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# Paracle te Health Sector Develop ment Partner Forum

HSDPF SecretariatForum Report

# Sector Develop ment Partner Forum

HSDPF Secretariat

Forum Report

# The Paracle

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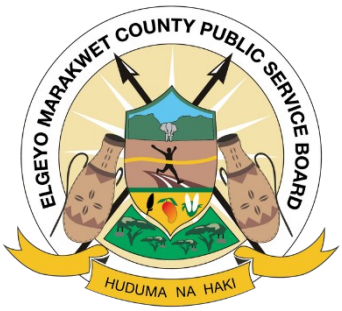
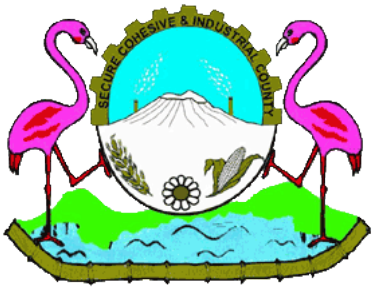




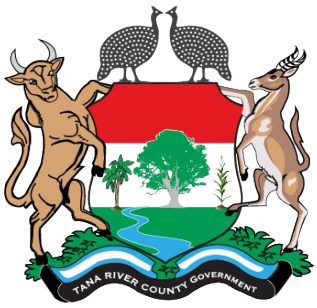




MACHAKOS COUNTY






THARAKA NITHI COUNTY
GOVERNMENT
STRONGHOLD
A Haven Of Value Addition


TURKANA COUNTY
PAMOJA TUJIJENGE
GOVERNMENT


COUNTY GOVERNMENT OF UASIN GISHU
THE CHAMPIONS


KISII COUNTY
PROSPERITY FOR ALL


COUNTY GOVERNMENT OF NYAMIRA
County of Possibilities


COUNTY GOVERNMENT OF
LAIKIPIA


UMOJA
NA
UCHUMI
MANDERA COUNTY GOVERNMENT


HOMA BAY COUNTY

# FOREWORD

The decision by the Paraclete Health Sector Development Partner Forum (HSDPF) secretariat to hold an intergovernmental meeting, alongside key health sector development partners and international organisations, academia, the private sector and civil society on partnerships for healthcare in devolution on 8th – 9thOctober 2015 was a significant milestone and opportunity. It was a result achieved only through the collective action of many different stakeholders over several years. As part of the build-up to the inaugural HSPDF, research and consultations were undertaken across all 47 Kenyan counties to provide input into the preparations for the devolution-level meeting, as well as the meeting itself.

By July 2015, HSPDF partners had completed their consultations, and informal dialogues with a representative sample of county governments, academia, health development organisations, CSO's and diverse private sector players. Development partners and other public sector players were consulted up to October 2015 and their cooperation availability needs be lauded.

The Paraclete Health Sector Development Partner Forum is a mechanism towards domestic health financing and to *crowd in* health finance through multidisciplinary partnerships with the health sector; its actors working towards sustainable development with especial focus to increasing opportunities and responsibilities at county level.

The Paraclete HSDPF has also worked build the capacity of local healthcare stakeholders for broad and active partnerships from 2014, providing training and capacity building for leadership in more than 25 county governments, including in Public Private Partnerships, leading to the development and registration of County PPP Nodes and projects and, as a county PPP Transaction Advisor, is responsible for the early stage project development of subnational health sector PPPs and developed a PPP synopsis for the Kenya Healthcare Federation that provides guidance for health sector players in their interactions with legal and financial parties to PPPs.

By fostering deliberations between stakeholders with congruent objectives, HSDPF helped ensure that the perspectives of a broad-range of stakeholders informed the discussions at the county level health leadership forum, with the Ministry of Health, providing direction and recommendations on health economics, planning, policy and financing.

The inaugural Health Sector Development Partner Forum, themed '**Sustainable Partnerships for Healthcare in Devolution**' and addressing the WHO pillars of the health system was an important new development, bringing together the full range of stakeholders to share and listen to each other's views and experiences, and develop local solutions to local problems in an innovative sub-national partnership model.

I am pleased to provide this report on the inaugural Paraclete Health Sector Development Partner Forum (HSDPF), which I hope does justice to the richness and breadth of the discussion held on 8-9 October at the Catholic University of Eastern Africa in Nairobi. The Report and other Forum documents are available on the university's website and the Facebook group Health Systems Strengthening Kenya.

Finally, I wish to thank the Ministry of Health, the World Health Organisation, The World Bank Group, GIZ Health Sector Program, CDC, PEPFAR, USAID and the Development Partners for Health Kenya for their continued support of HSDPF initiatives. The Paraclete HSDPF looks forward to continuing to work with all stakeholders both ahead of and beyond the 2nd HSDPF, to crowd in finance with local, academia driven, evidence based solutions and private sector contribution to the healthcare financing

The Paraclete Health Sector Development Partner Forum

HSDPF Secretariat10/18/15

gap. **Emmanuel Mosoti Machani – Paraclete HSDPF Convener**

# Acknowledgements

Dr. Custodia Mandlhate-WHO Country Representative

Dr. James Teprey-WHO Outbreak, Disaster Management and Nutrition Officer

Dr. Humphrey Karamagi-WHO Health Systems Strengthening Advisor

Dr. Gandham Ramana-The World Bank Group. Lead Health Specialist and Program Leader, Kenya, Rwanda, Ethiopia.

Mr. Maxwell Marx-PEPFAR Senior Advisor, Policy and External Relations

Mr. James Kwach - CDC Health Information Systems Technical Advisor

Dr. Joanne Ondera-GIZ Component Lead Healthcare Financing

Cynthia Macharia-GIZ Public health specialist

Sandra Erickson-Development Partners for Health Kenya

Dr. Walter Obita – Afrihealth.

Dr. Andrew Were - Medical Practitioners and Dentists Board

Dr. Elizabeth Ogaja – CECM Health, Kisumu County Government

Mrs. Sarah Omache – CECM Health, Kisii County Government

Mr. Ahmed Sheikh – CECM Health, Garissa County Government

Elizabeth Mwashuma – Africa Capacity Alliance

Collete Tele, Karen Miricho, James Ongamo, Immaculate Wandera, Sharon Muthoki, Elsie Karanja, Serah Achieng' – The Catholic University of Eastern Africa

# Introduction

HSDPFs overarching role is to crowd-in finance for county level partnerships in Kenya's health sector. By strengthening the health finance pillar of health system at county and service provider levels, HSDPF sets out to provide a platform for cooperation to all actors working towards the development of Kenya's health sector through a health system approach.

In today's rapid and complex world it has become almost impossible to do anything alone. This is especially true in health, where diminishing resources, constantly rising prices, changing disease patterns and the increasing use of sophisticated technology for diagnosis and treatment have made it virtually impossible for a single entity to provide the range of services in isolation or without some type of institutional partnership.

Partnerships in health are increasingly recognized as a major opportunity in the pursuit of global goals and present challenges that require a multi-sectorial response.

These partnerships may take many forms, ranging from global to national, sub-national and institutional partnerships. The partners too may vary from private sector players, civil society organisations, local governments and other public sector stakeholders, FBO's and development partners, to community groups.

All partnerships have in common that they have come about because partners have something to gain from the agreement. Sustainable partnerships call for mutual benefit and HSDPF provides a platform for these varied types of partnerships, advice on the various models of partnership and how to take up opportunities present in today's health finance landscape, that is far removed from what it has been the last few decades.

The decision by the HSDPF Secretariat to convene a county-level meeting on 'Partnerships for Healthcare in Devolution', with development partner led, inter-governmental, academia and varied private sector participation, presents a unique opportunity for the full range of stakeholders to shape that avenue of response.

The Forum enabled these stakeholders to share knowledge, views and experiences on the opportunities and challenges in the development of the health system.

The Forum followed extensive academia backed research and county level public participation events and county government and private sector engagement. The research provided an opportunity for the development of an agenda directly informed by regionally disaggregated health sector gaps. In order to provide access to the Forum for people unable to attend in person, the Forum plenary and break-out sessions were streamed online and can still be viewed online at the Catholic University of Eastern Africa's Website and HSDPF's Facebook page.

# Rationale

From a development studies perspective, HSDPF is predicated on a scoping review and resultant gap development and analysis on private sector participation towards harmonisation and coordination in efforts to strengthen the health system and achieve Universal Health Cover

HSDPF sets out to drive academia's and the private sector's participation to address a range gaps that beset the health sector in Kenya, ranging from skills, knowledge and technology to insufficient infrastructure, financial and human resources for health levels as well policy implementation.

# HSDPF Objectives

1. Bridge skills, knowledge and technology gaps through creation of a platform for devolved health sector harmonisation, capacity building, and North-South and South-South partnerships;
2. Align sector health to the theory of change to provide a basis for long term transformational change, with increased engagement, community participation and broaden the attribution to, and impact of, cohesive development partner activity by reducing overlaps and duplication.
3. Analyse value for money, coherence and socioeconomic factors to highlight opportunities and risks for health sector development;
4. Build capacity for 'managing for results' by facilitating joint planning and review processes, and data driven decision making as well as contribute to knowledge and research gaps;
5. Working with university students from each county, contribute to social and mutual accountability;
6. Provide recommendations to establishing a more effective aid coordination mechanism in devolved Kenya, including a proposed model and key steps for its introduction.

# HSDPF Deliverables

The Forum provides a platform for the development of partnerships in health between county governments, development partners and different stakeholders - at the county and service delivery levels - that augment access, quality, equity and demand for healthcare services in all 47 counties to improve public health outcomes. This in

pursuit of human welfare and sustainable economic and social development, for the attainment of which, good health is essential.

This is done by focusing on 3 thematic areas:

i. Domestic health financing – to take ownership at county and service delivery levels of funding diversification and resource mobilisation for healthcare, to aid plug the resource gap in health.
ii. Medical technologies and commodities- to seek local solutions that bolster supply side efficiencies and effectiveness.
iii. Human resources for health and governance – to build leadership capacity and share best practices.

In a departure from previous modes of consultation and dialogue convened for the health sector by the financial services sector, HSDPF brought together the different stakeholders in a format that allowed for discussion and interaction rather than a two-way dialogue between individual stakeholder groups. HSDPF was also a self-financed event and the participation of health sector leadership from more than 30 counties underscores their commitment towards domestic health financing.

HSDPF was an opportunity for the different attendant healthcare stakeholders to listen and respond to each other and allow all stakeholders and the HSDPF secretariat to canvass a wider and richer range of views to inform their work in contributing to building cohesion and coherence into development partner activity in the health sector; with increased private sector participation.

The forum provides partners an opportunity to conceptualise projects, interventions and business opportunities and a mechanism towards crowding in finance for the sub-national health sector and PPPs.

