Health Sector Intergovernmental Consultative Forum,

A Summary of Discussions

27-28 October, 2014
Panafric Hotel, Nairobi

Contents

Background and Introduction

The Health Sector Intergovernmental Forum (HSIF) drew in 80 participants comprising health sector managers from the national and county governments, the Public Service Commission, the National Treasury, and development partners (the USAID-funded Health Policy Project and Capacity Project). The forum was chaired by the Cabinet Secretary of the Ministry of Health, Mr. James Macharia, and Dr. Maurice Siminyu, the Chair of the Council of the County Executives for Health (CECs).

Purpose

The purpose of the forum was to bring together the two levels of government (national and county) to discuss issues of mutual interest in the transition to devolved governance. These issues included human resources for health, essential health products and technologies, health finance, and other cross cutting issues. The forum was also intended to give updates to participants on pertinent national issues such as Ebola preparedness and response and the development of key foundational policies and legislation.

This was the third intergovernmental forum since the commencement of devolution in March 2013. Previous forums were held in September 2013 at Kenya School of Government and the Stanley Hotel. This most recent forum, held October 2014, came in the wake of a September 2014 CEC meeting held in Naivasha, whose aim was to identify and prepare agenda items from the county governments that would be carried forward to the intergovernmental forum.

Opening Statements

The Director of Medical Services (DMS), Dr. Nicholas Muraguri, expressed his apologies for the changes in the meeting dates that had consequently led to some CEC members of the forum not making it to the meeting. He hoped that the forum would agree on a concrete schedule of future meetings to ensure proper planning. An advance schedule would also enable the national government to take advantage of the presence of the CECs in the capital and to organise other activities requiring their participation, such as programme launches.

Dr. Maurice Siminyu, in his remarks, tendered the apologies of several CECs who could not attend due to their work commitments. He lauded the fact that the forum attendance approached 75 percent representation from the counties as good enough. He gave a breakdown of key issues that the counties were still grappling with, and which needed to be addressed at the forum. These included the following:

- Commodities and drugs (e.g., only fractions of orders were filled);
- Poor coordination/linkages with the national government (the National Office is in the process of establishing a Liaison Office for counties to enhance communication, including discussing funding with the World Bank);
- Health finance;
- Staff rationalisation and challenges with human resources (e.g., service delivery by disgruntled employees);
- Challenges working with political and health leaders as well as and moderating forces from the government;
- The Ebola scare, especially for those in border towns; and
- Upgrade of health centers

Official Opening by Chair – Cabinet Secretary for Health, Mr. James Macharia

In his address, Mr. Macharia commended the successful efforts and collaboration between the national and county governments, particularly in stabilizing human resources by ensuring that staff salaries are paid on time and that staff are encouraged to work productively. He also noted the support the counties had given towards national initiatives and programmes, including free maternity services and financing of primary health services and immunisation, which have helped to significantly reduce maternal and child mortality. Mr. Macharia also reported that a program to equip 94 health facilities across the country was progressing well and that the Ministry of Health (MOH) would continue to engage with the counties towards its success.

Mr Macharia said that his ministry was in the process of developing a comprehensive financing strategy that will help reorganize how funds for health services are collected and pooled and how health services are purchased. He reported that pilot project on universal health coverage was underway to test how the country can effectively reach the poor and the vulnerable through the Health Insurance Subsidy Programme. As a result of the programme, an agreement was reached between the MOH and 15 of the counties with the poorest health indicators, where the pilot project is being implemented.

The Cabinet Secretary also reported that the draft Kenya Health Policy and Kenya Health Bill were currently before the Health Cabinet, having received the input from all counties and stakeholders. He was encouraged by the efforts of the Kenya Medical Supplies Authority (KEMSA) in ensuring adequate supply of health commodities to meet nationwide demands. He encouraged the county governments to continue working with KEMSA to ensure that the supply chain for health commodities meets international standards in terms of adequacy, safety, and efficacy; and to realise value for money for the limited available resources. He reiterated that KEMSA is a national security institution, asking county representatives to protect it given its crucial role.

Mr. Macharia went on to express concern about the low allocation of funds (13 percent of the total county allocations) to the health sector by many county governments. Further, of this 13 percent, only about allocation quarter went to finance development projects. The Cabinet Secretary challenged the Council of the County Executives for Health to lobby for more resources for the health sector and to use those resources more efficiently.

The Cabinet Secretary also outlined the government's preparedness response to emerging health threats, like Ebola, which include providing additional resources to surveillance and response mechanisms. He urged the CECs to support these efforts by enhancing surveillance on the country's entry points. He called for improvements in national reporting on health services and other important data, noting that the ministry has not been receiving prompt feedback on the utilization of free maternity services. He asked the CECs to support this reporting so that the programme can succeed.

Questions and Answers

Question	Response/Comment
Some areas do not have enough personnel for screening Ebola. In particular, the Trans-Nzoia and Busia borders each have only one health staff screening for Ebola. The staff also does not have thermo-guns and test temperatures by physically touching foreheads of immigrants. They also have no tents or isolation facilities and operate from a bench. Why was there no structure and protection for those working there, and what is the government doing in this regard?	Kenya has prepared an Ebola contingency plan and the government has allocated Kshs350 million for the purpose. The plan focuses on coordination, case management, laboratory investigation, capacity development for health workers, procurement of commodities, and social mobilisation. There is enhanced screening at 31 points of entry, with JKIA and Eldoret airports doing 100 percent screening. This plan will be updated and disseminated to the counties. Counties were encouraged to form multisectoral Ebola taskforces.
Concern was expressed about the data that had been cited regarding county allocations to health, arguing that it was incorrect.	It was agreed that it was critical to have the data as this forms a basis for future planning especially in estimation of Abuja targets. The researchers (the Health Policy Project) used data submitted from the budget controller's office and counterchecked with county data. However, only five counties submitted their validated budgets for the exercise. It was agreed that all the counties would submit their 2014-15 budgets.
Before counties make budgets, the MOH is expected to provide guidelines, so that counties know how much is required to run health services. No such guidelines have been given so far, and this is why issues of poor allocations keep coming up.	A liaison office will be set up to coordinate intergovernmental issues including costing the devolved functions.

