such as condoms, and medical equipment.

The extent to which critical HPT technical committees such as the County Medicines and Therapeutics Committees (MTC) and the HPT Security Technical Working Group have been operationalised is also too low for desired impact.

Sharing of information on budgets allocated to health commodities and the supply chain as well as the levels of utilisation of the budget has also been inadequate. Budget justifications are mainly based on historical allocations as opposed to quantified needs. Similarly, full disclosure on support from partners for both commodities and system strengthening are also lacking budget visibility and accountability with the alignment of budget allocations to health sector objectives and outcomes has yet to be prioritized. Specifically, there is no focus on efficiency and effectiveness on HPT financing with aspects such as appropriate supplier and debt management mechanisms, a factor that has a direct bearing on the achievement of minimal order turnaround times and maximization of order fill rates. Additionally, efforts towards the acquisition of HPT at the most competitive prices and pricing transparency to drive down costs in the counties are minimal. Inefficiencies continue to be experienced through irrational use of HPT and system losses.

County governments are required under the KEMSA Act, 2013 to procure HPT for their facilities from KEMSA in a bid to reap from economies of scale from bulk purchasing and distribution, and benefit from centralised quality assurance. KEMSA's institutional capacity has been strengthened towards this end with the support of key partners such as the Global Fund, the USAID, and the World Bank. The support has included: capitalisation, strengthening of procurement, warehousing, and quality control systems. KEMSA has had challenges at oversight level with significant delays in sharing of reports with key stakeholders such as county governments and COG. Further, the entity has inadequacies in procurement planning, apparent conflicts of interests in procurement, weak management information systems, and weak financial base. County governments delays in settling their debts with KEMSA has continued to stifle KEMSA's ability to replenish supplies. These accountability deficits affect the responsiveness of KEMSA to county requirements with order fill rates consistently being below par.[18]

18 Order Fill Rates consistently below 70% (target is 90%)

HEALTH PRODUCTS AND TECHNOLOGY	
INDICATOR DESCRIPTION / SOURCE	**SCORE / FIGURE**
Product vailability (2018/19 readiness assessment)	44%
Proportion of women accessing family planning ervices	43%
Order fill rate (Delivery value) (May 2021)	73%
Reporting rate (MOH 647 Tracer HPT) KHIS May 2021	51%
Tested pharmaceutical pass rate (NQCL 2018 & 2019) n=1623	97%
Proportion of functional MTCs at County Level MTR 2019/20	4.3 (2 Counties)
Estimated HPT needs KSH (2018/19 County data)	29,789,510,297*
Total Budgetary allocation to HPT kSH (FY 2018/19) (32%)	9,621,635,648
HPT Budget as a % of the Total County Health Budget	7 - 10%
Averge HPT expenditure as a % of Budgetary allocation to HPT (2018/18; 2018-19; 2019/20) (40-60%)	51%
Allocation to HPT systems strengthening KSH	Not indicated
Per capita Allocation to hpT KSH*	201

Generation of accurate and timely reports on key sectoral performance indicators on HPT has been negatively impacted by inadequacies in maintenance of essential health commodities supply chain records at all levels. Recent reviews and experiences during the annual quantification exercise for HPT revealed that stock cards, receipts, and issuance vouchers as well as ledgers were well maintained in the case of medicines. However, there is a huge gap in non-pharmaceutical supplies, laboratory consumables, oxygen, and medical devices. These have resulted in inability to know real consumption patterns and disrupted the cycles for ordering leading to stock outs. For instance, during the last year, there were reported stock outs of oxygen in cylinders, surgical gloves, ARVs, PPES, diagnostic reagents and testing kits with record keeping deficiencies being one of the attributable factors.

Inconsistencies in application of laid down procedures and processes have been highlighted in both external audits and procurement audits. These have been attributed to inadequate procurement planning and linkage with budgets, mishandling of acquisitions for emergency needs for HPT and centralised acquisition of specialised equipment and related consumables.

Recommendations

Appreciating that the supply chain for HPT is complex and involves many partners, county governments should undertake the following actions towards strengthening accountability of health commodities and technologies:

1. Redefine accountability requirements at the various levels of the county health supply chain with clarity of incentives, rewards, and sanctions. The accountability framework will define clear sanctions for actions/inactions leading to stock outs, expiries, and wastages
2. County governments should improve transparency through documenting and sharing information on HPT budgets and utilization by product categories, source (local/international), and pricing. County governments should fully embrace the program-based budget approach and consider having HPT at the sub-program level. Additionally, clear monitorable HPT financing indicators focused on the key elements of efficiency and effectiveness of budget execution should be introduced to facilitate the county governments in evaluating and assuring value for money for all product categories invested in.
3. Strengthen the Health Products and Technologies (HPT) functions at county level through anchorage under the County Health Services Act, bringing the management of all health products and technologies under one roof. Further, county governments should provide a budget for county health supply chain activities such as quantification, health commodities supply chain quarterly audits and reviews, MTC's activities.
4. Undertake comprehensive review of the KEMSA Act, 2013 to build in joint accountability of KEMSA to both national and county governments. Joint accountability will be ensured through providing for reporting by KEMSA.

POLICY BRIEF 006: ENHANCING CONTRIBUTION OF COUNTY GOVERNMENT IN PROMOTING LOCAL PRODUCTION/MANUFACTURE OF HEALTH COMMODITIES BY THE PRIVATE SECTOR

Introduction

Sessional Paper No.4 of 2012 on Kenya National Pharmaceutical Policy underlined the pharmaceutical sector's unique characteristics and impact on health, national economy, international trade, and cooperation. It recognises the role of local manufacturing in providing essential HPT towards not only self-sufficiency in the domestic market but also enhanced exports. The importance of local production of HPT as a key contributor to availability, quality and affordability of HPTs is not in doubt. Indeed, the sector has already set clear policy objectives on reversing dependency on imports specifically expanding product portfolio to cover 90% of disease conditions, increasing value of purchases from local firms to 50%, and getting firms to venture in production of advanced formulations such as delayed release formulations, small injectables and double layered tablets.

Sizing the Market

The demand for HPT for use in the Kenya public health sector is over KES 110 billion[19] excluding medical devices, medical oxygen, and blood products. Counties needs account for almost 50% excluding the strategic program commodities. Budgetary allocations to HPT only meet about 32%[20] of the estimated counties' requirements. County governments acquire almost half of their HPT needs through KEMSA (43% in 19/20). In turn KEMSA has been procuring approximately 30% of from local manufacturers in line with the preferential and reservation schemes provided for in the Public Procurement and Disposal Act, 2015.

Considering that a significant proportion (circa 40%) of Out of Pocket (OOP) spending in health is on HPT, that imports of pharmaceuticals have experienced growth year on year[21], utilisation of production capacity of local manufacturing firms ranges from 60-70%, the untapped potential in local production of HPT is immense.

Opportunities Transcend Pharmaceuticals

Opportunities for increasing production of HPT transcend pharmaceuticals. Only 16% (118 of the 764) products in the essential medicines list are locally produced. Most of these, fall into the following categories – dialysis solutions, pain medicines, disinfectants, and antiseptics, gastrointestinal, anticonvulsants, anti-allergy, diuretics, and cardiovascular medicines. Significant gaps exist in the following categories – muscle relaxants, immunological, immunomodulators, antineoplastics, blood products and plasma substitutes, diagnostic agents, and vaccines. In terms of essential medical supplies, there is some local production of syringes, needles, catheters, hospital linen, surgical mask, Personal Protective Equipment (PPE) but little production of physiotherapy, occupational, orthopaedic, and dental consumables despite the immense demand from facilities. There is also wide scope for growth of production of medical devices such as drip stands, wheelchairs, examination couches, medicine trolleys, suction machines and pumps, beds, and examination lamps. Only two local manufacturers produce laboratory diagnostics -blood collection

19 MOH - Draft Annual HPT Quantification Report estimated requirement for counties KES 41B, national referral facilities KES 7.8B, Strategic Programs – HIV, TB, Malaria, FP, and TB- KES 41B, Immunization – KES 20B*

20 Estimate based on County HPT Budgetary Allocation Analysis

21 Economic Survey Report, 2021 - Kenya imported pharmaceutical products worth an estimated US$.690 million in 2020 and US$.570 million in 2019. Medicinal and pharmaceutical exports were valued at US$. 14.9 million in 2019 and US$. 14.2 million in 2020

tubes, viral transportation media, bacteria culture media. Since most diagnostics are machine specific, the reliance on imports is quite high.

Laudable Ongoing Initiatives

Kenya has gained recognition as a regional leader in the medical and pharmaceutical research sector, has a well-established legal and regulatory system that supports product safety and quality assurance and operates in harmony with other regulators in the African Region. The national government through the Ministries of Industrialisation and Health has spearheaded several interventions to shore up HPT local production capacity. These include the development and support to implementation of the Kenya Pharmaceutical Sector Development Strategy (KPSDS) geared at helping the pharmaceutical industry to attain the WHO GMP Standards through a stepwise approach, and as such be able to compete for and improve market access. The regulator (PPB) has continued to support local manufacturers towards enhancing their compliance with the Good Manufacturing Practices (30 out of the 41 local manufacturers of pharmaceuticals are currently deemed to be compliant). Quality of other locally manufactured HPTs (e.g., masks, sanitisers, and disinfectants) is assured through KEBS inspection, testing and certification.

Additionally, the government has provided taxation incentives for importation active pharmaceutical ingredients (APIs), and capital support through provision of land under the special economic zones. The updated preferential procurement muster roll for public agencies that incorporates 128 HPT items provides a backbone for applying preferential rules in procurement of HPT from local firms. Most recently, the directive by the President to the Ministry of Health to work with Kenya Biovax Limited to initiate local production of COVID 19 vaccine in April 2021 has provided further momentum.

Industry players with the support of ministry of industrialization continue to explore potential bankable projects such as setting up multipurpose chemical plant for bulk production of intermediate inputs, manufacture of non-pharmaceuticals, commercial processing of traditional medicines, processing of locally available sugar, salt (sodium chloride) and ethanol to pharmaceutical grades for use as inputs by pharmaceutical industries, and investment in manufacture of medical equipment.

Need for acceleration

However, there has been little traction in making local production impactful despite the various policy actions initiated at regional and national level. Dependency on imported pharmaceutical products continues while local firms continue to produce below capacity. Key constraints in enhancing local production include inadequate raw materials and machinery; high cost of inputs including taxes and clearance charges, high cost of bioequivalence studies owing to absence of clinical research organisations, inadequate incentives, misperceptions on local products especially medical devices as being of low quality, gaps in definition of local content and standards for medical devices.

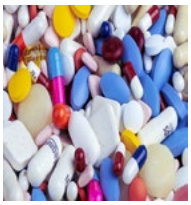
To move the local manufacturing agenda, it is important that policies are linked to action and focus more decisively on quality improvement to adhere to international standards especially WHO-GMP, price preferences; allocating increased budgets for local firms embedding quality GMP linked incentives. As the largest users of health commodities in the country, county governments should prioritise the local production agenda and complement the current efforts by the national government for acceleration. Regional economic blocs should be optimised for economies of scale.

Considerations for county governments

County governments as key purchasers of health commodities have a significant role in enhancing local production. The following proposals should be considered in creating an enabling environment for production of various essential HPT – essential medicines, essential medical supplies, essential medical devices, and essential medical diagnostic supplies:

- Sensitisation of county executive committees, county health supply chain and procurement staff on opportunities in local production including but not limited to PPDA 2016 and PPDA Regulations 2020 incentives, preferential procurement muster roll: process of approval and certification
- Encourage local firms to update their manufacturing capabilities with the county government whilst ensuring that appropriate databases are maintained, and validation undertaken during the annual business license renewal process
- Apply preferential procurement provisions provided in the law for local producers within counties
- Apply restricted tendering for locally manufactured HPT and guaranteeing purchase of new products based on active demand estimation
- Advocate for taxation regime that supports local production through amongst others enabling recovery of input VAT
- Enhance collaboration with regulators (PPB and KEBS) in post market surveillance and support sharing of information to counter wrong quality perceptions
- County governments to facilitate collaborate with local research institutions, County Technical and Vocational Education and Training institutes and private firms in research and manufacture of select HPT especially diagnostics - One County One Product

PRESENTATION BY DR. JOSEPH MUREGA, CECM FOR HEALTH, KIAMBU COUNTY



Health Commodities Security: Financing, Local Production, Governance, and Accountability in the Devolved Context

Session Objectives

- Interrogate critical policy and legislative barriers stifling county governments from availing quality assured, affordable health products and technologies (HPT)
- Develop a feasible action plan to improve Implementation of HPT policies and legislation

Process

- Presentation
- Plenary Discussions

BACKGROUND

- Access to affordable and quality HPT is a pointer to the responsiveness of the health system
- Core HPT functions include Product selection, Procurement, Distribution, and Rational use
- Core functions are supported by appropriate policy and regulatory environment, sustainable funding, strong leadership, and governance, effective HR management and a strong Logistics Management Information System
- Gradual improvement of the health supply chain registered over time
- Several challenges continue to impede the achievement of desired Health Supply Chain outcomes
- Addressing these bottlenecks requires policy and legislative interventions

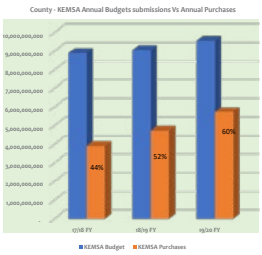
PROGRESS ON KEY METRICS

- Availability of essential medicines **(circa 44%)** (KHFA 2018).
- Average lead time : **44 days**
- Order fill rate : **< 50%**
- HPT Reporting rate KHIS October 2021 **(71.4%)**
- Tested HPT pass rate NQCL 2019 (n=836) : **99%**; MEDS 2020 (n= 717) : **98.5%**
- Number of HPT Units : **39**
- Out of Pocket Spending (26%) Approx. **40** % HPT.
- County Budget Allocations to HPT as % of Health Budget : **7-10%**
- Total County Governments HPT needs – KShs **41.07** Billion
- Allocation to HPT systems strengthening – No data

FINANCING OF HPT

Challenges

- **Inadequate government (exchequer) allocation to meet HPT needs**
- **Lack of ring-fencing of the public HPT budget**
- **Delayed disbursement of funds to county governments affects procurement**
- **Low insurance reimbursements for essential HPT**
- **Significant off-budget financing for HPT**
- **Elements of supply chain inefficiencies with unsustainably high prices of HPT**



FINANCING OF HPT CONT'D

Recommendations

- **Improve budgetary allocations and ring fence HPT budgets**
- **Clarify HPT components of UHC Benefit package**
- **Building a strong and sustainable market for generics and biosimilars to enhance price competition**
- **Increasing transparency of the prices in the supply chain – County market surveys**
- **Improving public accountability public procurement for HPT including for procurement plans and tenders**

LOCAL PRODUCTION OF HPT

LOCAL PRODUCTION (1)

- **A significant untapped potential in local production of HPT with current production capacity ranging from 60-70%**
- **Only 16% (118 of the 764) products in the essential medicines list are locally produced**
- **County Government initiatives towards local production increasing**
- **Local production of COVID 19 supplies and vaccine set to provide further momentum towards local production**
- **Major constraints in local production include; reliance on imported raw materials and machinery; high cost of inputs including taxes and clearance charges, and misperceptions on quality of local products**

LOCAL PRODUCTION (2)

- The current COVID 19 Pandemic exposed the long-standing vulnerability of national and county HPT supply chain.
- Shortages of ordinary HPT experienced owing to surge in demand in producer countries with lengthened lead times and high prices.
- Products affected include Personal Protective Equipment, diagnostics supplies, pharmaceutics, oxygen, and oxygen related infrastructure.
- Solutions need to extend beyond pandemic response capacity and include *bold* and *sustained* reforms and actions

LOCAL PRODUCTION (3)

Recommendations

- Preferential procurement provided in the law for local producers within counties (Utilisation of Preferential List)
- Collaboration with local research institutions, TVET and private firms in research and manufacture of select HPT especially diagnostics - *One County One Product*
- County governments to fund and incentivise experimentation in local production through regional economic blocs

ACCOUNTABILITY DEFICITS

- HPT Supply chain is highly underfunded, yet high inefficiencies experienced on the little investment available
- Inefficiencies brought about by accountability deficits
- Extent to which existing accountability structures have been operationalised is too low for desired impact
- Accountability demands are costing the health supply chain a great deal of time and financial resources

ACCOUNTABILITY FRAMEWORK

Recommendations

- Comprehensive Reforms for HPT oversight institutions to strengthen governance and enforcement capabilities e.g. KEMSA.
- Repositioning the county HPT units as an integral unit for management of HPT at county level
- Operationalisation of the County MTCs with clear mandate supported by legislation
- Review of HPT legislation to entrench suitable rewards and sanctions for non-compliance
- Embracing electronic LMIS to improve HPT visibility as a critical accountability measure

VISIBILITY OF HPT DATA

- Effective management HPT should be supported by information technology
- Persistent challenges with availability, timeliness, quality, and visibility of HPT data - with negative implications on data for decision making
- Limited integration of existing HPT LMIS components - fragmentation and unsustainable interventions continues
- HPT data not yet adequately appreciated at the individual facility level.