# HSDPF PARTICIPANTS

In keeping with the intent of the Forum, participants were invited from the following stakeholder groups:

- The Ministry of Health;
- All county Governments;
- Development partners for Health – Kenya;
- Civil Society and Faith Based Organisations;
- Health Development Organisations;
- Health professional associations;
- Patient and consumer organizations;
- Private sector representative organizations and businesses;
- Academia, researchers and research bodies
- Multilateral and bilateral development partners;
- Medical technology and commodity firms;
- Free standing think tanks;
- Health regulatory and oversight boards;

# Health sector cohesion

The scoping survey findings shows room for improved private sector in broad and active partnerships by:

i. Lending private sector expertise to improve the quality of coordinating structures of development partner activity;

ii. Lending private sector efficiencies to meet opportunities and challenges presented by devolution of the health sector.

iii. Harmonisation of development partner inputs to health systems strengthening and by applying the knowledge management value chain to offset fragmentation and curb duplication of efforts and project overlaps.

iv. Active participation in bridging the health funding gap by increased (private sector and academia led) resource mobilisation activity

to finance the strengthening of the health system;

iv. Increased, constructive participation in joint planning and reviews;

v. Improving the quality and practices of using data to: aid decision making, provide beneficiary feedback, monitor equity issues and aid effectiveness as well as build coherence into development partner activity;

vi. Support transparent and monitorable performance assessment against national strategies and sector progress;

vii. Support sector impact and social accountability by adding transparent private sector, CSO and FBO channels;

vii. Academia contributing to building the capacity of Ministry of Health leadership, county health management teams;

viii. Building evidence bases for scaled interventions and supporting managing for results;

# HSDPF PROGRAMME

The Forum programme was designed to provide a range of opportunities for participants to engage and contribute actively. It included five plenary sessions and concurrent, county focused break-out sessions on approaches to county specific development support opportunities.

The opening plenary session set the forum tone and the final plenary session was to consolidate the key messages and findings from the two days and sound the HSDPF's secretariats availability to contribute to building the capacity of the Ministry of Health and County Governments' health leadership for domestic financing of the health system.

The final annotated agenda is attached as Appendix 1

# Opening Session

The purpose of the opening plenary session was for the HSDPF secretariat to welcome participants, outline the purpose and format of the Health Sector Development Partner Forum and set the scene for the two-day event.

The HSDPF's convener, Mr. Emmanuel Machani, opened proceedings and welcomed participants to the Forum. He gave a brief on the conceptualisation of the inaugural HSDPF, as a knowledge sharing forum, aimed at fostering partnerships to nurture domestic participation in strengthening the health system and the growing currency of knowledge, especially in light of Kenya's newly acquired lower-middle income status, and the opportunities and challenges that this presents.

He said HSDPF is a driven, resourceful and innovative approach to the 3 of the 5 Kenya Health Policy Objectives of devolution, namely:

i. Facilitating self-governance and enhancing participation in making decisions on health;
ii. Enhancing the right of communities to manage own health affairs and further development.
iii. Enhancing capacities of the two levels of government to deliver health services in mandates;

He then told those present HSDPF goals are predicated on the Kenya Health Policy Framework goals of:

i. Leadership and governance restructuring;
ii. Improving procurement;
iii. Availability of essential health products and technologies;
iv. Digitization of health records and health information systems;
v. Accelerating the process of equipping health facilities, including infrastructure development;
vi. Human resources for health development;
vii. Initiating mechanisms towards universal health coverage.

Mr. Michael Okuku, Head of Department of Development studies then welcomed the WHO Country representative, Dr. Custodia Mandlhate and the attendees on behalf of the Catholic University of Eastern Africa, acknowledging the efforts students from the departments of: development studies, law, business and social sciences, had put in to actualise HSDPF.

Speaking of the Catholic University of Eastern Africa's efforts in support of the Health Sector Development Partner Forum, he sounded the institutions availability by: faculty, consultants and facilities to build capacity of MoH leadership and county teams, and work as liaison on behalf of county governments.

Mr. Okuku then welcomed Dr. Mandlhate to deliver the keynote address and open the forum for deliberations.

# Keynote Address

The WHO Country Representative in Kenya, Dr. Custodia Mandlhate, gave the Keynote address which commended the approach to HSDPF's deliverable by approaching the pillars of the health system, recommending.

She reminded attendees of the unique set of challenges facing Africa in her opening remarks (appendix 2),and that the extremely high burden of communicable conditions, coupled with the rapidly rising burden of noncommunicable conditions, is straining health services with a double burden of disease, a new experience in countries that have undergone epidemiological transitions in their disease profiles.

Dr. Mandlhate spoke of unfinished business from the recently phased out Millennium Development Goals and the African continent continuing to address this with the just launched Sustainable Development Goals. She highlighted SDG 3 "**ensure healthy lives and promote well-being for all ages"** and the targets addressing the diseases and determinant factors, a key guiding principle of which is Universal Health Coverage**.**

She spoke of our being in the context where access to, and coverage of, essential health services is a matter of concern. Highlighting maternal health statistics, while pointing out the disparity between effective well known interventions and improved health outcomes, Dr. Mandlhate said this is occasioned by challenges in intervention system design.

Dr. Mandlhate underscored the focus of Universal Health Coverage on three challenges to desired health goals, namely availability, coverage and financial access and advocated for an approach that regards this as we move in building partnerships in health.

She said that the WHO are placing a strong emphasis on the role of appropriate health systems to deliver on health goals and look at its constituents as all organizations, people and actions whose primary intent is to promote, restore and/or maintain health.

With regard to the gains made, Dr. Mandlhate shared that the thrust, in many African countries, to strengthen the health system today requires an effective system for it struggles with enormous challenges. This effective system shall enable provision of critical services required to attain Universal Health Coverage goals. Placing more emphasis on attaining health goals and improving the health system, not just running health services, requires regard from a health determinants perspective, these should include stewarding actions in health related sectors towards attainment of health goals. Calling for a change in perspective of the role of Governments and partners in health from just managing health services to stewardship of the health agenda, Dr. Mandlhate said the Universal Health Coverage agenda needs to be looked at in this perspective to have a maximum effect on health.

She reiterated the WHO six pillars that make up the health system, namely:

i. Health Service Delivery;
ii. Health Workforce;
iii. Health Information system;
iv. Medical products, vaccines and technologies;
v. Health financing; and
vi. Health leadership and Governance (stewardship), should always be considered when contextualising efforts for improvement of health outcomes.

Dr. Mandlhate highly commended HSDPF's theme "Sustainable Health Care Partnerships in Devolution" and called for people-centred integrated care, affordability, access, sufficient capacity of health workers and recognition of the role other sectors play in assuring human health.

In her closing remarks, Dr. Mandlhate appealed on behalf of the WHO to Governments and policy makers to embrace Universal Health Coverage Principles and the establishment of coherent health financing policies and financial risk protection.

Stating '**We know what needs to be done: we have no reason to fail'**, Dr. Mandlhate said the forum provides a critical mechanism to support the momentum towards evidence-based UHC in Kenya and reiterated the World Health Organizations commitment in making Africa a healthier continent and Kenya the place to be.

World Health Organization

(Read full speech by Dr. Custodia Mandlhate at: www.cueaconsultancy.com/hsdpf; or Joining closed Facebook Group: **Health Systems Strengthening Kenya).**

# County Perspectives

## Kisii County

Mrs. Sarah Omache, Health Executive Committee Member, Kisii County gave a talk on the need for innovative local solutions to address local problems. From governance structures that deliver health services more efficiently and effectively and exploring domestic resource mobilisation, to

innovative ways of 'crowding-in' local public and private resources, including county and other public sector partnerships as an innovative way of sharing resources.

Mrs Omache then spoke of the need to strengthen talent identification and reward structures, modernize the training of human resources in health and ancillary sectors, with increased focus on community level capacity building. She called on academia and other players in the private sector to participate packaging research information for broad by understanding. *An example of which was to follow in the second plenary session with the WHO's Dr. James Teprey sharing findings of multi-county research on Disaster Risk Management Capacity, conducted with Kenyatta University.*

Mrs. Omache said the high expectations of Kenyans, in light of the constitutional right to health, requires actions beyond the ordinary, calling for financial and non-financial support. She closed by singling out preventive health interventions to address the non-communicable disease burden and protect the young and future generations. Urging those in attendance to make a difference.

## Kisumu County

Dr. Elizabeth Ogaja, on behalf of the Governor of Kisumu and Council of Governors Chair of the Committee of Health and Biotechnology, then spoke about the changes on the health sector and health service delivery, driven by increased consumer rights and information.

Calling for partnerships with sectors beyond health, Dr. Ogaja reminded the gathering of the need to address cross-cutting social determinants of health such as infrastructure, education and transport, social protection and gender, as well as equity and human rights.

Speaking of strides made in sanitation and access to water and the gaps remaining unique to Kisumu, Dr. Ogaja highlighted the disparate opportunities and challenges present in each county and the need for county led solutions that are in tandem with the national policy; to build county participation in meeting the country's health needs.

Dr. Ogaja also urged the strengthening of outreach programs and community level engagement.

She closed with a call to county health departments to engage and explore innovation in healthcare financing with the input of multi-disciplinary subject matter experts.

Acknowledging gains from the HSDPF secretariat's capacity building of the Kisumu County Government's leadership for Public Private Partnerships, Dr. Ogaja encouraged counties to set up Public Private Partnership nodes and legislation for partnerships in health, as well as seek capacity building to drive the domestic health financing agenda.

Following briefs from all attendees from the private and public sector representing 40 counties, 5 development partners and 16 private and public sector players, Dr. Walter

Obita, a consultant at Afrihealth Consulting, HSDPF members, closed the opening session.

*View Opening Session video on: [www.cueaconsultancy.com/hsdpf](www.cueaconsultancy.com/hsdpf) ; or join closed Facebook group: Health Systems Strengthening Kenya*

# Domestic Health Financing Plenary I

## Local health financing.


Mr. Elkana Ong'uti, the Ministry of Health's Chief Economist and Head at the Division of Planning, Policy and Health Financing began his presentation on Domestic Health Financing and Financing Health Care Activities by providing social, economic and demographic data, disaggregated by various measures including depth of insurance coverage, utilisation of services, choice of provider. Disaggregated coverage data by county showed considerable variations.