Policy and Programme Updates

Emergency Preparedness in View of Ebola

Dr. Ian Njeru

Global Perspective: Dr. Njeru gave an overview of the Ebola Virus Disease (EVD) since it was confirmed in Guinea, Numay in March 2014. Dr. Njeru stated that EVD had started in December 2013, cases had been confirmed in eight countries by October 9, and had already affected approximately 9,000 people. The most severely affected countries have been Guinea, Liberia, and Sierra Leone. Other countries that have recorded cases include Nigeria, the United States, Mali, Spain, and Senegal. Nigeria and Senegal have reportedly contained its spread.

Preparedness Measures Taken in Kenya

Kenya is at risk of Ebola, and the situation is aggravated by these factors: a) EVD has occurred in several countries immediately neighbouring Kenya; b) Kenya has previously reported outbreaks of other viral diseases, including Rift Valley Fever; and c) human traffic between Kenya and the affected West African countries is significant.

These factors make it necessary for the country to take precautionary measures to contain the disease should it be reported within its borders. In preparedness, the government has put in place the following measures:

1) **Coordination:** A multisectoral task force, headed by the DMS with oversight from the Cabinet Secretary, was set up in April 2014 and meets every two weeks. It has four sub-committees: Surveillance and Laboratory; Case Management and Prevention Management and Control; Advocacy Communication and Social Mobilization (ACSM); and Coordination and Resource Mobilization. The government has also granted Kshs350 million towards Ebola preparedness. An Ebola contingency plan has been developed and is being implemented.

2) **Surveillance and laboratory testing:** National surveillance and lab sub-committees are in place and meets weekly. Standard operating procedures (SOPs) are finalized and posted at www.ddsr.or.ke. Screening has been enhanced at all 31 points of entry. Further, 31 port health staff were posted at JKIA in August 2014 to enhance screening. Training is being conducted to develop staff capacity for screening and isolation. The government has also supplied entry points with thermo-guns and other basic items needed for screening and expected to add thermo scanners. The DMS asked the participants to monitor the surveillance activities in the county and inform the national office on any lapses.

3) **Case management:** The government has intensified training of staff in case management with the training of 35 national trainers in September 2014. In addition, 62 lab staff had been trained on specimen collection and packaging and shipment. An additional 450 county trainers have been trained, who in turn have sensitized 4,100 health workers. In total, it is expected that 20,000 staff will have been trained in case management by December 2014. The government is also printing 6,000 clinician pocket books and 10,000 posters to be distributed during trainings.

4) **Setting up of Ebola Treatment Centers:** A temporary isolation facility has been set up and is functional at Kenyatta National Hospital. A permanent Ebola Treatment Centre is under construction at the hospital and is expected to be ready by the end of the year. The government is also mobilizing funds to put up more temporary isolation facilities at Mbagathi, Busia, Eldoret, Kisumu, Namanga, Mombasa, and Garissa hospitals, with the entire necessary infrastructure. The DMS assured the participants that in the case of an emergency, tents can be put up with equipment to manage the disease.

5) **Personal protective equipment (PPE):** This year, 1,000 sets of PPE have been distributed across all points of entry and in selected high risk areas (including Nairobi, Mombasa, Busia, Bungoma, and Malaba) by the Government and the US Centers for Disease Control and Prevention (CDC), and more will be procured if necessary. In 2012, the ministry had

distributed 5,000 PPEs in most provincial general hospitals and points of entry. In 2013, the CDC distributed an additional 20,000 PPEs. A further 2,000 have been procured and will be distributed to counties that have none. Dr. Muraguri assured meeting participants that the national government planned to mobilize funds for more equipment, and urged counties to also buy them.

6) **Pharmaceuticals:** The essential drugs for managing Ebola infection have been procured, but will be retained at the national level and distributed only when there is a confirmed case. These include Tetracycline eye ointment, Erythromycin, Ibuprofen, Paracetamol, Diazepam, Augmentin, Ceftriaxone, and IV Fluids.

7) **Public education and advocacy:** To enhance public education, the national government has commenced distribution of information and education material including posters distributed to counties. Other materials include frequently asked questions (FAQs); brochures; and newspaper, TV, and radio adverts. Two Ebola hotlines are currently operational to handle queries from the public.

Dr. Muraguri reported that 600 health workers had applied to travel to West Africa as part of the global response to the crisis in Liberia and Sierra Leone.

Questions and Answers

Question	Response/Comment
Why are we allowing Ethiopian Airlines to fly into Kenya even though it is still flying to countries with Ebola?	Kenya has only banned travellers originating from Sierra Leone, Libera, and Guinea, not airlines. Kenya Airways chose to stop flying into those countries.
Do we have special insurance coverage for health workers going to work in the Ebola areas in West Africa and those that work in the country's ports of entry?	The package for the health workers going to the three countries will be negotiated with the hiring authority; including plans on their treatment should they fall ill. The DMS offered to give more feedback on these issues.
At the screening level, are we checking immigrant's passports for their travel history to check whether they've travelled to any of the five countries under threat?	Immigration officials do a good job of screening passports and refer suspect cases to Port Health officials.
We have risk from porous borders/points of entry (e.g. Mandera, which borders Somalia which has no government, and in Wajir where direct international flights land but which has inadequate surveillance). Further the islands of Lake Victoria are also a possible entry into Kenya, and Taita Taveta given the traffic from Tanzania. Other areas at risk include Bungoma and Trans-Nzoia where trucks come in through	The DMS offered to follow up on these leads and provide staff and equipment for screening.

Question	Response/Comment
border towns to spend the night.	
Managing information on Ebola within communities is difficult, especially if health workers have inadequate information. For instance, in Bungoma, a case was reported where a woman had died with nose bleeding. This caused a stampede in the hospital and morgue workers refused to handle her body. Another case illustrating poor surveillance involved a mother who left a refugee camp in Kenya with her five children and travelled overland to the DRC for funerals and back without any significant screening.	Lack of public education was a concern, with heavy implications, health and otherwise. The MOH is trying to address people's fear and anxiety through education campaigns.
Ferrying suspected patients and specimen is a critical concern as Commercial couriers were not willing to ferry specimen and patients to the Kenya Medical Research Institute (KEMRI). Why can we not have a helicopter to ferry patients and specimen?	It was agreed that hospitals should continue to use ambulances to transport specimens.
Our facilities are already congested but for Ebola we need isolation space. How can we manage this?	Facilities should consider putting up temporary isolation areas.
Is there a risk of animal to human transmission of Ebola?	The risk of animal to human transmission may not be very high for Kenyans as consumption of the risky bush meat (bats and monkeys) is not high. However, the government will maintain vigilance.