VISIBILITY OF HPT DATA

Recommendations

- County governments provision of budgets towards end-to end visibility of HPT
- County governments to implement end to end visibility systems in phases – Be bold to pilot after detailed needs assessment and mapping of existing systems
- Mapping out existing systems should include ICT infrastructure, internet connectivity, application of mobiles as well as the capacity for use by the health workers.
- Enhance platforms for sharing experiences on the end-to-end visibility systems amongst counties

HPT POLICY AND LEGAL ENVIRONMENT

- Regulation of HPT play a key role in safeguarding the public from harm associated with use (quality, safety, and efficacy)
- Broad Policy Imperatives articulated overall health policies and legislations under the Kenya Health Policy 2014 -2030, The Health Act, 2017 and; The Kenya National Pharmaceutical Policy – Sessional Paper 4 of 2012
- However, Single regulatory body for HPT, (Health Act, section 62) yet to be established
  - Pharmacy and Poisons Act, Cap 244 – main legislation regulating HPT
  - The Kenya Food and Drugs Authority Bill still in the pipeline
  - KEMSA Act, 2013 - 2019 amendments contested by county governments

HPT POLICY AND LEGAL ENVIRONMENT

Many laws and entities involved in regulation of HPT

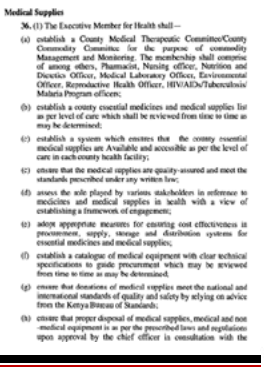
- Various health sector Bills (including those on provision of preventive and treatment services) place obligations on county governments implicitly place the obligation of providing relevant affordable HPT of assured quality

Piecemeal review of policies and legislations

COUNTY LEGISLATIONS

- County Health Services Acts (over 35 counties)
- Alcoholic Drinks Control Acts (over 20 counties)

County legislations yet to provide specific and elaborate sections on HPT aspects governance, management and enforcement



Medical Supplies

36. (1) The Executive Member for Health shall—

(a) establish a County Medical Therapeutic Committee/County Commodity Committee for the purpose of commodity Management and Monitoring. The membership shall comprise of among others, Pharmacist, Nursing officer, Nutrition and Dietetics Officer, Medical Laboratory Officer, Environmental Officer, Reproductive Health Officer, HIV/AIDs/Tuberculosis/ Malaria Program officers;

(b) establish a county essential medicines and medical supplies list as per level of care which shall be reviewed from time to time as may be determined;

(c) establish a system which ensures that the county essential medical supplies are Available and accessible as per the level of care in each county health facility;

(e) ensure that the medical supplies are quality-assured and meet the standards prescribed under any written law;

(d) assess the role played by various stakeholders in reference to medicines and medical supplies in health with a view of establishing a framework of engagement;

(e) adopt appropriate measures for ensuring cost effectiveness in procurement, supply, storage and distribution systems for essential medicines and medical supplies;

(f) establish a catalogue of medical equipment with clear technical specifications to guide procurement which may be reviewed from time to time as may be determined.

(g) ensure that donations of medical supplies meet the national and international standards of quality and safety by relying on advice from the Kenya Bureau of Standards;

(h) ensure that proper disposal of medical supplies, medical and non -medical equipment is as per the prescribed laws and regulations upon approval by the chief officer in consultation with the

SUMMARY OF ISSUES IN HPT LEGISLATION

Recommendation

- Ensure that ongoing review and development of national policies on HPT embeds enforcement role of county governments
- Review county health legislation to explicitly capture enforcement responsibilities by County Governments in respect to pharmacies
- Effective legal and regulatory framework that encourages sustainable intergovernmental collaboration, cooperation, and consultation on HPT
- Establish mechanisms and forums for information sharing between the regulator and county governments

CONCLUSION

- Effectiveness of HPT supply chain hampered by policy and legislative barriers
- Resolution of these barriers requires bold and urgent actions
- Candid interrogation of these concerns necessary to arrive at immediate actions

BIOGRAPHIES

H.E Salim Mvurya

Governor, Kwale County

H.E Salim Mvurya has 17 years of social development and leadership experience. His education background is summarized as follows: University of Sussex in England, UK - Masters Degree in Participation, Power and Social Change; Egerton University - Bachelors in Agri-Business Management; and MSTDC- Arusha, Tanzania - Certificate in NGO management. Before becoming the first Governor for Kwale County in 2013, he had over the years designed and implemented development programs in Education, Health, Livelihoods, Child Protection and Democratic Governance centered on citizens' participation in decision-making processes and policy advocacy. Some of the programs he implemented were funded by DFID, USAID, Ministries of Foreign Affairs in Netherlands and Finland, and NORAD, Norway.

Dr. Joseph Murega

CEC Member for the Department of Health Services, Kiambu County

Dr. Joseph Ng'ang'a Murega currently serves as County Executive Committee (CEC) Member for the Department of Health Services in Kiambu County. He holds a Bachelor of Medicine and a Bachelor of Surgery - University of Nairobi. He has over 33 years' experience both in public and private sectors in the medical field. Before his appointment, Dr. Murega was serving as a private medical practitioner since 1989. He also served as a Medical Officer at the Ministry of Health between 1984 and 1989 attached to the then Thika District Hospital.

Prof. Gilbert Kokwaro, PhD

Director, Institute of Healthcare Management, Strathmore University

Prof. Gilbert Kokwaro is currently a Professor of Health Systems Research and Director, Institute of Healthcare Management at Strathmore University. He has a Bachelor of Pharmacy and an MSc in Pharmaceutics from the University of Nairobi and a PhD in Pharmacokinetics from the University of Liverpool, UK. Prior to this, Prof. Kokwaro was a member of a Technical Advisory Committee for GSK on antimarial drug resistance, and a member of the editorial board of Malaria Journal (2009-2012). He is also interested in research on improvement of standards of care for HIV/AIDS patients. Prof. Kokwaro is also Professor of Pharmaceutics (since 2000) at the University of Nairobi and a Fellow of the Kenya National Academy of Sciences (FKNAS) and the African Academy of Sciences (FAAS).

CHAPTER FIVE

SESSION 4: INSTITUTIONAL AND STRUCTURAL ISSUES IN HEALTH POLICY AND LEGISLATION: Re-engineering of igr, unbundling of functions, transfer of power, and recruitment/transition of health care workers

Introduction

Kenya's devolved system of governance is based on two levels of government that are distinct and interdependent, combining the concept of self-governance at the County level and shared rule at the national level in a way that necessitates intergovernmental relations among the governments. For this reason, the CoK has explicitly determined that such intergovernmental relations must take the form of mutual cooperation and consultation. This has produced a unique concept of cooperative devolved government that is critical to the success of devolution but which is yet to be fully understood and operationalized by the two levels of government.

Thus, this session focused on the understanding of how cooperative devolved government and intergovernmental relations can be re-engineered, including the institutions that have critical intergovernmental responsibilities to ensure the success of devolution. In addition, the session also re-examined the issue of unbundling and transfer of functions and powers since clarity in functional assignment is critical to policy and legislations that support rather than undermine the devolved system.

Session discussions

This session was chaired by **H.E. Francis T. Kimemia**, Governor of Nyandarua County. The presentation for this session was delivered by **Dr. Mutakha Kangu**, an Intergovernmental Relations Expert at the CoG Directorate of Health, with initial feedback before the session plenary provided by **Mwalimu Thomas Kibua**, a public policy expert. In trying to address institutional and structural issues in health policy and legislations, the session focused on two critical issues: the role of cooperative devolved government and re-engineered intergovernmental relations; and the need for re-examination of unbundling and transfer of functions and powers.

The session identified and highlighted the following key issues:

1. Lack of proper understanding and operationalization of cooperative devolved government and intergovernmental relations is a major policy and legislative barrier to effective delivery of health services by the national and County Governments. This has resulted in a discretionary as opposed to a collaborative approach to policy and legislation making in the health sector, leading to imposition of policies and legislations that undermine devolution and encroach upon County Government functions.

2. The need for collaborative joint policy and legislation making approaches realized through intergovernmental structures and institutions such as joint committees of the two levels of government were identified as major solutions. This will require re-engineered cooperative devolved government and intergovernmental relations that encourage collaborative and joint pursuit of policy and legislative solutions and strategies.

3. The existence of several constitutional and statutory institutions that have an important intergovernmental role but are either not constituted as such or do not undertake their responsibilities as critical intergovernmental institutions was also identified as a major problem in health policies and legislations. Good examples are Cabinet which plays a critical role in the approval of draft policies and legislations before they are tabled in Parliament; the Ministry of Devolution which was envisaged by legislation as being responsible for intergovernmental relations; the National Treasury which ought to have been established

as an independent state organ that serves both levels of government in a neutral manner; and the bicameral Parliament whose two houses make many decisions that impact devolution. In particular, the poor working relations between the two houses of Parliament and the persistent conflicts between them have posed serious threats in the legislative process that need to be addressed.

4. Similarly, gaps in the IGR institutional arrangements arising out of the vacuum left in the policy and legislation making process following the expiry of the term of the defunct CIC which had responsibility to ensure that draft policies and legislations were in conformity with the CoK and the devolved system have contributed to the policy and legislative barriers. As a result of this institutional vacuum the process of comprehensive review of old order policies and legislations ceased, and Parliament has resorted to piecemeal amendments of the existing legislations.

5. Due to the incomplete process of transition to the devolved system of government and the institutional vacuum resulting from the expiry of the term of the CIC, many policies and legislations from the old constitutional order which are not in conformity with the CoK and the devolved system remain in existence. Parliament has also continued to formulate policies and enact legislations that are not fully aligned to the CoK and the devolved system which undermine devolution. The need for comprehensive review of these legislations to fully align them to the CoK and the devolved system was identified as a major solution.

6. In addition, wrong interpretation of some constitutional provisions such as the place of repayment of public debt in the interpretation of Article 203 criteria for sharing revenue raised nationally; and the non-implementation of some legal provisions such as sections 54 and 114 of the County Governments Act have also contributed to the policy and legislative barriers. The failure to properly and fully unbundle and transfer functions and powers, which has enabled old order policies, legislations, and institutions such as parastatals dealing with devolved health functions to continue to exist in the unitary form; and the policy and legislation making process to proceed without being informed by proper constitutional interpretation of the functions and powers, was identified as a major policy and legislative barrier.

7. Consequently, it was recommended that the two levels of government form a joint committee to work with the IGRTC to unbundle functions in all the devolved sectors, leading to the enactment of a Functions and Powers Act. The Act should provide for the following: creation of three lists of functions and powers; creation of two lists sharing out the different aspects of concurrent functions and powers to the two levels of government; and a legal framework for assignment of additional functions by National Government to County Governments under Articles 186(3) and 183(1)(b) of the CoK; and a legal framework for the transfer of functions from either level of government to the other under Article 187 of the CoK.

Figure 13: Dr. Mutakha Kangu, H.E Francis T. Kimemia, Mwalimu Thomas Kibua during a plenary session on Institutional and structural issues in health policy and legislation

Recommendations

1. County Governments and the National Government will jointly undertake a coordinated and comprehensive review of the existing health policies and legislation, starting with;
   i. NHIF Act;
   ii. KEMSA Act, 2013; and
   iii. Pharmacy and Poisons Act, in the next six months to align these to the requirements of the devolved governance system.

2. Having reviewed various laws and policies that are problematic in institutionalising and financing devolution, through a clear division of functions between the national and County Governments, the meeting resolved that the CoG, County Assemblies, National assembly, and Senate jointly work together to streamline all these laws and policies to be fully aligned to devolution or, where repugnant, be repealed.

3. Recognizing the critical role of the following institutions in Intergovernmental Relations -Cabinet, National Treasury, Ministry of Devolution - County Governments will engage the National Government to restructure processes of approval of health policies and legislation to ensure compliance with the CoK and the devolved system.

4. County Governments and National Government shall engage Parliament to resolve conflicts between the two houses of Parliament in legislative processes and support harmonized and efficient review of health laws and policies.

5. The County Governments will ensure that, on an annual basis and in collaboration with the MoH, a database of doctors undergoing postgraduate studies is submitted to the MoH, and the National Treasury, through MoH, to make provision in every budgeting cycle for the payment of Personnel Emoluments for those doctors to the Counties.

Figure 14: Dr. Thomas Kibua making his presentation during the meeting.

POLICY BRIEF

POLICY BRIEF 007: RE-EXAMINATION OF UNBUNDLING AND TRANSFER OF FUNCTIONS AND POWERS

Introduction

The failure to properly and fully unbundle and transfer functions and powers is a major policy and legislative barrier to effective and efficient delivery of health services by the national and county governments. This has enabled old order policies, legislations, and institutions such as parastatals dealing with devolved health functions to continue to exist in the unitary form. Moreover, this has also enabled policy and legislation-making to proceed without being informed by proper constitutional interpretation of the functions and powers, resulting in policies and legislations that undermine devolution and encroach upon the functions and powers of county governments. This problem manifests itself in several ways identified and discussed below.

THE UNFINISHED UNBUNDLING AND TRANSFER OF FUNCTIONS AND POWERS

After the promulgation of the Constitution of Kenya, 2010 and the establishment of the Transition Authority in 2012, functions assigned by the constitution to the two levels of government were supposedly analyzed, unbundled, and transferred to the two levels of government by the Transition Authority beginning the year 2013. By the time the term of the Transition Authority expired sometime in 2016 the Transition Authority had not yet completed its work and as required by legislation, the residual functions of the TA were taken over by the Intergovernmental Relations Technical Committee (IGRTC) with effect from March 2016.

The IGRTC has reported that the analysis and unbundling of functions is an ongoing exercise and remains unfinished. Quite a lot especially regarding the analysis and unbundling of the functions of over 156 state corporations remains undone due to lack of goodwill from the two levels of government and lack of adequate resources for undertaking the exercise. Many of these state corporations were established under old order legislations which have not been reviewed to align them to the devolved system of government.

The need for review of the old order legislations

It is often said that it is one thing to adopt a new constitution and yet another to review the old order legislations to make them consistent with the new constitution. County governments should coordinate with the national government and form joint committees to undertake the review of the old order legislations to align them to the devolved system of government. In the process of this review, some state corporations that were established as entities of national government may have to be abolished while others are re-established as joint entities of national and county governments or joint entities of county governments or a few county governments within a region in terms of Article 189(2) of the constitution.

Re-examination of unbundling and transfer of functions as a constitutional interpretation exercise

There is urgent need to re-examine the unbundling and transfer of functions and powers as a constitutional interpretation exercise to first, complete the unfinished unbundling and transfer of functions and powers; and secondly, to re-evaluate the unbundled and transferred functions to ensure that the result is consistent with the constitutional assignment of functions. This process should aim to determine the content of every function assigned by the constitution; isolate the exclusive functions from the concurrent ones; and determine the residual functions which the constitution says are assigned to the national government.

As a constitutional interpretation and application exercise, unbundling and transfer of functions ought to be objectively undertaken based on the constitutional provisions assigning functions and informed by the following guiding principles.

The exclusive/concurrent dichotomy

Given that Article 186(2) of the constitution recognizes that some functions are assigned as exclusive functions, while others are concurrent functions of both levels of government, constitutional interpretation for purposes of unbundling and transfer of functions must seek to determine the content of each function, and the categorization of functions as exclusive and concurrent.

Use of national and county prefixes in assignment of functions

The Fourth Schedule to the Constitution sometimes assigns functions and powers by describing them as national or county. Thus, a common functional area is assigned to both levels of government but differentiated by referring to certain aspects of the functional area as national while other aspects are referred to as county. These differentiated aspects may be assigned exclusively to each of the two levels of government or concurrently to both levels of government. For instance, in the functional area of health the Fourth Schedule assigns to the national government 'National referral health facilities'; while it assigns to county governments 'County health services.'

Ambit and scope of such prefixed functions

Interpretation of such prefixed exclusive and concurrent functions of national and county governments to determine their ambit and scope is normally complex as the functions and powers tend to overlap. The terms of the functional areas listed in the Fourth Schedule or set out in other constitutional provisions create overlaps that can make broadly defined national government powers and functions subsume the more narrowly defined county functions and powers in the same functional area, leaving county governments without any exclusive functions. For example, the national government's 'National economic policy and planning' functional area may appear to include the 'county planning and development functional area'.

The Bottom-up approach to interpretation of such prefixed functions

South African comparative experience indicates that a bottom-up approach to interpretation of such prefixed exclusive functions and powers is the best way to address the problem of overlaps in exclusive functional areas. This approach commences by asking the question of whose functions and powers should be defined first. The essence of the bottom-up approach is that the interpretation must begin by determining and scooping out the exclusive functions and powers of the county governments before determining the remainder as national government exclusive functions and powers.

Implied assignment of functions by use of such prefixes

Functions could be interpreted as having been assigned by implication depending on how the prefix has been used. Where the prefix is used in assigning a functional area to one level of government without a corresponding assignment of the same functional area to the other level of government the corresponding function could be interpreted as having been assigned to the other level of government by implication. In contrast however, when the constitution assigns a function to a level of government without using the prefix of national or county, the whole function is deemed as having been assigned to that level of government.

Implied assignment of functions by use of the 'Including' principle

Functions and powers of county governments can also be assigned by use of the 'including' principle. The content of most county government functions is defined and broadened using the term 'including' followed by a listing of some of the activities that constitute the functional area. The significance of the use of this term is that the list is not exhaustive and closed, other related items can be identified and added to the list.

The *ejusdem generis* principle dictates that other activities that are related to the listed ones can be identified and included as functions of county governments. First, this means that several functional areas that may at a glance appear to be unassigned may actually have been assigned by such implication and are therefore not residual functions and powers of national government. Secondly, in trying to fill these lists of 'including', the interpreter must also examine the national government functional list for what is excluded to ensure that additions are not made to the county list of what has been expressly assigned to the national government.[22]

Implied assignment of functions by use of the 'incidental' principle

The use of the phrase 'incidental to' in Article 185(2) also serves to expand the ambit of the legislative powers of county governments. An incidental power refers to a situation where a matter that would have fallen in the functional area of the national government is regarded as being so integrally linked to matters in a functional area of county government as to be incidental and form part of that functional area. Incidental powers and functions deal with grey areas around cut-off points of the functional areas; however, they are not meant to introduce new functional areas for county governments.

The 'full effect' principle

A purposive interpretation of the functions and powers which seeks to give 'full effect' to the intention of the framers of the constitution will also serve to expand the scope of county government functions and powers. This approach requires that functional areas and powers be interpreted in a manner that gives full effect to the functions and powers of the levels of government. The approach emphasizes a functional view which seeks to ensure that each level of government is enabled to discharge its 'responsibilities completely and successfully' and to exercise its powers fully and effectively.

