



MINISTRY OF HEALTH

# **KENYA HEALTH POLICY FORUM**

Improving Health Outcomes and Services  
for Kenyans: Sustainable Institutions and  
Financing for Universal Health Coverage

*Summary of Proceedings*

March 18–20, 2014, Windsor Hotel, Nairobi, Kenya

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# Kenya Health Policy Forum

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## EXECUTIVE SUMMARY

The Kenya Health Forum took place in Nairobi on 18–20 March 2014, bringing together local and international experts to discuss the way forward for Kenya towards achieving Universal Health Coverage (UHC).

The following key messages resulted from the forum:

### Service Delivery

- Despite increased health sector investment over the last decade, Kenya continues to experience significant supply- and demand-side challenges affecting health service provision. The country can secure increased value from current investments by improving efficiency and allocating funds to proven high-impact interventions.
- Kenya is uniquely placed to benefit from the private sector (both for- and not-for-profit) in improving service delivery, especially for remote and rural populations.

### Health Financing

- Health policymakers need to focus on improving efficiency and accountability to create more fiscal space for achieving UHC. In addition, Kenya needs to mobilize domestic resources for health and reduce donor dependency.
- Data from the 2013 Kenya Household Health Expenditure and Utilisation Survey (KHHEUS) show increased utilisation of health services, and demonstrate the importance of the public sector in service delivery. While out-of-pocket payments have fallen, they remain high and continue to contribute to households' impoverishment—with the impact continuing to fall hardest on the poorest segments of the population.
- Priority public health programmes need innovative domestic financing as donor support declines, creating contingent liabilities.
- Experience from India shows that effective regulation of health insurance is necessary to address market failures. Regulation can also safeguard against systemic risk, protect consumers, and enhance efficiency. Consumer information, cost containment, and quality of care are equally important.
- Kenya needs to make choices for an appropriate legal framework for regulating health insurance. However, health products regulation should remain an MOH mandate.
- Experience from Mexico shows that health financing must respond to the political economy of the country and that national governments can facilitate progress towards UHC.

### Governance

- Improving governance at all levels is essential if Kenya is to obtain full benefits from investments in the health sector.
- Communication and collaboration between national and county governments will help improve service delivery by fostering coordination and effective use of resources.
- Public health sector staff need to be sensitised about the devolution process and accountability relationships.

- The Parliamentary Committee on Health can provide oversight and help put in place the legislative framework needed to support effective service delivery.
- International experiences show that although health challenges across different countries may be similar, there is no “one size fits all” solution. A learning-by-doing approach underlies successful implementation of many different strategies.
- Experiences in India show that the greatest challenge in the medical supply chain is uncertainty of financial flows. Shorter cycles for forecasting and fewer layers in the distribution system can improve efficiency and reduce wastage.
- Even with devolution, Kenya needs to maintain a unified health system, guided by a national health policy, one strategic plan, common regulations, and integrated information systems.

## **Client Safety and Quality of Service Delivery**

- High-quality health services enhance public trust in the health system, increasing clients’ willingness to pay, and enhancing sustainability.
- Health services can be improved by implementing innovative step-wise quality assurance programmes for providers and facilities, such as those implemented by PharmAccess/SafeCare and NHIF.
- Quality improvement may require Kenya to provide legal instruments and resources to enforce compliance with set standards, as well as incentives.

## ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
CHIPS	Community Health Planning and Services
DfID	Department for International Development
FBO	faith-based organisation
FP	family planning
GHS	Ghana Health Service
GIZ	German Federal Enterprise for International Cooperation
HIV	human immunodeficiency virus
KEMSA	Kenya Medical Supplies Agency
KePSIE	Kenya Patient Safety Impact Evaluation
HPP	Health Policy Project
KENAS	Kenya Accreditation Service
KHHEUS	Kenya Household Health Expenditure and Utilisation Survey
KQMH	Kenya Quality Model for Health
MCH	maternal and child health
MDGs	Millennium Development Goals
MOH	Ministry of Health
NACC	National AIDS Control Council
NCD	noncommunicable disease
NGO	nongovernmental organisation
NHIF	National Hospital Insurance Fund
PETS	public expenditure tracking survey
PHC	primary healthcare
PLHIV	people living with HIV
PPP	public-private partnership
RH	reproductive health
SPSH	Social Protection System in Health
TA	Transition Authority
TB	tuberculosis
UHC	universal health coverage
USAID	United States Agency for International Development
WHO	World Health Organisation

## BACKGROUND

Kenya has made impressive gains over the years in improving the health and well-being of its citizens. For instance, the country has reduced child mortality; made significant progress in the control of communicable diseases; achieved significant gains in the use of modern family planning (FP) methods; and reduced HIV prevalence and AIDS-associated deaths. Kenya has also improved the management, control, and treatment of tuberculosis (TB), and reduced deaths related to malaria. Life expectancy has improved—rising from 45 years in 1994, to 60 years in 2009 (MOH, 2014).

However, Kenya continues to face significant challenges that impede health system performance. High numbers of deaths associated with immunisable diseases persist among children, and the rate of maternal mortality has not abated. TB remains a major cause of ill health, and the number of people living with HIV (PLHIV) continues to increase, despite the decline in HIV prevalence.

Injuries and noncommunicable diseases, such as cancer, are increasing as causes of ill health and death. Kenya's persistently high birth rate is fuelling population growth of 2.4 percent per year, generating increased need for investment in basic services and utilities. Severe poverty is also a problem, with an estimated 46 percent of the population living in extreme poverty (MOH, 2014). Despite government contributions to health sector funding, Kenya is struggling to provide enough health staff and infrastructure to meet the needs of its growing population.

To address these challenges, Kenya must closely examine its health system—identifying ways existing resources can be harnessed to provide universal health coverage (UHC) to all Kenyans, regardless of their ability to pay. In March, the Ministry of Health (MOH) convened an international consultation forum to deliberate on these challenges and explore strategic and sustainable health financing options. The Kenya Health Policy Forum reviewed options and lessons learned from other countries, and proposed recommendations on how the country can improve efficiency to achieve UHC. The conference, organised in collaboration with the World Bank Group and the USAID-funded Health Policy Project (HPP), focused on four themes:

- Delivering services to improve health outcomes among women and children, with emphasis on poorer segments of the population
- Enhancing health system governance and effectiveness to deliver high-quality healthcare in a devolved setting
- Ensuring sustainable health financing to achieve universal health coverage
- Promoting client safety and quality of care

The forum proceeded based on three guiding principles:

- Leadership by Kenyan experts and institutions, with global experts and institutions sharing knowledge and experiences
- Learning with emphasis on practical expertise from countries with devolved health systems (Brazil, Ghana, India, etc.)
- Provision of analytical and advisory inputs to inform pros and cons of different options, and ensure that choices are compatible with the Kenyan context

The meeting brought together local and international experts with diverse expertise spanning the health sector, including both the public and private sectors. Participants from Kenya included representatives from both levels of government, nongovernmental organisations (NGOs), faith-based organisations (FBOs), and the private sector. International speakers shared experiences from Brazil, Ethiopia, Ghana, India, and Mexico. Development partners who support Kenya’s health sector were also represented, including the United States Agency for International Development (USAID), the UK Department for International Development (DfID), the German Federal Enterprise for International Cooperation (GIZ), and the World Bank.