While highlighting increased county health expenditure Mr. Ong'uti said that counties need not work in isolation of other financing channels. He also spoke on the competing needs in resource mobilisation to finance the health system and the benefit of County health leadership, he highlighted domestic solutions to strengthening the Health Financing pillar, namely:

i. Resource reallocation;
ii. Efficient use of available resources;
iii. Allocative efficiencies in decision making between competing health needs;
iv. Reduction in non-discretionary health expenditure;
v. Reforming revenue collection for efficiency;
vi. Increased, prudent borrowing;
vii. Resource mobilisation and alignment of developmental support, procurement, financial management, project implementation and frameworks, based on national development strategies;
viii. Progressively increasing domestic financing for health;
ix. Increased private sector financing, pooling of pre-payment options including health insurance and risk sharing via PPP's to better engage the private sector.

Highlighting challenges in domestic efforts towards financing health and healthcare activities, Mr. Ong'uti noted the following;

i. Out of Pocket Expenditure – While health expenditure at $67 per capita lends credence to the country's gains towards domestic health financing, Out of Pocket expenditure still is disproportionately high and could be tapped more efficiently. Mr. Onguti recommended pooling via NHIF to strengthen prepaid health care.

ii. Catastrophic Health Spending, still represents thousands of Kenyans annually pushed into poverty.
iii. Inefficient allocation of resources could be mitigated by astute capital budgeting, and allocative efficiencies;
iv. High external revenue contribution presents dual dependency and concentration risks;
v. Limited uptake of prepaid health solutions;
vi. Limited national government resources and counties dependency on this.

Mr. Ong'uti closed by emphasizing the country has room to be responsive, in acknowledgement of the creation of the relevant regulatory framework to attract private sector investments and an enabling environment for these to thrive.

Mr. Onguti's presentation drew varied audience reactions, ranging from requests for increased county level human resources for health capacity building on health financing matters through requests for specialized support structures for disparate regional needs, such as nomadic communities, to direction in local, county driven, resource mobilisation efforts to bridge the health financing gaps.

## Gains of Devolution in Health Financing: a microcosm of frontier counties.

Mr. Ahmed Sheikh – Health Executive Committee Member, Mandera County was called upon and spoke passionately of the strides made in Mandera County's health sector since the inception of devolution.

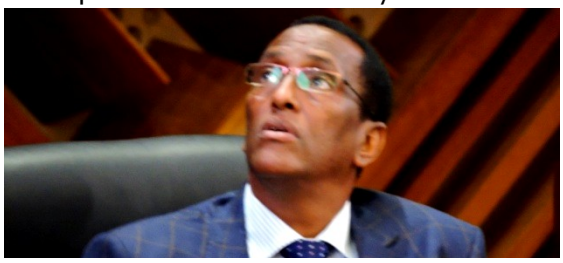
Mr. Sheikh presented the results of a comparative analysis in the growth of the health sector in Mandera from improved health outcomes - especially in Maternal and Newborn Health - development of service solutions bespoke to the nomadic nature of the county's population, to ongoing developmental initiatives.

Mr. Sheikh shared with HSDPF a county produced video that highlighted the transformational infrastructural development of the Mandera County Hospital in the period since devolution that has greatly increased quality of health services to patients. It also highlighted gains made in improving access by operationalising ambulances and increasing by 23 the number of public healthcare facilities in Mandera.

Mr. Sheikh also shared Mandera's innovative incentive based approach to attracting and retaining human resources for health and the contribution in growth of personnel from a 97% workforce deficit at devolution, with 164 healthcare workers to the current 600, a truly remarkable feat given the short period the county government has been in existence. In spite of this, challenges remain, including the lack of specialists. The enormity of the task in attracting talent was brought to the fore when he said there was a lack of interest in recent openings for specialist positions in the county, with advertisements failing to elicit response.

He also espoused Mandera county Government's preparation and commitment for service delivery as a best practice for other counties to follow and encouraged his contemporaries in other county cabinets to take the initiative to grow public-private partnerships while calling for Ministry of Health stewardship.

In closing, Mr. Sheikh decried the lack of support for mobile / nomadic communities, though he pointed out that this is tempered by the resilient nature of residents of arid and semi-arid regions. He called for increased county level relationships with development partners and an improving further the mode of cooperation with the Ministry of Health.



# PPP's and other Private Sector engagement for Domestic Health Financing

Mr. Emmanuel Machani of the HSDPF Secretariat then addressed the gathering on private sector participation in the health sector, highlighting the need for Strengthening **Public-Private Dialogue Mechanisms** and private-public partnerships, for which, and resounding Dr. Mandlhate's comments, in her keynote address, HSDPF is a critical mechanism.

By creating a favourable policy and regulatory environment, the Government of Kenya - especially the National Treasury, through the PPP Unit and the Ministry of Health - Mr. Machani noted, have made great headway towards laying grounds that enable an enhanced role for private health sector players in economic development. Legal frameworks on Public Private Partnerships have been developed for counties and the Ministry of Health's approach to private sector engagement greatly enhanced.

He also spoke of the benefits, role and importance of independent advisors in PPPs that included:

1. Building PPP public support by ensuring:
i. Sound transaction structures;
ii. Public objectives and rationale articulation;
iii. Public information and education;
iv. Objective and transparent bidding;
v. High service provision standards and targets;
vi. Defined and articulated labour transition.

1. Appropriate risk distribution and regulatory conformity, while optimising long-term public and partnership benefits.
3. Fostering competitive investment and ensuring equal access to data.

In his address, he encouraged county teams to seek partners who present:

1. Capacity to balance private and public sector interests through:
a. Safeguarding long lasting social benefits and public interests of ownership and affordability;
b. Applying legal and regulatory aspects;
c. Constancy and valence in pursuit of global goals and commitments.

2. Capacity to build transparency, investor confidence and stakeholder consensus;
3. Multi-disciplinary teams;
4. Localised understanding;
5. Ties with the global investment community to facilitate partnerships and apply rigor.

To address **sustainability** of PPP's, Mr. Machani called on county health leadership to address:

i. Conflicting government objectives including: financial and political, long and short term, infrastructure and services;
ii. Social needs, affordability, consumer rights and public sense of ownership;
iii. Investor requirements of acceptable risk, profitability and bankability.

He presented, as an opportunity for increased private sector contribution to access and service delivery participation, the disparity in access to private sector health care between rural and urban populations and the unmet need for healthcare.

Mr. Machani pointed out that HSDPF offers an opportunity for development partners and the public and private sectors to share knowledge on efficiency in health finance allocation and utility, encouraging counties to work with academia to build their leadership and other human resources capacities.

Acknowledging the high county turn-out, he pointed out they would be edified for the quality and value of the two-day deliberations, for the high-level development partner and public and private sector support.

Mr. Machani closed by sounding the HSDPF's availability, that of the Catholic University of

Eastern Africa and CUEA Consultancy in capacity building in preparation for private sector partnerships, at all stages of the PPP Lifecycle which he summarised as:

1. Idea generation, Project conceptualisation, identification, prioritisation, pre-feasibility analyses and early stage project development;
2. Project development;
3. Financial close;
4. Construction / delivery;
5. Operation.

*View Plenary Session 1 video on: www.cueaconsultancy.com/hsdpf ; or*
*Join closed Facebook group: Health Systems Strengthening Kenya*

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# Plenary Session 2

## Patient and Caregiver Rights

Mrs. Alice Mwongera, the first non-medic to be appointed to the Kenya Medical Practitioners & Dentist Board professional conduct committee and founder of the Moses Morris Foundation, a patient rights organization that advocates for Compassionate, Quality and Affordable Healthcare opened the second plenary session with a reminder to attendees that all were gathered for the benefit of the patient as a human being.

A USAID appointee to the Africa Patient Centered Care Task Force (APCCTF), instrumental in designing the African Patient Centered Care Model and with the support of Planetree, Mrs. Mwongera has developed a curriculum to train personnel in health facilities on patient centred care.

In a notable dual display of civil society and community level activity influencing policy, Mrs. Mwongera spoke about the patient rights charter she had earlier developed and had been distributing for four years without the approval of the government which, after refinement by the APCCTF, became a legal document that is now called Kenya National Patient Rights Charter, launched in October of 2013.

Mrs. Mwongera asserted change in the health sector is possible and it will occur when there is active participation of the patient, who is the consumer of the health services. Calling for patient-centric health systems strengthening, with due regard to health caregivers' rights and safety.

She urged contextualisation of disease by caregivers and the teaching of compassion to health professionals.

In closing, Mrs. Mwongera acknowledged participant feedback on the still inadequate dissemination of the Kenya National Patient Rights Charter 2013 to counties and urged participants to access it via the internet as policy document dissemination activity continues.

Mrs. Mwongera closed by calling for the strengthening of the place of the Patient from a weak center to the focal point.

# KENYA HEALTH SECTOR DISASTER RISK MANAGEMENT CAPACITY

Dr. James Teprey, the WHO Kenya Disaster Risk Management and Nutrition Advisor followed to address the gathering. Beginning by defining risk as a product of likelihood and impact, he then shared findings documented from an assessment the WHO conducted May and June 2013 with Moi University that utilized a multicounty tool (Baringo, Kitui, Marsabit, Migori, Mombasa, and Nairobi) and which also captured National institutions, the Ministry of Health and line ministries. Its findings would inform the development of a roadmap for strengthening Disaster Risk Management capacity at National and County levels.

Dr. Teprey the addressed findings in critical areas of Disaster Risk Management and gave recommendations as follows:

1. Legal and policy support frameworks;

   i. DRM Bill yet to be enacted and subjugates the Health Sector;
   ii. DRM legislation and policies not harmonized and coordinated.

   WHO recommendations
   i. Health Sector DRM Strategy and All Hazard plan including Disaster coordination;
   ii. Lobby for passing of the DRM bills.

2. Ministry of Health coordination mechanisms;
   i. Established structure but inadequate coordination mechanism for DRM within the health sector.

   WHO recommendations
   i. National DRM committee and multi-sectorial, interagency health sector DRM forum.

3. Hazards and risk vulnerability, surveillance information;

   i. Inadequate risk assessment information;
   ii. Health sector facilities aren't established based on the risks and some are located in hazard prone areas.

   WHO Recommendations:
   i. Comprehensive disaster risk assessment, Map and relocate facilities as necessary;
   ii. Integrate IDSR information management mechanism

4. Institutional plans and logistical support for response and recovery;
   i. The National Pandemic Preparedness and Response Plan (NPPP);
   ii. An all-hazard national health disaster plan gap;
   iii. Health facilities emergency operation plan gap.

   WHO Recommendations:
   i. Operationalize the NPPP;
   ii. All-hazard national disaster plan;
   iii. Ambulance services framework;
   iv. Utilize KEMSA stores for disaster preparedness
   v. Accessible disaster contingency funds.
   vi. Support health facilities recovery.

5. *There were inadequate resources for maintenance of most health facilities*

6. Community disaster preparedness;
   i. Community health strategy and structures;
   ii. Unclear community coordination structures for DRM.