Update on Kenya Health Policy, Health Bill, and Norms and Standards

Dr. Pacifica Onyancha, MOH

This presentation provided an overview on the status of recent policies and legislation.

1) **Kenya Health Policy 2014-2030:** The new *Kenya Health Policy* is a comprehensive document giving direction to the health sector on all issues that have an impact on health. Its development was informed by an analysis of county health status and trends and achievements of health goals during the implementation period of the previous policy framework (1994-2010). It responds to the *2010 Constitution of Kenya*, *Vision 2030* economic blueprint, and provides guidance on Kenya's response to global commitments and obligations. The policy was developed with the involvement of all stakeholders in the health sector, including the county governments, other government sectors, departments and agencies, constitutional bodies, private sector, and civil society organizations.

Its objectives are to:

- Eliminate communicable conditions;
- Halt and reverse the rising burden of non-communicable conditions and mental disorders;
- Reduce the burden of violence and injuries;
- Provide essential health services;
- Minimize exposure to health risk factors; and
- Strengthen collaboration with private and health related sectors.

All input from stakeholders was received and incorporated into the final document presented to the Cabinet in June 2014. Once approved by the Cabinet, a sessional paper will be presented to the National Assembly for adoption, and then the policy will be launched, disseminated, and implemented.

2) **The Health Bill, 2014**: The purpose of the proposed new Health Bill is to provide a legal instrument to regulate the health sector in-line with the devolved governance structure. Drafting began in November 2011 and key stakeholders provided input through public participation. In October 2012, the Cabinet approved the draft Health Bill but the Attorney General and Committee on Implementation of the Constitution (CIC) raised concerns, which had to be addressed before the draft could go further. Between February and June 2013, interrogative meetings took place with various stakeholders to address the concerns raised by CIC and AG offices. The resulting expert draft bill was forwarded to the MOH and the CIC in July 2014. The MOH has tabled this expert draft to the Cabinet for approval and hope that the approved Bill will be gazette soon for deliberation in Parliament and enactment.

3) **Human Resources Norms and Standards 2014:** Norms and Standards Guidelines provide guidance on the levels and skills of health workers needed to deliver the Kenya Essential Package for Health (KEPH), including establishment by cadre**.** These norms and standards were developed through the Workload Indicator of Staffing Needs (WISN) approach, an evidence-based method that considers the work actually performed by staff at a facility. The methodology considers three factors: the effort (i.e., time) required for specific health staff to carry out particular activities; the category allowance factor, which is additional time spent on non-service activities (e.g., management or record keeping); and individual allowance factor**,** which is time spent on activities by specific individuals in a staff grouping (e.g., a matron's additional activities above other nursing staff).

The document is being produced and will be launched during the next national Health Summit, and thereafter disseminated to counties.

Questions and Answers

Question	Response/Comment
Is there any administrative board/body in the Kenya Health Bill? Do the county governments have representation in this body? How much input from the counties was	There was initial engagement with counties on the bill. The CIC invited input from the counties and only five counties responded. The bill is open to further comments and counties were encouraged to forward

Question	Response/Comment
incorporated into the current draft bill? The counties have had a back and forth with the drafting team and at each level we have found out that county views had not been included.	their inputs to CIC.
Promotions have budgetary implications. We sent our budgets earlier. Where do we get the money to pay those that the national government has promoted within the country governments?	There was a circular issued that stated that the counties can go ahead and promote staff. However, at the county level staff cannot be promoted unless they go through the due process.
How are we planning to use ICT and health informatics? Is this planned?	This has been taken into consideration by using the WSIN methodology, which will reveal what work staff does, including ICT staff.
If we are elevating new health facilities in the new health bill, what will we do with Level 5 facilities?	There was a proposal to bring Level 5 under the national government but this may be unconstitutional and against the spirit of devolution.

Progress on Devolution in the Health Sector

Mr. Elkanah Ong'uti, MOH

In this presentation, Mr. Ong'uti outlined the key achievements made so far in the transition to devolved health services.

- Launch of the Health Sector Intergovernmental Consultative Forum during its first meeting on 2-3 September, 2013 at the Kenya School of Government. Since then, three forums have been held to discuss sector specific issues requiring urgent, intergovernmental consultations, including the Governors' Summit Forum at Naivasha in January 2014. The key issues addressed by this forum included:
    - The draft Kenya Health Policy, 2014-2030, that is awaiting Cabinet approval;
    - The draft Health Bill, currently awaiting finalization;
    - The unbundling, transfer, and implementation of functions and roles assigned to national and county levels;
    - Resolution of disputes arising from the devolution of health services;
    - Human resource management and development;
    - Health sector financing;
    - Procurement of essential health products and technologies and redefining KEMSA's role;
    - Management of Level 5 hospitals;
    - Equipping of public hospitals;
    - Management of shared functions and cross-county services;
    - Management of user fees at the hospitals; and

    - Communication between the two levels.

- Setting up of four Technical Working Committees to work on specific subject matters.
    - Management of shared functions and cross-county services
    - Human resource management and development
    - Health care financing, existing bilateral agreements, and conditional grants including financial flows
    - Procurement of essential health products and technologies, vaccines, anitretrovirals (ARVs), and tuberculosis (TB) drugs

- Transfer of the IPPD (payroll system) to all 47counties in January 2014.
- Issuing of guidelines to smooth transition of staff to counties through Gazette Notice No. 825 of 7th February 2014.
- Support to counties through Health Sector Services Fund, Free Maternity Services, Health Insurance Subsidy Programme, Equipping of Public Hospitals, and others including the funding and management of Cross-County Referral Hospitals.

Some of the challenges that have been faced in the process include:

- Transfer of functions was not phased as envisaged in the Constitution;
- Delay in finalizing some of the sector policy and legal documents;
- Teething problems during the transfer of the payroll to counties;
- Slow pace of the sectoral intergovernmental consultative forum and technical committees; and
- Inadequate costing of county functions and services.

Performance Report on Health Service Delivery

Dr. John Odondi, MOH

This presentation summarised the findings of a quarterly assessment on service delivery performance conducted in July 2014, which covered 66 primary level facilities and 155 hospitals. The assessment sought to identify gaps and challenges in service delivery in a devolved setting and make recommendations for improvement.