# SUMMARY OF PROCEEDINGS BY SESSION

## Opening Session

### 1.1 Opening remarks

In a speech read on his behalf, James Macharia, the Cabinet Secretary for Health, noted that Kenya's health system faces critical challenges, including

- A shortage of human resources, exacerbated by inequitable distribution and brain drain
- Health-related legislation that is inadequate and weakly enforced, coupled with governance constraints
- Health infrastructure and health technologies that are dilapidated
- A lack of an overarching health financing strategy, leading to low public investments in health, high out-of-pocket expenditures, inadequate social safety nets to protect the poor, weak financial management, and inefficient use of resources

Cabinet Secretary Macharia said the MOH needed to learn from local and global experiences to expedite progress towards UHC. The Ministry has already established a technical working group and steering committee to develop a road map and strategy to achieve UHC. The Cabinet Secretary added that the Ministry has plans to reform the National Hospital Insurance Fund (NHIF) to make it an effective vehicle for achieving this goal. He welcomed the forum, saying that the outcomes would help refine the priorities of the new Kenya Health Policy (2014–2030) which is currently being developed.

### 1.2 Key presentations

*Measuring health service coverage: What we have learned: Dr. Ariel Pablo-Mendez, Global Health Administrator, USAID*

USAID provides financial and technical assistance to enhance the sustainability of the Kenyan health system through leadership, governance, and capacity building. The agency's support covers a wide spectrum of health services, including programmes to reduce the spread and impact of HIV and AIDS, and support for improvements in maternal and child health (MCH), family planning (FP) and reproductive health (RH). In addition, USAID supports strengthening of Kenya's health system by improving policy, logistics, health worker effectiveness, and monitoring and evaluation.

In his remarks, Dr. Pablo-Mendez noted that Kenya and other African countries have made significant improvements in healthcare, achieving reductions in maternal and infant mortality. In Kenya, infant mortality has declined 30 percent over the last 30 years. Dr. Pablo-Mendez remarked that it is imperative for Kenya to mobilize resources to improve the quality and coverage of health services.

*Key points:*

- In designing UHC schemes, Kenya and other countries should carefully decide on who pays, how funds are pooled, and how funds are paid out.
- “Catastrophic health spending can be avoided by providing health insurance.”
- Achieving UHC will require judicious use of resources, better investment of tax revenue, and increased investment in technology to improve the quality of health services while reducing costs.

*The challenge of UHC and its relevance to Kenya: Dr. Timothy Evans, Director, Health Nutrition and Population, The World Bank*

In his presentation, Dr. Evans noted that health is the best investment for any economy, as it provides the biggest returns on investment. He pointed out that UHC reforms are now a priority in Kenya, due to a combination of popular expectations, political commitments, and growing recognition that too many people lack access to high-quality healthcare. Further, payments at point of care have become too expensive—both for families, and for the health system itself. Too often, paying for healthcare has led to financial ruin for families.

Dr. Evans highlighted lessons for Kenya from other countries' experiences:

#### **Who should be covered?**

- The poor and disadvantaged should be given priority.
- Mandatory enrolment is preferable to voluntary enrolment, especially in countries with a large informal sector.
- It is important to avoid all forms of discrimination and take into consideration factors other than poverty that may hinder access to health services.

#### **What services should be offered and how should they be delivered?**

- UHC should include a package of essential services beyond those geared towards achieving the Millennium Development Goals (MDGs), and should include noncommunicable diseases (NCDs).
- To deliver services effectively, governments should ensure that the necessary human resources, supplies, and equipment are in place and equitably distributed.
- A good mix of public and private services should be considered.
- Health services should be decentralised.

#### **What is the cost, and how would resources be raised?**

- While most countries rely on taxation (general and earmarked/supplemental taxes), there may be other options, such as employer contributions.
- Pooling resources has been shown to be most effective.
- The World Bank is assisting countries to institute reforms that would allow revenue for health services to be generated from tobacco products, foods with low nutritional value, high-sugar drinks, alcohol, roads/transport, and clean-burning stoves.

#### **How should service providers be paid?**

- Common approaches to paying providers include fee for service, diagnostic-related groupings, capitation, and results-based financing.

**Politics, power and accountability:** UHC alters relationships between stakeholders because its implementation involves issues of money, power, and accountability. Consequently, securing short-term and longer-term “wins” are equally important for the government. Relevant factors to consider include

- Explicit entitlements to population/patients
- Decentralisation and delegation of service delivery
- Greater and lesser autonomy and independence

- Input- to output-based financing
- Appropriate accountability mechanisms
- Shortfalls in systematic monitoring
- People, services, and financing

Dr. Evans also presented key highlights of the UHC monitoring framework developed by the World Health Organisation (WHO) and the World Bank (WHO and World Bank, 2013).

<b>Overall Goal</b>	Reach UHC in all countries by 2030, so that all people have access to the high-quality, essential services they need without financial hardship.
<b>Specific Targets</b>	<ul style="list-style-type: none"> <li>• At least 80% of the poorest 40% of the population have coverage to ensure access to essential health services.</li> <li>• Everyone (100% of the population) has coverage to protect them from financial risk, so no one is pushed into poverty or kept in poverty because of health expenditures.</li> </ul>
<b>Indicators for Monitoring Country Progress</b>	<p><b>Health services coverage</b></p> <p>(a) <i>MDGs</i></p> <ul style="list-style-type: none"> <li>• <i># Aggregate</i>: a measure of MDG-related service coverage that is an aggregate of single intervention coverage measures for the health MDGs</li> <li>• <i># Equity</i>: A measure of MDG-related service coverage for the poorest 40% of the population</li> </ul> <p>(b) <i>Chronic conditions and injuries (CCIs)</i></p> <ul style="list-style-type: none"> <li>• <i># Aggregate</i>: a measure of CCI service coverage that is an aggregate of single priority interventions to address the burden of NCDs, including mental health and injuries</li> <li>• <i># Equity</i>: a measure of CCI service coverage for the poorest 40% of the population</li> </ul> <p><b>Financial risk protection coverage</b></p> <p>(a) <i>Impoverishing expenditure</i></p> <ul style="list-style-type: none"> <li>• <i># Aggregate</i>: a measure of the level of household impoverishment arising from out-of-pocket health expenditures, equal to the ratio of the poverty gap in a world without out-of-pocket payments to the actual (larger) poverty gap</li> </ul> <p>(b) <i>Catastrophic expenditure</i></p> <ul style="list-style-type: none"> <li>• <i># Aggregate</i>: the fraction of households incurring catastrophic out-of-pocket health expenditures</li> <li>• <i># Equity</i>: the fraction of households among the poorest 40% of the population incurring catastrophic out-of-pocket health expenditures</li> </ul>

## Session 2: Delivering Health Services for Rural Women and Children—Access and Quality

### 2.1 Key presentations

*Key challenges in service delivery: Patrick Amoth, MOH*

Mr. Amoth’s presentation discussed the challenges facing Kenya’s health system. He noted that supply-side challenges include inadequate human resources, poor availability of equipment and supplies, a large “know-do gap” (a gap between what is known and what is done in practice), inequities in coverage, limited funding, and gaps in leadership and management. On the demand side, challenges include the low priority placed on preventive and promotive health services in some communities, poor service uptake as a result of myths and misconceptions, inadequate information, and sociocultural and religious beliefs. Mr. Amoth suggested that addressing these challenges will require strengthening county health systems, scaling up high-impact interventions, building strong public-private partnerships (PPPs), and improving accountability for resource use.