   WHO Recommendations:
   i. Develop clear community, multi-level DRM structure;
   ii. Enhance community strategy scope;
   iii. Train stakeholders on DRM tools;
   iv. Enhance the capacity of relevant professionals.

7. Health facility mitigation measures;

i. Few Health facilities have a master plan and some were constructed with minimal professional consultations;
ii. Inadequate resources for maintenance of most health facilities

WHO Recommendations:

i. All Health facilities should create and keep master plans, and fund preventive maintenance;
ii. Harmonize policies & guidelines for building construction to address DRM;
iii. Identify and assess the resilience of old health facility buildings.

8. Communication strategies;

WHO Recommendations on comprehensive health disaster risk communication strategy:

i. Review to address all phases of disaster;
ii. MOH communications office should be in tandem with other government structures;
iii. Institute mechanisms for Monitoring & Evaluation and Knowledge Management;

9. Human resource plan and capacity

i. Capture DRM in basic health related courses
ii. Few Staff are trained in DRM
iii. MOH doesn't have a comprehensive health sector human resource plan.

WHO Recommendations:

i. DRM training needs assessment;
ii. DRM in in-service training;
iii. Database of mobilisable DRM health experts;
iv. Finalize the human resource development policy;
v. Formulate policy on exercise/mock drills for level 4-6 health facilities.

In closing, Dr. Teprey, reiterated the importance of investment in Disaster Risk Management at national, county and institutional levels.

# Health Financing Plenary II

## Global Financing Facility in support of Every Woman Every Child

Dr. Gandham Ramana, the World Bank Group's Health Specialist and Program Lead Kenya, Rwanda and Eritrea then addressed the gathering, launching locally the Global Financing Facility in support of Every Woman Every Child that has Kenya as one of four frontrunner countries.

Beginning by crediting the unprecedented global momentum to further accelerate progress in Reproductive Maternal Newborn Child, Adolescent Health (RMNCAH), Dr. Ramana said the Global Financing Facility provided an opportunity for a final push on what is lagging behind on the MDGs and ensure a solid foundation for post-2015 work toward the 2030 convergence targets.

The accelerated benefit provided by GFF goes to the importance of women's and children's health, at the centre of global development efforts.

Dr. Ramana's presentation began by showing the dramatic drop in child and maternal mortality as a result of country efforts and development partner support. He said however more needs be done with 6.6million children dying annually, mainly from preventable conditions and 1% of pregnancies to girls aged 15-19 years, with complications linked to pregnancy and childbirth the second most common cause of death.

Dr. Ramana noted that despite the 75 highest burden countries spending 69.5 billion on RMNCAH in the past decade, a significant financing gap still remains and called the audience's attention to the urgent need for a **'grand convergence'** by 2030**,** accelerating progress that would help prevent a total of 4 million maternal deaths, 107 million child deaths and 22 million still births in target countries. He also emphasized the importance of Civil Registration and Vital Statistics **(CRVS)** in promoting women and children's health**.**

He went on to outline what the Global Financing Facility is by defining its three key financing components, designed to achieve and measure results:

i. **Smart**– a focus on evidence based, high impact interventions, coupled with 15% efficiency gains by 2030 towards the gap;
ii. **Scaled** - mobilizing additional resources necessary from, 'crowding-in 'local resources both public and private, and international sources leveraged by support from development partners;
iii. **Sustainable** – by anticipating and capturing the benefits of economic growth and- to bridge the funding gap- supporting the transition to long-term sustainable domestic financing.

Describing how GFF works, Dr. Ramana noted Kenya is the first country to have in place an investment case aligned to GFF and the need for the development of County Investment Cases for RMNCAH and comprehensive Health Financing: assessment, strategy development with a long-term sustainable vision and costed implementation plans that include capacity building and institutional strengthening. He then explained the GFF partnership and the Every Woman Every Child movement and how this supports a country platform, informed by a Country-led, multi-stakeholder process based on International Health Partnerships (IHP+) principles.

Dr. Ramana's presentation went on to describe "best-buy" interventions as those covering the full continuum of health services, recognizing that sectors beyond health are critical areas of investment to achieve RMNCAH goals, 'to end preventable maternal and child deaths and improve the quality of life of women, children and adolescents', by health systems strengthening, multisector approaches (including CRVS), clinical service delivery and prevention interventions. GFF is based on mainstreaming equity, gender and rights. Dr. Ramana added GFF will advocate for and facilitate multi-sectoral financing opportunities and efficiency gains.

He then described the development of Kenya's RMNCAH investment case from the high-level country vision with consultations and core analytics leading to impact level results and defining main obstacles to be focused on. This was followed by analytics of obstacles to: demand, supply, an enabling environment and multi-sectoral factors, before agreeing on output and outcome level evidence based interventions that in turn defined the investment case. He noted that improved alignment to reduce gaps and overlaps as financiers' increase RMNCAH funding is required, as is complementary financing of the investment case.

Dr. Ramana finished his presentation by drawing a parallel between the RMNCAH investment case and health financing strategy beginning with the investment case's timeframe of 3-5 years, with a longer-term vision for 2030 and includes needs assessment, identification of prioritized smart interventions and county relevant innovations for scaling up to get better value for money and development partner harmonisation. He went on to the financing strategy's health sector wide approach and timeframe through 2030 identifies approaches to sustainable financing for achieving Universal Health Coverage and includes financing assessment, domestic resource mobilisation and pooling, strategic purchasing and efficient payment supported by relevant policy changes, public finance and administration reforms.

*The World Bank board is tasked with final commitment of Trust Fund and International Development Association resources as well as fiduciary oversight.*

## Health Financing Strategy Development

Dr. Joanne Ondera, Component Lead Healthcare Financing at GIZ followed to address the HSDPF. Beginning by sharing that the objective of the GIZ-Health Sector Program (GIZ-HSP) is to improve access for poor and disadvantaged groups to high quality basic health services and hedge against health related financial risk. She said the financial and technical modules are implemented through KfW and GIZ (HSP) respectively.

Dr. Ondera noted that the Kenyan government's commitments towards achieving Universal Health Coverage by 2030, the constitutional right to health for all Kenyans and vision 2030's identification of UHC as a key pillar for the transformation to a middle income country, all bode well.

Stating health financing reforms are important aspects of a country's progress to UHC, she gave a background of the development of Kenya's Healthcare Financing Strategy (HFS). Beginning with the Social Health Insurance (SHI) bill in 2004 that wasn't assented to the NHIS initiated in 2007 to the 2012 draft Healthcare Financing Strategy developed to guide the country towards Universal Health Coverage.

Saying a 2012 draft Healthcare Financing Strategy review conducted with the Partners for Health (P4H) consortium support identified areas of strength and weakness to be addressed in its finalisation, Dr. Ondera then shared the process of developing the Healthcare Financing Strategy. She said the Ministry of Health has now embarked on activities towards the draft Health Financing Strategy. The Healthcare Financing Inter-sectoral Coordinating Committee has formed 5 technical working groups to extensively

explore and make recommendations on the functions of health care financing, namely:

i. Revenue Collection;
ii. Pooling;
iii. Purchasing and Benefits;
iv. Governance Structures;
v. Quality.

The 5 technical working groups shall submit their final outputs to the Coordinating Health Financing Strategy Committee for inclusion in the draft Healthcare Financing Strategy. Concurrently, a stakeholder analysis is underway to identify and engage critical stakeholders, primarily the Council of Governors, to better understand their views on elements of the Healthcare Financing Strategy.

A communication plan is also to be implemented that shall engage stakeholders and build consensus on the Healthcare Financing Strategy , after which the Ministry of Health will present it to parliament and subsequently to the president for assent.

Dr. Ondera finalised her talk by highlighting the importance of the Healthcare financing strategy, as the first step towards Universal Health Coverage, for it provides direction on:

i. Improving social health protection by enrolling all Kenyans in a health financing plan;
ii. Moving towards a pre-payment system that raises revenue through tax, health insurance or hybrid of both.
iii. Improving the effectiveness, quality and efficiency of the health financing system, the National Hospital Insurance Fund and public budget execution mechanisms.
iv. Developing a uniform basic benefit package;
v. Retaining pluralistic service delivery and public hospital autonomy.

## The Role of Independent Provider Networks: UHC

Nairobi Outpatient Centre

Dr. Mary Madumadu of the Nairobi Outpatient Center - representing Afya Capital, a countrywide partnership modelled to provide access to quality healthcare at constituency level, through a growing network of private hospitals - followed with a presentation on the role of the private sector, through Independent Provider Networks, in financing healthcare and the drive to Universal Health Coverage.

Beginning by describing sources of healthcare financing in Kenya as out-of pocket, pre-paid (usually by employer) and development partner funded/attributable, she also categorized service providers as public and private sector, with the latter comprising individual standalone facilities and *rich* chains of medical institutions.

Defining the comparative merits and demerits of each private sector service provision category, Dr. Madumadu began with the strengths of standalone facilities which include: quick decision making and turnaround times, price elasticity and the benefit of growing the local health industry. These however, she said, have limited capacity and referral systems.

Facility chains on the other hand offer referral systems, which can be very good in cases, and have more capacity though are impeded in their service delivery by slower decision making. However, these also affect healthcare seekers consumer rights and financial protection due to their capacity for collectivized industry action and non-competitive economic models, especially

where these same have business interest in insurance companies and Health Management Organisations, exposing healthcare seekers to financial risk and catastrophic health expenditure.

Their limited capacity to absorb healthcare professionals, while displacing many local independent players – who are unable to extend similar benefits of economies of scale - also stifles growth in the local health industry.

She went on to describe a system of setting up a support structure for an independent provider network that allows standardisation of individual standalone health providers and allows them to function like one seamless institution. This, she said, would give the payer of healthcare the best of both private sector service delivery models: quick decision making, price elasticity, referral system, increased capacity, a holistic system involving medical protocols and quality standards as well as administrative and ICT support.

The independent provider network facilities also shall benefit from marketing and other demand creation activities as well as economies of scale by aggregating procurement and training for human resources in health across several institutions. Dr. Madumadu said independent provider networks support the growth of the local private health sector, which in turn improves the quality of and access to healthcare, which coupled, are a demand driver for health care.

Dr. Madumadu finished her talk by giving the example of the Nairobi Outpatient Center, who offer a broad range of medical services as well as medical sub-specialties, such as neurodevelopment that would otherwise be inaccessible for many outside the Afya Capital country wide network's referral system. She said independent provider networks would be integral contributors in achieving universal health coverage due to their geographic spread (including in hard to reach, underserved places) and unique ability pool countrywide populations of smaller, single risk pools (such as the informal sector, the indigent, prison populations or other disaffected population) efficiently and inexpensively. She said, by lending private sector efficiencies in cost containment, creating incentives for quality and mitigating fraud, Independent Provider Networks provide an innovative solution to: raising revenue, pooling risks and purchasing services, all key elements of Universal health coverage as well as addressing Human Resources for Health, Infrastructure, Essential Health Products and Technologies.