The principle of resources must match and follow functions in unbundling and transfer of functions

The principle of resources must match and follow functions is also important in constitutional interpretation for purposes of unbundling and transfer of functions. Often, this principle is rendered in narrow financial terms of funds must match and follow functions thereby limiting its role to financial resources. Properly conceived however, the principle goes beyond financial resources and includes infrastructural resources such as facilities; and the human resources that were managing those facilities and amenities. If the functions are interpreted as having been assigned to county governments, then unbundling and transfer would require that all these resources must follow the functions that are now with county governments and should be transferred to county governments.

Where those resources and facilities were owned and or managed by state corporations established under the State Corporations Act or any other specific statute, such legislations ought to be reviewed or interpreted in a way that aligns them to the functional assignment to the two levels of government. This may even mean the abolition of some of those state corporations whose functions have been assigned to county governments with all their resources and properties being transferred to county governments.[23]

Role of the territorial dimension in unbundling and transfer of functions and powers

Determination of the scope of exclusive county functional areas may be guided by functional appropriateness which requires that functions be assigned or left to the level of government that can best perform the function. This is sometimes referred to as the subsidiarity principle. This is informed by the territorial dimension, which requires that matters that are best regulated intra-county are exclusive to the county, while those that are inter-county are left to the national government.

22 TMutakha Kangu Constitutional Law of Kenya on Devolution (2015) Strathmore University Press at pages 204 & 205

23 See Kenya Agricultural and livestock Research Organization (KALRO) v County Government of Kitui [2019] eKLR, a case which concerned unbundling and transfer of the roads functions.

A county would therefore not have exclusive power to regulate a matter that has external dimensions. Although some items specifically refer to 'county', it is an inherent principle of all county functions and powers that they are limited to intra-county matters. Territorial dimension thus serves to limit the scope of the county functions and powers. These limitations may however be mitigated by the application of Article 189(2) of the constitution.

Role of Article 289(2) joint committees and joint authorities in unbundling and transfer of functions and powers

Article 189(2) of the constitution provides that 'Government at each level, and different governments at the county level, shall co-operate in the performance of functions and exercise of powers and, for that purpose, may set up joint committees and joint authorities.' For this reason, functions that are inter-county could still be interpreted and unbundled as county government functions since Article 189(2) provides for establishment of joint committees and joint authorities for purposes of cooperating to perform their functions and exercise their powers. Two or more counties can therefore cooperate and form a joint committee or a joint authority through which they can perform functions that may be inter-county and yet be interpreted as county functions.

Role of other functions and powers assigning constitutional provisions

In the interpretation of Article 186 and the Fourth Schedule to determine the content of the functions of each level of government and whether the functions and powers are exclusive or concurrent, the following other functions and powers assigning constitutional provisions and factors must be considered:

Article 185 county legislative functions and powers

Although the Fourth Schedule assigns to national government health policy functions which because of the principle of rule of law include legislative functions, health policy and legislative functions are not exclusive functions of national government. Article 185 which assigns and confers upon county governments legislative functions and powers must be interpreted to include policy functions and powers since rule of law requires that legislation be preceded by and anchored in policy. This makes health policy and legislation concurrent functions of both national and county governments.

Article 209 revenue raising functions and powers

Article 209(4) confers upon national and county governments some revenue raising functions and powers in the form of 'charges for services' that are linked to the functions assigned to the levels of government. Joint formulation of policies and legislations or review of existing ones ensures that one level of government does not use legislation to assign to itself functions of another level just because those functions have higher revenue raising potential. Indeed, some disputes over functions and powers are informed by ulterior motives based on the extent of revenue raising ability of some of these functions.

Implied procurement functions and powers and Pork Barrel expenditure functions and powers

Implied in most of the service delivery functions of national and county governments are procurement functions. While some functions are light expenditure functions, others are pork barrel expenditure functions that provide ulterior motives for national government officials to want to recentralize. This may explain why even with more health service delivery functions having been assigned to county governments; there has been insistence on retaining a centralized system of procurement, warehousing and distribution of drugs and medical supplies through KEMSA.

Article 235 county governments' public service functions and powers

Interpretation of Article 186 and the Fourth Schedule to determine the content of the functions of each level of government must be guided by the fact that implied in all the functions of county governments are the public service functions and powers assigned by Article 235. In ***Kenya National Union of Teachers v Attorney General and 4 others*** **[2016] eKLR,** the court was called upon to determine the functions

and powers of county governments to recruit and employer ECE teachers vis-à-vis the functions of the Teachers Service Commission. Although the court correctly decided the case in favour of county government functions and powers to recruit and employ ECE teachers, what was surprising was the fact that the court in its determination never considered the impact of Article 235, despite one of the parties having cited the Article.

Role of functions in Article 203 criteria in sharing of revenue raised nationally

Assignment of functions plays a critical role in the criteria for sharing of revenue set out in Article 203 of the Constitution. In terms of this Article, county governments are supposed to be allocated an equitable share of the revenue raised nationally that can enable them to perform their functions.

A strict and narrow interpretation of residual functions and powers

Residual functions and powers refer to functional areas that are not assigned by the constitution or national legislation to any one of the two levels of government, and these are assigned by Article 186(3) to the national government. To determine residual functions and powers one must first determine whether the subject matter has not been assigned to any one of the two levels of government by examining first the functional lists, second, other provisions of the Constitution which assign functions, and finally, any legislation that may have assigned unassigned functions and powers to the county. Thus, for purposes of interpretation in respect of unbundling and transfer of functions, residual functions and powers ought to be interpreted strictly and narrowly to ensure that functions that may have been assigned by implication due to the 'including', or 'incidental' principles, or the use of the prefixes in the assignment of functions or any other principles discussed above are not wrongly regarded as residual.

The need for a functions and powers Act

Guided by the above interpretation principles there is urgent need for the two levels of government to form a joint committee to work with the IGRTC to unbundle functions in all the devolved sectors leading to the enactment of a Functions and Powers Act to provide for the following matters.

Create three lists of functions and powers

The functions and powers Act should clarify the constitutional assignment of functions and provide for three lists of (a) exclusive functions of the national government; (b) exclusive functions of county governments; and (c) concurrent functions of both levels of government. This is informed by the fact that since the adoption of devolution many Kenyans have decried the lack of clarity in the assignment of functions to the two levels of government. Many have complained that while many federal systems normally provide for three lists of functions in the constitution, the Kenyan constitution through the Fourth Schedule provides for only two lists of functions—the list of national government functions and that for county government functions. The problem is however, compounded by the fact that Article 186(2) then recognizes that while some of the functions in the two lists are exclusive to the two levels of government, others are concurrent. This therefore leaves to interpretation the question of which of these functions are exclusive and which ones are concurrent.

Create two lists sharing different aspects of the concurrent functions to the two levels of government

The functions and powers Act should also make provision on how to share out the various aspects of the concurrent functions among the national and county governments and create two lists of (a) the aspects of the concurrent functions to be performed by national government; and (b) the aspects of the concurrent functions to be performed by county governments. This sharing is necessary to provide clarity in the allocation of financial resources to the two levels of government informed by the principle that funds must match and follow functions. This sharing out should be informed by the subsidiarity principles based on the most efficient way to discharge the functions.

Provide for a legal framework for assignment of additional functions by National government to county governments

The functions and powers Act should provide a framework for assignment of additional functions by the National government to county governments through an Act of Parliament as envisaged by Articles 186(3) and 183(1)(b) of the constitution. The essence of these provisions is that the national government can assign some of the functions assigned to it by the constitution, including residual functions, to county governments. The framework must raise and address questions such as can the national government unilaterally do the assignment, or must it undertake the assignment after intergovernmental negotiations with the county governments? Has the assignment ensured that the resources necessary for the performance of functions have been provided for to avoid the emergency of unfunded mandates?

Provide for a legal framework for transfer of functions from either level of government to the other

The Functions and powers Act should provide for transfer of functions by agreement from one level of government in terms of Article 187(1) of the constitution. The framework must address questions of the institutional framework through which such agreed transfer can be done. Can the Governor sit alone and effect such transfer? Should other structures of the county or national government be involved in the intergovernmental negotiations leading to such transfer? Once such transfer has been executed how do the oversight structures of the transferring government continue with their oversight functions? Will such oversight be undertaken by both the transferring and receiving governments? How do you manage transition from the transferring government to the receiving government and subsequently, at the termination of the transfer agreement? Questions of how to avail resources for the performance of the functions must be addressed. A legal framework in this regard is urgent given that the provisions under the Intergovernmental Relations Act are inadequate as has been demonstrated by the case of Nairobi County and the Nairobi Metropolitan Services (NMS).

Way forward and recommendations

In light of the matters discussed above the following recommendation and way forward is made.

The County Governments should coordinate with the national government through the Summit and form a joint committee of the national government and county governments to work with the IGRTC, to undertake a thorough unbundling and transfer of functions in all the devolved sectors leading to the enactment of a Functions and Powers Act

POLICY BRIEF 008: UNDERSTANDING AND OPERATIONALIZATION OF COOPERATIVE DEVOLVED GOVERNMENT AND INTERGOVERNMENTAL RELATION

COOPERATIVE DEVOLVED GOVERNMENT AND RE-ENGINEERED INTERGOVERNMENTAL RELATIONS

The constitution establishes a system of cooperative devolved government which necessitates cooperative intergovernmental relations, and the pursuit of joint solutions to most policy and legislative problems. Lack of proper understanding and operationalization of cooperative devolved government and intergovernmental relations are major policy and legislative barriers to effective and efficient delivery of health services by the national and county governments.

The essence of cooperative devolved government

The essence of cooperative devolved government is that although the constitution creates two levels of government that are distinct and assigns them both exclusive and concurrent functions and powers; the levels of government are also interdependent and must cooperate with each other when performing their functions and exercising their powers. The concept refers to collaborative and coordinated partnership between the two levels of government that seeks to ensure a well-coordinated and cohesive system of government that provides services to the people as a whole, based on the system of effective service delivery at the local level that is well coordinated with national priorities. It also seeks to avoid competition among the governments and their working at cross-purposes or in a mutually destructive way. It aims to avoid duplication of roles and expenditures as well as provide harmonious coexistence among the governments and their institutions.

The obligations of cooperative devolved government

In terms of Articles 6(2) and 189 of the constitution, cooperative devolved government imposes upon the two levels of government certain obligations, the implications of which are to limit the way the levels of government perform both their exclusive and concurrent functions and exercise their powers. The obligations require the governments to (1) respect the constitutional status of the institutions of each other; (2) respect the functional and institutional integrity of each other; (3) assist, support and consult each other, and where appropriate, implement the legislation of the other level of government; (4) liaise with each other, exchange information, coordinate policies and administration and enhance each other's capacity; (5) cooperate with each other in the performance of functions and exercise of power, and for that purpose, set up joint committees and joint authorities; and (6) avoid judicial settlement of disputes. These obligations certainly go beyond mere consultation and among others, require collaboration, coordination, and cooperation based on partnership, as well as pursuit of joint solutions to policy and legislative problems as opposed to unilateral imposition of policy and legislative solutions.

MANIFESTATION AND MAGNITUDE OF THE PROBLEM

The problem of lack of proper understanding and operationalization of cooperative devolved government and intergovernmental relations which affects the process of policy and legislation-making manifests itself in several ways identified and discussed below with recommendations for addressing it made in respect of each dimension to the problem.

The problem of discretionary policy and legislation making

Despite the above-mentioned obligations, which favour pursuit of joint solutions to policy and legislative problems; policy and legislation making have suffered from what appears to be unilateral imposition of policies and legislations by the national

government. Many draft policies and legislations touching on devolved health matters are originated and sometimes passed by the national government without any involvement of county governments. Other times the policies and legislations are originated by the national government and then passed over to the Council of Governors for comments in what amounts to mere consultation that falls short of full compliance with the obligations of cooperative government. Often, the COG is given very short notice to comment, yet its statutory mandate is to coordinate the forty-seven counties to develop common positions in respect of the policy or legislation under consideration. The approach enables national government which tends towards discretionary decision-making to encroach upon and recentralize the functions and powers of county governments; undermines the relative autonomy of county governments; disrupts mutual trust and interdependence among the governments; and destabilises the balance of power between national and county governments, including the checks and balances the devolved system was meant to create.

The need for joint policy and legislative solutions

As a solution to the problems created by unilateral imposition of policies and legislation by the national government, re-engineered cooperative devolved government and intergovernmental relations encourages collaborative and joint pursuit of policy and legislative solutions and strategies. Joint formulation of policy and legislative solutions or reform of existing policies and legislations protects the functions and powers of each level of government; avoids discretion, usurpation, encroachment and recentralization of functions and powers by national government without the consent of county governments; safeguards the autonomy of county governments; ensures stability and the balance of power within the devolved system; and increases the capacity to make good policies and laws that are easily accepted and implemented by both levels of government, which results into improved delivery of services to the citizenry. Collaborative joint policy and legislative solutions should be realised through intergovernmental structures and institutions such as joint committees of the two levels of government.

The problem of intergovernmental institutions that are not constituted as such

Several constitutional and statutory institutions that ideally have an important intergovernmental role are either not constituted as such or do not undertake their responsibilities as critical intergovernmental institutions that ought to serve both levels of government in a neutral way.

The role of Cabinet in approving draft policies and legislation

Ordinarily, draft policies and legislations are first tabled before the National Government Cabinet for approval before presentation to Parliament for consideration, debate, and passage. The Cabinet is thus a critical player in ensuring that such draft policies and legislations are originated and developed jointly by the two levels of government. The President may require such draft policies and draft legislations to be accompanied by a statement indicating whether they were developed jointly by the two levels of government. He may also require such draft policies and draft legislations to be approved by the Ministry for Devolution which must also make its own statement about the draft policy or legislation at the Cabinet before approval by cabinet.

The institutional vacuum in the policy and legislation making

The process of transition from the unitary to the devolved system of government was overseen by the Commission on Implementation of the Constitution (CIC) established under the Constitution and a statutory Transition Authority (TA) established under the Transition to Devolved Government Act, both of which had responsibility to ensure that the draft policies and legislations were in conformity with the constitution. The terms of both CIC and TA expired before the completion of the transition process thereby leaving an institutional vacuum in the process of development of enabling policies and legislations.

The role of MODA in the devolved system and processing of draft policies and legislations

Section 121(1) of the County Governments Act envisages the establishment of a 'ministry or government department responsible for matters relating to intergovernmental relations. According to Executive Order Number 1 of 2013, the President established a Ministry of Devolution and Planning. However, Executive Order Number 2 of 2013 assigned to this ministry only five functions relating to intergovernmental relations; and twenty-nine other functions not directly related to intergovernmental relations. These other functions may have distracted the ministry from its intended core function of coordination of national and county governments. The Ministry should be established as a Ministry of Devolution, Justice and Constitutional affairs or Devolution, Justice and Constitution Implementation Affairs and be charged with the responsibilities that the defunct CIC used to perform. While respecting the functions of the Intergovernmental Relations Technical Committee (IGRTC), the functions of the ministry should be refocused on matters of coordination between national and county governments, especially in the development and implementation of policies and legislations. The Ministry of Devolution should play a critical role in the development of draft policies and draft legislations by other ministries to ensure that they do not undermine devolution. All other ministries should be required to coordinate with the ministry of devolution to ensure that any policies and legislations they are developing are undertaken jointly with county governments. Both Cabinet and Parliament should require a statement from the ministry of Devolution in respect of any draft policy or legislation tabled before them for approval or consideration, debate, and passage.

The role of the National Treasury in the devolved system of government

Article 225(1) empowers Parliament to enact an Act of Parliament to 'provide for the establishment, functions and responsibilities of the National Treasury'. In the context of the devolved system of government, parliament should have established a national treasury that is an independent organ of state serving the interests of both national and county governments in a neutral manner. On the contrary, section 11 of the Public Finance Management Act establishes the national treasury as 'an entity of the national government'. This is despite the fact that the functions of the national treasury set out by section 12 of the Act affect both national and county governments. These provisions undermine mutual trust and interdependence between national and county governments whenever the National Treasury deals with disputes between the national and county governments. It is recommended that the provisions be amended to allow for establishment of the national treasury as an independent state organ.

Should debt repayment be a first charge on the shareable revenue?

Currently, debt repayment is regarded as a first charge on the shareable revenue. This undermines the concept of equitable sharing of revenue raised nationally as it allows the national government to increase its equitable share through borrowing. The correct interpretation and application of Article 203 criteria is that all the criteria should be considered together although some will have higher weighting than others.

The role of the Bicameral Parliament in the enactment of policies and legislation

The Constitution establishes a Parliament that is composed of two houses—the National Assembly and the Senate. While Article 96 specifies that the Senate represents the counties and serves to protect the interests of the counties and their governments; even the National Assembly makes many decisions that affect devolution and county governments in fundamental ways, and this makes both houses of Parliament critical players in the devolution arena. However, poor working relations between the National Assembly and the Senate have become serious barriers in the legislation making process.

Persistent conflicts between the National Assembly and the Senate

Persistent conflicts between the National Assembly and the Senate regarding the interpretation and application of Article 110 of the constitution in the law-making process have led to policy and legislative barriers to the efficient and effective delivery of health services by both levels of government. These conflicts degenerated into a High Court judgement in October 2020 declaring 23 laws unconstitutional and invalid for having been passed by the National Assembly without involving the Senate. Although the Court of Appeal recently delivered judgement partly allowing and partly rejecting the appeal of the National Assembly, there is urgent need to address and conclusively resolve this conflict to ensure a smooth legislative process with appropriate participation of both houses as envisaged by the constitution.

The challenge of piecemeal Amendment Bills

Since the expiry of the term of the CIC, comprehensive review of old order unitary legislations to fully align them to the constitution and the devolved system of government almost ceased and an approach of piecemeal amendment of existing laws adopted. At times different Amendment Bills that propose contradictory amendments to the same legislation are introduced in each of the two houses of Parliament. Good examples in this regard are proposed amendments to the Mental Health Act; the Health Act; and the Hospital Insurance Fund Act. It is recommended that the two Houses of Parliament Jointly amend their Standing orders and establish a joint Committee of the two houses to be charged with the responsibility of examining all the Bills introduced in each of the houses to determine whether they concern counties and advise the Speakers of the two houses to make a decision based on the advice; identify any multiple Bills on the same issue and seek to merge and or harmonise them before any of the houses considers them; and to undertake any other functions that require a joint solution of the two houses of Parliament. The amended Standing Orders should also expand the scope of the necessary disclosures that should be made in all Bills to include a disclosure on whether the Draft Bill was originated by the national government alone or jointly with county governments.