*Key findings from a study to estimate the technical efficiency of public and private health facilities in urban and rural counties: Urbanus Kioko, University of Nairobi*

This study sought to discover how efficient health facilities in Kenya are, and whether efficiency varies according to health facility ownership. The findings show that, among public facilities, technical efficiency is higher in referral facilities and health centres than in district hospitals and dispensaries. In the private sector, technical efficiency is highest in mission and faith-based hospitals, followed by private for-profit facilities. Overall, the study found that faith-based hospitals were the most efficient in utilising their inputs. If public district hospitals operated efficiently, they would produce 27 percent more goods and services without additional investment. Mr. Kioko concluded that to achieve UHC, Kenya must address inefficiencies in the health system, identify specific areas of improvement to maximize outputs achieved with existing resources, and redistribute resources across levels of care for efficiency gains.

### 2.2 Panel discussion

*Challenges and progress in primary healthcare, especially maternal health: David Ojaka, AMREF*

Mr. Ojaka’s presentation highlighted demand-side factors affecting health service provision, and brought out the need to involve communities in programme design. AMREF’s experiences show that health services must be tailored to fit the context of the communities served. For instance, for mobile populations, static services may be ineffective, and services must be flexible with regard to time, location, and staff. Similarly, in northern Kenya, health services must take into consideration cultural issues that affect health, such as gender attitudes. AMREF has also learned that empowering communities to make their own health decisions is critical to the success of health interventions. Regular staff training is also essential to equip health workers with the right skills set.

*Supply side constraints—evidence from PETS-Plus, 2012: Thomas Maina, HPP*

Mr. Maina’s presentation highlighted key findings from the 2012 public expenditure tracking survey (PETS-Plus). The study found that supply-side constraints are enormous, especially in lower-level facilities, but do not receive as much attention as other issues affecting health service delivery. For instance, the flow of allocated funds to facilities is inadequate—50 percent of dispensaries and 30 percent of health centres received inaccurate amounts of funds, which were disbursed in unequal amounts inconsistently throughout the year; and most facilities surveyed also experienced delays of between two and three months in receiving funds. To achieve UHC and improve service delivery, the MOH and county governments must address these supply-side challenges.

*The role of the private sector in service delivery: Sam Thenya, Nairobi Women's Hospital*

Mr. Thenya noted that there has been a steady rise in lifestyle diseases in Kenya, which are likely to become a key cause of ill health in the country by 2020. He concluded that the private sector has made significant contributions to health services in Kenya, including training medical staff and mobilising significant funding and other investments. Mr. Thenya suggested that innovative PPPs could help address the rising burden of disease and illness. Such partnerships can be created in several areas, including

- Equipment—joint supply, lease, or operation
- Human resources—staff training, sharing personnel to fully utilise specialist skills
- Leadership and management—more joint involvement at the county level
- UHC—leveraging the private sector's long experience with management of medical insurance

*The role of FBOs in service delivery: Sam Mwenda, Christian Health Association of Kenya (CHAK)*

Mr. Mwenda highlighted the challenges faced by FBOs running medical institutions, which hinder their ability to operate optimally. One key challenge is taxation. FBO-run facilities are subject to a range of taxes, including clearance fees for donated equipment. This particular hurdle has led some facilities to refuse equipment donations because of resultant clearance expenses. Other significant challenges include having multiple regulators in the sector, which means facilities have to procure several types of licences and submit to inspection by different bodies. To increase their contribution to Kenya's efforts to achieve UHC, FBO-run facilities require the appointment of one central regulator to run the sector, and exemption from some of the taxes currently levied on their operations.

*County perspectives: the case of Mandera County: Ali Roba, Governor, Mandera County, Kenya*

Mandera County offers an example of the potential benefits of the devolution of health services. At the onset of devolution in 2013, the Commission on Revenue Allocation ranked the county second in the list of marginalized counties in Kenya, a situation aggravated by historical injustices. According to Governor Roba, when the county government came into office in March 2013, the county had few operational health facilities and low motivation among health workers. Over the past year, the county government has revived most health facilities, retained staff seconded to the county by the central government, and employed an additional 287 health workers. The county has also secured six new ambulances, and streamlined the procurement system for drugs and medical supplies to ensure that the county only receives drugs that are needed. Anecdotal reports indicate that these measures have resulted in increased staff motivation, improved services, and increased uptake of services by the local community.

## **Session 3: Ensuring Sustainable Financing to Achieve UHC**

### **3.1 Key presentations**

*Kenya health financing strategy—issues and the way forward to UHC:  
Elkana Onguti, MOH*

In this presentation, Mr. Onguti outlined the current progress in Kenya towards attaining universal coverage, challenges in the process, and opportunities for improvement. Currently, public spending on health is low and there is limited service coverage with high inequity, as illustrated in the chart below.

UHC-related Indicator	Year	Value
Total health expenditure per capita	2009/10	US\$42.2
Out-of-pocket expenditure per capita	2009/10	US\$10.3
Catastrophic expenditures (health expenditure > 40% of non-food expenditure)	2007	14.8%
Skilled attendant at delivery	2008/09	44%
Travel to health facility < 5km <sup>4</sup>	2008	89%

A large proportion of the population (78%) have no health insurance, and most of those who have insurance are covered by the NHIF. To move the country towards achievement of universal coverage, stakeholders have agreed on a raft of recommendations, which include implementing the following:

- Universal health insurance—all Kenyans to join health plans
- Pre-payment systems—tax and/or insurance
- Efficiency improvements
- Reforming the NHIF, according to recommendations of the 2012 NHIF Strategic Review
- Pooling and purchasing improvements
- Pluralistic service delivery—public and private
- Semi-autonomy for public hospitals

*Healthcare utilization and expenditure—evidence from the 2013 Kenya Household Health Expenditure and Utilisation Survey (KHHEUS): Stephen Muchiri, HPP*

Mr. Muchiri shared preliminary findings from the 2013 Kenya Household Health Expenditure and Utilisation Survey (KHHEUS) conducted by HPP. The study found there has been an increase in per capita utilisation of health services in Kenya, from 1.9 in 2003, to 3.1 in 2013. The study also found a decline in the number of people reporting untreated illness (people who were sick and did not seek care), and an increase in the number of people with access to inpatient care.

However, the study found large disparities in utilisation of inpatient care between different socioeconomic groups. The proportion of individuals in the lowest wealth quintile who were able to access inpatient care was half that of individuals in the wealthiest quintile. Overall, out-of-pocket health expenditure was found to be high, with the poorest spending a larger share of their income on healthcare than other socioeconomic groups. Inequities in per capita utilisation were also found between the different counties. For example, although the findings showed an overall decline in the number of households incurring catastrophic health expenditures (from 13.8% in 2003 to 9% in 2013), the rate of catastrophic health expenditure remains above the national average in 19 counties.

### 3.2 Panel discussion

*Fiscal space options for health financing in Kenya: Bernadette Wanjala, Kenya Institute for Public Policy and Analysis (KIPPRA)*

Ms. Wanjala outlined three ways in which Kenya can improve fiscal space and mobilize increased resources for health services:

- Rationalization of health sector—by reducing waste, cutting down on unnecessary expenses, and adopting more efficient service delivery approaches

- Raising additional revenue—by broadening the resource base, enhancing efficient allocation of available resources, enhancing tax compliance and expanding the taxation net, revising excise tax policy, taxing informal sectors and capital gains, and achieving more efficient taxation of the real estate sector
- Borrowing—the government should consider borrowing more from foreign sources, while decreasing domestic borrowing

*Sustainable HIV financing: Regina Ombam, National AIDS Control Council (NACC)*

Ms. Ombam described how the NACC is exploring options to raise funds for HIV programmes and reduce dependency on shrinking donor funds. Currently, two options are being considered:

- Social health insurance—establishing a scheme that could cover PLHIV
- Setting up an HIV trust fund—some possibilities have been discussed regarding how to raise capital for an HIV Trust Fund, including imposing a mobile phone airtime levy, using unclaimed assets, and taxing funds remitted by Kenyans in the diaspora

A Cabinet memorandum has been approved, and NACC is continuing to move the process along.