*View Plenary session 1 at [www.cueaconsultancy.com/hsdpf](www.cueaconsultancy.com/hsdpf) ; or*
*Join closed Facebook group: Health Systems Strengthening Kenya*

# County Break-out session I

## Domestic Health Financing – County led resource mobilisation: bridging the health financing gap.

Mr. Nathan Kaula, the Development Partner Liaison at Paraclete Consult, then led deliberations in a county government break-out session on county-led resource mobilisation to bridge local health financing gap, saying that while increasingly reliable

external funds are needed in most counties, more can be done to raise funds, or use them more efficiently, domestically.

He encouraged counties to not only participate more in Public Private Partnerships - that cover a wide variety of ventures, arrangements and size - in tackling the health problems of highest priority, as perceived locally, but also to seek complementary development partner and private sector funding to strengthen the health system.

Recognising that partnerships between the public sector, private sector entities and civil society have a contribution to make in improving the health of the poor by combining the different skills and resources of various organizations in innovative ways and that while the general public benefits from the working in collaboration of the private and public sectors in certain areas, there are areas, such as public health policy-making and regulatory approval, where partnerships are not appropriate, saying the purposes of partnerships should be carefully considered and well-articulated to the public.

He also encouraged county health leadership to work with academia to better design public sector programmes with private sector participation and build understanding of other forms of private sector engagement, such as privatisation.

Saying achieving the post-2015 health and other development goals will require the mobilization of resources from private sources including Foreign Direct Investment, bank loans, bond issuance, institutional investors and private transfers, Mr. Kaula also highlighted the role of non-traditional development assistance flows, saying the last decade saw a diverse group of countries and organisations gain prominence in the evolved aid landscape..

Giving the example of vertical funds, multi-stakeholder global programs that provide earmarked funding for specified purposes, Mr. Kaula said these have proved very effective to channel assistance to core but chronically underfunded development sectors, such as disease eradication. However, he said, the proliferation of vertical funds may not always been conducive to aid effectiveness and can create distortions, particularly in low-capacity environments with weak planning and budgeting systems, urging county leadership to delve with a mind to national goals for these new development partners, breaking out of the mould of traditional ODA financing, though sometimes promoting their own economic and strategic interests, at least partially meet some needs not addressed by traditional development partners. He also listed Non-DAC flows, Philanthropic and institutional giving, Social impact investment and countries such as Korea and China that provide Other Official Flows.

Sharing mapping results of non-traditional development partners in health with a view to encourage county health leadership to take up the initiative and tap into complementary financing, Mr. Kaula noted that resource mobilisation requires county Government ownership and pointed out the need to build county level capacity to work through the fundraising value chain of: mapping, lobbying and application writing. This, he said, should be made a supportive function of county's efforts to mobilise domestic and external resources. Advising counties to actively participate in open calls, fund matching schemes and challenge funds through strategic partnerships, citing the example given in Plenary Session 1 by ACA's Elizabeth Mwashuma of the County Innovation Challenge Fund that recently ran a KES. 3

billion challenge fund for the benefit of 6 counties and funded several innovative solutions for maternal and neonatal health as a transformative approach to health financing.

He then looked at the Global Innovation Fund, as another opportunity in isolation towards complementary funding to plug the health financing gap. Defining the fund's target beneficiaries as: women and children, the disabled, displaced people, minority and indigenous groups and other poor and vulnerable populations, Mr. Kaula went on to explain the Global Innovation Fund accepts applications of between £ 50,000 and £10,000,000 and would provide successful applicants with transformative ideas that have a social impact, an opportunity to implement an evidence based interventions.

Supporting cost effective new: business models, technologies, behavioural practices, policy practices and pro-poor product and service delivery in a three phase process, Mr. Kaula said the Global Innovation Fund presents a good opportunity for county governments to coalesce and take ownership of resource mobilisation activity by taking advantage of this and other such opportunities to contribute towards the health financing gap.

He said further that the need to build capacity at county level on the **Theory of Change** was apparent and again urged county health leadership to work with academia in pursuit of this; while approaching the same in a practical manner with increased participation in resource mobilisation that include activities like the GIF.

Emphasizing health financing's change in focus from inputs to results and evidence based interventions, Mr. Kaula said equity promotion in service delivery to the poor and financial protection as well as an environment that enables client choice and behaviour is required to creates ground for long-term, high impact interventions that enhance efficiency by improving productivity, quality and integration of services to optimize resources.

Mr. Kaula also said broad and active partnerships are a critical coordination mechanism to support the health as a professional association and create a client centric health system. By strengthening knowledge management, specifically in areas such as: result based financing verification, use of disaggregated data and other independent verification mechanisms, beneficiary feedback collection, community level engagement, citizen participation, research and evidence base development, performance measurement, supportive supervision as well as local context based innovations and interventions. This would improve data quality and collection, reporting population level data, to improve information systems, civil registration and quality of vital statistics.


*View the Global Innovation FundCounty break-out session video on:www.cueaconsultancy.com/hsdpf ; or*
*Join closed Facebook group: Health Systems Strengthening Kenya*

Mr. Machani then addressed the county break-out session, encouraging health leadership to familiarise itself with the new Kenya External Resources Policy, that governs the mobilisation and use of external resources in the country. Its conformity to ODA (Official Development Assistance) and the aim for increased aid effectiveness through harmonization, alignment and coordination are to serve as learning in embedding consistency with national priorities.

Noting that while every effort should be made in the drive to domestic health financing, Mr. Machani remarked the sector would be remiss not to delve into monetary and non-monetary budget support available from a range of non-traditional partners.

He then shared with participants the HSDPF Secretariat's mapping results, with grant funding opportunities from non-traditional partners, open to the public and private sector and encouraged counties to incorporate the preparation of quality applications in their health financing remit.

Echoing Kisumu County Health Executive Committee Member, Dr. Elizabeth Ogaja's remarks in plenary session one for counties to prepare comprehensively for Public-Private Partnerships and to diversify funding sources , Mr. Machani welcomed participants, principally county Governments, to tap the HSDPF's multidisciplinary and the Catholic University of Eastern Africa's collective expertise in funding diversification and resource mobilisation, which in addition to PPP's, corporatization and other forms of private sector engagement, includes mapping, lobbying and application writing with non-conventional development partners

Ms. Immaculate Wandera, a student of the Catholic University and volunteer at the Health Sector Development Partner Forum then closed the days deliberations and sounded the Catholic University of Eastern Africa's student body readiness to contribute towards the development of partnerships for health in devolution, citing the forum itself as part of the sterling effort of a student body and subject matter experts, she said their participation has greatly broadened their horizons, as a group in readiness to enter the job market.

Ms. Wandera expressed gratitude on behalf of the students present who were accorded an edifying opportunity to interact with development partners, government and private sector leaders, and various players in the health sector. Noting that the university's approach to add value to development efforts from a development studies perspective, with the support of other faculties is most welcome as it provides a basis for interdisciplinary deliberations and cooperation as well as a platform on which to foster county collaboration with development partners.

Also, the approach to provide students with professional attachments in their home counties would benefit development partner cohesion efforts by building research based inter-agency cooperation to contribute to value for money, measuring results, the efficient use of resources and attribution to contribution. This would also contribute in addressing supply and demand barriers that limit the scale-up of high impact interventions, such as socio-cultural and religious beliefs and practices, and lack on information and knowledge.

Day 2

# Plenary Session 2

The HSDPF's convener, Mr. Emmanuel Machani, opened proceedings and welcomed participants to the second day of the Forum.

He then invited the day's first speaker, a program officer in healthcare financing from

the technical arm of the German Development Cooperation (GIZ, Health Sector Program), Cynthia Macharia, a public health specialist with a keen interest in health systems management with special focus on health care financing, tasked with supporting strengthening of financial management in the county health departments of Kisumu, Vihiga, Kwale and Nairobi counties.

## Strengthening County Financing Systems

Ms. Macharia began her presentation by defining Health financing as the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively. The purpose of health financing, she said, is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care"

She went on to describe the Division of Health Sector's functions as set out by the 4th Schedule of the Constitution of Kenya (2010): with the distribution of functions between the national and the county governments.

She then defined various sources of revenue for counties:

- Transfers from the nationally collected revenue shared equitably, not equally.
- Local revenue –taxes and service fees.
- Equalisation fund and conditional grants.
- Funds and in-kind resources from development partners.
- Loans – Counties can borrow if the national government guarantees the loan (Constitution of Kenya Article. 22).

Ms. Macharia then spoke on county level budgeting, saying counties determine how funds are shared between different sectors based the county development plan, explaining the finance executive committee member's mandate to manage the budget and its approval process through the County Executive Committee to County Assembly.

She also said that public participation and consultation is provided for under the Public Finance Management Act through County Budget and Economic Forums (CBEFs).

She went on to note issues most county departments are grappling with, including: Inadequate allocation of funds for the health sector, averaging 6.25%. Over the last 2 years and high recurrent expenditure inhibiting capital growth, averaging 75% in the same period. She also noted social accountability, for inadequate community involvement in financial management and that National/County coordination seems weak, giving the example of delayed disbursement of funds from the national government.

Ms. Macharia finalised her presentation by making the following recommendations for counties to strengthening Financial Management**:**

- **Resource Mobilization**: need innovative ways of raising additional funds (e.g. PPPs)
- **Programme Based Budgeting** as per the PFM Act. Advantages include:

    i. Shift focus from inputs to outputs/outcomes;
    ii. Focus on performance by linking performance measurement to budget;
    iii. Helps justify choices among competing priorities.

- **Observance of fiscal responsibility principles**: according to Public Finance Management Act (Section 107)

i. County government to strive at allocating a minimum of 30% of budget to development expenditure;
ii. County government recurrent expenditure within revenue;
iii. Government borrowings to be used for development expenditure.

- **Capacity building,** both human and systems to ensure proper accounting and those resources are used in a way that is lawful and authorised, and effective, efficient, economical and transparent. (Public Finance Management Act Section 162)
- **Public participation** in public finance management by: formation of county budget and economic fora that provide platforms for public participation in county planning and budgeting and publication and publicizing of budget documents and reports to enhance public participation.