The need to implement sections 54 and 114 of the County Government Act

Section 54 of the County Government Act provides for establishment of a county Intergovernmental Forum chaired by the County Governor and brings together all the heads of the national government departments rendering services in the county and all the County Executive Committee members. The responsibilities of this forum are harmonisation of services rendered in the county; coordination of development activities in the county; and coordination of intergovernmental functions. National and county governments have not operationalized this section in many counties and yet it provides an important infrastructure for coordinated development and delivery of services in the counties.

On the other hand, section 114 of the County Government Act requires that one, development of nationally significant development projects within counties be preceded by mandatory public hearings in each of the affected counties; and two, after such mandatory hearings, the projects be considered and approved or rejected by the County assembly. This is an extremely important provision for even ensuring accountability and equity in distribution of national government projects, yet the national government continues to implement development projects even in the health sector without complying with this section.

The need for a legal framework to operationalize Article 189(2) Joint Committees and Joint Authorities

Given the important role of joint solutions to policy and legislative problems and the delivery of health services generally, there is urgent need for enactment of a legislation to operationalize Article 189(2) which envisages that both national and county governments; and the county governments among themselves can establish joint committees and

joint authorities through which they can perform some of their functions and exercise some of their powers. The legislation should provide for a legal framework including processes for establishment of such joint entities. County governments have currently informally established various Regional Blocs that bring together counties in the same region to work together and rip the benefits of economies of scale through establishment of shared specialised facilities and services. Establishment of these regional Blocs is best facilitated by a national legislation of the kind proposed.

The legal status, institutional and financial capacity of the COG secretariat

Sections 11, 12 and 15 of the Intergovernmental Relations Act of 2012 envisage that the Intergovernmental Relations Technical Committee (IGRTC) and its Secretariat will be the Secretariat of the Council of Governors (COG). For various reasons including the fact that IGRTC was not established until early 2015 long after the COG had been established and forced to establish its own Secretariat, this has not worked well or at all. COG thus operates with a Secretariat that is not established in law and is not funded by the exchequer. This has been a major barrier to the effective performance of the COG's coordination functions. Through various proposed amendments to the Intergovernmental Relations Act, there is consensus among the COG, IGRTC and the Ministry of Devolution that there is a need to amend the legislation to establish a separate Secretariat for COG that would be legally recognized in law and funded by the exchequer. It is recommended that a Joint Committee of the three institutions be established to study and harmonise these proposed amendments and hasten their being tabled in Parliament for enactment.

Health workforce issues.

Although there have been many health workforce issues that have posed challenges to the delivery of health services, this policy brief addresses a few that have intergovernmental relations dimensions. First, there is the problem of an apparent misinterpretation and application of Article 235 which empowers each county government to, 'within a framework of uniform norms and standards prescribed by an Act of Parliament' establish and abolish offices in its public service; appoint and confirm persons to those offices; and exercise disciplinary control over its public officers. The misinterpretation of this provision has led to an apparent unconstitutional section 31 of the Health Act which assigns to the Kenya Health Human Resources Advisory Council functions to review and establish uniform norms and standards without requiring them to be prescribed by an Act of Parliament as stipulated by Article 235 of the constitution. Secondly, contrary to the obligation to pursue joint policy and legislative solutions, recent statements from the Minister for Devolution indicate that the Ministry has without involvement of county governments embarked on drafting legislation to provide for transfer of county staff to other counties. Thirdly, there is the problem of county governments continuing to pay the personnel emoluments of county health workers when they are on study leave, even when such health workers are rendering services in National Government teaching and referral health facilities. It is recommended that county governments coordinate with the national government to take over the burden of personnel emoluments during the training period of such health workers. Fourthly, there is a need for the national government to coordinate with county governments when negotiating bilateral agreements touching on health workers such as agreements to bring in foreign health workers to work in county health facilities; and to recruit Kenyan health workers for employment in foreign countries.

Recommendations and way forward

Considering the matters discussed above, the following recommendations and way forward should be considered:

1. County governments should engage the national government and agree to re-engineer cooperative devolved government and intergovernmental relations to embrace the pursuit of joint policy and legislative solutions in the health sector, undertaken through joint committees and joint authorities.

2. The County Governors should coordinate with the President through the Summit and secure his consent to restructure the process of cabinet approval of draft policies and draft legislations to require--

    a. Disclosure by the relevant ministry on whether the policy or legislation was originated jointly by the national and county governments.
    b. The involvement of the Ministry of Devolution in the development of the draft policy or legislation to confirm whether the policy or legislation concerns county governments and coordinate the involvement of county governments in its development.
    c. A statement by the relevant ministry on whether the Ministry of Devolution was involved in the development of the policy or legislation.
    d. A statement of the Ministry of Devolution to confirm its involvement in the development of the policy or legislation.

3. The County Governors should engage the President through the Summit on the need to restructure the Ministry of Devolution into a ministry of Devolution, Justice and Constitutional affairs or Devolution, Justice and Constitution Implementation Affairs to take over the functions of the defunct CIC, and also focus its mandate on coordination of the national and county governments; coordination of intergovernmental relations; and ensuring strict compliance to the constitutional mandates of the two levels of government, especially in the process of development of policies and legislations.
4. The County Governors should coordinate with the President through the Summit and establish a Joint Committee to review the Public Finance Management Act leading to Amendments that aim to establish the National Treasury as an independent state organ that serves both levels of government in a neutral manner.
5. The County Governors should engage the President through the Summit on the need to engage the Speakers; Majority; and Minority Leaders of the two houses of Parliament regarding the need to amend the Standing Orders of the two houses of Parliament to--

    a. Conclusively resolve the persistent conflicts between the two houses over the interpretation and application of Article 110 of the Constitution regarding the role of the Senate in the legislative process.
    b. Establish a Joint Committee of the two houses charged with the responsibility of determining and advising the Speakers on whether a Bill concerns county governments and reviewing and harmonising bills introduced in the two houses of Parliament to avoid multiple piecemeal Amendment Bills.
    c. Require each Bill to disclose whether it was originated jointly by the national and county governments.

6. The County Governors and the national government should take the necessary steps to implement sections 54 and 114 of the County Government Act
7. The County Governors should engage the President through the Summit and establish a joint committee of the national government, county governments, IGRTC and the Ministry of Devolution to review the Intergovernmental Relations Act and all the previously proposed amendments and propose amendments that streamline intergovernmental relations including amendments to establish a separate COG Secretariat that is legally recognized and funded by the Exchequer
8. The County Governors should engage the Ministry of Health and the National Treasury to find agreement on how best the National Government can take over the payment of Personnel Emoluments of county governments' Health workers when they are on further studies and working in the National Teaching and Referral health facilities.

PRESENTATION BY DR. MUTAKHA KANGU, AN INTERGOVERNMENTAL RELATIONS EXPERT

Cooperative devolved government and re-engineered intergovernmental relations

- The Constitution establishes a system of cooperative devolved government which necessitates cooperative intergovernmental relations, and the pursuit of joint solutions to most policy and legislative problems.
- Lack of proper understanding and operationalization of cooperative devolved government, and intergovernmental relations are major policy and legislative barriers to effective and efficient delivery of health services by the national and county governments.

The essence of cooperative devolved government

- The essence of cooperative devolved government is that—
  - Although the constitution creates two levels of government that are distinct, and
  - Assigns them both exclusive and concurrent functions and powers;
  - the levels of government are also interdependent and
  - must cooperate with each other when performing their functions and exercising their powers.
- The concept refers to collaborative and coordinated partnership between the two levels of government.
- The concept imposes obligations that go beyond mere consultation and require collaboration, coordination, and cooperation based on partnership, and pursuit of joint solutions to policy and legislative problems as opposed to unilateral imposition of policy and legislative solutions.

The problem of discretionary policy and legislation making and the need for joint policy and legislative solutions

- Despite the obligations of cooperative devolved government which favour pursuit of joint solutions to policy and legislative problems; policy and legislation making have suffered from what appears to be unilateral imposition of policies and legislations by national government.
- Some policies and legislations are passed without involvement of county governments, while Others are subjected to mere consultation and on short notice.
- This enables national government imposition and encroachment of county functions.
- As a solution re-engineered cooperative devolved government and intergovernmental relations encourages collaborative and joint pursuit of policy and legislative solutions and strategies.

The problem of intergovernmental institutions that are not constituted as such

- The following constitutional and statutory institutions that have critical intergovernmental responsibilities are not constituted as such or do not realize their IGR role.
- The national Cabinet plays a critical role in approving draft policies and legislations before the go to Parliament and is a critical player in ensuring that such draft policies and legislation are originated and developed jointly by the two levels of government.
- The President has constitutional powers to structure and organize cabinet, assign functions to various departments, determine the processes of cabinet operation, and can require other Ministries to coordinate with the Ministry of Devolution when originating draft policies and legislations.
- The National Treasury which as envisaged by Article 225 should have been established as an independent state organ that serve both levels of government in a neutral manner.

The institutional vacuum in the policy and legislation making

- The terms of both CIC and TA which were responsible for overseeing transition and auditing draft policies and legislations before submission to Parliament expired before the completion of the transition process thereby leaving an institutional vacuum in the process of development of enabling policies and legislations.
- This vacuum could be filled by MODA which was envisaged by section 121(1) of the County Governments Act as a 'ministry or government department responsible for matters relating to intergovernmental relations and could be established a Ministry of Devolution, Justice and Constitutional affairs or Devolution, Justice and Constitution Implementation Affairs and be charged with the responsibilities that the defunct CIC used to perform.

The role of the Bicameral Parliament in the enactment of policies and legislations…1

- The Constitution establishes a Parliament that is comprised of two houses—the National Assembly and the Senate that have critical intergovernmental responsibilities, especially in legislative matters.
- Both the Senate and the National Assembly make critical decisions that affect devolution and county governments.
- However, poor working relations between the National Assembly and the Senate have become serious barriers in the legislation making process.
- Persistent conflicts between the National Assembly and the Senate regarding the interpretation and application of Article 110 of the constitution in the law-making process have led to policy and legislative barriers to the efficient and effective delivery of health services by both levels of government.

The role of the Bicameral Parliament in the enactment of policies and legislations…2

- The two Houses of Parliament should—
  - Jointly amend their Standing orders and
  - establish a joint Committee of the two houses
  - For examining all the Bills introduced in each of the houses
  - to determine whether they concern counties and advise the Speakers of the two houses; and
  - identify any multiple Bills on the same issue and seek to harmonize them consideration by either house.
  - Require disclosure whether a Draft Bill was originated by national government alone or jointly with county governments.

The need for a legal framework to operationalize Article 189(2) Joint Committees and Joint Authorities…1

- Given the important role of joint solutions to policy and legislative problems there is urgent need for enactment of a legislation to operationalize Article 189(2) which envisages that both national and county governments; and the county governments among themselves can establish joint committees and joint authorities through which they can perform some of their functions and exercise some of their powers.
- The legislation should provide for a legal framework for establishment of regional blocs to rip the benefits of economies of scale through establishment of shared specialized facilities and services.

The legal status, institutional and financial capacity of the COG Secretariat... 1

- There is need to amend the intergovernmental Relations Act to establish the Secretariate of the COG to give it legal status and exchequer funding to enable it discharge its functions effectively.
- Through various proposed amendments to the Intergovernmental Relations Act —
  - There is consensus among the COG, IGRTC and the Ministry of Devolution that there is need to amend the legislation.
  - To establish a separate Secretariat for COG that would be legally recognized in law and funded by the exchequer.
- A joint Committee of the three institutions should be established to study and harmonize these proposed amendments and hasten their being tabled in Parliament for enactment.

Health workforce issues... 1

- There is the problem of an apparent misinterpretation and application of Article 235 which empowers each county government to, 'within a framework of uniform norms and standards prescribed by an Act of Parliament' establish and abolish offices in its public service; appoint and confirm persons to those offices; and exercise disciplinary control over its public officers.
- The misinterpretation has led to an apparent unconstitutional section 31 of the Health Act which assigns to the Kenya Health Human Resources Advisory Council functions to review and establish uniform norms and standards without requiring them to be prescribed by an Act of Parliament as stipulated by Article 235 of the constitution.

Health workforce issues... 3

- Contrary to the obligation to pursue joint policy and legislative solutions, recent statements from the Minster for Devolution indicate that the Ministry has without involvement of county governments embarked on drafting legislation to provide for transfer of county staff to other counties.
- The problem of payment of personnel emoluments of health workers on study leave.
- The need for coordination between national government and county governments when negotiating bilateral agreements touching on health workers such as agreements to bring in foreign health workers to work in county health facilities; and to recruit Kenyan health workers for employment in foreign countries.

Re-examination of unbundling and transfer of functions and powers... 1

- Failure to properly and fully unbundle and transfer functions and powers is a major policy and legislative barrier.
- This has enabled old order policies, legislations, and institutions such as parastatals dealing with devolved health functions to continue to exist in the unitary form.
- It has also enabled policy and legislation-making to proceed without being informed by proper constitutional interpretation of the functions and powers.

Re-examination of unbundling and transfer of functions and powers... 2

- This results in policies and legislations that do not conform to the constitution and the devolved system; undermine devolution; and encroach upon the functions and powers of county governments.
- This has let to unfinished unbundling and transfer of functions since the term of the Transition Authority expired before the exercise was complete.
- As required by legislation, the residual functions of the TA were taken over by the IGRTC from March 2016.
- The IGRTC has not completed the analysis and unbundling of functions exercise with functions of over 156 state corporations established under old order legislations still being performed by these corporations.

Re-examination of unbundling and transfer of functions as a constitutional interpretation exercise

- There is urgent need to re-examine the unbundling and transfer of functions and powers to—
  1) Complete the unfinished unbundling and transfer of functions and powers
  2) To re-evaluate the unbundled and transferred functions to ensure consistence with the constitutional assignment of functions.
- This process should aim to—
  - determine the content of every function assigned by the constitution;
  - isolate the exclusive functions from the concurrent ones; and
  - determine the residual functions which the constitution says are assigned to the national government.

The need for a functions and powers Act... 1

- Guided by the constitutional interpretation principles—
  - there is urgent need for the two levels of government
  - to form a joint committee to work with the IGRTC
  - to unbundle functions in all the devolved sectors; and
  - lead to the enactment of a Functions and Powers Act.
- The Functions and powers Act should provide for the following matters.
  1) Create three lists of functions and powers.
  2) Create two lists sharing out the different aspects of concurrent functions and powers to the two levels of government.

The need for a functions and powers Act... 2

3) Provide for a legal framework for assignment of additional functions by national government to county governments under Articles 186(3) and 183(1)(b).

4) Provide for a legal framework for transfer of functions from either level of government to the other under Article 187

The need for comprehensive review of old order legislations...1

- Adoption of a supreme constitution necessitates comprehensive review of all old order legislations to comply with the constitution and the devolved system.
- A joint committee of national and county governments should be established to undertake the comprehensive review of all the old order legislations.
- Some state corporations established as entities of national government may have to be abolished while others are re-established as joint entities of national and county governments under Article 189(2) of the constitution.

Recommendations and way forward...1

1) County governments should engage the national government and agree to re-engineer cooperative devolved government and intergovernmental relations to embrace the pursuit of joint policy and legislative solutions in the health sector, undertaken through joint committees and joint authorities.

2) The County Governors should coordinate with the President through the Summit and secure his consent to restructure the process of cabinet approval of draft policies and draft legislations to require—
   a. Disclosure by the relevant ministry on whether the policy or legislation was originated jointly by the national and county governments.

Recommendations and way forward...2

   b. The involvement of the Ministry of Devolution in the development of the draft policy or legislation to confirm whether the policy or legislation concerns county governments and coordinate with COG the involvement of county governments in its development.
   c. A statement by the relevant ministry on whether the Ministry of Devolution was involved in the development of the policy or legislation.
   d. A statement of the Ministry of Devolution to confirm its involvement in the development of the policy or legislation.

3) The County Governors should engage the President through the Summit on the need to restructure the Ministry of Devolution into a ministry of Devolution, Justice and Constitutional affairs or Devolution, Justice and Constitution Implementation Affairs to take over the functions of the defunct CIC, and also focus its mandate on coordination of the national and county governments; coordination of intergovernmental relations; and ensuring strict compliance to the constitutional mandates of the two levels of government, especially in the process of development of policies and legislations.

Recommendations and way forward...3

4) The County Governors should coordinate with the President through the Summit and establish a Joint Committee to review the Public Finance Management Act leading to Amendments that aim to establish the National Treasury as an independent state organ that serves both levels of government in a neutral manner.

5) The County Governors should engage the President through the Summit on the need to engage the Speakers; Majority; and Minority Leaders of the two houses of Parliament regarding the need to amend the Standing Orders of the two houses of Parliament to—
   a. Conclusively resolve the persistent conflicts between the two houses over the interpretation and application of Article 110 of the Constitution regarding the role of the Senate in the legislative process.

Recommendations and way forward...4

   b. Establish a Joint Committee of the two houses charged with the responsibility of determining and advising the Speakers on whether a Bill concerns county governments and reviewing and harmonizing bills introduced in the two houses of Parliament to avoid multiple piecemeal Amendment Bills.
   c. Require each Bill to disclose whether it was originated jointly by the national and county governments.

6) The County Governors should take the necessary steps to implement sections 54 and 114 of the County Government Act.

Recommendations and way forward...5

7) The County Governors should engage the President through the Summit and establish a joint committee of the national government, county governments, IGRTC and the Ministry of Devolution to review the Intergovernmental Relations Act and all the previously proposed amendments and propose amendments that streamline intergovernmental relations including amendments to establish a separate COG Secretariat that is legally recognized and funded by the Exchequer.