*Benefits incidence analysis: Jane Chuma, HPP*

Ms. Chuma highlighted findings from a study that examined KHHEUS data from 2003, 2007, and 2013 to establish who benefits from public health expenditures. The results showed a shift towards the poor, with increased investments in primary healthcare (nearly 50% of the resources). However, access to inpatient services remains inequitable, with the rich crowding out the poor in hospitals. Many homes experience catastrophic spending to access inpatient care. The study findings indicate that Kenya needs deliberate policies to encourage more people to use primary health services as the first point of care, and to address inequalities in access to curative services.

*Health insurance subsidies for the poor and the role of NHIF: Nellie Keriri, NHIF*

The NHIF offers medical insurance to about 4.5 million people, most of them in formal employment. NHIF has received a subsidy from the World Bank to reduce out-of-pocket health expenditures and provide coverage to people who cannot afford to pay for services. Currently, the NHIF is running a pilot project—covering 500 households per county—which offers a benefits package that includes inpatient and outpatient care for both public and private services, with providers receiving payment through capitation and fee for service.

### **3.3 International perspectives: Ensuring sustainable financing**

Three speakers offered international perspectives that Kenya could learn from in seeking to secure sustainable financing for health services.

*Global lessons from health financing reform for UHC: Matthew Jowett, WHO*

UHC aims to reduce unmet health needs, reduce inequalities in access, improve service quality, and improve financial protection. UHC is about practical, concrete healthcare reforms in a context of fiscal limitations. In his presentation on implementing health insurance, Mr. Jowett shared key lessons learned from around the globe.

In many countries, public insurance is funded through taxes and payments through line-item budgets, leading to poor “effective coverage”. To move towards UHC, some countries, such as Thailand and Mexico, rely on tax funding to support individuals outside the formal sector. China and Rwanda maintain voluntary membership, but with very high levels of enforcement and subsidisation. In the Philippines,

public health insurance is included in traditional budget funding. The cost of enrolling the poor is shared between national and local government, but there are challenges in committing the funds.

### Lessons for Kenya

- Tax financing plays a critical role in UHC regardless of the approach adopted.
- Declarations of entitlements do not automatically translate into effective coverage. Having a health financing policy alone is insufficient; coordinated and aligned actions/reforms across the health system are required.
- Significant progress on UHC will not be made through voluntary insurance.
- Strong national risk pools and well governed/managed single purchaser institutions are important features of success stories.
- Ensuring the efficient use of resources is central to UHC progress, and strengthens arguments for increased public funding.

### *Health insurance regulation in India: Somil Nagpal, World Bank*

Why regulate health insurance? Mr. Nagpal presented lessons learned from India, which indicate that self-regulation does not work well in the health insurance sector. Systemic instability, information asymmetry, and market failures highlight the need for formal regulation. Such regulation, Mr. Nagpal argued, protects consumers, protects the industry from system failures, and ensures that health insurance achieves its social objectives.

Various models of regulatory structures for health insurance exist. Mr. Nagpal highlighted several aspects to consider when establishing regulatory structures:

- Statutory/legal basis and administrative location—Where should the regulator be based? Administrative location and legal/statutory basis affect whether the regulator is independent and has adequate “teeth” with which to act effectively.
- Regulatory roles—Regulators can have a wide array of roles, each of which require different competencies and instruments:
  - Licensing and registration require a management background and integrity, financial strength, and business plans.
  - Financial regulation requires prudent regulations, accounting rules, reporting requirements, and monitoring systems.
  - Product regulation requires filing/approval requirements, transparency, and fairness requirements.
  - Other potential regulatory roles include price regulation, market conduct examinations, and enforcement.

Mr. Nagpal also pointed out that contextual factors should inform health insurance design, including country needs, the insurance market, and the existence of a private sector. Programmes for the poor and the informal sector have been shown to increase membership, and a limited benefit package is an important starting point.

## Lessons for Kenya

- Benefits package—Most schemes only cover inpatient care and avoid ambulatory/outpatient care, which contributes significantly to the financial burden on the poor.
- Provider control—It is important to monitor and act upon incidents of induced demand, unauthorized charges, and fraud.
- Cost containment—The benefits package must be well-defined, and systematic costing and collection of market prices are required.
- Institutional and managerial capacity—Capacity to monitor private health insurance is critical.
- Information—Insufficient information on enrolment processes, benefits, and providers can affect uptake and increase the level of financial risk, especially if exclusions and services not covered are unclear.
- Quality of care—Maintaining a high quality of care is important. To do so, insurance schemes need to include quality reporting requirements.

### *Developing sustainable health insurance programs—lessons from Mexico: Jorge Coarasa, IFC*

Mr. Coarasa's presentation highlighted lessons learned in Mexico, through development of the Mexican Social Protection System in Health (SPSH). Before the SPSH, healthcare in Mexico was characterized by public budget allocations that were driven by infrastructure and payroll, high out-of-pocket expenditure (52.4% of total health expenditures), and a high proportion of the population lacking coverage by any insurance scheme. Reforms aimed to move away from out-of-pocket expenditure, improve financial protection, and increase the quality and efficiency of the health system.

Under the SPSH, the federal government allocates resources to states based on insurance enrolment. Usage of these funds is governed by a regulated formula:

- Payroll—up to 40 percent of transferred resources
- Drugs for the public health insurance benefits package, and diseases covered—up to 30 percent
- Promotion, prevention, and disease detection activities included in the entitlements—at least 20 percent
- Operating and administrative costs—up to 6 percent
- Catastrophic fund, to eliminate impoverishment due to healthcare costs—8 percent

The reforms have led to an overwhelming increase in the number of people covered by insurance—from 15.7 million in 2006, to 52.5 million in 2012. To achieve this success, Mexico made political compromises to implement the reform:

- States agreed to the introduction of SPSH, but retained control over financing. As a result, additional resources are not used to pay providers based on production or performance, but on historical budgets.
- There is no strategic purchasing.
- The General Health Law included a requirement that only accredited providers be allowed to serve public health insurance affiliates, however the measure is not enforced.

- While the original SPSH vision was to fully subsidize premiums for the poor, and only partially subsidize coverage for non-poor in the informal sector, states lacked incentives to collect income-adjusted contributions. As a result, only 1 percent of affiliates pay.
- Despite reduced inequality in public health expenditures, large disparities in health outcomes remain across states.

### Lessons for Kenya

The national government should

- Aim to build technical capacity and provide sufficient funding to support the design of evidence-based insurance policies.
- Consider increasing investment in data collection and analysis.
- Strengthen the capacity to leverage evidence for policy decisions.
- Pilot and evaluate any proposed national scheme rigorously before crystalizing into law.

## Session 4: Enhancing Health System Governance and Effectiveness to Deliver High-quality Healthcare

### 4.1 Key presentations: Governance challenges in Kenya's devolved health system

*Key health systems governance challenges: S. K. Sharif, Former Director of Public Health and Sanitation, MOH*

Dr. Sharif discussed the efforts made by the MOH to improve public health sector governance. Governance is a political process that involves balancing competing influences and demands, and can include providing policy direction, detecting and correcting undesirable trends and distortions, and regulating the behaviour of a wide range of actors—from healthcare financiers to healthcare providers. Public health governance also includes managing collaboration and coalitions, and establishing transparent and effective accountability mechanisms. Poor governance and bureaucracy have negative impacts on health outcomes. National and county governments, health providers, and other stakeholders must be accountable to the communities they serve.