## Strengthening Healthcare through Infrastructure, ICT and Capacity Building

Ms. Elizabeth Mwashuma of the Africa Capacity Alliance was the second speaker at plenary session 2, where she made a presentation on the alliance of 37 member institutions in 12 countries whose key pillars are Health systems strengthening, community systems strengthening and public private partnerships, with one of their key strategic objective as fostering Public Private Partnerships in health through: technical support, capacity and skills enhancement and facilitating a platform of engagement and partnering process

She then gave a brief history &highlighted ACA's achievements, saying it began as RATN in 1997 as a joint project of the University of Nairobi & University of Manitoba, with support from the CIDA, now Department of Foreign Affairs and Trade& Development (DFATD).

Forming a network of training institutions to address the lack of HIV and AIDS-specific training for healthcare workers in resource-limited settings, the network originally included 17 Member Institutions in 7 countries then evolved into an independent NGO with a focus on capacity building for health.

Saying that while over the last 16 years ACA has delivered 570 courses & trained close to 8,000 healthcare workers who have impacted millions of patients, and while training remains a core component of its work, ACA has expanded its activities to include technical & institutional capacity building, advocacy, research, knowledge & information sharing.

She went on to say that ACA has built the capacity of its 37 Technical & Institutional member institutions, and other organisations through projects such as (RECABASO, RAIG, INSTANT, Fanikisha) and that its technical expertise has expanded beyond HIV and AIDS.

To reflect this larger mandate & its expanded geographical scope, ACA'S recalibrated mission to *provide sustainable capacity solutions that will improve health outcomes, & therefore lives, in Africa*

Ms. Mwashuma then explained ACA's capacity building components, namely: influencing capacity for or*ganisations as change agents for the health sector*, adaptive capacity to d*evelop Learning Institutions*, institutional capacity *for organisational systems and t*echnical capacity, building h*uman capacity skills and knowledge*.

Ms. Mwashuma the shared Cross-Cutting Functions of the Alliance, namely: evidence and accountability of results, advocacy and

partnerships, knowledge sharing, resource mobilization and grants management, technical support and quality assurance.

She explained the logic overview that sees these capacity building components and cross cutting functions feed into aforementioned ACA pillars to improve health outcomes and lives in Africa.

Sharing ACA's institutional strengthening process, from awareness creation & applications through screening for deficiencies and an alignment / tailoring of solutions to development of or supporting learning communities she gave examples of ACA projects and activities in healthcare strengthening through Capacity Building that included:
**Network for Africa**- an online community that strengthens health sector leaders' capacity.
**Business skills training**- for small & medium sized healthcare enterprises
**Centre for Health Market Innovations (CHMI) -** a global initiative to make quality private health care affordable and accessible.

Describing a series of CHMI roundtable discussions to '*strengthen the healthcare ecosystem through innovations'*by facilitating a platform of engagement and partnering process, formation of PPPs and scale up of innovations, she said these roundtable discussions were held to: meet innovators, diffuse innovation, facilitate collaboration and partnerships between innovators, investors, government –national and county - and development partners.

These were an open and included, technical exchanges, policy dialogues, showcasing of innovative work in Maternal, neonatal and child health as well as offered a networking opportunity.

Ms. Mwashuma pointed out a partnership borne of these roundtable discussions between Meru County and IFC – World Bank to strengthen the quality of care in the county and with both Phillips Healthcare and Mobile ODT with a focus on improving cancer care.

She also noted ACA's strengths in policy development to strengthen the health market ecosystem-, having supported the development of Malawi's PPP guidelines for HIV&AIDS, adding ACA also Links of innovators and investors giving the example of the Makers movement MNCH with Intellecap.

She finished her presentation by telling those present that **questions still remain, such as** financing models most likely to unlock additional private sector participation in health, reconciliation of diverse needs and varying Country and County contexts, how to better structure support, for those convening MNCH PPPs. Saying innovators are challenged in mobilizing adequate start-up capital and investors (development partners or private sector) demand for value or scale.

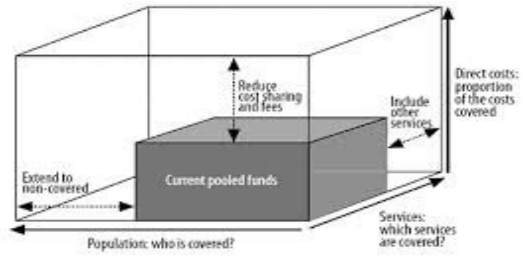
For additional information on **ACA** and **CHMI**, please visit

www.africacapacityalliance.org
www.africacapacityalliance.org/n4a
www.healthmarketinnovations.org

*View the Plenary Session 2 video on: www.cueaconsultancy.com/hsdpf ; or Join closed Facebook group: Health Systems Strengthening Kenya*

Dr. Matiko Riro of Afrihealth Consulting then made a presentation on 'enabling partners identify and unlock value in health'. He said that with the growing focus on Health Financing, health managers are increasingly paying attention to the UHC cube (below)

which gives an overview of the need to: increase the number of people,and range of services, covered and lower costs of care that is not covered.



Three dimensions to consider when moving towards universal coverage

He went on to say that, for the provision to all people of access to needed health services of sufficient quality to be effective, and to ensure that the use of those services does not expose users to financial hardship, there needs be renewed focus at counties, by county health managers, on health financing concepts that drive value in health. Defining these as:

i. Revenue collection: way money is raised to pay health systems costs;
ii. Pooling of resources – accumulation and management of financial resources to ensure that financial risk is borne by all pool members;
iii. Purchasing of services -the process of paying for health services.

Dr. Matiko emphasised the importance of governance on equity the latter of which he delineated as:

- Horizontal equity, i.e. equal treatment of equals (thus equal expenditure, utilisation or access for equal need, equal health outcomes)
- Vertical equity, i.e. unequals being treated differently according to the same criteria (thus unequal treatment for unequal need or unequal payment for those with unequal incomes).

Dr. Matiko presented a case study of maximizing value, improving equity, affordability, and access to care according to UHC alongside county priorities that reviewed an ongoing PPP pilot between Lancet Pathologist and Voi County aimed at increasing lab capacity, describing their approach that began with an understanding of client needs and the design of a study protocol followed by data collection and a review of medical records, financial data and stakeholder interactions

Some highlighted results included:

- ✓ Studied and documented the positive impact of the initiative in regards to sustainability and health impact.
- ✓ Revealed the technical and 'soft' issues that were a threat to scale up and sustainability.
- ✓ Our recommendations were adopted by the client and there are plans to replicate the model with our recommendations to other counties in Kenya.

Dr Matiko went on to areas Afrihealth can support the health sector in, including:

1. Capacity assessments
2. HRH management
3. Health policy formulation
4. Economic evaluation
5. Monitoring and evaluation
6. Technical support and Training

## Reach to Recovery Kenya

Mrs. Elizabeth Ragui and Mrs. Petronilla Maina, both of Reach to Recovery Kenya, a cancer awareness and advocacy civil society organisation then addressed group and shared community level campaigns focused on screening and linkage to treatment. Stating they had carried out over 100 campaigns since inception in 2008 that have availed them accurate, current data on

breast and prostrate cancer, she also spoke on other community level activities they conduct including training health workers, Kenya Cancer Organisation participation, home visits to breast cancer patients and the provision of treatment literature - including in local dialects – and kits that help breast cancer patients maintain their feeling of self-worth following mastectomies.

Mrs. Maina highlighted that the organisation also provides telephone support and counselling for patients to increase the breadth of patients to access to their services.

## Social Media Africa

Resian Lebai of Social Media Africa shared with HSDPF how county health system can use social media to engage the public and increase accessibility to both public and private health professionals. Citing health and healthcare as a popular topic on social media, generating both positive and negative content and commentary.

Acknowledging inherent risks to the health system participating in social media, she highlighted the risk of not participating, saying that the wide use of mobile devices and increased internet penetration are an opportunity to interact with the public on health matters at a level not known heretofore, facilitating listening, consuming, participating and providing a platform off which to lend their voice.

Ms. Lebai also explained how social media could health service providers leverage positive network effects by interacting with direct followers, who in-turn disseminate those interactions with their own networks, exponentially increasing both the reach of messages and perceived value of the network to its members. This positive network effects enable fast, free distribution of health information to health product and service consumers  while providing a platform for data collection and knowledge management.

Citing numerous examples of social media helping patients manage chronic conditions, promote health seeking behaviour and accelerate knowledge acquisition dissemination for patients and clinicians. Social media also contributes to preventative efforts, primarily through knowledge dissemination and behavioural change communication.

Ms. Lebai emphasised that well executed social media strategies give primacy to patient privacy, allowing non-identifiable participation without detracting from the quality of interactions.

Social media could also be used to provide beneficiary level feedback to both public sector players and development partners or NGOs in the health sector.

Ms. Lebai recommended the development of organisational social media policies to both acknowledge and encourage employee activity and manage risks while staying responsive to the groundswell of social media users that use these platforms as a component of their interactions with the health sector. These may be healthcare seekers, policy makers, healthcare workers, actors in sectors in which social determinants of health are nested and the general public. Saying that for health systems to keep pace with innovation, there is a need for responsible, organized social media participation which can improve the quality and quantity of health care seeker interactions and enhance their relationships with healthcare workers.

She closed by stating social media is a formidable platform that is gaining momentum and there is need to upskill healthcare practitioners to a level that allows their direct interaction and participation.

## Data - driven healthcare service delivery

Dr. Meenal Pore, Research Scientist at IBM Research – Africa, the first in Africa and based at the Catholic University of Eastern Africa then made addressed the gathering, beginning by sharing IBM capabilities. She began with a detail of IBM research lab's service range and depth, summarised as follows:

1. Engagement - With customer centric: digital urban renewal, consumer and public safety engagement services;
2. Inclusive Services – With cognitive learning for the education sector, credit and savings for the financial services industry and healthcare solutions in public health;
3. Basic Infrastructure –digital aquifers for water, living roads for mobility and outage prediction for the energy sector;
4. Regulatory environment for ease of doing business.

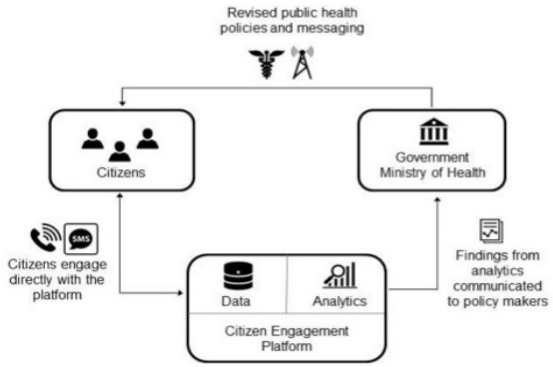
She then delved into data in healthcare, first by the comparing sources of data in developed and African markets.

| | |
|---|---|
| Insurance claims | Citizen generated |
| Prescriptions | Crowd sourced |
| Electronic Medical Records | Electronic Medical Records |
| National health registries | Satellite imagery |
| Consumer points | Humanitarian data |
| Patient generated | Social media |
| Diagnostic & monitoring services | Traditional media |
| Telco | Provider generated |

Dr. Pore went on to share IBM public health case studies with transferrable, dynamic learnings, that can be deployed locally in areas such as Disaster Risk Management, aligned to the previous day's plenary session 2 recommendations made by the WHO in an Integrated Disaster Surveillance and Response information management mechanism around: disaster coordination, hazard and risk vulnerability surveillance, comprehensive disaster risk assessment and mapping.