8) The County Governors should engage the Ministry of Health and the National Treasury to find agreement on how best the National Government can take over the payment of Personnel Emoluments of county governments' Health workers when they are on further studies and working in the National Teaching and Referral health facilities.

Recommendations and way forward...6

7) The County Governors should engage the President through the Summit and form a joint committee of the national government and county governments to work with the IGRTC, to undertake a thorough unbundling and transfer of functions in all the devolved sectors leading to the enactment of a Functions and Powers Act.

BIOGRAPHIES

H.E Governor Francis Thuita Kimemia, EGH, CBS, HSC

Governor - Nyandarua County

H.E Kimemia is one of the longest-serving civil servants in the history of Kenyan Government. He has a Master's degree in Business Administration from the Eastern Southern African Management Institute, a Bachelor of Arts degree in Public Administration from Moi University and a Bachelor of Arts degree in Political Science from the University of Nairobi. He currently serves as the second Governor of Nyandarua County, a seat he holds from 2017. Before joining politics, he served in several positions in the government including Secretary to the Cabinet, Head of Civil Service and Permanent Secretary in the Ministry of State for Provincial Administration and Internal Security.

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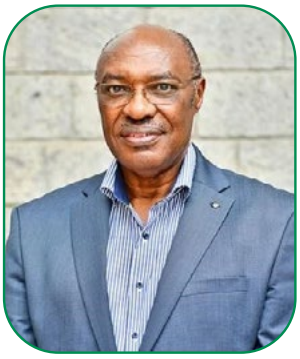
Dr. Mutakha has a Doctor of Law (LLD) degree in the area of Local Government and Decentralization in Africa - University of the Western Cape, an LLM - University of South Africa, and an LLB - University of Nairobi. Dr. Kangu currently serves as an Inter-Governmental Relations Expert Consultant seconded by USAID to COG Health Committee. He is also a Senior Lecturer in law at the School of Law, Moi University, where he has been teaching since 1997. Previously, Dr. Mutakha has served as a Commissioner in the Constitution of Kenya Review Commission (CKRC) where he played a central role in the conceptualization and design of the Kenya devolution.



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SESSION 5: COUNTY HEALTH SERVICE DELIVERY READINESS AND PREPAREDNESS

Introduction

For nearly two (2) years, COVID-19 has presented humanity with one of the biggest public health challenges in recent history. The COVID-19 pandemic, as well as health consequences of increased drought and floods associated with climate change, have brought to the fore the need to assess and strengthen Kenya's health sector emergency management and disease surveillance capacities. Studies and practice have shown that jurisdictions that lack health disaster preparedness and risk reduction measures are more likely to have their public health and medical systems overwhelmed when disaster strikes, causing more morbidities, mortalities, and other negative direct social and financial impacts to communities and governments.

Effective disease surveillance and response systems are critical components of disease prevention and control. A good disease surveillance system provides effective tools and processes to collect, analyze and interpret data to generate useful information on patterns and determinants of disease occurrence in a timely manner for action by policy makers, health managers and health personnel. While the COVID-19 pandemic highlighted gaps in Kenya's routine disease surveillance mechanisms that were filled through parallel COVID-19 specific case reporting, patient tracking and vaccination systems, studies have shown various gaps in County level routine surveillance systems, especially in regard to collection, analysis and use of community level data for decision making in public health facilities and the completeness of data collected from non-government owned health facilities. This session reviewed health service delivery in the context of COVID-19, allowing a critical analysis and review of Kenya's emergency health systems, disease surveillance and response and investments in preventive health.

Session Discussions

This session was moderated by H.E. Sospeter Ojaamong, Governor, Busia County and Vice Chair of the CoG Health Committee. The thematic presentations were delivered by Dr. Eda Mohamed, CECM for Health, Mandera County and critically analyzed by a discussant, Dr. Khadija Shikely, Chief Officer of Health, Mombasa County, who provided professional and constructive criticism and raised issues for broader consideration. Key thematic issues discussed during this session included: strengthening health sector emergency preparedness and response; increasing focus and investments in preventive health; and strengthening disease surveillance and response.

Figure 15: H.E. Hon. Sospeter Ojaamong moderating a session on County health service delivery readiness and preparedness flanked by key discussants Dr. Mohamed Eda - CEC Health (left) - Mandera County (left) and Dr. Khadija Shikely (right) - Chair of the Caucus of Chief Officers of Health Caucus

On emergency preparedness and readiness of County health care systems, the meeting agreed on the following key issues:

1. Kenya has faced a significant increase in disasters over the past decades (including health disasters) causing increased death, sickness, loss of livelihoods and loss of property. The health sector has a critical role in disaster preparedness, mitigation, response and recovery. The overall cost of disasters in Kenya has also significantly increased over the past decades.
2. Jurisdictions with weak health disaster management are vulnerable when disasters hit, thus more likely to have their governments, communities, families and individuals more severely affected by the negative effects of disasters.
3. The COVID-19 pandemic as well as health consequences of increased drought and floods associated with climate change have brought the need to assess and strengthen Kenya's health sector disaster management capacities.
4. There is need to improve coordination of health disaster management between the two levels of government, horizontally between Counties and between health sector actors and security disaster management actors. This can be achieved through activation of Sec 54 of County Governments Act, unbundling of the Disaster Management function to provide clarity on the functions between the County Governments and National Government given that this is a concurrent function, among other deliberate measures.
5. While the Public Finance Management Act section 110 provides that County Governments can establish Emergency Funds, only few County Governments have established these, and even for the established funds routine contribution remains a challenge. Health facilities providing emergency care to patients in need of urgent care, but not able to pay for these services are also accruing large liabilities.
6. The Public Health Act, and the Disaster Management bill 2019 are insufficient in addressing challenges around health disaster management and need to be reviewed to make them effective tools in addressing these challenges.
7. Other key issues on health disaster management include the fact that: a) Most health sector personnel do not have formal training in disaster management - both pre-service and in-service; b) Although Kenya has elaborate border surveillance programs, strengthened during the COVID-19 pandemic, there is lack of elaborate frameworks on cross border management of health disasters with most neighbouring nations; c) County capacity for health disaster prediction and early warning, as well as use of data for decision making in health disasters needs to be stepped up; and d) Health services continuity planning in disasters needs stepping up.
8. National and County leadership should increase investment in emergency preparedness and response for health and training and specialisation based on risks which are specific to each County.

Figure 16: Meeting participants keenly follow the discussions

On expanding investments in preventive care, the forum agreed on the following key issues:

1. Kenya's investments in preventive health to build a healthy population, reduce morbidity and mortality and save resources in both healthcare and social services have been, and remain suboptimal.
2. Prevention is cost effective – reducing cost of treatment, saving on time & other things lost to bad health, optimising treatment and rehabilitation.
3. Changing burden of disease, population dynamics like aging, high cost of healthcare calls for stronger prevention interventions.
4. The meeting noted that a good preventive health system translates into a healthier and frees up more resources for other health care services. Eliminating basic illnesses provides sufficient time for clinicians to better diagnose some cases rarely picked, like cancers, early in time, but also allows better patient and clinician interactions and further makes health facilities more socially accountable.
5. Preventive health goes beyond typical health sector activities and should include other sectors including agriculture, education, physical planning, and WASH.
6. There is need to enhance outcome measurement for preventive health services.
7. Social health insurance should be administered in a manner that promotes and encourages preventive health and healthy living.

On strengthening County-level disease surveillance and response, the meeting agreed on the following key issues:

1. Effective disease surveillance systems that collect, analyze and interpret data to generate useful information are critical components of any health system.
2. A good disease surveillance system provides practical tools and processes to collect, analyze and interpret data to generate timely and useful information on patterns and determinants of disease occurrence for action by policymakers, health managers, and health personnel.
3. Community-level data management, use of data for decision making and completeness of data collected from non-government owned health facilities are persistent challenges in disease surveillance.
4. Kenya has developed the Event-Based Surveillance (EBS) Technical Guidelines 2020. Counties need to implement the EBS.

Other key issues discussed during the meeting included:

1. A consensus on the need for County Governments to promote collegiate training for specialists.
2. An agreement that future meetings should include all the regulatory bodies in the health sector.
3. The need to cost County health functions in order to support advocacy for sufficient budgetary allocation to the health function within Counties.

Recommendations

On enhancing emergency preparedness and readiness of County Health Care Systems, there is need for:

1. Ensuring clarity in the assignment of disaster management roles between the two levels of government.
2. Increasing structured multi-sectoral and multi-agency coordination in addressing disasters.
3. Review of the Public Health Act Cap 242 to make it an effective tool for emergency management, and the Disaster Management Bill 2019.
4. National and County leadership to increase investment in emergency preparedness and response for health.

Figure 17: H.E Hon. Stephen Sang, Governor - Nandi County, contributes to the discussion

On expanding Investments in preventive care, there is need for:
Determining and increasing investment in disease prevention.

1. Improving outcome measurement for preventive health – both human capacity and databases like KHIS.
2. Strengthening inter-sectoral collaboration.

On strengthening County Level Disease Surveillance and Response, there is need for:

1. Supporting the roll out of EBS.
2. Strengthening disease surveillance - community level, health data in emergency contexts.
3. Fostering use of data for decision making - community level, health facility and management levels.
4. Reviewing policy on routine reporting - targeting community level, Private health facilities and faith-based health facilities.

POLICY BRIEF 009: EMERGENCY PREPAREDNESS AND READINESS OF COUNTY HEALTH CARE SYSTEMS

Introduction

In the past two decades, the world has realized astronomical increases in humanitarian needs and costs of responding to disasters, including health disasters.[24] The COVID-19 pandemic, as well as health consequences of increased drought and floods associated with climate change, have brought to the fore the need to assess and strengthen Kenya's health sector disaster management capacities. Studies and practice have shown that jurisdictions that lack health disaster preparedness and risk reduction measures are more likely to have their public health and medical systems overwhelmed when disaster strikes, causing more morbidities, mortalities, and other negative direct social and financial impacts to communities and governments.

KEY ISSUES, CHALLENGES & POLICY OPTIONS

Coordination between National and County level Governments in health disaster management

The Constitution of Kenya 2010 identifies Disaster Management as a concurrent function between the National and County Governments. Schedule 4, Section 1 gives the Disaster Management role to the National Government, while Section 2 gives the role "disaster management and firefighting" to County Governments. The National Government has formed various disaster management agencies with both exclusive and overlapping roles. Through an Executive order, the National Disaster Management Unit (NDMU) has been formed within the National Police Service to take charge on all issues of disaster management in the country. Through acts of parliament, the National Drought Management Authority (NDMA) and the National Disaster Operations Centre (NDOC) were formed. NDMA is mandated to exercise overall coordination over all matters relating to drought risk management and to establish mechanisms, either on its own or with stakeholders, that will end drought emergencies in Kenya; while NDOC acts as a focal point for emergencies and disasters response coordination, resource mobilization, and reporting and operates and emergency operations center. All these agencies operate under the Ministry of interior and coordination of the National Government. The implementation of Kenya's 2010 constitution anticipated that the Transition Authority was to facilitate a process that ensured all concurrent functions to be clearly unbundled so as each level of government is clear on specific responsibilities within the broader function that it is responsible for. With the unbundling of the Disaster Management function not yet done, there is lack of clarity on the functions of County and National Governments in this area. There is a proposed National Disaster Management Bill 2019 that recommends the formation of a single disaster management authority, but this bill too is unclear on the function split between the two levels of Government. There is thus a need to clearly highlight the roles of each level of Government in health disaster management.

Coordination between health sector actors and the disaster management actors

Whilst the disaster management structures are in charge of all disaster activities, it is key to note that health teams have significant roles when in contexts of health disasters. In addition to lack of structural clarity between levels of Government, experiences from both the COVID-19 pandemic and recurrent health emergencies such as drought and floods have shown challenges in coordination and communication between health sector actors and the disaster management actors primarily under the Ministry of Interior, leading missed opportunities to for cross sector learning in health emergency management. While the health sector experts have

22 U.N. Office of Coordination of Humanitarian Affairs. Saving Lives Today and Tomorrow: Managing the Risk of Humanitarian Crises, accessed September 15, 2015, http://www.unocha.org/saving-lives/ Carolyn M. Clancy and Kelly Cronin, Evidence-Based Decision Making: Global Evidence, Local Decisions, Health Affairs Vol. 24, No. 1

knowledge and skills in epidemiologic prediction and health service delivery in emergencies, disaster management practitioners can more clearly predict the course of the disaster and apply broad disaster management principles to save lives and property in emergency contexts. There is thus a need to foster closer partnerships between these two sectors.

Financing mechanisms for health disaster management

The Public Finance Management Act under section 110 provides that County Governments with approval from the County Assemblies may establish county government Emergency Fund. While a number of County Governments have established these funds through legislation, routine contribution to the fund remains a challenge to most governments and their agencies due to financial strain in providing regular services. There are also challenges in emergency management faced by health facilities as they provide emergency care to patients in need of urgent care but are not able to pay for these services. In addition to broader health disaster management financing, there is a current burden faced by health facilities as they provide their constitutional mandate of saving lives of people in need of emergency medical care, since some of these patients are unable to pay for services they receive.

Public Health Act Cap 242 as key tool in health Disaster Management

Laws that protect the health of the population may be organized and administered quite differently across different countries, depending on historical and constitutional factors, as well as specific health challenges each country has faced in the past. The concept of public health law is not limited to laws regulating the provision of health care services but extends to the legal powers necessary for the State to discharge its obligation to realize the right to health for all members of the population. The right to health is a fundamental human right guaranteed in the Constitution of Kenya. Article 43(1)(a) of the Constitution provides that every person has the right to the highest attainable standard of health. In order to provide this to the population, the Government uses various tools, including legislation. One key legislation from a Public Health perspective is the Public Health Act, Cap 242 of the laws of Kenya. This paper reviews and makes suggestions to strengthen Kenya's preparedness on emerging diseases like COVID-19. While the central reason for this proposed review is to entrench within the Public Health Act lessons learned from the COVID-19 pandemic response, some reviews were to align it to Kenya's devolved context. Various sections of this act are not aligned to the devolved health system of governance, and bodies formed through the act – like the Central Board of Heath – have not considered the COG and County Governments as key stakeholders. In addition to this, there is a need to review this act to strengthen Public Health actions for existing public health challenges, as well as emerging challenges like the COVID-19 Pandemic. Key recommended areas for amendment include: a) Making the act relevant and responsive to the current devolved context including ensuring county governments are supported in executing their mandate on devolved health functions; b) Realigning bodies formed under the Public Health Act to be aligned to the current constitutional and health sector context. Specifically, review the purpose, function, and constitution of the Central Board of Health; c) Reviewing fines and penalties under this Act in view that these are low in comparison to offenses. This has mainly been due to the devaluation of the Kenyan Shilling over time; d) Alignment of the Act to the current disease trends, both communicable and non-communicable diseases, as well as aspects of maintaining preventive health; e) Alignment of the Act to current health policy; f) Strengthening obligations of health workers in the Act; g) Ensure the act supports Kenya's compliance with relevant international obligations and laws; h). Strengthen the Monitoring and Evaluation mechanisms of this, and other health laws in order to understand their effectiveness and contribution to the health sector; i) Clarifying the relationships between this Act and other Acts of Parliament, including re-defining supremacy between these Acts; and j) Ensure the act is aligned to the Constitution of Kenya 2010.

Other Key issues in strengthening health disaster management

In addition to the highlighted aspects necessary in strengthening health disaster management, there are various other issues of interest: a. The critical mass of Kenya's health sector human resource does not have any formal training in disaster management, both pre-service and in-service, b. Although Kenya has elaborate border surveillance programs, strengthened during the COVID-19 pandemic, there is lack of elaborate guidance on cross border management of health disasters with most neighboring nations; c. County capacity for health disaster prediction and early warning, as well as use of data for decision making in health disasters needs to be stepped up; and d. Health services continuity planning in disasters needs stepping up.

Conclusion

Overall, this paper calls for a clear split of disaster management roles between the two levels of government, increased coordination between health and disaster management sectors in addressing disasters and the review of the Public Health Act Cap 242 to make it an effective tool for emergency management. Further, the paper calls for National and County leadership to increase investment in emergency preparedness and response for health.

POLICY BRIEF 010: EXPANDING INVESTMENTS IN PREVENTIVE CARE: Policy and Legislative Facilitators to this Paradigm Shift

Introduction

Variations in health care services have been widely documented across the world. There is consensus that although per-capita expenditure on health remains a critical indicator in measuring various nations pursuit of good health, increased health care spending is not uniformly associated with improved health.[25] For Countries and Counties to optimize health investment, there is need to pay attention to its investment details, including resource split to prevention, curative and rehabilitative services. This policy paper critically reviews key barriers to preventive health, and suggests policy solutions

Why preventive health now?

In recent decades, Kenya's population has rapidly grown, life expectancy improved and an ageing population started to emerge despite the fact that the majority of Kenyans are aged below 35. The disease profile has changed from a context where communicable diseases comprised a majority of priority diseases, to a new norm where communicable diseases, non-communicable diseases and injury all pose a big strain to the health system. The prevalence of chronic lifelong conditions continues to increase. All these are critical pointers that Kenya needs to prioritize investments in preventive health and classical Public Health interventions if it's to achieve universal health coverage[26] . Studies have shown that in contexts like these, a failure to invest adequately in preventive health is likely to cause unsustainable increases in health costs. With most counties already investing about 30% of their budgets in health – despite having 14 devolved functions – and with continuous emerging needs for further investment in healthcare, and reducing donor funding, it is time to make a paradigm shift in health investments and ensure more elaborate investments in preventive health. Early investment in effective prevention would enhance good population health, reduce morbidity and mortality including from lifelong chronic illnesses and save resources in both healthcare and social services. A dollar invested in preventive health has been found to save 5 dollars in direct medical costs and up to 11 dollars on the overall costs, factoring in other potential losses like individual's productivity and caretaker costs. Despite this knowledge, investing in preventive care remains a big challenge to governments, both at national and sub national levels. Overall, countries that do not invest in preventive health spend much more per capita cost, in both direct and indirect costs, than those who invest in preventive health.