In Kenya, several tools are available to monitor governance and collect evidence to inform reforms. These include regular surveys, such as PETS, national health accounts, and citizens' report cards. Mr. Sharif concluded that results from such surveys must be utilised to improve systems. Moreover, the MOH needs to effectively engage with stakeholders—especially counties—to improve systems, focusing on equity, efficiency, and quality of services. Forums are required at all levels to enable clients to voice concerns, and deliberate efforts should be made to shift from input-based to results/performance-based financing.

*Emerging issues on governance in health sector: Maurice Siminyu, County Executive Committee Member, Busia County*

In his presentation, Mr. Siminyu discussed measures that have been put in place to enhance accountability and governance in the devolved health sector. At the national level, the Summit and Council of Governors meet regularly to forge collaborations and recommend ways to enhance efficiency. The sectoral intergovernmental committees serve as forums for county executives and policymakers from the national government to develop and jointly review plans and progress. At the county level, similar mechanisms are in place to facilitate public and stakeholder participation in developing and monitoring county plans.

Mr. Siminyu highlighted challenges at the county level which may negatively impact performance: fear of job loss and delayed salaries, industrial action, low staff morale, poor working environment, bureaucratic

obstacles hindering counties from accessing facility improvement funds, and decreased availability of funds to cover operating and maintenance expenses. Addressing these challenges, he concluded, will inevitably require an increase in health sector funding. The high wage bill and huge recurrent expenditures pose a threat to counties' performance because they inhibit capital expenditures. There is also an urgent need to develop norms and standards for the health sector, and to develop county-level capacity in legislation and management.

#### **4.2 Panel discussion**

*The role of the Parliamentary Health Committee in supporting health sector governance: James Nyikal, Member, Parliamentary Committee on Health*

Dr. Nyikal regretted that challenges experienced in the devolution of health services have arisen due to a lack of synchrony between Parliament and county governments, and lack of information. The Parliamentary Health Committee plays an oversight role in the health sector. It also supports the health sector by lobbying for appropriate legislation and, when necessary, drafting laws. The committee can also mobilise funds and lobby development partners for increased funding. To accomplish its mandate, however, the Parliamentary Committee on Health must receive information on needs from both the national and county governments. Dr. Nyikal noted that Kenya needs a social health insurance scheme to achieve UHC. He emphasized that, once funds are pooled together, they must be properly assigned to ensure that marginalised and vulnerable groups are not disadvantaged.

*Governance in the public sector pharmaceutical supply chain system—challenges and opportunities: Maureen Nafula, Strathmore University*

Ms. Nafula noted that the enormous amount of funds invested in the procurement of pharmaceuticals for the public sector increases the risk of abuse and fraud. Improving governance, particularly in the area of procurement, can minimize these risks and ensure efficient management of resources. Nafula acknowledged that many efforts had been made in Kenya to strengthen and reform the Kenya Medical Supplies Agency (KEMSA). Regardless, she noted, significant challenges remain:

- There is a lack of initiatives to reform lower levels of the supply system, including functions such as prescription of medications.
- County governments have limited capacity to manage the medical supplies system.
- Distribution of supplies is not based on equity.
- Supply chain management is in the hands of pharmacists, who are not trained to do this and have no skills in forecasting.
- Devolution has fragmented the supply chain, increasing the risk of inefficiency.

Ms. Nafula noted that, while devolution presents opportunities for increased public participation and competition in the supply chain, it is important to strengthen training in supply chain management and downstream operations (distribution and prescription) to avoid waste.

*International experiences in promoting governance in pharmaceutical supply chain: Prashant Yadav, University of Michigan*

Supply chain systems in many settings face similar challenges, such as how to leverage public and private investments, and how to learn and be responsive to patients' needs. Professor Yadav identified the following global trends and lessons learned about increasing accountability in the pharmaceutical supply chain:

- Autonomy of supply chain systems is important, and there is an increasing trend towards semi- or fully autonomous medical supplies agencies.
- Limited competition is healthy for the supply chain system.
- Flow of funds is a major challenge for the supply chain system. If money does not flow on time, the system cannot function effectively. Managing uncertainty surrounding financial flows is critical to smooth functioning of the supply chain system.
- There is need to devise strategies to manage uncertainties in the supply chain system. In Kenya, there is an urgent need to strengthen capacity at the county level to predict demand.
- Simplified structures improve accountability and performance of the system. In Kenya, KEMSA has simple structures and these should be protected.
- The private sector has agility and self-organising ability, but it is important to give some attention to its supply chain system.

## Session 5: Strengthening Health Systems in a Devolved Setting: Kenyan Challenges

### *5.1 Key presentations: Common challenges affecting service delivery in Kenya's devolved setting*

*Lessons learned on delivering effective interventions: David Peters, Johns Hopkins University*

Mr. Peters identified several lessons learned in delivering effective interventions that should inform Kenya's efforts to achieve UHC. Overall, he noted that evidence-informed policies and effective implementation lead to good health outcomes. Adopting evidence-informed interventions can ensure governments take appropriate action, promote innovation and organisation change, and support flexible and inclusive planning and problem solving.

#### Lessons for Kenya

- Choose the right (cost-effective) health interventions
- Set ambitious, common targets
- Fund these interventions
- Implement interventions as designed
- Generate evidence by including an implementation research agenda in the implementation of important health policies and programs. Many different types of strategies can succeed in the “real world” (outside of pilots), but these may not be replicable.
- Policymakers define strategies, but often have limited influence on how they are implemented.
- Follow through on commitments to the poor and vulnerable groups. Many health policies state that a desire to serve the poor and vulnerable, but they rarely measure and show how to improve services for disadvantaged people.

*Opportunities and challenges for the health system in devolution: Ruth Kitetu, MOH*

Ms. Kitetu's presentation provided the background to Kenya's devolution process, and outlined the provisions in the Constitution regarding devolution of health services. Through analysis and interpretation of Schedule Four, the MOH has made efforts to align its policies with the new Constitution, restructuring

its operations and clarifying the roles and functions of the two levels of government. The Ministry has also established an intergovernmental forum to enhance consultation and collaboration between the two levels of government. Moreover, budgets have been disaggregated to match newly transferred functions, which were successfully devolved in August 2013. Funding for Level V hospitals has been secured through conditional granting. Counties are now paying salaries for health staff, and most national staff have been absorbed by counties, which have County Public Service boards in place.

Ms. Kitetu identified the key lesson learned: successful devolution of health services depends on clarification of functions and roles, having the right policies and legislation, and establishing and sustaining strong working relationships between the two levels of government.

*County experience with opportunities and challenges in devolution in the health sector: Elizabeth Ogaja, CEC, Kisumu County*

At the county level, health plans and budgets are integrated into county development plans. County assemblies bear responsibility for approving health plans and budgets. In some counties, county assembly health committees have been established and can play lobbying and resource mobilization roles similar to the Parliamentary Committee on Health. However, the performance of the health sector in counties has been affected by several factors, including lack of capacity among Members of County Assemblies (MCAs) and low levels of awareness of health priorities. Governors' desire to deliver on their political parties' manifestos and promises has also affected priority setting.

Regarding management of financial resources for health services, Dr. Ogaja reported that interpretation of the Public Finances Management Act has been a challenge, especially because counties have to learn new budgeting processes. Insufficient funds for development have also been a hindrance, as the bulk of resources go to fund recurrent expenditures.