Beginning with the example of a Citizen Engagement Platform implemented in Sierra Leone during the peak of the recent Ebola outbreak Dr. Pore said with no cure, prevention was the only way to curb the outbreak and the platform was an integral tool to this end.

Dr. Pore explained how the citizen engagement platform communicated findings from analytics to policy makers through the Ministry of Health. The ministry in turn communicated required - data driven -revised health policies and messages to the citizens




whose direct engagement with the platform influenced the decisions, policy and communication.

Dr. Pore detailed the categorization citizen level feedback on a slew of pertinent issues and how this was collected from voice calls which were geographically disaggregated. This built the quality of data, capacity for geographic prioritisation and public participation and inclusion into the decision making process. She noted that as perceptions and behaviours are dynamic, responses and messaging need to be too.

The second case study Dr. Pore shared was on cervical cancer decision support in Kenya, *where prevalence, at53 of every 100,000 women, is 7 times higher than in Western countries.* Dr. Pore took HSDPF through the cadastral Decision Support Solution's county and facility centred work-streams and its

capacity to disaggregate data by: rural and urban settings, county and health facilities, mobile clinics and age; and status data on: cervical cancer, HPV, HIV, death and primary school attendance, facility awareness programs and vaccination programs, all interacting towards treatment and a registry.

Dr. Pore's final case study on 'middle income country, middle class problems' looked at the role of data in healthcare, specifically social media, as a vehicle towards containing non-communicable conditions such as obesity. As a social influencer of health decisions such as fitness and diet, she illustrated the impact strategic use of social media for sensitization has on both individual and societal levels.

## Strengthening National and County Health Information System (His) Towards E-health


James Ojwang' Kwach of the Centres for Disease Control and Prevention followed with an edifying presentation for the benefit of County health leadership. He began by explaining the Health Information Systems and its place as one of the 6 WHO Health System building blocks.

After defining HIS as systems that, geared towards decision making, have the capabilities to capture, store and process individual and organizational health related data, he explained their role in the health system. Saying the health system building blocks are interrelated, he took the gathering through these relationships working towards healthcare access, coverage, quality and safety in pursuit of improved health, efficiency, responsiveness and financial protection goals.

Mr. Kwach then defined eHealth as healthcare practice supported by electronic processes and communication to enhance decision making efficiency. Espousing its benefits, he listed: security, accuracy, complete data, ease of use, speed, broad reach, privacy, accuracy, promptness for decision making, responsiveness, cost control efficiencies, better quality of care and ultimately, improved health outcomes, as reasons to take-up eHealth practice.

Detailing the ingredients of HIS as: the regulatory framework, people, software, infrastructure and hardware, Mr. Kwach went on to highlight Kenya's HIS landscape achievements in the regulatory framework and software.

The regulatory framework, he told the gathering, is a function of laws, policies, strategic plans, standards and guidelines and enterprise architecture -which he urged county health leadership to adapt - detailing these as follows:

1. Laws, where he said the basis is:
   i. The Constitution of Kenya, 2010's articles43, 46 and 232;
   ii. The Health Bill 2015's parts II and V that detail Rights and Duties governing health information and dissemination and standards respectively;
   iii. The Jubilee Government's manifesto, giving credence to political goodwill.

2. Policies, highlighting the pertinence of:
   i. The Kenya Health Policy 2013;
   ii. The draft eHealth policy 2015-2030

3. Strategic plans, citing:
   i. The Kenya Health Sector Strategic and investment plan (KHSSP) 2013-2017;
   ii. The draft Kenya eHealth Strategy 2015 – 2020;
   iii. The Kenya Aids Strategic Framework 2014 – 2019.

4. Standards and Guidelines, which Mr. Kwach said offer an opportunity for

technology to improve efficiency in the health sector, aredefined for the following:

i. Primary Health Care Electronic Medical Records Systems;
ii. Electronic Laboratory Information Systems;
iii. Electronic Pharmacy Information Systems;
iv. Standards for Interoperability (Draft);
v. mHealth Standards (Draft).

5. Enterprise Architecture, which is still in development, with the Kenya Health Enterprise Architecture – Definition Document (Draft).

Moving the focus of his presentation away from achievements in the regulatory environment ingredient of HIS, Mr. Kwach's presentation went on to feature those in software. He touched on each of: Data Registries, Repositories, Health Data Warehousing, Electronic Medical Records (EMR) Systems, Laboratory Information Management Systems (LIMS), Mobile Health (mhealth), and Human Resources Information Systems (HRIS).

Citing ongoing initiatives on Data Registries, Mr. Kwach brought to the audience's attention to:

i. The Master Facility List (MFL);
ii. Andthe Master Persons Index (MPI), worked through the National Unique Persons Identification (NUPI).

In like manner, on data repositories and data warehousing, he highlighted the District Health Information System (DHIS II) and NASCOP's Health Data Warehouse respectively.

Speaking on electronic Medical Records (EMR) Systems, Mr. Kwach lauded the standards based approach, saying 27 EMR products had been assessed of which 4 closest to standards compliance were selected (Funsoft Open MRS, IQCare and CPAD, the last 3 of which are to upgrade to meet standards.

Showing 643 health facilities were deployed with standard EMRs. Kenya and 600 further targeted, he said the current focusing is on optimizing data use.

He said Laboratory Information Management Systems (LIMS) standards-based approach has reference laboratories equipped with LABWARE and 20 Health Facilities deployed with Basic LIS (BLIS) and 1 other Health with Open ELIS.

Mr. Kwach then highlighted Pharmacy Information Systems, using the example of an Antiretroviral Dispensing Tool (ADT) developed by USAID/MSH which he described as easy-to-use electronic pharmacy management software that tracks patient information and monitors ARVs prescribed and dispensed. The ADT tool will be rolled out in all health facilities offering ART in Kenya.

On Mobile Health (mHealth),he gave the example of mHealth Kenya, who through a PPP grant under CDC foundation provide: Health Commodities solutions for KEMSA, Text for Life (T4L) a service for Blood donor management, mPEP for Health care worker Post Exposure Prophylaxis adherence, ART for Life (A4L) for ART adherence, SMS Printers for lab results transmission (EID, CD4, Viral Load, TB), eLearning for Mobile Learning and other alert/reminder systems to increase access.

To round up his highlights of Kenya's HIS landscape achievements in software, he presented on Human Resource Information System (HRIS) giving the examples of: rHRIS, a single platform system supporting eight regulatory bodies (NCK, MPDB, KMLTTB, COC, PPB, PHOTC, RPB, SORK) and iHRIS, an open source HRIS system used by the Ministry of Health and now deployed in 20 counties for managing the health workforce in devolution including training monitoring.

He went on to summarise challenges in the Health Information building block of the health system that included: uninformed implementation methodologies, low adoption rates, lack of HIS coordination, duplication of

efforts and parallel systems, proliferation of systems, slow stakeholder buy in, inadequate technical support, scanty evidence base for success, low utility rates, lack of interoperable solutions, change management, policy framework gaps and lack of policies for unique identification of patients.

Mr. Kwach outlined opportunities he encouraged counties to take up, including:

i. Adaptation of existing strategy and policy documents;
ii. Scale-up of tested EHR systems which have been shown to work in HIV care;
iii. Implementing interoperable solutions;
iv. Taking up available technical capacity for advice;
v. Application of mHealth solutions due to wide cell-phone coverage; and
vi. The possibility of public-private-partnerships in eHealth projects.

In closing, he made the following recommendations to county governments:

i. Create HIS coordination structures and promote integrated solutions;
ii. Increase eHealth adoption including academia;
iii. Create data demand, to increase data use and improve quality that shall support evidence based decision making.
iv. Sensitization on approaches to the implementation of HIS projects.

See links to Laws, Policies, Strategic Plans, standards and guidelines and other documents in this session on *www.cueaconsultancy.com/hsdpf ; or*
*Join closed Facebook group: Health Systems Strengthening Kenya*

## Human Resource in Health, Governance and Universal Health Coverage

The plenary's last speaker, Dr. Elizabeth Ogaja the Minister of Health Services & Promotion of Health Investments, in Kisumu County, gave a county perspective on Human Resource in Health and Universal Health Coverage.

Dr. Ogaja began with a background of Health Reform in Kenya, predicated in Vision 2030the Kenya Constitution 2010and the Kenya Health Policy 2012 – 2030 that seeks to realise the right to health by all Kenyans.

Referring to the WHO Health System, she defined Human Resource for Health as a pillar of health and county health leadership's role, principally in strengthening the place of *Patient Focused Healthcare and* Community Strategies to the medicines, medical supplies, equipment, prevention, investigations, diagnostics and treatment continuum for improved community health services; within National Ministry of Health policies and standards for service delivery in the 47 counties.

She went on to give the HSDPF a closer look at devolution of the health sector, with Kisumu county, its population of over 1 million and poverty rate at 47%(national 45.9%) as a microcosm of the country.

Listing 4 institutions with 6 Human Resources for Health Training Centres in Kisumu County that offer medicine, nursing, community health, public health, clinical medicine, and medical laboratory services, she brought out the capability in counties to build Human Resources for Health capacity and called for

the increased participation of academia in strengthening the health system.

Sharing her thoughts on human resource management policy, Dr. Ogaja said that the National Policy on Human Resources for Health had been finalized and launched; counties now had it in the remit of their work to undertake its customisation and implementation. She urged a move away from one-person health facility management structures, saying, ideally a primary health facility should have a minimum of 12-14 staff, depending on work load, namely a: clinical officer, nursing officer, pharmacist, technician, laboratory technician, public health officer, administration officer and nutritionist; with a need of at least two staff per cadre and more if the workload demanded it.

Dr. Ogaja further said counties need to plan for the application of WHO Workload Indicator of staffing needs methodologies. Highlighting Human Resources for Health statistics per 100,000 peope, she ran a comparative analysis of Kisumu county and Kenya against WHO minimum recommendations through various cadres showing understaffing of nurses at 54% & 36%, and doctors at 28% & 19% in Kisumu and Kenya respectively. Pharmacy technicians at 1/100,000 in both Kisumu and Kenya, laboratory technicians at 6/100,000 and 7/100,000 and public health officers at 10/100,000 and 4/100,000 were also said to be short of requirements for adequate coverage.