KEY ISSUES, CHALLENGES AND POLICY OPTIONS

Most Kenyan leaders, Policy makers, health managers, healthcare workers and communities agree to the slogan *Prevention is better than cure* - but that is as far as it goes. Investments in primary disease prevention remains low at individual, community, county, and national levels. This paper critiques key barriers to this investment and provides policy and practice options.

Expanding operational definition of preventive health in Kenya's health sector?

In recent decades, scientific and technological advances have rapidly expanded and accelerated understanding of disease causes, progression and transmission. This has resulted in innovative preventive, curative and rehabilitative approaches.[27]

Once a preserve of classical public health interventions, disease prevention currently encompasses a wide range of activities – both clinical and non-clinical – that are aimed in some way

25 Carolyn M. Clancy and Kelly Cronin, Evidence-Based Decision Making: Global Evidence, Local Decisions, Health Affairs Vol. 24, No. 1

26 https://healtheconomicsreview.biomedcentral.com/track/pdf/10.1186/s13561-021-00321-3.pdf

27 Institute of Medicine. 2010. Redesigning the Clinical Effectiveness Research Paradigm: Innovation and Practice-Based Approaches: Workshop Summary. Washington, DC: The National Academies Press. https://doi.org/10.17226/12197

to reduce the acquisition or transmission risk of any disease. With this expansion, most health managers perceive community level and primary health facility level interventions as preventive health, thus showing budgets as such. It is important to note that Community Health Volunteers in Kenya perform preventive, curative and rehabilitative work, and this is true for most levels of health care. As such, in identifying Kenya's investment in preventive health, there is a need for functional analysis. Evidence also shows minimum investment in classical Public Health interventions.

Perceptions and misconceptions on preventive health

Studies show that negative perceptions and misconceptions among policy makers, health decision makers and healthcare workers on disease prevention could result in lowered investments in the area. In this paper, we have given an indicative three perceptions and misconceptions that negatively affect preventive health and suggest policy options.

First and foremost, we note the misconception that increasing investment in disease prevention means there will be fewer resources available for treatment, leading to increased complications and death among patients. Also associated is a misconception that effective prevention could reduce patient flow numbers leading to job losses among treatment-based staff. These misconceptions fail to acknowledge the fact that better health potentially frees up resources for health care services by reducing avoidable health problems, thus allowing more investment in prevention, care, treatment and rehabilitation. Rather than reduce investments, preventive health has been found to allow the health sector to optimize the prevention and treatment investments since it's a cost-effective solution. For instance, effectively preventing diseases like malaria and diarhoea at community level will cut off a large number of patients seeking healthcare at health facilities, thus freeing up time for the already overwhelmed clinicians and saving on other resources. This will allow better patient – clinicians interactions, this improves not just the quality of diagnosis for complex conditions, but also foster the patient clinician relationship, making health facilities more socially accountable.

Secondly, there is a general misconception that disease prevention interventions can only make sense if they save money within the health sector sphere. While some disease prevention interventions are cost saving in the immediate term and within the sector, it should be noted that there are wider and longer-term cross-sectoral benefits of disease prevention beyond health. A disease successfully prevented means more hours of productivity for would-be patients and their caretakers, alternative utilization of medical costs by families (especially off-pocket health spending) and a reduction of days learners are absent from school among other benefits. Improving school attendance has been found to have lifelong benefits to learners, their families and the broader national development agenda.

Last, despite population level evidence from studies and evaluations showing disease prevention as an effective tool, there remain perceptions among some health workers and decision makers that the evidence base on the effectiveness of health promotion and disease prevention interventions is weaker than that for treatment-based care.

We note that the Kenya Health Information System (KHIS) and other available health information tools do not capture preventive data in a way that allows attribution of various positive outcomes and specific prevention efforts. As such, most disease prevention practitioners rely on scientific studies to make arguments for investments rather than local data. There is however a wide base of data that proves the effectiveness and cost efficiency of disease prevention. There is therefore a need for continued efforts to change negative misconceptions, perceptions and beliefs about preventive health interventions.

Measuring and presenting health outcomes

In recent years, evidence-based decision making has become a benchmark of best practice. With this, investments in healthcare have increasingly followed demonstratable outcomes. Apart from evidence from wider studies, various challenges face preventive health practitioners in presenting solid local evidence bases to convince policy makers on investment. The longer timeframes needed for most preventive health interventions to impact overall health outcomes, capacity gaps in preventive health care to accurately harvest outcomes and the population nature of preventive health outcomes – which are sometimes difficult to measure – remain key challenges in effective measurement of health benefits attributable to prevention. Much as most policy makers agree that for instance, hand washing has been an important component in COVID-19 prevention, it is difficult to quantify its contribution at local levels. What would have been the cost if this intervention was not taken up? What did this intervention really save? In addition to this, there are economic models that disadvantage preventive health. For example, the conventional use of discounting in economic analysis means that benefits appear less appealing the further into the future they occur, thus most preventive health interventions are disadvantaged, in contrast, many health care treatments have more immediate benefits that are not affected as much by discounting. We also note that Population interventions are impersonal and less attractive since they lack 'identifiable victims' while clinical many other interventions have this. Public health practitioners need to integrate social marketing approaches to give a human face to the potential beneficiaries of public health interventions, creating an image of a single individual who could benefit, and with whom decision-makers can identify – rather than a whole community or county. As such, there is a need to invest in improving measurements of outcomes for preventive health – both in human capacity as well as systems like the KHIS. Preventive health specialists need to integrate interventions with both short, medium term and longer-term results, and educate stakeholders on benefits of prevention – immediate, mid-term and long term.

Intersectoral Collaboration

Preventive health goes beyond activities done within the health sector. There is a wide range of activities and actions that promote and protect health that are delivered in other sectors outside the mainstream health system. Whilst in a few cases the mother sectors either underestimate or under-prioritize the importance of such interventions, the most common scenario is insufficient capacity in understanding and maximizing cross sectoral health benefits. Agriculture, education, physical planning, infrastructural development, water and sanitation as well as many other sectors directly drive health outcomes. In certain contexts, there are also fragmented funding structures for intersectoral activities. For instance, much as there are the current Kenya national sanitation function is delivered under the Ministry of Water, Sanitation and Hygiene, there still is a sizable sanitation workforce under the Ministry of Health. As such, there is a need to strengthen intersectoral collaboration in maximizing intersectoral benefits in preventive health. This collaboration should seek sectors to prioritize activities and interventions that pose benefits to health. There is a need to: a. Showcase non-health sector specific benefits associated with health promotion and disease prevention when making a case for investment; b. Identify potential shared objectives and goals and highlight 'win-win' situations for both sectors by investing in disease prevention; and c. Seek opportunities to co-locate relevant health and other sectors to help establish working relationships and trust.

Conclusion

Kenya's policy and legislative structures need to support optimal investment in disease prevention. In doing this, there is need to itemize and determine the level of funding spent on disease prevention, especially classical public health interventions; invest in changing negative misconceptions, perceptions and beliefs about preventive health interventions; invest in improving measurements of outcomes for preventive health – both in human capacity as well as systems like the KHIS; and strengthen inter-sectoral collaboration.

POLICY BRIEF 009: STRENGTHENING COUNTY LEVEL DISEASE SURVEILLANCE AND RESPONSE: Are There Gaps?

Introduction

Effective disease surveillance and response systems are critical components of disease prevention and control. A good disease surveillance system provides effective tools and processes to collect, analyze and interpret data to generate useful information on patterns and determinants of disease occurrence in a timely manner for action by policy makers, health managers and health personnel. While the COVID-19 pandemic highlighted gaps in Kenya's routine disease surveillance mechanisms that were filled through parallel COVID-19 specific case reporting, patient tracking and vaccination systems, studies have shown various gaps in County level routine surveillance systems, especially in regard to collection, analysis and use of community level data, the use of data for decision making in Public Health facilities and the completeness of data collected from non-government owned health facilities.

Key issues, Challenges and Policy Options

Are disease Surveillance needs changing? Although Kenya has largely dependent on an indicator-based health facility surveillance systems, there is need to expand and strengthen this approach given disease dynamics. With an increasing number of new infectious disease outbreaks emerging from animals and the environment – including COVID-19, SARS, Ebola, influenza, and the H1N1 swine flu among other examples - there is need to expand disease surveillance methodologies beyond just tracking cases of human disease to closely monitoring trends and triggers in the environment, animals, and other contextual sectors. Using the One Health approach, Kenya needs a surveillance system that identifies events and diseases to allow measures to be taken even before human illness. We note the importance of changes in other sectors to human health. For instance, Climate Change has been found to play a key role in facilitating the emergence of novel infectious agents, modifying habitats for vectors and cause various conditions that affect health; Deforestation has been found to increase proximal living of humans and wild animals, thus increasing chance of zoonotic disease transmission; agriculture affects nutrition and child health while education outcomes of mothers have been positively correlated with child survival. As such, tracking of events and occurrences in other sectors could provide vital early warning information for enhanced disease surveillance, thus saving lives.

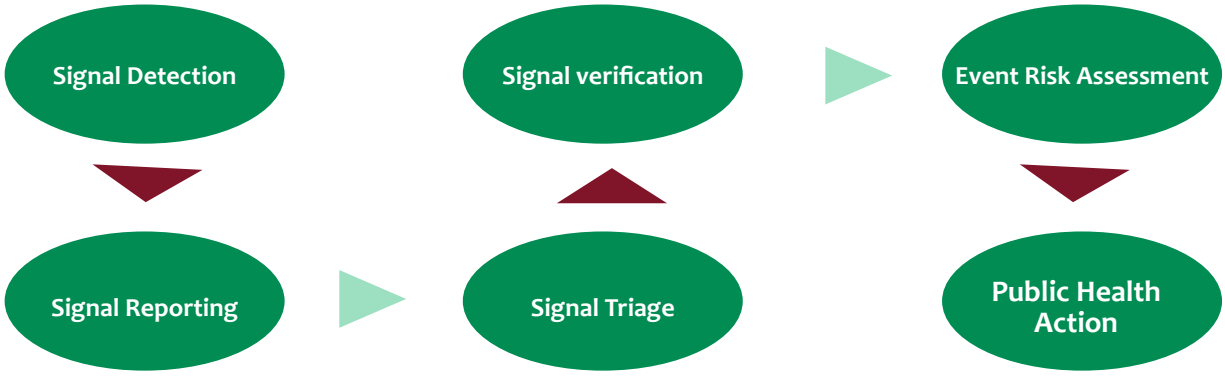
Event-based surveillance (EBS). What is EBS, and do Counties, Sub-Counties, Health Facilities and Communities need to roll out this surveillance system? Over the past decades, Kenya has implemented the Integrated Disease Surveillance and Response strategy as its primary surveillance system. This is an indicator-based surveillance system that monitors routine structured data for selected priority diseases and conditions mainly at health facility level. In order to strengthen surveillance in the Country, the Ministry of Health has recommended the step up of EBS to complement Integrated Disease Surveillance and Response, developed the Kenya Event Based Surveillance Technical Guidelines 2020 jointly with other agencies and working with select County Governments, conducted pilot roll out of EBS in select counties. EBS is the organized collection, monitoring, assessment and interpretation of mainly unstructured ad hoc information regarding health events or risks that present an acute risk to health.[28] EBS targets information from a wide range of sectors, including animal health, the environment and other sectors. There are four types of EBS based i) The Hotline/Phone EBS (PEBS); ii) The Media Scanning EBS (MEBS); iii) The Community EBS (CEBS) and iv) The Health Facility EBS (HEBS). The EBS is undertaken through six (6) steps: signal detection, signal triage, signal verification, event risk assessment and public health action. CEBS is rapid collection of information on events within the community by the community

28 WHO, International health regulations, 2005

members. HEBS is rapid collection of information on events at health facilities by healthcare professionals. PEBS is using dedicated telephone lines to collect information on events of public health concern from the Public, and MEBS includes searching for information on events that present a public health threat from both print and electronic platforms.
Community Event-Based Surveillance (CEBS) was piloted in Siaya and Nakuru counties from September 2019 to May 2020 while Health Facility level Event-Based Surveillance (HEBS) was piloted in three counties (Mombasa, Nakuru and Meru). It is key to note that a number of outbreaks were detected following investigation of the reported signals, including acute flaccid paralysis, scabies, foot and mouth disease (FMD). A foot and mouth disease outbreak in animals was detected through collaboration with the Directorate of Veterinary Services. All these illustrate the value of EBS roll out to supplement IDSR. Despite these, pilot studies noted various challenges, mainly technological challenges in the implementing of m-Dharura - the mobile application that was used in reporting, surveillance interruption due to transfers of trained staff especially given the pilot nature of the activity, and the intense supervision requirement for the initial roll out phases.

Management of event-based surveillance data is a key component of successful surveillance. The Ministry of Health has developed an application that will be used to capture community and health facility information on EBS. This application is called the m-Dharura which has inbuilt validation checks to ensure accuracy and completeness of data. Key next steps in rolling our EBS include: a) Engaging closely with DDSR to roll out EBS within Counties, and strengthen areas where this has been rolled out; b) Capacity building of County, Sub-County, Health Facility and Community level staff on EBS. This should include both technical aspects of the roll out, such as the application use, as well as capacity building to ensure the actors are able to analyze data and utilize generated information to foster disease surveillance and response, as well as give feedback, and c) Monitor EBS as it's rolled out to enable identification of weaknesses and take corrective measures.

Strengthening reporting? The International Health Regulations (IHR), entered into force in 2007 and to which most countries are signatories provide a solid basis for disease surveillance at a global level. The IHR sets up a number of alert, response, and capacity building mechanisms for the member states to develop and follow, including supporting surveillance and reporting of potentially pandemic infectious diseases. Locally, various policy and legislation make it mandatory to report priority diseases, the key tool being the Public Health Act Cap 242 which lays down notifiable diseases and mechanisms for reporting these diseases. Although various studies show that Kenya's reporting efficiencies for notifiable diseases is good, there are gaps in regard to regular health data reporting, especially at community level. Community Health Units, which are the primary reporting units at community level often lack reporting tools security, and even in cases where tools are available, utilization of generated data by the



Steps in EBS Process

wider health system is a challenge. It is key to note that this is a critical level to collect data on community level events, thus needs strengthening. The other key gap in routine data reporting in completeness of data from Private and Faith bases health facilities. There is need for critical evaluation to better understand this issue and put in corrective measures.

Enhancing use of gathered surveillance data for decision making: Data-driven decision-making (DDDM) is defined as using facts, metrics, and data to guide strategic, tactical, and operational decisions that align with set goals, objectives, and initiatives. Strengthening IDSR and EBS must include capacity building initiative that allow actors at all levels to appropriately put to use information available from them from the surveillance systems. This capacity building must thus target all levels – County, Sub County, Health facility and community levels. It is key to note that data analysis varies with level, with each level taking action based on information most appropriate for their action.

Conclusion

This paper critically reviews county level capacities in operationalizing event-based surveillance, as well as evidence-based health decision making including at community level, surveillance gaps, health data in emergency contexts, and comprehensive reporting including community, Private health facilities and Faith based health facilities. The paper makes call for county leadership to invest in the roll out of EBS, strengthen disease surveillance at all levels, end foster data use for decision making as well as provides policy suggests to enhancing reporting.

PRESENTATION BY DR. EDA MOHAMED, CECM FOR HEALTH, MANDERA COUNTY

COUNTY HEALTH SERVICE DELIVERY READINESS AND PREPAREDNESS

Presented by:

Dr. Eda Mohamed
CECM for Health services, Mandera County

Focus Areas

This session will focus will on 3 areas:

- Emergency Preparedness and Readiness of County Health Care Systems
- Expanding Investments in Preventive Care: What are the Policy and legislative facilitators to this Paradigm Shift
- Strengthening County Level Disease Surveillance and Response: What shifts do we need?

Emergency Preparedness and Readiness of County Health Care Systems

Why is this important

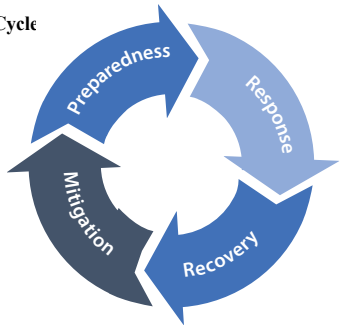
- All disasters affect health in one way or another
- Significant increase in disasters (including health disasters) causing increased death, sickness, loss of livelihoods and loss of properly
- Costs of responding to disasters are on the increase
- COVID-19 and health consequences of recurrent drought and floods show need to strengthen health sector disaster management capacities
- Studies and practice – Jurisdictions with weak health disaster preparedness and risk reduction measures are more vulnerable when disasters hit, more likely to realize negative impacts to communities and governments

Key Issues and Policy Options on Emergency Preparedness and Readiness

- Coordination of Health Disaster Management
  - Between the two levels of Government
  - Horizontally between Counties & Cross-border
  - Between health sector actors and the disaster management actors
- Financing Mechanisms for health disaster management
- Key legislative tools (Public Health Act Cap 242 & Disaster Management Bill) health Disaster Management
- Other key issues in strengthening health Disaster Management.

The Four Phases of the Disaster Cycle

- Preparedness: Preparing to handle a disaster
- Response: Responding to a disaster and putting plans into action
- Recovery: Actions taken to return to normalcy or safer conditions
- Mitigation: Preventing future disasters & minimizing their effects



Coordination of Health Disaster Management

- The Constitution of Kenya 2010 identifies Disaster Management as a concurrent function between the National and County Governments
- Unbundling of Disaster Management function not yet done – Thus lack of clarity on the functions of County and National Governments on this area
- Coordination and Communication Challenge is two-fold
  - Between the National Government DM agencies and the County Government Health Authorities
  - Between DM technocrats in Ministry of Interior and Health Experts in Counties
  - While the health sector experts have knowledge and skills in epidemiologic prediction and health service delivery in emergencies, disaster management practitioners can more clearly predict the course of the disaster and apply broad disaster management principles to save lives and property in emergency contexts. There is thus need to foster closer partnerships between these two sectors.