## **5.2 Panel discussion**

*Devolution in the health sector—Transition Authority's (TA) experiences and challenges: Dabar Abdi Maalim, TA*

Dr. Maalim traced the process of devolving health services and the achievements made to date. He regretted that low civic awareness of the devolved system in Kenya, especially among health workers, had caused problems. He recommended more public education on the Constitution's provisions regarding devolution and the roles of both levels of government.

## **Session 6: Health Systems in a Devolved Setting: International Experiences**

### **6.1 Key presentations: Lessons learned on successful management of decentralised health services and devolution from India, Ghana, Brazil, and Ethiopia**

*India's experiences in managing devolved health systems: Sujatha Rao, Former Secretary of Health, Government of India*

India instituted devolution reforms in 1993, when Parliament passed constitutional amendments that created local governments in rural and urban areas. Since then, a concerted effort has been made to devolve powers and finances to local governments all over India. However, until 2005, inflexible institutional arrangements led to delays in both the disbursement of funds to states and the return of unutilised funds to the central government by states. Reforms in 2005 enhanced decentralisation at all levels and put a flexible funding system in place, under which states are no longer required to return unused funds.

Other innovations helped improve the decentralised system, including reforms in human resource management, which allowed facilities to hire staff locally and remain open 24 hours throughout the week. A system of monitoring service performance against standards (Indian Public Health Standards, Monitoring Committees, Social Audit) was also created, as well as an improved management system. Resource centers were established in both national and state health systems to support capacity development on a concurrent basis.

### Lessons for Kenya

- India's experience shows that decentralisation of funding and priority-setting based on evidence are critical for better accountability.
- Training, supervision, and monitoring for coverage and quality are essential to ensure decentralisation does not become abdication.
- Assignment of functions, clarity of roles, simplicity in guidelines, and flexibility in operation are highly important in delivering devolved services.

*Lessons from Ghana in health sector devolution: Abdulai Tinorgah, Former Health Services Director, Government of Ghana*

While devolution in Kenya is a national and political imperative, in Ghana, decentralisation was largely driven by demands from within the health sector. The Ghana Health Service (GHS) Act and the Teaching Hospital Acts created a separation of roles, with the MOH responsible for policymaking, resource allocation, and monitoring; and the GHS and teaching hospitals responsible for service provision. The GHS has a hierarchical command structure: divided into national/headquarters, regional, districts and sub-districts, and is managed by a Director-General. Health budgets are allocated within the sector, rather than by district assemblies.

### Lessons for Kenya

- County health systems strengthening should be given meaning by defining a basic unit for management and organisation of the health system and building its capacity.
- An effective system to reach the community is fundamental. Ghana utilised the Community Health Planning and Services (CHIPS) project to deliver essential services to communities.
- Partner coordination plays a major role in transforming the health sector/system. Ghana organises joint annual planning and review summits, which involve partners and solicit inputs from independent experts. Mechanisms for dialogue and consultation should be regular; and should be based on agreed frameworks and analysis.

*Brazilian experiences in devolution: Marcia Huculak, Superintendent of Health, State of Parana*

Ms. Huculak shared experiences from Parana State to demonstrate lessons learned in devolution. Brazil is a federal republic composed of 26 states and 5,570 municipalities. In the health sector, the three levels of government share financial resources according to an established formula: 50 percent to federal government, and 25 percent each to states and municipalities. To ensure social participation, states and municipalities must establish health councils (composed of clients, suppliers, health managers, and professionals), which are responsible for the control of health policies. The federal government provides funding for the public health service and formulates national policies. States and municipalities are responsible for policy implementation and contribute to financing health services. Since 2006, municipalities are responsible for primary healthcare (PHC) services. States and municipalities jointly organise tertiary care services in their respective regions.

Evidence from Parana State shows that improving PHC has a greater impact on health outcomes than any other policy intervention. Investing in improving PHC infrastructure and technology was found to be more cost effective than any other health investment. To enhance PHC services, Parana State invested funds in improving infrastructure and improved resource disbursement to health units. A financial incentive was established to help municipalities keep their health workers—US\$15 million per year paid out in varying amounts (US\$1.30 to 9.60 per month) to those who were more vulnerable/impooverished. Training programs were also devised for PHC teams in partnership with universities and scientific societies.

*Ethiopia's experiences with delivery of primary healthcare services in devolved health systems: Roman Tesfaye, Heath Insurance Agency, Ethiopia*

Ethiopia adopted a decentralised system of government in 1990. To achieve national consensus on the health sector decentralisation process, serious and continuous consultations with health professionals were held at several levels before devolution of health system responsibilities to regions, states, and districts. Resources (manpower, financial resources, etc.) were also redistributed between the national and state levels. Basic legal frameworks were developed, and guide all regions and states. Continuous capacity development and systems development investments were also implemented through different projects and programs at the national and devolved levels.

#### Lessons for Kenya

- Strong and functional governance systems and coordination mechanisms, including a unified system of planning, budgeting, and reporting, are critical.
- Clear definition of roles (service delivery and financing) among different administrative tiers is vital.
- There is a need for continuous learning and sharing of best practices.
- Strong political support is essential.
- A shared vision across all levels, including strategic thinking/planning and priorities/targets helped to strengthen PHC services and improve health outcomes.

## Session 7: Promoting Client Safety and Quality of Health Service Delivery

### 7.1 Key presentation

*How quality can be improved by implementing step-wise, innovative, and realistic quality assurance programmes for healthcare providers and facilities: Dr. Pacifica Onyancha, MOH, Kenya*

In healthcare services, quality contributes to clients' trust and willingness to pay for services, helping secure sustainability and accountability. Dr. Onyancha noted that, although key health indicators are improving in Kenya, maternal mortality remained stagnant, and disparities in access to care persist, both regionally and across wealth quintiles. Further, quality of care remains a barrier to improving health outcomes.

Dr. Onyancha outlined the quality assurance processes and practices being institutionalized in Kenya under the Kenya Quality Model for Health (KQMH):

- Evidence-based medicine—development/revision and dissemination of evidence-based clinical and public health standards and guidelines.

- Quality management—application and integration of quality management principles into the organisation of healthcare.
- Patient partnership initiatives—respecting patients’ rights and views, recognising clients as co-producers of health outcomes, and promoting community involvement and participation.

Initiatives are also underway in Kenya to regulate the health sector—including providers, practices, infrastructure, technology, and products—to ensure that quality of care is improved, patient safety guaranteed, and standards of conduct established. Accomplishing this will require Kenya to provide legal instruments, resources to enforce regulation, and incentives to comply with quality improvement. A national accreditation system is needed, and KQMH will be the framework to guide the process towards one unified system of quality assurance.

### ***7.2 Panel discussions: Other efforts to regulate health service delivery in Kenya***

*The role of the Kenya Accreditation Service (KENAS) in regulating health service quality: Doris Mueni, KENAS*

KENAS was established in 2009 through a Legal Notice. The body does not regulate, but rather works with regulators to accredit medical laboratories, pharmaceutical laboratories, medical reference laboratories, veterinary laboratories, and test and calibration laboratories, among others. According to Ms. Mueni, KENAS has been in discussion with stakeholders to devise a system for hospital accreditation. To date, KENAS has accredited several facilities, including five medical laboratories, 25 testing and calibration laboratories, two inspection bodies, and three certification bodies.