Key Findings

Staffing

In general, there are more numbers of different cadres of staff in hospitals in FY2013-2014 compared to FY2011-2012. However, the numbers are still far off from the recommended norms. Huge gaps also exist across the board but of most concern is that only 30 percent of the hospitals had specialists. The least available were orthopaedic surgeons, only available in 5.5 percent of facilities. The table below summarises health worker distribution.

Staffing levels, 2013-14					
	Low volume	**High volume**	**Level 5**	**Overall**	**Overall**

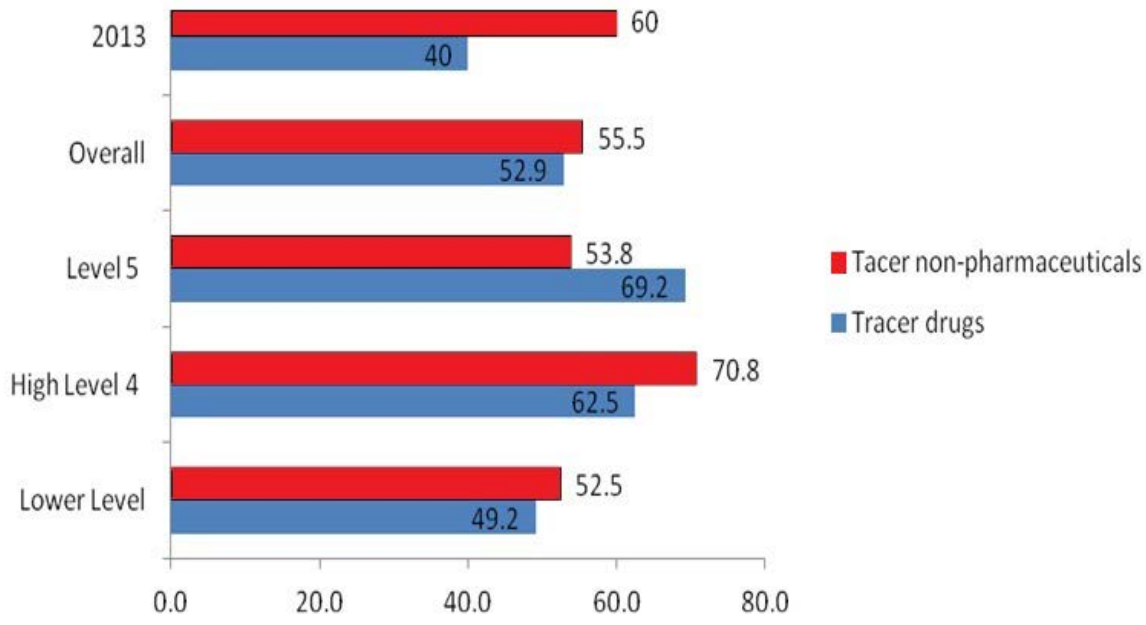
	Level 4	Level 4		2013-14	2011-12
Medical officers	3.4	9.7 **(16)**	17 **(50)**	5.7	3.0
Nurses	33.8	115.8 **(251)**	214.8 **(842)**	58.8	37.0
Clinical officers	7.8	26.2 **(68)**	25 **(89)**	11.9	7.0
Lab personnel	4.6	12.75	20.2	9.6	-
Pharmacists	1.9	5.9	7.8	3	2.0

Financing

The assessment found that no clear guidelines on financial management exist for facilities in the counties. Further, only 40 percent of facilities had received authority to incur expenditure from county governments to cater for their operations, and only 40 percent had received a full refund of what they had spent. In only 43 percent of cases was the full facility improvement fund (FIF) returned to the hospitals. Concerning the free maternity services, 65.8 percent of facilities had received expenditure returns for services rendered. Several facilities (73.6%) had installed computerized cash collection systems.

Drugs and commodities supply

The availability of tracer drugs (20 common use drugs, including antibiotics) improved after devolution, but supplies of non-pharmaceuticals declined. The chart below summarises the trend observed in supplies.



Leadership and governance

Only 26 percent of hospitals had held management meetings in the period under review, down

from 35 percent in 2012-2013. In addition, contracts for some members of the management committee expired and, on average, supervision was conducted only in 50 percent of the cases.

Quality of care and medical records

Overall, urgent efforts are needed to improve the quality of care in public facilities. The assessment found that medical history was well documented only in 60 percent of cases in the wards, and 33.5 percent in outpatient services. The table below summarises the findings on quality of care.

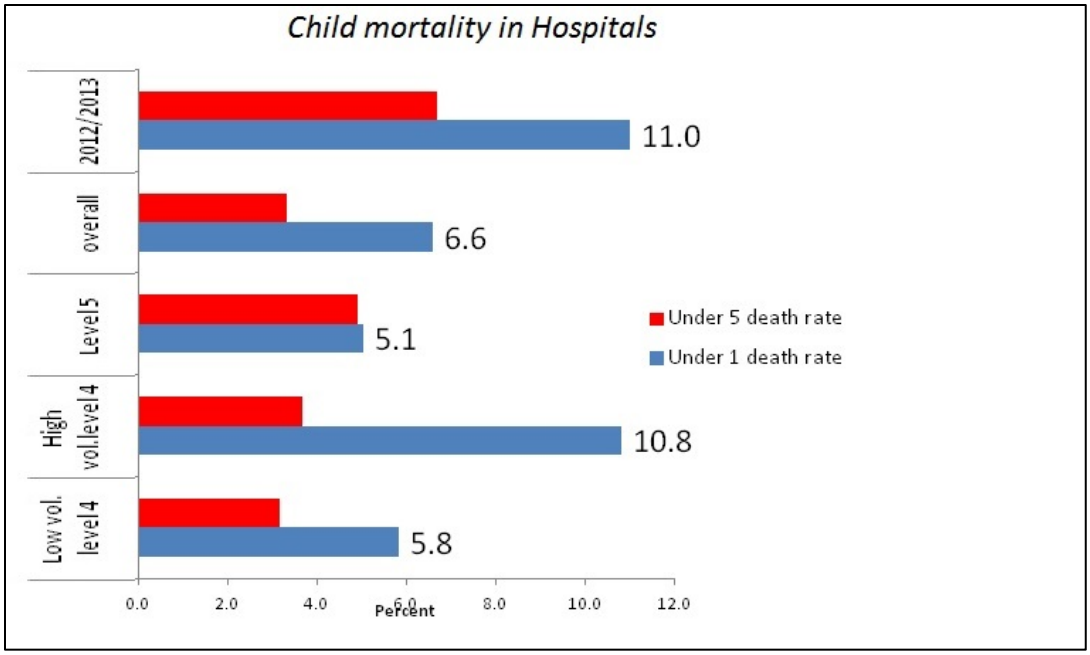
Quality of Care and Medical Records, June 2014		
	Outpatient Department	**Wards/Inpatient**
History well documented	33.5	60
Examination documented	38.7	56.1
Vital signs recorded	32.9	51.0
Appropriate investigations done	32.9	57.4
Clear diagnoses made	52.3	63.9
Records signed, dated and timed by clinicians	30.3	37.4
Treatment sheet clear and signed	43.9	54.2