What do we need to do?

- Clarity in the split of disaster management roles between the two level of government
- Increased structured coordination between health, security and interior ministry actors in addressing disasters
- Review of the Public Health Act Cap 242 to make it an effective tool for emergency management
- National and County leadership to increase investment in emergency preparedness and response for health.

Expanding Investments in Preventive Care: Policy and legislative facilitators to this Paradigm Shift

Why is this subject important

- Kenyan leaders, Policy makers, health managers, healthcare workers, communities agree - *Prevention is better than cure*
- Prevention is cost effective – reducing cost of treatment, saving on time & other things lost to bad health, optimizing treatment and rehabilitation
- Most counties already investing about 30% of their budgets in health – despite having 14 devolved functions – thus limited fiscal space
- Changing burden of disease, population dynamics like ageing, high cost of healthcare calls for stronger prevention interventions
- Early investment in effective prevention would enhance good population health, reduce morbidity and mortality including from lifelong chronic illnesses and save resources in both healthcare, social services and other sectors.
- Overall, countries that do not invest in preventive health spent much more per capita cost, in both direct and indirect costs, than those who invest in preventive health
- BUT investments in primary disease prevention remains low at individual, community, county, and national levels

Expanding Definition of Preventive Health

- Recent Rapid Scientific & technological advances have allowed accelerated understanding of disease causes, progression and transmission – thus innovative preventive, curative and rehabilitative approaches
- Disease Prevention no longer preserve of classical Public health interventions. Clinical and non-clinical approaches can reduce the acquisition or transmission risk of diseases – expanding prevention definition
- Most managers perceive community level & primary health facility level interventions as preventive health, assume budgets to these levels are for prevention [like CHVs, who do preventive, curative and rehabilitative work]
- Evidence show minimum investment in classical Public Health interventions – is the expanded view causing this?

Critical question on Preventive Health

- Does increasing investment in disease prevention mean reduced investment in curative services?
  - There are wider and longer-term cross-sectoral benefits of disease prevention beyond health
  - Hours of productivity for would be patients and their caretakers, alternative utilization of medical costs by families
  - Reducing days learners are absent from school has positive lifelong impacts on health, family and broader national development agenda
  - Better population health frees up more resources for health care services
  - Cutting off basic illnesses provides sufficient time for clinicians to better diagnose some cases rarely picked, like Cancers early in time
  - Also allows better patient and clinician interactions - makes health facilities more socially accountable, improve health seeking behaviors

Measurement of Preventive Health Outcomes

- Evidence-based decision making has become a benchmark of best practice, with investments in healthcare increasingly following demonstratable outcomes
- Preventive health most commonly has long term cross-sectoral impacts, thus difficult and costly to measure. Difficult to measure short term localized results
- KHIS and other available health information tools have minimal prevention data

Let me illustrate this….

- We agree "hand washing, physical distancing and masks wearing have been important measures in the COVID-19 response – BUT - Can you quantify their impacts?
- How big would the problem be if these were not taken up? What did this intervention really save – in number of lives, in KES?
- Now let's talk about providing Oxygen – you can easily count the lives people saved, and name them one by one
- Population interventions are impersonal and less attractive since they lack 'identifiable victims'
- Some economic models also disadvantage long term results like preventive health

What do we need to do?

- Determine and increase investment to disease prevention
- Changing negative misconceptions, perceptions and beliefs about preventive health interventions;
- Improve outcome measurement for Preventive health – both human capacity and databases like KHIS
- Strengthen inter-sectoral collaboration
- Innovate: Use social marketing approaches to give a human face to the potential beneficiaries of public health interventions
- Ensure interventions have short, medium and longer-term results, and educate stakeholders on benefits of prevention

Strengthening County Level Disease Surveillance and Response: Are there gaps?

Rationale - Why is this important

- Effective disease surveillance and response systems are critical components of disease prevention and control
- A good disease surveillance system provides effective tools and processes to collect, analyze and interpret data to generate useful information on patterns and determinants of disease occurrence in a timely manner for action by policy makers, health managers and health personnel
- COVID-19 pandemic highlighted gaps in Kenya's routine disease surveillance mechanisms that were filled through parallel COVID-19 specific case reporting, patient tracking and vaccination system
- Gaps exist in County level routine surveillance systems -
  - Community level data Collection, analysis and interpretation
  - Use of data for decision making in Public Health facilities
  - Completeness of data collected from non-government owned health facilities

Changing Disease Surveillance Needs

- Kenya largely dependent on indicator-based health facility surveillance system
- An increasing number of new infectious disease outbreaks are from animals & environment – COVID-19, SARS, Ebola, influenza, and the H1N1 swine flu etc
- Need to closely monitoring trends and triggers in the environment, animals, and other contextual sectors
- Tracking of events and occurrences in other sectors provides vital early warning information for enhanced disease surveillance, thus saving lives.
- Identify these events and diseases and take measures before human illness
- Climate Change, Deforestation, agriculture, education all affect health

Event-based Surveillance

- Kenya had developed Event Based Surveillance (EBS) Technical Guidelines 2020
- EBS - Organized collection, monitoring, assessment and interpretation of mainly unstructured ad hoc information regarding health events or risks that present an acute risk to health
- Targets information from a wide range of sectors - animal health, environment etc
- EBS can use various ways to collect information: Hotline/Phone EBS, Media Scanning EBS, Community EBS and Health Facility EBS
- Community EBS: Piloted (Siaya and Nakuru) from Sept 2019 to May 2020
- Health Facility EBS: Piloted (Mombasa, Nakuru and Meru)
- Pilot Studies showed EBS works – Captured of cases
- Challenges noted - technological with *m-Dharura* platform & Surveillance interruption due to transfers of trained staff

What do we need to do?

- Support the roll out of EBS
- Strengthen disease surveillance - Community level, health data in emergency contexts
- Foster use of data use for decision making - community level, health facility and management levels
- Review policy on routine reporting - targeting community level, Private health facilities and Faith based health facilities.
- Management of EBS is a key component of successful surveillance. Need to:
  - Engaging closely with DDSR to roll out EBS within Counties, and strengthen areas where this has been rolled out
  - Capacity building of County, Sub-County, Health Facility and Community level staff on EBS
  - Monitor roll out to identify and correct weaknesses

BIOGRAPHIES

H.E Sospeter Ojaamong', EGH

Governor - Busia County

H.E Ojaamong' is the current governor of Busia County. His education background is as follows: Kenyatta University - Bachelors Degree in Education, Biology and Chemistry.; and Kenya Institute of Management - Post graduate Diploma in Business. He is serving as the governor of Busia for the second time after he was re-elected in 2017. Before politics, H.E Ojaamong' served as a teacher and later Deputy Principal at Moding Secondary School in Teso South. In 2008, he became the Assistant Minister for Labour. He has also ever served as a Member of Parliament for Amagoro constituency. In 2013, he was elected as the first governor of Busia County under the devolved government.

Mohamud Adan Mohamed

County Executive Committee (CEC) - Member for Health services, Mandera County

Dr Mahamud Adan Mohamed currently serves as CECM for Health services in Mandera County. Prior to this appointment, he worked in various urban and rural settings of Kenya including as a medical officer at King Day hospital in Lamu County, Msambweni District Hospital and Coast General Hospital. Dr. Adan has also served as the Chairman Kenya Association of Muslim Medical professionals between 2014-2017 and is a Founder member and County representatives in the World Islamic Health Union.

CHAPTER SEVEN

CONCLUSION AND NEXT STEPS

Figure 18: CoG Chair, H.E Martin Wambora addresses the press at the High-Level meeting

The High-level consultative forum successfully facilitated interrogation of policy and legislative barriers in the health sector and enabled the generation of joint actions. There was clear consensus on the gaps and urgency for concerted action, riding on the renewed goodwill and collaborative efforts.

The forum appreciated the need to sustain the momentum created in view of looming transitions in government at national and County level. The forum participants identified several important resolutions to be pursued to strengthen the policy and legislative environment for health service delivery. The need for application of evidential analysis in formulation of policies and legislations and monitoring of progress of implementation was underscored.

Participants expressed their satisfaction on contributions made during the forum and lauded the joint action plan as a critical milestone for furthering engagements and facilitating broader inputs into the policy and legislative reforms in health.

The vote of thanks was delivered by the H.E. Prof. Anyang' Nyong'o, Chair, CoG Health Committee who appreciated all the participants including the Cabinet Secretary and Principal Secretary for the State Department of Health, Governors, Deputy Governors, the Senate, CAF, CECMs for Health, Chief Officers, County Attorneys and the CoG Secretariat for their support and the candid deliberations in the two-day forum. He also acknowledged USAID's continuous support to the CoG and Kenya's health systems and particularly support towards the forum.

In his closing remarks H.E. Martin Wambora, the Chair of CoG expressed his satisfaction on the depth and candor of the deliberations and the resultant action points. He called for collaboration towards full implementation of resolutions for the overall success of devolved governance.

Finally, specific commitments, captured in a communique, were made to help address the barriers (Please find the communique on page 3-5).

APPENDICES

Appendix I: Speeches

Speech by H.E. Hon. Martin Wambora,
EGH – Chairperson, Council of Governors (CoG)

- Fellow Governors
- Hon. Senators
- Hon. Members of the National Assembly
- Hon. CEC Health
- Distinguished Ladies and Gentlemen

On behalf of the Council of Governors, I take this opportunity to express my pleasure to be present during this important meeting to discuss matters touching on the performance of devolved functions -particularly Health and Agriculture for the next few days.

Ladies and Gentlemen

As you are all aware, Devolution of the health system as provided for in the 2010 Constitution was meant to enhance fair resource allocation between regions, strengthen democracy and accountability, increase community participation, improve efficiency, and reduce inequities. Indeed, all County Governments have tried their best to make these constitutional aspirations a reality to our people. Significant public funds have been allocated for investment in the health sector over the last 8 years of devolution. These investments have significantly changed the landscape within which health services are delivered across the country and enhanced access to quality health services. However, the objectives of devolving health services are yet to be fully attained and the counties continue to face many challenges in terms of systemic, legislative and policy barriers to the realization of the full potential of devolution.

Ladies and Gentlemen

It is against this background that the COG Health committee undertook policy and legislative analysis and suggest proposals and strategies aimed at improving health systems and service delivery at the county level. The analysis shows the need to strengthen policies at the county and national levels with a special focus on ensuring that they are aligned and support the delivery of health care through the devolved health sector.

Ladies and Gentlemen

There are various issues in the systems, policy and legal framework in the health sector that continue to impede the delivery of health services at the county level. A comprehensive general review of the legal and policy framework shows the following:

1. Lack of proper understanding and operationalization of cooperative devolved government and intergovernmental relations which affects the process of policy and legislation-making.
2. The role of the National Treasury in the devolved system of government. Article 225(1) empowers Parliament to enact an Act of Parliament to 'provide for the establishment, functions and responsibilities of the National Treasury'. section 11 of the Public Finance Management Act establishes the national treasury as 'an entity of the national government'. This is despite the fact that the functions of the national treasury set out by section 12 of the Act affect both national and county governments. These provisions undermine mutual trust and interdependence between national and county governments whenever the National Treasury deals with disputes between the national and county governments.
3. Lack of a legal framework to operationalize Article 189(2) Joint Committees and Joint Authorities. Given the important role of joint solutions to policy and legislative problems and the delivery of health services generally, there is urgent need for enactment of a legislation to operationalize Article 189(2) which envisages that both national and county governments; and the county governments among themselves can establish joint committees and joint authorities through which they can perform some of their functions and exercise some of their powers.
4. Health workforce issues.

5. First, there is the problem of an apparent misinterpretation and application of Article 235 which empowers each county government to, 'within a framework of uniform norms and standards prescribed by an Act of Parliament' establish and abolish offices in its public service; appoint and confirm persons to those offices; and exercise disciplinary control over its public officers. The misinterpretation of this provision has led to an apparent unconstitutional section 31 of the Health Act which assigns to the Kenya Health Human Resources Advisory Council functions to review and establish uniform norms and standards without requiring them to be prescribed by an Act of Parliament as stipulated by Article 235 of the constitution. Secondly, contrary to the obligation to pursue joint policy and legislative solutions, recent statements from the Minster for Devolution indicate that the Ministry has without involvement of county governments embarked on drafting legislation to provide for transfer of county staff to other counties. Thirdly, there is the problem of county governments continuing to pay the personnel emoluments of county health workers when they are on study leave, even when such health workers are rendering services in National Government teaching and referral health facilities. Fourthly, there is need for national government to coordinate and consult with county governments when negotiating bilateral agreements touching on health workers such as agreements to bring in foreign health workers to work in county health facilities; and to recruit Kenyan health workers for employment in foreign countries.
6. Inadequate investment in emergency preparedness and response for health coupled with unclear split of disaster management roles between the two level of government has led to challenges in the response to the disasters such as the covid pandemic and opened a floodgate to mismanagement and lack of proper accountability for resources meant for such responses.
7. UHC

   Despite high-level political goodwill and support, the UHC goal is yet to be attained for Kenyans. Accordingly, substantive conclusion of the NHIF reforms remains of key interest for all stakeholders, most importantly, for the County Governments reforms that take into consideration the devolved context.

Ladies and Gentlemen

The technical experts at COG have prepared draft policy briefs that will guide us as we engage with various key stakeholders as we seek solutions to the identified challenges.

As I conclude, I implore us to pay keen attention to these deliberations so that at the end of this retreat we all embark on the journey to making devolution a reality to our people.

Thank you and God bless you.

Speech by H.E. Prof. Anyang' Nyong'o,
EGH – Chairperson, CoG Health Committee

- **The Chairman, Council of Governors,**
- **Fellow Excellency Governors,**
- **Cabinet Secretary, Ministry of Health,**
- **Honorable Members of Parliament,**
- **Various Governmental Officials,**
- **Distinguished Guests,**
- **Ladies and Gentlemen.**

Good morning.

It is great pleasure to be here today and take part in these very important discussions on policy and legislative barriers to health service delivery. But before I make my comments, allow me to thank you excellency Governors, and various leaders at the County level for always keeping a keen eye on the delivery of health services. Good leadership and governance is central to achieving a good health system. As such, your leadership is very much appreciated.

We also thank other important actors in health for the roles they continue to play to achieve better health for Kenyans. We have done well so far, but we still have a long road to walk before we achieve high quality and affordable healthcare for all Kenyans. We need to work closely with the Ministry of Health and relook at some of our key institutions in health – like KEMSA and NHIF – so as to achieve progress.

Ladies and Gentlemen,

In recent decades, Kenya has achieved marked progressive in key health indicators. We have seen significant improvements in maternal health, child health and overall health outcomes as illustrated by the increased life expectancy among our populations. We have also significantly excelled in specific disease areas like HIV. For example, Kenya has achieved progressive decline in adult's HIV prevalence, from a peak of about 10.5% in the mid 90's to 4.5% in 2020. We have not only expanded access to high quality HIV testing services, but also significantly stepped-up HIV prevention, care and treatment services. County Governments – ladies and gentlemen - continue to be a critical link in achieving these results. We will continue working closely with the National Government and its agencies, Communities and other stakeholders to ensure we sustain this progress.

With devolution, we have seen significant improvement in health infrastructure across the country, have achieved better distribution of health care workers – including specialists – and continue to work toward achieving better levels of commodity security in our health facilities.

Ladies and Gentlemen,

Having said that, let me acknowledge some of the big challenges we have been facing, noting that there are proven ways to address these challenges out there that we need to learn and seize. I will only mention a few of these:

First - Kenya's disease profile has significantly changed from a context where communicable diseases comprised most priority diseases, to a new norm where communicable diseases, non-communicable diseases and injury all pose a big strain to the health system. The prevalence of chronic lifelong conditions continues to increase and take a huge toll on the health of our communities. Cancers, Diabetes, cardio-vascular diseases are now a major challenge. Although we have invested in these areas, we note that our health system – both preventive and curative is struggling in dealing with these emerging diseases.

Second – Today more than ever, we are realizing negative impacts of Climate Change on health. Climate Change is modifying vector behaviors and with it, we are seeing change in epidemics like Malaria. We are also seeing negative impacts from floods and drought, just to mention a few.

Third - We have resource constrains when it comes to investing in health. Although County Governments are investing over 30% of their funding in healthcare, this amount remains sub-optimal. The COG health committee is now advising that we prioritize preventive health so that we reduce some of these illnesses before they occur. That does not only save treatment costs for Counties and Communities, but it also allows community members and potential caregivers time for productive work, and for students, more time in school instead of at health facilities.

Last – Many communities cannot afford quality healthcare today. All of us - including Parliament - have been critically thinking on ways to reduce the cost of healthcare to government and communities. We are making positive steps in this issue, but we still have a lot to do on this issue. It is my hope that this meeting will give ample time to this issue so that we come up with some agreement areas.

These are just but a few challenges facing the health Sector in Kenya. Internally, we have some issues to address in regard to Human Resources for Health and Commodity Security. As you all know, health workers at all levels are a very important resource in delivering quality care. As policy makers, we need to look at these challenges and give policy directions that are practical, make sense and will help our health sector overcome.

Ladies and Gentlemen,

As we discuss these important issues for the next two days, I want to retaliate the commitment of the COG Health Committee to work closely with all of you here, to tear down all barriers that stand between us and the provision of high-quality healthcare to all Kenyans. We are here because we believe that all Kenyans, regardless of their social or economic standing, can access the highest quality of healthcare across our counties. This, ladies and gentlemen is a very important course.

Finally, Ladies and Gentlemen,

County Governments place significant importance to health, **investing over 30% of their total budgets to health**, despite having about 14 devolved functions. The Council of Governors and County Governments will remain committed to this course. Ladies and gentlemen, we have come a long way, but there is still a race to do. On behalf of our Counties, I like to tell you this - **We will run the full course**. I hope you – our partners here today – are ready to run with us.