She went on to show in the county's health sector, 84% of salaries are paid by the County Government -16% of county health budget, - and 16% are paid by working with partners through funding attributed to PEPFAR. With more than half of the latter's contracts coming to an end in the next year and lauding PEPFAR inputs in support of Human Resources in Health in Kisumu County she pointed out dependence on additionality and challenged counties present to seek innovative, sustainable HRH solutions.

Highlighting Kisumu as one of the 7 most sparsely populated counties; she decried poor coverage, citing skilled birth delivery as an example, and giving another comparative analysis of health indicators in Kisumu, Nairobi and Germany that highlighted stark differences in life expectancy at birth, maternal and under 5 mortality rate, skilled birth attendance, malaria and HIV prevalence.

Speaking of Health Financing and the drive to UHC in Kisumu, in addition to the aforementioned HRH spending, Dr. Ogaja said 33% of the county government annual budget is spent on health, including free public Primary Health Care services, and free maternity services following a 2013 national government endorsement to sink maternal mortality rate. With fees for services at 3$^{rd}$ and 4$^{th}$ tier public facilities she drew attention to national statistics on out-of-pocket payments at 77%, saying that while NHIF are the primary providers of health care, there still was low coverage and more needs be done towards financial protection.

Dr. Ogaja shared 3 innovative contributions to health financing in Kisumu County, first highlighting STIPA, KMET and ChangaMuka, NGO's providing low-income and informal sector beneficiaries Community Based Health Insurance (CBHI). She then spoke about a Pharmaccess two-county pilot on social franchising, with funding attributed to the Dutch Government, where insurance premiums provide access to referral, outpatient and maternity services to low-income earners in the private sector. Lastly, output based aid attributed to KfW and BMZ that offers vouchers for safe motherhood services that targets economically disadvantaged women.

Highlighting Kisumu County's framework for policy direction and Strategic Plan 2013-2017, she showed their predication on the Kenya Health Policy (KHP) 2012-2030's Policy Orientation 3 'Adequate and equitable distribution of HRH', as a prerequisite for the implementation of KHP strategy towards achieving its goals and objectives. She

underscored attraction, retention and motivation, especially in marginalised areas and consumer based measurement of performance and competence, saying her county is determined to strengthen the health workforce through intervention areas that include recruitment and secondment of staff from the national government, upward review of personnel and community health worker emoluments and allowances, pre- service and in-service training and staff motivation.

Dr. Ogaja summarised challenges in HRH and proffered solutions to include:

i. Critical HRH shortages to be addressed by using a professional method of estimating number;
ii. Attrition of HRH and the need to regenerate this by professional, qualified human resources management and development managers embedded within the County Ministries of Health;
iii. Discontinuation of partner support will have critical outcome on health coverage saying the Government needs to rationalize and invest in HRH for sustainability and UHC;
iv. Leaders in health sector with little experience in management that should be addressed by proper preparation for service through: orientation, management training, professional development and mentorship;
v. A third of Kisumu County's health budget is allocated to the regional referral hospital creating bottlenecks in Primary Health Care and HRH regeneration.

Saying that County Governments Primary responsibility is implementing health policies, strategies and guidelines, she called for training needs assessments and training in: program based budgeting, strategic planning, health systems management, management for coordination of health services, and communication strategy development.

She said counties should entrench Human Resource Management to gauge the numbers required scientifically by using the WHO Methodology – Work Indicator of Staffing Needs for facility-based calculation based on workload and available work days per cadre and facility numbers aggregated to sub-county and county level. Saying human resource budgets should be based on current schemes of services (including approved allowances) and should include capacity building on the use of the WHO Workload Indicator of Staffing Needs methodology.

Dr. Ogaja went on to say the decentralised health sector provides an opportunity to fully utilise resources effectively and efficiently as well as engage in PPPs, engage academia in research and work with partners taking the lead in UHC, citing MSH who are launching a UHC program.

Listing the investment pillars for UHC as Human Resources for Health, Infrastructure, Essential Health Products and Technologies and Health Financing, she recommended further, towards adequate HRH and UHC on a national level, the development of comprehensive evidence-based policy framework to address critical shortage of HRH (e.g. Innovated Human Resource Solutions/ IHRS) and the development of Service Charters(SOPs, Quality Management, Benchmarks) and the provision to affected counties with sufficient conditional grants for regional referral hospitals.She called for strengthening HRH capacity for policy formulation, referring to formal training in policy formulation and analysis, monitoring and evaluation, strategic planning and the development of standards of health service delivery

Similarly, at county level, she recommended counties: take an active role in coordination of PPPs towards UHC and to strengthen resource mobilisation towards domestic health financing, invest in Primary Health Care and in HRH and build capacity of health managers to plan resources effectively, efficiently and equitably.

Citing a World Bank report on possible Financial, Geographic and Therapeutic

Barriers to UHC, she listed: Little risk-pooling, High out of pocket payments, insufficient quantity and quality of health care services, hard to reach areas, mismanagement of resources, demotivated staff and understaffed health facilities.

Dr. Ogaja lastly spoke on the governance of health sector, beginning with at the Policy Level, detailing the hierarchy from the Ministry of Health's department for HRH Management & Development to county Governments through the Council of Governors committees on Human Resources and Health and Biotechnology. This is followed by the Council of County Health Ministers who have committees for HRH, EHPT, Health care Financing and Inter-county relations, ICT in Health and Health Informatics, PPP in Health, Health Research, Quality Assurance and an Inter-county HRH Forum.

She then described intra-county governance structures as headed by County Executive for Health Services with direct reporting from the County Health Management Coordinating Committee to whom the Sub-county Health Management Teams (ScHMT) report. There is mooted the development of Ward Health Management Teams though the current set-up has Facility Health Management Teams reporting to the ScHMT.

She said the county health management coordinating teams will depend on the way the Health department is structured in each County though these must reflect the functions as transferred by: The Constitution (including Sch 4 as well as the Transition Authority Gazette Notice no. 139) and the governance structure be developed with assistance of organizational reform experts.

She explained the constitution of the county health management coordinating committee as the CEC, chief officer, directors of: Preventive Promotive Healthcare, Community Health Services, Referral Health Services and Curative Health Services. Also included are medical superintendents/ facility managers and their service delivery teams in: Medicine and Therapeutics, Nursing, Surgical, Paediatrics, Maternal Health, Adolescent Health and Patient Support Services.

Emphasizing the need to get it right from the beginning, Dr. Ogaja shared county structures, beginning with the county assembly and its role to pass and enact legislation, vet and approve appointments of public officers and approve budget and expenditure of county government.

She then defined the administrative structures from county, through sub-county, ward, village (in the Constitution – yet to be formalized in some counties) municipality and City (for some counties).

Dr. Ogaja said the policy, legal & regulatory environment provide for enabling legislation, regulations and enforcement oversight and policy formulation while the staffing structures oversees harmonization of different levels of staff, their skills & competencies, deployment& secondment, terms & conditions of service, remuneration and human resource audits.

*See county structure organograms and other diagrammatic representations of county government structures in Dr. Ogaja's presentation online on closed Facebookgroup Health Systems Strengthening Kenya and [www.cueaconsultancy.com/hsdpf](www.cueaconsultancy.com/hsdpf)*

Paraclete Consult

Emmanuel

# Machani – Paraclete Consult

Domestic Health Financing, Resource Mobilisation and Private Public Partnerships

Mr. Machani of Paraclete consult was the final speaker, sharing that the status of health financing and reforms in Kenya requires considered strategies to improve health financing.

Mr. Machani spoke on Domestic Resource Mobilisation, advocating county policy and financial frameworks which include public private partnerships and the development of county health investment cases as ways to promote mobilising domestic resources and facilitating the effective use of these resources to strengthen the health system and for its sustainable development. This, he said, includes building on the enabling and effective national regulatory frameworks that govern private sector resources and adequate capacity to raise public revenues in counties.

Mobilisation at county level entails greater emphasis on local resource mobilisation as the major source of financing for development, where strengthening revenue collection efforts and extending the funding base should be priorities. Counties are yet to be expected to have a well-developed domestic private finance sector though are uniquely able to attract higher levels of international private finance and portend growth to more complex financial instruments, advocating small amounts of ODA available to counties be used in a catalytic fashion to stimulate other finance, especially revenues. Citing PPPs and the development of sub-national health sector bond markets to mobilise additional private resources, especially with the country having moved to Middle Income status.

He restated that use of tools that enable effective use of data for costing and analysing expenditures in county health departments, creative examples of successful social media and local advocacy to monitor and support accountable health expenditures shared by GIZ, CDC and Social Media Africa earlier at the forum should be embraced as contributors to health systems strengthening.

Saying domestic resource mobilization should be taken as both a strategy and county development objective to lead to capacity in counties to fund their own health programs Mr. Machani advocated differentiating the capabilities of aid driven strategies that focus on specific health development objectives that may be well removed from county needs, highlighting the opportunity domestic resource mobilization affords county governments, by empowering them to focus on county specific needs and indicators, using their own financial and administrative resources.

Domestic resource mobilisation, he stated, represented a win-win; aid donors benefit from a potential scale-down of funding, while developing countries increase their governance capabilities while independently enhancing their own development goals.

He noted considerable resources could be realized from health sector efficiency gains and reallocated towards county specific health objectives. Strengthening county health expenditure and investment management would help limit waste and graft and improve the quality of health expenditure, including through better selection, design, and management of health investment projects, thereby improving the environment for county health sector investment. Procurement, Mr. Machani noted was another area for potential savings. Saying that **b**eyond maximising value for money, procurement best practices can bring additional benefits to counties, including better service delivery, e.g., through sound

management of health sector PPP contracts and transparency, including through public participation in procurement through community driven development

He further encouraged private sector participation at county level, citing the private sector as a key source for health investment, saying that whereas there remain some challenges in increasing their involvement and incentivizing their participation, these challenges are not insurmountable. Mr. Machani cited vehicles to this end that included: establishment of social markets for health products, development of a sustainability plan for programs, cost recovery and cost saving plans for health products, monetizing accreditation of private health facilities, establishment of new revenue streams across all levels of the health system and promoting Public Private Community Partnerships.

Karen Miricho of the Health Sector Development Partner Forum then closed the 2 day event. Acknowledging partner participation and attendance, Ms. Miricho echoed the WHO Country representatives sentiments, saying the forum is a mechanism towards UHC and encouraged attendees to participate in subsequent HSDPF and follow-on the action points that the inaugural forum had brought forth.