Further findings show that

- Only 51 percent of hospitals were offering 24 hours laboratory services (drop from 75% the previous year);
- The proportion of laboratories that have standard operating procedures (SOPs) present on site is 71 percent (down from 82% in 2011-2012); and
- Blood stock levels are poor and only an average of 14 units were available on site. Further, an average of 10.8 units of expired blood was found in Level 5 and 1.3 units in Level 4 facilities.

Child health

There was noticeable improvement in child mortality rates compared to FY 2012-2013 as illustrated in the following chart. Overall, there is need to improve reporting rates in order to get accurate data.



Maternal Health

In general, facilities performed poorly in maternal services, as illustrated in the following figures.

Maternal Health					
Indicator (%)	**Type of facility**				
	Low volume level 4	**High volume level 4**	**Level 5**	**Overall score 2014**	**Overall score 2012-2013**
Fresh still births rate (fresh still birth/still births)	56.3	48.7	53.5	56.4	-
Hospital based maternal death rate (per 100,000 deliveries)	144.5	200.8	225.6	227.6	741
Percent of maternal deaths audited	64.7	60.0	55.2	86.6	-
Still births rate	2.2	3.6	4.3	2.5	-
CS section rate	9.8	20.0	28.1	17.0	17

HIV and AIDS

HIV counselling and testing dropped in the 2014 assessment, but deaths due to HIV and AIDS declined. Only 47.9 percent of eligible patients were put on ARVs in 2014, compared to 55.3 percent in 2012-2013.

Malaria
The study did not find any significant changes in malaria incidences leading to hospitalization among adults and children over the past two years.

Assessment Recommendations

- There is need to document training needs for the health sector in order to adequately plan capacity-building programmes. Consideration should also be given to innovative capacity building initiatives for all technical staff (e.g., through reverse referral/expertise movement to lower levels).
- Concerted efforts should be made to address the staffing gaps noted in the facilities, especially among specialist cadres.
- Further guidance is required on financial management to the facility teams in the counties, and orientation on the public finance management law.
- Regular supportive supervision in facilities is required, and should be implemented jointly by county and facility management teams.
- Management teams should be established where they have lapsed, in order to provide support to hospital processes.

Questions and Answers

Question	Response/Comment
The monitoring and evaluation (M&E) study focused on clinical services, not on equipment and promotive services and did not cover Level 6. Can we have these included in next studies?	They will be included, as this will make the evaluation more comprehensive.
On quality, we notice that most areas dropped. Which facilities were sampled and in which counties? Does it mean that we are not performing well because of devolution?	The transition to devolved units has had some teething problems, which may have affected quality. Going forward, it is important to focus on the quality of the care provided in all public facilities.

Equipping of Public Hospitals –The Managed Equipment Service Project

Dr. John Odondi, MOH

Background
A proposal to equip health facilities with modern equipment was discussed and approved at the intergovernmental consultative meeting between the Ministry of Health and CEC members for Health and Finance held at the Multimedia University, Nairobi on 22nd – 23rd October 2013. In the proposal, the national government was to mobilise resources to support the initiative over a four-year period and equip 94 Level 4 and 5 facilities countrywide. The project was going

to be financed wholly by the national government, and was not as part of the county share revenue.

Highlights of the communique

- The National Government committed to mobilize resources to support this initiative
- The two levels of government will work together to prioritize the type of equipment and the facilities to be covered under the initiative
- The initiative needs to be fast tracked to address urgent need to equip public hospitals in the counties
- The County Governments committed to fully support the realization of this initiative

However, this proposal was not implemented, because although it was endorsed by the Council of Governors, controversy arose thereafter. Counties were asked to identify two health facilities to be supported under the initiative, for upgrading to Level 4 and 5 respectively by January or February 2014. Most had not by the time of the meeting. This presentation highlighted the proposed mechanism and update of status.

Proposed approach
The Managed Equipment Services (MES) arrangement will have three major partners: the National Government, the County Governments, and private contractors/providers. The MES will cover long-term contracts, running for an initial period of seven years with options of renewal for an additional three years. Under the MES arrangement, the private contractors will assume the risk and responsibility of procuring, installing, maintaining, and replacing the equipment in selected hospitals.

Type of equipment to be procured
The types of equipment prioritized under this initiative were informed by the assessment exercise conducted in the selected hospitals in March 2014. It will cover seven categories of equipment (Lots) as follows:

- Lot 1: Theatre equipment
- Lot 2: Theatre, CSSD equipment
- Lot 3 and Lot 4: Laboratory Equipment
- Lot 5: Renal Equipment
- Lot 6: ICU Equipment
- Lot 7: Radiology Equipment

In addition, the MES contractor/provider will provide the following services:

- Supply of the equipment;
- Delivery and installation;
- Testing;
- Maintenance;
- Repair and replacement of spare parts;
- Replacement of medical equipment on expiry of their useful lifespan;
- Supply of consumables and reagents; and
- Training for staff using the equipment in the hospitals.