*The NHIF’s step-wise accreditation process—early experiences: Nellie Keriri, NHIF*

Ms. Keriri shared progress on NHIF’s step-wise accreditation process. NHIF has devised a system of accrediting healthcare providers. Facilities progress through the following steps, eventually leading to accreditation:

- **Step 0** – Entry level: poor quality
- **Step 1** – Very modest quality: continuous need for technical support
- **Step 2** – Modest quality strength: requires medium technical assistance
- **Step 3** – Medium quality strength: acceptable but vulnerable to changing environment
- **Step 4** – Strong quality systems: quality systems in place
- **Step 5** – Continuous quality improvement: evident long-term commitment to quality
- **Step 6** – Excellent quality systems: accreditation

The accreditation system is currently being pilot tested. So far, 50 hospitals have been trained on using the step-wise approach. NHIF currently recognizes 1,700 accredited healthcare providers. In collaboration with external evaluation organisations, NHIF is working towards achieving international accreditation standards for healthcare.

### ***7.3 International perspectives on regulation and measuring quality***

*International experiences in measuring quality and safety in health services: Jishnu Das, World Bank*

Mr. Das highlighted the need to have good systems to measure the quality of care being delivered to patients, noting that static measures may not provide true measures of health service quality. For instance, fewer stock outs do not necessarily indicate better patient care. Programme experiences and research have shown that it is hard to find *any* relationship between health spending and health outcomes in most countries. This is because poor quality of care weakens the link between spending and outcomes.

Indicators that public health services could measure as proxies for quality of care include provider knowledge and skills, structural inputs or caseloads, incentives to provide effort for diagnosis, and incidence of incentives to distort treatment away from optimal. The World Bank is piloting several approaches to measurement through the Kenya Patient Safety Impact Evaluation (KePSIE) project to establish the current quality of practice among Kenyan health providers. As in other countries, better quality measurement will help pinpoint areas for discussion and improvement.

*Experiences on quality improvement in Nigeria and Tanzania: Nicole Spieker, SafeCare/PharmAccess Foundation*

High-quality healthcare includes giving clients the right care at the right time. Health facilities need standards of care and licencing and accreditation systems to ensure high-quality performance. Ms. Spieker’s presentation discussed SafeCare, a quality improvement programme that encourages motivation and transparency in service delivery. Lack of transparency can lead to “unknown and unbearable risks,” inefficient use of resources, and low investments. For patients, lack of transparency means they have no information, no benchmarking, and must rely on “word of mouth” when choosing services. This leads to low trust in the health system.

SafeCare supports healthcare providers in resource-restricted settings to go through step-wise, structured improvement programs that enable them to deliver safe and quality-secured care to their patients, in accordance with internationally recognized standards. Introducing standards allows healthcare facilities in resource-restricted settings to measure and improve the quality, safety, and efficiency of their services; and facilitates rating and benchmarking of providers across the health system. Facilities receive recognition for incremental achievements towards meeting the following standards:

<b>A. Healthcare Organisation Management</b>	<ol style="list-style-type: none"> <li>1. Management and leadership</li> <li>2. Human resource management</li> <li>3. Patient rights and access to care</li> <li>4. Management of information</li> <li>5. Risk management</li> </ol>
<b>B. Care of Patients</b>	<ol style="list-style-type: none"> <li>6. Primary healthcare services</li> <li>7. Inpatient care</li> </ol>
<b>C. Specialised Services</b>	<ol style="list-style-type: none"> <li>8. Operating theatre and anaesthetic services</li> <li>9. Laboratory services</li> <li>10. Diagnostic imaging services</li> <li>11. Medication management</li> </ol>
<b>D. Ancillary Services</b>	<ol style="list-style-type: none"> <li>12. Facility management services</li> <li>13. Support services</li> </ol>

## Session 8: Discussion of the Way Forward

Dr. John Masasabi, speaking on behalf of the MOH, closed the conference and outlined how the Ministry will utilise the lessons learned from the conference as it charts the way forward in establishing universal health access. The MOH made the following key commitments:

### Service Delivery

- The MOH will prepare a clear road map for further strengthening engagements with FBOs and create an enabling environment for PPPs.
- Implementation research will be prioritized to fine-tune sector strategies and translate policies into practice.
- Conditional grants will be used to improve service delivery and health outcomes, and the MOH would be pleased to extend such support to interested counties through ongoing projects.

### Health Financing

- The MOH will create a UHC unit to compile and generate evidence to inform UHC reforms.
- The MOH oversight committee for UHC will include representatives from county governments and the Ministry of Finance.
- The national government will reform the NHIF, which is the largest purchaser in the country; and will create a strong regulatory framework for all health insurance to provide better healthcare services for the poor.

### Governance

- The MOH, the TA, and the Parliamentary Health Committee will work together to reduce information gaps by creating an effective communication strategy to inform all stakeholders in the health sector about devolution, including their roles and responsibilities.
- The new platforms established for dialogue between the two levels of government will be sustained and further strengthened.
- Capacity building will be done at all levels of government and service delivery to manage the transition.
- Evidence-based planning based on disease burden and costing data will be promoted.

### Client Safety and Quality of Service Delivery

- Kenya will establish a unified legal framework for regulation to improve quality of care.
- A mechanism will be created to support facilities in improving quality, including putting in place appropriate incentives.

## APPENDIX 1: CONFERENCE PROGRAMME

March 18, 2014—Policy Perspectives		
Moderator: Mr. Francis Musyimi, Secretary Administration, MOH		
09:00–09:55 Chair—Prof. Fred Segor, PS, Health	Opening Session: Introduction of Institutions	Prof. Fred Segor, Principal Secretary, Ministry of Health
	Remarks	Dr. Kamau Thugge, Principal Secretary, The National Treasury (10 mins)
	Expectations from the Forum	Hon. James Macharia, Cabinet Secretary for Health (15 mins)
	The Challenge of UHC and Its Relevance to Kenya	Dr. Timothy Evans, Director, Health Nutrition and Population, The World Bank (15 mins) Dr. Ariel Pablo-Mendez, USAID/Global Health Administrator (15 mins)
09:55–10:15	<b>Tea</b>	
10:15–10:30	Summary of expectations	<ul style="list-style-type: none"> <li>Prof. Fred Segor, Principal Secretary, Health</li> </ul>
10:30–13:00	Delivering Health Services for Rural Women and Children: Access and Quality  Panel chair: Dr. Francis Kimani, Director of Medical Services	<ul style="list-style-type: none"> <li>Key challenges in service delivery—Dr. William Maina, MOH (20 mins)</li> <li>Key findings from efficiency study—Dr. Urbanus Kioko, UON (20 mins)</li> </ul>
		<b>Panel Discussion: Kenyan Experiences</b> <ol style="list-style-type: none"> <li>Primary healthcare, especially maternal health: Challenges and progress—Dr. David Ojaka, AMREF (10 mins)</li> <li>Supply-side constraints: Evidence from PETS-Plus Survey, 2012—Mr. Thomas Maina, USAID/HPP (10 mins)</li> <li>Role of private sector in service delivery—Dr. Sam Thenya, Nairobi Women’s Hospital (10 mins)</li> <li>Role of faith-based organisations in service delivery—Dr. Sam Mwenda, CHAK (10 mins)</li> </ol>
		<b>International Lessons</b> <ol style="list-style-type: none"> <li>Prof. David Peters, Head, International Health, Johns Hopkins University (20 mins)</li> </ol>
Q&A, followed by panel chair summary (40 mins)		
13:00–14:00	<b>Lunch</b>	
14:00–17:00	Ensuring Sustainable Financing to Achieve Universal Health Coverage for Kenyans	<ul style="list-style-type: none"> <li>Key health financing challenges and efforts towards UHC—Mr. Elkanah Onguti, Chief Economist, MOH (20 mins)</li> <li>Healthcare utilisation and expenditure: Evidence from the Household Survey of 2013—Mr. Stephen Muchiri, USAID/HPP (20 mins)</li> </ul>
		<b>Panel Discussion: Kenyan Experiences</b> <ol style="list-style-type: none"> <li>Fiscal space options for health financing in Kenya—Ms. Bernadette M. Wanjala, KIPPRA, Kenya (10 mins)</li> </ol>