Thank You

Speech by Sen. Mutahi Kagwe,

EGH – Cabinet Secretary, Ministry of Health

- Your Excellency Martin Wambora, Governor Embu County and Chairman of the Council of Governors,
- Chairpersons of the Parliamentary Committees on Health, Hon Sabina Chege of the National Assembly and Hon Michael Mbito of The Senate,
- Your Excellency Governors,
- Members of the Health Committees from the houses of Parliament,
- Development Partners,
- Distinguished Guests,
- Ladies and Gentlemen,

Good morning,

I am greatly privileged to join you today at this meeting whose theme, *'Reflections on Policy and Legislative Experiences for Accelerated Delivery of the UHC Agenda at County Level'* is something we need to critically look into.

This meeting is a continuation of the discussions we have been having around actualizing His Excellency the President's UHC agenda in the country. We have known that there is a need to have a fundamental shift in health service delivery for a long time now and I am glad to see that together, we are making notable progress.

The 2010 constitution and the Health Act 2017 envisions a unified health system with seamless coordination between the national and county government health systems for the regulation of health care services and health care service providers, health products and health technologies. Additionally, we have various other laws and institutions that govern the health sector. However, our experience with implementing the UHC agenda has been that these are not sufficient and that there is a need to address not only what health services are covered but also how they are funded, managed and delivered.

Ladies and Gentlemen,

Some of the current Laws and Regulations were developed before the promulgation of the 2010 Constitution e.g., Public Health Act, NHIF Act, Mental Health Act, Malaria Prevention Act as well as the HIV/AIDS Prevention and Control Act among others. You will find that some provisions in these laws do not conform to the provisions of the Constitution especially on the two levels of governance. Whilst we all have to do what we must to make our healthcare system more efficient and responsive to the needs of our people, I am glad to note that the Ministry has initiated efforts to review some of these Legislations to align them with the Constitution, Health Act, 2017, and Health Policy (2014-2030).

A couple of laws certainly require a further review, and I will take some few minutes to highlight some of these for us to think through them together as we look to improve our healthcare ecosystem.

We know that regulation of training, registration, licensing and practice of health professionals is done by various government agencies established through Acts of Parliament. The eleven Acts of Parliament establishing those health professionals' regulatory agencies leave out some health professionals which then impacts the quality of their training and practice. Out of these, five already have fully constituted boards while we are in the process of inaugurating boards for the remaining agencies.

In addition, an allied health professionals' regulatory body has been proposed to cater for the health cadres who are not regulated including radiographers, biomedical engineers, dental technologists, optometrists, Emergency Medical Technicians, Orthopedic technologists, morticians and medical social workers among others.

I want to note that there also exists an overlap in the functions of registration of health facilities as provided for in the Medical Practitioners and Dentists Act, Clinical Officers Act, Nurses Act, Medical Laboratory Technicians and Technologists Act, Pharmacy and Poisons Act, Physiotherapy Act as well as Nutritionists and Dieticians Act. For instance, KMPDC is mandated to license all health institutions whereas Council of Clinical Officers and Nursing Council of Kenya license clinics and medical centres owned by clinical officers and Nurses respectively. Kenya Medical Laboratory Technologists and Technicians Board, Pharmacy and Poisons Board, Kenya Nutritionists' and Dieticians Institute as well as Physiotherapy Council also license laboratories, pharmacies, nutrition, and physiotherapy units in private health facilities. These multiple registrations and licensing contribute to high operational costs in health facilities which result in high cost of healthcare.

Ladies and Gentlemen,

Besides the laws touching on the professionals in the health sector, we see challenges in other areas as well. For instance, the Public Finance Management Act is the principal law on the management of funds under the National Government and the Counties. The Act provides for the establishment of a County Revenue Fund for each county government as well as the establishment by each county treasury of a single account through which payments of money by the various county government entities are to be made.

Due to the said provisions in the PFM Act, funds allocated or collected at the health facilities level are not fully utilized for the improvement of health services or to defray costs of providing the services and managing the institutions. The Ministry of Health has made attempts to have it changed but were referred to the aforementioned provisions for County Legislation. To date, only 7 Counties have passed County legislation aimed at ring fencing health funds which is a further delay in the journey towards UHC.

On the procurement and distribution of health commodities, the KEMSA Act states that a national or county public health facility shall, in the procurement and distribution of drugs and medical supplies, obtain all such drugs and medical supplies from the Authority. This criminalizes procurement of pharmaceuticals and non-pharmaceuticals by national referral facilities and county facilities from suppliers other than KEMSA. If we are to be honest, this plays a part in the shortages of medical supplies which we see every so often. We can address this issue by allowing a few more players into the scene.

Ladies and Gentlemen,

When it comes to policies, I am happy to note that the lack of policies and strategies that speak to the UHC agenda has been remedied by the development of various Policies and Strategies for example:

a. The UHC Policy
b. The Health Financing Strategy
c. The Human Resources for Health Strategy
d. The Internship Policy
e. The Community Health Policy and Strategy
f. The Primary Health Care Framework
g. Kenya Heath Sector Partnership and Coordination Framework

Still under development is the Referral Strategy and a review of the Kenya Essential Packages for Health. We still have a few more policy issues that remain persistent in the sector. For example, lack of comprehensive Stakeholder engagement and lack of stakeholder participation delays the development process and hampers unity of purpose in the sector. We also have in the past developed good Policies and Strategies but lack of implementation has seen us miss out on our vision. It is surprising to see that other Countries have used our own policies and have succeeded by implementing them, yet we remain in the same position that we were in when enacting the progressive policies.

Additionally, policies become quickly outdated with the dynamic changes in the Health Sector. What needs to be done is a timely assessment of the impact/ outcomes of the policies, and readjustment based on evidence and international best practices for our policies to remain relevant. To this end, there is a need for investment in Monitoring, evaluation and research. As we commence these discussions, I urge you to bear in mind these very many gaps in our legislation and come up with actionable solutions.

Ladies and Gentlemen,

Even as we continue with our deliberations, let us not forget that we are still in the midst of a pandemic. We have seen our positivity rate climb steeply from 1% to over 11% in the last one week. This is a clear sign that the enemy is once again on the war path, but this time round, we should be better prepared as we have learnt many lessons from the previous four waves.

This is the time to ramp up our vaccination programme through our fixed post health facilities and targeted outreaches to ensure no one is left behind and that we are all protected. Vaccination is the surest and safest means to achieve protection from getting severe COVID- 19 and death, and science has proven this.

I ask all of you, excellency Governors' to ensure that we ready our isolation and quarantine facilities, some of which we had closed due to the reduced case-loads, to deal with a potential surge in the number of cases we expect in the coming few weeks based on the rapidly increasing positivity rates.

In addition, we should prepare a health workforce surge capacity and ensure they are ready to respond to the potential increase in cases and any emergencies thereof. We must ready our ability to provide oxygen to all the cases that shall require this precious commodity.

The critical care facilities established under your care must be able to respond to any cases that require intensive care. The time to do all these things, which may appear routine is **NOW!**

Counties should also enhance their testing capacity as it is only through testing that we would be able to know the true magnitude of the disease at the community level.

Finally, we should all continue to advocate for adherence to the public social health measures of wearing proper well-fitting masks, avoiding crowded places, closed spaces and close contact and proper hand washing with soap and water or use of alcohol-based sanitizers. Speaking of handwashing and use of sanitizers, I take note that one of our greatest lessons from Covid-19 is the value of good hygiene. We now know that a clean environment does more to keep diseases away than most of other measures.

I have called on counties to pay more attention to this in the past, but I won't tire to reiterate the the value of good hygiene. We should ensure all public places are kept kept clean to keep diseases away.

Indeed cleanliness, and the other simple measures have proven effective in combating the burden of Covid-19 including the new emerging variants.

Thank You.

Appendix II: Program

Time	Session	Session Chair
DAY 1 (14th Dec)		
	Participants' Arrival and Check In	Peris, Linet, James Kamau (MSP)
DAY 2 (15th Dec)		
7.30 am – 8.00 am	Participants Registration	James Kamau (MSP), Peris, Ambasa, Linet
8.00 am - 8.30 am	Welcome and Introduction	Ms. Mary Mwiti – Ag. CEO COG
8.30 am - 9.30 am	*Opening Remarks* • Mark Maessick, USAID/KEA Mission Director • Hon. Sabina Chege, Chair of National Assembly Departmental Committee on Health • Sen. Dr. Mbito Michael Maling'a, Chair of Senate Departmental Committee on Health • Sen. Mutahi Kagwe EGH, Cabinet Secretary, Health • H.E. Martin Wambora, EGH, Chair of Council of Governors	H.E. Prof Anyang' Nyong'o, EGH Chair, COG Health Committee
9.30 am - 9.35 am	***Video clip*: *A voyage through delivery of devolved health services***	
9.35 am - 10.25 am	Session One Health policies and legislations under devolved context: Successes and Challenges ***Presenter*** – H.E. Prof. Kivutha Kibwana, EGH Governor Makueni County ***Discussant*** – Mr. Wachira Maina, Constitutional Lawyer & Policy Expert	H.E. Anyang Nyong'o, EGH Governor Uasin Gishu County
10.25 am - 11.00 am	Plenary 1 – Q&A, Comments	
11.00 am - 11.30 am	Health Break	

Time	Session	Session Chair
11.30 am - 12.30 pm	**Session Two** Sustainable Financing for Universal Health Coverage (UHC): NHIF Reforms, Transition Arrangements, and alignment to the devolved system of government Presenter – Dr. Pius Wasunna Owino, Health Finance Expert Discussants – Hon. Dr. James Nyikal, Member National Assembly Committee of Health	H.E. Hon. Dr. Mohammed Kuti, EGH, Governor Isiolo County
12.30 pm - 1.00 pm	Plenary – Q&A, Comments	
1.00 pm - 2.00pm	Lunch	
2.00 pm - 3.30pm	**Session Three** Health commodities security: Financing, Local Production, Governance, and Accountability in the devolved context. Presenter – Dr. Joseph Murega, County Executive Committee Member for Health, Kiambu County Discussants – Prof. Gilbert Kokwaro, Director, Institute of Healthcare Management, Strathmore University.	H.E Governor Salim Mvurya, Governor, Vihiga County
3.30 pm - 4.30 pm	Plenary – Q&A, Comments	
4.30 pm - 5.00 pm	Health Break	
DAY 3 (16th Dec)		
8.30 am - 10.00 am	**Session Four** Institutional and structural issues in health policy and legislation: Re-engineering of IGR, unbundling of functions, transfer of power, recruitment/transition of health care workers ***Presenter*** – Dr. Mutakha Kangu, COG Intergovernmental Expert ***Discussants*** – Prof. Thomas Kibua, Public Policy Expert	H.E. Francis Kimemia, E.G.H, C.B.S Governor, Kirinyaga County
10.00 am - 10.30 am	Plenary – Q&A, Comments	
10.30 am - 11.00 am	Health Break	

Time	Session	Session Chair
11.00 am – 12.30 pm	**Session Five** County Health Service Delivery Readiness and Preparedness: COVID 19 Response hits and misses ***Presenter*** – Dr. Mohamed Eda, County Executive Committee Member for Health, Mandera County ***Discussants*** – Prof. Khama Rogo, Health Systems Expert & Chairman of the Committee of the Eminent Persons, on COVID-19 Response, LREB	H.E. Hon. Sospeter Ojaamong, EGH, Governor Busia County
12.30 pm - 1.15 pm	Plenary – Q&A, Comments	
1.15 pm - 2.15 pm	Lunch	
2.15 pm - 4.00 pm	Action Planning	H.E. Prof. Anyang' Nyong'o, EGH
4.00 pm - 4.30 pm	Way forward, Communique and Closure	
4.30 pm -	Departure	

Appendix III: List of Participants

	Participant	County/Institution
1	H.E Martin Wambora, EGH	Embu
2	H.E Edward Mutahi Kahiga	Nyeri
3	H.E Cyprian Awiti	Homabay
4	H.E Mwangi Wa Iria	Murang'a
5	H.E Jackson Mandago, EGH	Uasin Gishu
6	H.E Sospeter Ojaamong	Busia
7	H.E Salim Mvurya	Kwale
8	H.E Ali Bunow Korane, CBS	Garrisa
9	H.E Cornel Amoth Rasanga, EGH	Siaya
10	H.E Prof. Anyang' Nyong'o, EGH	Kisumu
11	H.E Ahmed Muktar Ali	Wajir
12	H.E Eng Alex Tolgos, EGH	Elgeyo Marakwet
13	H.E Stephen Sang	Nandi
14	H.E James Nyoro	Kiambu
15	H.E Francis Kimemia EGH, CBS	Nyandarua
16	H.E Joseph Ole Lenku, EGH	Kajiado
17	H.E Moses Lenolkulal	Samburu
18	H.E Okoth Obado	Migori
19	H.E. Hon. Dr. Mohammed Kuti, EGH	Isiolo
20	H.E Prof Paul Chepkwony	Kericho
21	H.E Stanley Kiptis	Baringo
22	H.E Major (Rtd) Dr. Dhadho Godhana	Tana River
23	H.E Adelina Mwau,	Makueni – Deputy Governor
24	H.E David Njeru	Embu- Deputy Governor
25	H.E Dr. Yulita Mitei Chebotip	Nandi – Deputy Governor
26	H.E Moses Mulomi	Busia Deputy Governor
27	Hon. Senator Mutahi Kagwe, EGH	Cabinet Secretary -MoH
28	Mrs. Susan Mochache, CBS	Principal Secretary -MoH
29	Ms. Rose Nafula Mudibo	MoH

	Participant	County/Institution
30	Dr. Lenai Kimario	MoH
31	Dr. Stephen Muleshe	MoH
32	Dr.Kwai Wanjaria	CECM - Nyeri
33	Dr Shadrack Mutai	CECM- Kericho
34	Dr. Mohamud Adan Mohamed	CECM- Mandera
35	Joseph Nyamita	CECM- Migori
36	Karapio Somoire, Esther	CECM-Kajiado
38	Dr. Joseph Murega	CECM-Kiambu
39	Collins Matemba	CECM- Kakamega
40	Everylne Rotich	CECM -Uasin Gishu
41	Vincent Learaman	CECM -Samburu
42	Dr. Misheck Mutuma	CECM Meru
43	Dr. Wainaina Daniel Ndung'u	Nakuru (CDH/COH)
44	Wario Galma Guracha	Isiolo CECM Health
45	Christine Apakoreng	West Pokot CECM Health
46	Hon. Prof. Justus Inonda Mwanje	Vihiga CECM Health
47	Nuno Roble Said	Garissa CECM Health
48	Claire Wanyama	Trans Nzoia CECM Health
49	Sarah Omache	Kisii CECM Health
50	Anita Toroitich	Elgeyo Marakwet CECM Health
51	Dr Ann Gathoni	Lamu CECM Health
52	Gregory Ganda	Kisumu CECM Health
53	Jane Ajele	Turkana CECM Health
54	Antony walela	Bungoma CECM Health
55	Prof. Richard Muga.	Homa Bay CECM Health
56	Dismas Wakla	Siaya CECM Health
57	Dr. Joseph K.Sitonik	Bomet CECM Health
58	Ruth Koech	Nandi CECM Health
59	Gladys Momanyi	Nyamira CECM Health

	Participant	County/Institution
60	Morgan M Silama	Narok CECM Health
61	Dr Mungai John	Nyandarua CECM Health
63	Ancent Kituku	Machakos CECM Health
64	Dr. Wolde Jama	Marsabit – CECM Health
65	Hon. Maita Rose	Laikipia CECM Health
66	Joseph Mbai	Muranga – CECM Health
67	Dr. Fredrick Oluga	Nairobi Metropolitan Services
68	Dr. Dadu Kharisa	Kilifi CECM Health
69	Francis Gwama	Kwale CECM Health
70	Javan Bonaya	Tana River CECM Health
71	Mr. John Mwangeka	Taita Taveta CECM Health
72	Dr. Godfrrey Nato	Mombasa CECM Health
73	Ismail Sheikh Issack	Wajir CECM Health
74	Hon. Dr. James Nyikal	The National Assembly
75	Hon. Ruweida Mohamed	Lamu County Woman Representative
76	Sen. Mbito Michael	The Senate
77	Hon. Ndegwa Wahome	County Assemblies Forum
78	Hon. Njuguna Mwaura	County Assemblies Forum
79	Mr. Caleb Nyamwange	Nakuru – County Attorney
80	Linton Kinyua	KEMSA
81	Josephat Mbuva	KEMSA
82	Ms. Sheila Yieke	Commission for Revenue Allocation
83	Mr.Wachira Maina	Consultant
84	Prof. Gilbert Kokwaro	Consultant
85	Mwalimu Thomas Kibua	Consultant
86	Dr. Pius Owino Wasunna	Consultant
87	Ms. Mary Mwiti	CoG-CEO
88	Khatra Ali	CoG
89	Meboh Abuor	CoG
90	Peris Njibu	CoG

	Participant	County/Institution
91	Barbara Awuor	CoG
92	Beth Ambasa	CoG
93	Sereina Sombol	CoG
94	Linet Kerubo	CoG
95	Irine Ogamba	CoG
96	Mukami Kibaara	CoG
97	Gerald Muka	CoG
98	Ronald Katana	CoG
99	Dr. Mutakha Kangu	CoG
100	Dr. Emmanuel Wamalwa	CoG
101	Dr. Sam Nyingi	CoG
102	Dr. Nancy Njeru	CoG
103	Leo Wabuke	CoG
104	Regina Ombam	CoG
105	Phylis Muturi	CoG
106	Washington Omwomo	USAID
107	Lilian Mutea	USAID
108	Mildred Sheshia	USAID
109	Wairimu Gakuo	USAID
110	Dhimn Nzoya	USAID
111	Monica Dea	USAID
112	Carolyne Ochieng'	USAID
113	Mark Meassick	USAID Mission Director
114	Bert Ubamadu	USAID
115	Patricia Ochieng	USAID
116	Francis Kahihu	USAID
117	Mercy Githanji	MSP
118	Elsie Opiyo	MSP
119	Jimmi Kamau	MSP
120	Sam Mwangi	MSP

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