Responsibilities under the MES arrangement

National government

1) Appointment of Ministry representatives to the MES oversight team
2) Timely payments to contractors
3) Receiving and verification of reports from counties
4) Capacity building for counties on contract management/project implementation

County governments

1) Appointment of county representatives to the MES oversight team
2) Ensure continuity of services
    - Provision and payment of utilities, including water and electricity
    - Ensure there are sufficient stocks of goods, consumables, and reagents to ensure performance standards are met
    - Ensure trained staff are available to enable optimum equipment performance
3) Preparation and timely submission of reports to the ministry to facilitate timely payments to contractor

Shared responsibilities

1) Monitor project performance
2) Follow-up on recommendations of liaison committees and investment committees as necessary
3) Documentation of lessons learnt

Progress Update

The tender for the supply, installation, testing, maintenance, and replacement of medical equipment, as well as associated training in the hospitals through an MES arrangement was issued by the Ministry of Health in July 2014 (Tender No. MOH/001/2014/2015). At the time of the meeting, the technical and financial evaluation had been completed to determine the successful bidders and the tender processing committee was preparing an evaluation report.

Key issues that needed inter-governmental consensus are as follows:

- Clarification on Ministry of Health and county responsibilities, obligations, and liabilities under the MES contract;
- Communication and reporting;
- Redress and recourse measures in case of a breach of either party's obligations;
- Shared responsibilities; and
- Consensus building and signing of the intergovernmental agreement.

Next Steps in the Process

1) The national government will share the draft MES contract and draft intergovernmental agreement with counties, November 2014.

2) A sensitization forum will be held for counties on the MES contract and intergovernmental agreement, November 2014.

3) Submission of inputs from counties on the above two documents, November 2014.

4) Signing of the intergovernmental agreement between the Ministry of Health and counties, December 2014.

5) Signing of MES contracts between the Ministry of Health, the contractors (MES providers), and the individual counties, December 2014.

6) Commence Phase 2

   - **Project implementation:** Delivery and installation and commissioning of equipment. This will differ with specific equipment. Schedules will be provided by MES provider once agreed upon contract signing. However, up to 12 months are allowable within the contract.

   - **Capacity building:** This will be provided continuously by an MES provider (private partner) for staff within hospitals operating the equipment; and by the Ministry of Health for implementers on contract management/programme implementation.

Questions and Answers

Question	Response/Comment
Who takes the responsibility for creating space for the leased equipment?	The responsibility to modify room is in the tender details and will be done by the contractor. If a facility does not have room, counties are encouraged to build new facilities under Phase 2.
What is the period of the supply of equipment? Previous projects took too long.	MOH is giving contractors a period of one year for the provision of these services; beyond one year they are liable to penalties. In this tender, we are dealing with the original manufacturers and they are allowed to form a team with other manufacturers in order to meet the demand.
Is the equipment on hire or lease? Are we going to charge for services?	The MOH negotiated a fixed rate and there will be levies to be paid. The procurement process followed the Public Procurement Act.
How are we planning to use ICT and health informatics? Is this planned?	*U*nder the new procurement, ICT has been integrated to enhance diagnosis.
What is the plan for training staff on the use of equipment? Will it be adequate?	It is in the interest of the provider that adequate training is provided to ensure the equipment is properly used and lasts the length of the project (seven years).
Who will have the equipment at the end of those seven years and what is the value of	It belongs to the supplier who can dispose the same.

the equipment?	
Can counties get the schedule of equipment, and the details of the tender, in case they want to tender their own?	The list is available and will be availed to the counties.

Day 2: Salient Issues Raised from CEC Forum

In previous meetings, the CECs had identified five areas which impact the counties' capacity to deliver high-quality healthcare services, and which need to be addressed for devolution to be successful. These areas are

- Human resources for health;
- Financing health services;
- Health commodities and technologies;
- Intergovernmental coordination and management of Level 5 hospitals; and
- ICT/health informatics in health delivery.

Sub-committees were set-up to address the areas causing most concern: financing healthcare; human resources; and commodities and technologies. A meeting by the CECs in September 2014 discussed these issues in detail and highlighted the critical areas that the intergovernmental forum would cover. The following is a summary of these issues and the subsequent discussion.

I: Healthcare Financing

The sub-committee report was tabled by Artuko Moses, CEC Baringo County. The sub-committee met twice and raised the following issues:.

Facility Improvement Fund (FIF) – for hospitals:

- Currently, monies from the facility improvement fund for hospitals go to the county revenue fund for reallocation. In the process, Level 5 facilities are not receiving adequate funds for their operations. Ring fencing remains a key challenge in most counties.
- There is an accounting staff gap. Most hospital accountants are casuals, not on a permanent contract.
- County treasuries do not top-up the collected funds, leaving some hospitals without adequate funds, and receiving fewer funds than in previous years.
- There are problems reported in hospitals of accessing these funds in county treasuries where signatories are not county employees.
- New guidelines are needed on the management of FIF. Currently, all funds in the county are considered county revenue.
- The committee recommends new national legislation on management of FIF.
- Counties should, in the meanwhile, consider opening imprest accounts to receive FIF fund.
- As they are currently being used for other purposes in the counties, there is also a need to rethink the management of conditional grants to hospitals.

In response, Dr. Peter Kimuu, MOH and Mr. Geoffrey Malombe, National Treasury, explained the following:

- The MOH/national government has signed memorandums of understanding (MOUs) with county governments to facilitate the transfer of these FIF funds as soon as counties sign.
- The PFM Act (PFMA) required closure of all facility accounts by July 1, 2014, and FIF is to be managed through counties treasuries to avoid mismanagement and disruption of services in the transition period.
- There are two types of Level 5 conditional grants provided for by Article 227 of the constitution. Currently, the constitution provides that any money received in counties goes directly to the CRF. The PFMA does not allow facilities to run accounts. Change in this process can only be effected through an act of Parliament. However, the law allows counties to budget for funds from the national government/MOH as Appropriations in Aid (AIA). Counties can also issue Authority to Incur Expenditure (AIE) to facilities to ensure the accountable management of funds.

Other issues raised by the sub-committee are summarised in the following table, with the appropriate response/commitment given by national government representatives.