Kenya Health Policy Forum—Improving Health Outcomes and Services for Kenyans

	<p>Panel Chair— Dr. J. Masasabi Wekesa, Head, Directorate of Policy Planning and Healthcare Financing</p> <p>Co-chair—Mr. Jackson Kinyanjui, Director, ERD, The National Treasury</p>	<ol style="list-style-type: none"> <li>2. Sustainable HIV financing—Ms. Regina Ombam, NACC (10 mins)</li> <li>3. Benefits incidence analysis—Dr. Jane Chuma, USAID/HPP (10 mins)</li> <li>4. Health insurance subsidies for the poor and role of NHIF: Ms. Nellie Keriri, NHIF (10 mins)</li> </ol> <p><b>International Lessons:</b></p> <ol style="list-style-type: none"> <li>1. Health insurance regulation in India—Dr. Somil Nagpal, World Bank (20 mins)</li> <li>2. Developing sustainable health insurance programs: Lessons from Mexico—Mr. Jorge Coarasa, IFC (20 mins)</li> <li>3. Global lessons from health financing reform for UHC—Dr. Matthew Jowett, Senior Health Financing Specialist, WHO (20 mins)</li> </ol> <p>Q&amp;A, followed by panel chair summary (40 mins)</p>
<p><b>18:00– 20:00</b></p>	<p><b>Reception</b></p>	<p>All invited participants</p>

March 19, 2014—Implementation Perspectives		
08:30–11:00	<p><b>Enhancing Health System Governance and Effectiveness to Deliver High-quality Healthcare</b></p> <p>Panel chair: Tawhid Nawaz, Acting Sector Director, Human Development, Africa Region</p> <p>Co-chair: Dr. John Munyu, CEO, KEMSA</p>	<ul style="list-style-type: none"> <li>Key health systems governance challenges—Dr. S. K. Sharif, Former Director of Public Health and Sanitation (20 mins)</li> <li>Emerging issues on governance in health sector: County experience—Dr. Maurice Siminyu, CEC-Busia County (20 mins)</li> </ul>
		<p><b>Panel Discussion: Kenyan Experience</b></p> <ol style="list-style-type: none"> <li>The role of Parliamentary Health Committee in supporting governance in the health sector—Dr. James Nyikal, MP and member of the Parliamentary Committee on Health (20 mins)</li> <li>Governance in the public sector pharmaceutical supply chain system: challenges and opportunities—Dr. Maureen Nafula, Strathmore University (15 mins)</li> </ol> <p><b>International Lessons</b></p> <ol style="list-style-type: none"> <li>International experiences in promoting governance in pharmaceutical supply chain—Prof. Prashant Yadav, Director, Healthcare Research, University of Michigan (20 mins)</li> </ol>
		Q&A, followed by panel chair summary (40 mins)
11:00–11:30	<b>Tea</b>	
11:30–13:00	<p><b>Strengthening Health Systems in a Devolved Setting: Kenyan Challenges</b></p> <p>Panel Chair: Hon. Isaac Ruto, Chair, Council of Governors</p> <p>Co-chair: Dr. Suneeta Sharma, Project Director, USAID/HPP</p>	<ul style="list-style-type: none"> <li>Kenyan Devolution: Opportunities and challenges for the health system: Dr. Ruth Kitetu – Ministry of Health (20Mins)</li> <li>Opportunities and challenges in devolution in the health sector, county experience: Dr. Elizabeth Ogaja, CEC–Kisumu County (20 mins)</li> </ul>
		<p><b>Panel Discussion Kenyan Experiences</b></p> <ol style="list-style-type: none"> <li>Devolution in the health sector: Transition Authority’s (TA) experiences and challenges—Dr. Dabar Abdi Maalim, Transition Authority (10 mins)</li> <li>Kenyan vision and aspirations from devolved health system—Mr. Joseph Mukui, Director of Rural Planning, Ministry of Devolution and Planning (10 mins)</li> </ol>
		Q&A, followed by panel chair summary (30 mins)
13:00–14:00	<b>Lunch</b>	
14:00–17:00	<p><b>Health Systems in a Devolved Setting: More Kenyan Experiences and International Experiences</b></p> <p>Panel chair: Dr. Olusoji Adeyi, Sector Manager, Health Nutrition and Population, Eastern and Southern Africa.</p>	<ul style="list-style-type: none"> <li>Broader political experiences, role &amp; responsibilities of old and new institutions/constitutional bodies in facilitating devolution—Sen. Kipchumba Murkomen (20 mins)</li> </ul>
		<p><b>International Experiences</b></p> <ol style="list-style-type: none"> <li>Indian experiences in managing devolved health systems: National Rural Health Mission—Ms. Sujatha Rao, Former Secretary of Health, Government of India (20 mins)</li> </ol>

	Co-chair: Hon Ali Roba, Governor - Mandera	<ol style="list-style-type: none"> <li>2. Lessons from Ghana in health sector devolution—Dr. Abdulai Tinorgah—Former Director, Health Services, Govt. of Ghana (20 mins)</li> <li>3. Brazilian experiences in devolution—Ms. Marcia Huculak, Superintendent of Health, Brazil, State of Parana (20 mins)</li> <li>4. Ethiopian experiences in effective delivery of primary healthcare services in devolved health systems—Ms. Roman Tesfaye, Director General, Health Insurance Agency, Ethiopia (20 mins)</li> </ol>
		Q&A, followed by panel chair summary (40 mins)

March 20, 2014—Service Quality Perspectives		
09:00–11:00	<p><b>Promoting client safety and quality of health service delivery</b></p> <p>Panel Chair: Dr. John Odondi, Head, Directorate of Clinical Services</p>	<ul style="list-style-type: none"> <li>• Regulatory and quality assurance challenges in Kenya — Dr. Pacifica Onyancha, MOH (20 mins)</li> </ul> <p><b>Kenyan Experience</b></p> <ol style="list-style-type: none"> <li>1. Role of KENAS in regulating quality of health services—Ms. Doris Mueni, KENAS (20 mins)</li> <li>2. NHIF step-wise accreditation process: Early experiences—Mr. Martin Ngari, Acting GM-Benefits and Quality Assurance, NHIF (20 mins)</li> </ol> <p><b>International Lessons</b></p> <ol style="list-style-type: none"> <li>1. International experiences in measuring quality and safety—Mr. Jishnu Das, The World Bank (20 mins)</li> <li>2. Experiences on quality improvement in Nigeria and Tanzania—Ms Nicole Spieker, Director of Quality, Safecare, PharmAcces Foundation (20 mins)</li> </ol>
	11:00–11:30	<b>Tea Break</b>
11:30–12:15	Q&A, followed by panel chair summary (40 mins)	
12:15–12:45	Way forward— Prof. Fred Segor, Principal Secretary Health (30 mins)	

## APPENDIX 2: LIST OF PARTICIPANTS

	Name	Designation	Organisation/Country	Email Address
1	David Peters	Head, International Health	Bloomberg School of Public Health, Johns Hopkins University	<a href="mailto:dpeters@jhsph.edu">dpeters@jhsph.edu</a>
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