Issue raised by sub-committee	Clarification/comment from national government
HSSF funds: Counties were to include HSSF line into their budgets on under operations and maintenance (O&M). DANIDA, MOH and the Treasury agreed in writing earlier this year to channel funds directly to counties, from the Treasury. Documentation to this effect exists. However, the funds were transferred to the Treasury by the MOH, but counties had not received them by the time of the meeting. A letter was sent from the Council of Governors regarding the issue. **Funds from the World Bank:** An Agreement was signed between the Treasury and the World Bank in January, 2014, and the framework for disbursement suggested was through MOH. These funds also had not reached counties by the time of the meeting. **Funds from the World Health Organization (WHO):** WHO funds were also being channeled through the national government and not reaching counties.	Although DANIDA funds go to CRF, they are earmarked for health. Further discussion will be held on how these funds will be authorised at county level Second schedule under the HMSF Act provides for the management of conditional grants.
Funds for free maternity services: The committee observed that funds for free maternity services continue to be channeled directly to facilities from the national government/MOH, and that budgets were developed at the MOH level. Amounts per delivery need to be reviewed from the current 2,500 for normal delivery and 5,000 for caesarean delivery to a higher figure (4,000 and 10,000).	These funds were supposed to complement counties' allocation to support deliveries and were not supposed to cover full costs. Funds should be budgeted as AIA to facilitate capturing in the IFMIS.

Issue raised by sub-committee	Clarification/comment from national government
Funds are not captured as it is by the IFMIS system. An operation framework needs to be agreed upon.	
Funds for national immunization days (NID) and campaigns: Counties are still unclear on the management of these funds and are not involved in national campaign planning. Reporting of campaign outcomes still remains unclear to counties. Recommendation: National government should involve counties in planning and implementing national immunization campaigns.	Counties will be involved in any catch-up campaign including planning and in rolling the campaign.
Transfer of county funds from national level: Delays experienced with transfer of funds from National Treasury to counties. The requisition process for counties to access funds is too complex. IFMIS causes delays. Several counties have low absorption of funds. Funds transfer (HSSF) to hospitals in some counties still pending/erratic at time of the meeting.	PFM Act requires that county governments issue receipts to National Treasury upon receiving cash, for accountability. Further disbursements are only made after accounting for previous sums. This is experienced at the begging of the FY and National assembly approved the necessary bills. The review of PFM Act to harmonise the disbursement schedules.
Loans and other donations: Do counties always have to go through the national government to borrow? Consensus and regulations are needed on guarantee on loans. Where does the financial accountability lie in terms of leasing equipment?	Legal framework being prepared by AG to guide county borrowing. However counties are allowed to receive donations and this must be reflected in the budget.
Delays in salary disbursement: Counties need reserve budget - hold-on funds –for 3 months to cover salaries and insufficiencies during the end of every month. **Promotions:** These have financial implications on county budgets and need to be discussed with national government before requiring counties to affect them, so that funds are provided for.	Funds passed to counties based on revenues collected by KRA. Difficult to provide any reserves. Promotions will be done by counties once the personal files are taken over by counties. Need to manage personnel budget to ensure counties do not spend all their money on emoluments.
National programme funds, including funds for malaria, HIV, TB, and reproductive health: Counties are still not clear about the allocations and management of these funds. There is a lack of clarity on several fronts. A meeting is required with the national government/ national programme managers and CECs to iron out these	The technical working group on pharmaceutical management will discuss this during their next meeting. Procurement of commodities for these programmes is better done at the national level. Counties/national government to

Issue raised by sub-committee	Clarification/comment from national government
issues.	collaborate on commodities quantification.
2015-2016 Budgets Process: In order to plan effectively, it is important for the country to look at function rather than need. In past budgets, some counties had low allocations to health due to lack of advice and office holders (CECs, COs) at the time of budget making. Most counties still do not have appropriation per department. It is recommended that the national government/MOH works with counties on function costing for budget purpose.	All CECs for finance have been given information on budgets and costing functions by the Treasury. Treasury staff has provided consistent training and tools to the officials to ensure efficient financial management at county level. National government will build the capacity of counties on costing and programme-based budgeting.

II: Human Resources for Health

Dr. Maurice Siminyu, CEC/Health, Bungoma, tabled the issues related to human resources for health (HRH) on behalf of the sub-committee chairperson. These were as follows:

Key issue	Clarification/comment from national government/(Mr. Gitari, MOH)
Human resource (HR) files/records: Transfer of all HR files/records to counties to facilitate management of seconded staff (promotions, retirements, etc.).	Transfer of the 42,619 files to counties was delayed because the files needed to be upgraded and brought in-line with the staff rationalisation process. These will be transferred as soon as upgrading is complete and counties have the appropriate storage and management facilities.
Schemes of service: Counties do not have the approved schemes of service for all cadres.	These are available online and counties can access them. HR/MOH will also liaise with the Public Service Commission to ensure all counties receive them.
Promotions: Guidance is required on resource implications for counties arising from promotions from the Ministerial Selection Board.	Over 9,000 promotions have been effected, for common cadres who must be promoted after three years of service. National government has included in its budget a 4 percent allocation to cover promotions in this financial year. Counties will have to plan for next year.

Key issue	Clarification/comment from national government/(Mr. Gitari, MOH)
Management of post-graduate training: Counties are not willing to pay salaries and training fees for staff who might not return to them after training.	Training policy has clear guidelines on bonding – counties can take advantage of current provisions to bond staff so they return to them after training. However, it may not be in the best interest of the staff's career growth, especially for specialists.
Sharing scholarship funds: Scholarship funds are currently managed nationally and not shared with counties.	The MOH does not have a scholarship fund. The PSC/DPM receives notice of scholarships from donors and MOH helps nominate candidates.
Staff guidelines: Guidelines are needed for inter-county transfers and rationalization of staff/redistribution of specialists.	Requests should go through county service boards to PSC who channel them to TA/Ministry of Devolution for authorization.
Employment of contract/ESP staff and staff hired under the Capacity Project, and cost-sharing accountants	Counties can absorb them if after suitability test. Counties reminded that they should absorb Capacity Project staff before March 2015, when the project comes to a close.
Implementation of CBA in counties: Counties had not signed any CBA with unions and therefore do not feel that they should have to implement any of them.	Legal opinion has been sought from AG and national government is following it up. Subsequent meetings on existing CBAs will include counties.
Liaison office for counties: Lack of a liaison and coordination office has negatively affected counties' ability to communicate with and seek guidance from the national office.	A liaison office will be set-up with support from the World Bank and staffed with high-level personnel who will be responsible for managing all communications and support to counties.

III: Essential Health Products and Technologies, Public Health Commodities

Dr. William Muraah, CEC/Health, Meru, tabled the issues regarding commodities on behalf of the sub-committee.

Key issue	Clarification/comment from KEMSA representative, Dr. Munyu
Sub-committee made several recommendations on the KEMSA Amendment Bill to improve the institution's efficiency, grow the commodity market, and	KEMSA welcomes the recommendations and would welcome counties participating in its development, including representation on board. However, KEMSA needs skilled and experienced people on its board.

Key issue	Clarification/comment from KEMSA representative, Dr. Munyu
reduce KEMSA's monopoly.	Competition is welcome; it is good for the country. KEMSA currently has over 80 percent of the public healthcare market and plans to expand its reach through strategic marketing and partnerships with the counties. KEMSA needs to be freed from Exchequer support to finance itself and be self-sustaining, and charge the government for services rendered. Amendment of the KEMSA Bill should be realigned to devolution and good cooperative governance.
Clarity is needed on donor support for public health goods, including vaccines and blood products.	These will continue to be sourced centrally and distributed to counties.
Clarity is needed on the distribution of equipment procured centrally, including the fate of equipment launched at Red Cross.	List will be made available to counties.
Status update required on the Kenya Essential Medicines list as a basis for KEMSA procurement /demand forecasts.	All counties are distinct and different and have various needs. Demand forecasting is a challenge. KEMSA needs a common forecast list for health products developed together with the county health officials to ensure adequate supplies. This was long overdue. Average fill rate on orders to KEMSA is 85 percent and agency is currently trying to improve this. The order turn -around time was initially 100 days but is currently 43 days.
Status of the Public Private Partnership guidelines for EHPTs – counties need guidelines	PPP workshop planned for November 19-20, 2014 to discuss this issue in detail. Recommendations to be tabled in the next meeting of the Technical Working Group (TWG) on Pharmaceutical Management.
Implications of Sessional Paper No.4 of 2012 on the Kenya Pharmaceutical Policy.	
Develop policy/tools for inter-county commodity trade/borrowing of commodities.	TWG on Pharmaceutical Management to discuss these issues.

IV: Intergovernmental Relations and Coordination: Closing Remarks

Remarks by the DMS, Dr. Nicholas Muraguri

HR: Dr. Muraguri agreed that HR was an issue but stated that the MOH was unique and therefore its human resource management required a different approach so as not to disrupt services. There will be more discussion on this during the next meeting.

Scholarships: Dr. Muraguri suggested that further discussion is required on the rationalisation of compelling health workers to serve the sponsoring county upon graduation, giving an example of one county where all candidates had chosen pediatrics. He wondered what their particular county would do with all these specialists upon graduation. He said they need to set-up proper systems to actualise that every Kenyan can find a specialist in their county when they need one.

KEMSA: On essential drug list, counties needed to agree on a standard for all.

Liaison office: Dr. Muraguri said that the CS had agreed that they would set-up an office. He hoped that they would agree on the next three meetings before June 30, 2015. He said that they needed to agree on the way forward before devolution.

TB, HIV, Polio, and family planning products and funds: These are public health security issues and should be managed as such, and the procurement of their commodities will therefore remain centralised at the national government level.

Remarks by Cabinet Secretary, Mr. James Macharia

Mr. Macharia lauded Dr. Maurice Simiyu and Dr. Elizabeth Ogaja for managing the intergovernmental forums well. He also commended his team for handling the technical issues well.

Liaison office: He said that this issue was long overdue and a lot of ongoing issues would have been dealt with long ago had it been in existence. He also said the forum needed to be empowered, effective, and efficient. It needed to be an office that makes decisions, with the highest levels of authority. The DMS has agreed that we shall fast-track the putting together of this office.

Intergovernmental forums: Mr. Macharia said that the frequency of these meetings needed to increase and that everyone was guilty for not holding them. This is because there are a lot of issues to be dealt with and the forums should be hosted in other parts of Kenya as well.

Devolution: Mr. Macharia hoped that the health sector would be devolved in a spirit that was deliberately devoid of the acrimony evidenced in political endeavors. They needed to focus on doing what was best for the nation. He mentioned that the spirit of acrimony was evident in the discussions on the issue of equipment. He reiterated that anything that was done here was done in the best interest of the country.

Budget: Level 4 and 5 hospitals have become dilapidated and embarrassing. To forestall disaster, the national government will equip at least two hospitals in each county, which should be identified in collaboration with county leadership.

Crucial programs and interventions: Mr. Macharia encouraged meeting participants to have a spirit of collaboration. He also stated that they needed more opportunities to understand how the government operates.

HRH: Mr. Macharia called for a separate forum dedicated to HR issues. He cautioned that devolution will seem to have failed if Human Resources were not well managed.

Dr. Siminyu, in his vote of thanks, confirmed that the counties were interested in the leased equipment project for their health centers and would seek audience with the CS at a later date.

Next Steps

Thematic area	Activity	Action taken by	Completed by
Pharmaceutical Management	Liaise with the Senate to finalize the 2014 KEMSA Bill	CS-Health	November 2014
	Develop essential pharmaceutical/non-pharmaceutical list to be used by KEMSA	TWG on Pharmaceuticals	February 2015
	Counties with support from national government to undertake a three year forecast of commodities in the "list"	TWG on Pharmaceuticals County Health management teams	April 2015
	KEMSA to engage counties on their new business model	KEMSA	January 2015
	MoH to discuss with the Treasury and Council of Governors on funding arrangement for commodities for national programmes	CS-Health, CEC-Health secretariat	February 2015
Human Resource for Health	Transfer files to counties Counties to provide storage capacity for the personnel files	CS-Health, County Public Service Board	June 2015
	Provide schemes of service	Head of HRH at	November

	to counties	MoH	2015
	Absorb staff on contract	County Public Service Board	June 2015
	Prepare HRH by county	TWG on HRH	February 2015
	Hold a one day conference on HRH issues		
Financial management	Develop template for programme-based budgeting	TWG on Finance	December 2015
	Conduct county budget analysis for 2014-15	TWG on Finance	December 2015
	Hold meetings with Senate and Parliamentary committees on health financing	TWG on Finance	January and March 2015
	Capacity build CEC-Health on PFM Act and Budgeting process		
Cross cutting issues	Set up intergovernmental (IG) liaison office at MoH	CS-Health	November 15
	Hold next IG meeting	CS-Health/ CEC-Health secretariat	March 15

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