



## DEVOLUTION OF KENYA'S HEALTH SYSTEM

THE ROLE OF HPP

*Brief*

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The USAID- and PEPFAR-funded Health Policy Project (HPP) works with a variety of governmental and nongovernmental partners in Kenya to establish well-managed and accountable health systems. In support of Kenya's devolution process, HPP provides technical assistance on public management and structures, as well as guidance on data use, evidence generation, and policy development. This brief provides context for devolution and outlines HPP's support to government institutions in guiding and managing devolved health services, up to and beyond the 2013 elections.

### Box 1: Types of Decentralization

**Devolution**—Power, responsibility, and budgetary authority are shifted to locally elected or appointed officials.

**Deconcentration**—National institutions place staff at the local level but retain decision-making power.

**Delegation**—Management of public functions is transferred to semiautonomous or parastatal organizations.

## What is Devolution?

Devolution is a form of decentralization, or the transfer of authority and responsibility from central to lower levels of government for a range of public functions. The purposes and forms of decentralization vary widely; there is no “one-size-fits-all” approach. Decentralization is usually defined using three categories that represent progressively larger transfers of autonomy and responsibility to subnational governments (see Box 1). Each category presents particular challenges and opportunities for health services.

Depending upon the functions and authorities transferred, decentralization processes can involve one or more categories. In Kenya, the constitution identifies the decentralization process as devolution—because of the existence of locally elected governors and county assembly members—although minor elements of deconcentration (e.g., seconded staff) and delegation (e.g., the National Hospital Insurance Fund) also exist.

## Decentralization Before the 2010 Constitution

Decentralization has a long history in Kenya. Following independence in 1963, the British colonial government proposed a system of regional governments based on ethnic and tribal considerations (Institute of Economic Affairs, 2011). This plan was quickly dropped by the Kenya National African Union, the dominant political party at the time. Instead, the party created a unitary state with eight provinces and 175 local authorities (Republic of Kenya, 1977). This structure effectively centralized power with the government in Nairobi, minimizing the control of resources exercised at lower levels (Norad, 2009). Under this act, the Ministry of Local Government provided strong central oversight of local governments, and government policy was enacted throughout the provinces. Although local authorities were responsible for service provision, they had little decision-making authority under this system (Kunnat, 2009).

Kenya attempted to decentralize decision making numerous times under this original framework. In the 1970s and 1980s, the government created six Regional Development Authorities to plan and coordinate activities (KHRC, 2010). In 1983, the District Focus for Rural Development Strategy put the district at the center of priority setting (Barkan and Chege, 1989). These strategies deconcentrated central ministry administrative staff, while also disempowering local authorities, creating few clear responsibilities or mandates between the two alternatives.

By the 1990s, World Bank and International Monetary Fund (IMF) structural adjustment programs were promoting deregulation and decentralization. In Kenya, the World Bank began directly funding local governments under its Local Government Reform Program (Esidene, 2011). These reforms continued to promote deconcentration, as provinces and districts took on more responsibility for service provision, but created no new decision-making powers.

During this time, finances were decentralized vertically because the rural development and structural adjustment programs had created overlapping mechanisms, such as the Rural Development Fund and the Local Authority Transfer Fund (KHRC, 2010). By 2010, there were 13 distinct vertical funding mechanisms available to the decentralized levels.<sup>1</sup> However, these mechanisms confused, rather than

Figure 1: Kenya's New Counties



Source: Kenya Ministry of Information and Communications, <https://www.opendata.go.ke/facet/counties>

clarified, lines of authority, increasing administrative inefficiency (Barkan and Chege, 1989). By most accounts, these efforts at decentralization were not successful and Kenya remained highly centralized (Ndi, 2010; Ndavi et al., 2009).

Various studies have found that previous decentralization frameworks were weakened by

- Limited decision space for local governments (Muriu, 2013)
- Poor legal basis for decentralization (Chitere, 2004)
- Weak citizen participation (Muriu, 2013; Chitere, 2004; Oyaya, 2004)
- Capacity gaps within local governments (Chitere, 2004; Oyaya, 2004)
- Continued civil servant dominance (Chitere, 2004; Oyaya, 2004)
- A focus on outcomes over process (Gilson, 1997)

Although Kenya's first constitutional review commission was organized in 2000, a disputed presidential election in 2007 provided the catalyst for change. As part of the agreement to end the dispute, a Committee of Experts was formed to begin drafting a new constitution to restructure the Kenyan government (Committee of Experts of Constitutional Review, 2010).

## A New Constitution

In August 2010, 67 percent of voters approved the new constitution in a referendum, commencing a new round of decentralization.

The drafters of the 2010 constitution chose to devolve a wide range of administrative, political, and financial functions to 47 newly created counties, based on Kenya's 1992 district framework (Republic of Kenya, 1992). These new functions would be administered by locally elected politicians and civil servants, with formula-driven funding from the national government and limited locally generated revenue. The national government could also provide grants to counties for priority services.

The drafters chose devolution for primarily political reasons, rationalizing that increasing both local autonomy and the number of actors holding political power could defuse ethnic and regional tensions (Sihanya, 2011). Technical rationales were also presented, such as service delivery efficiency and an increased citizen voice in the decision-making process.

The Fourth Schedule of the constitution provides specific guidance on which services the county or national governments would provide. In the health sector, essential health service delivery is assigned to county governments, while the national government retains health policy, technical assistance to counties, and management of national referral health facilities. Schedule 4, however, creates more questions than answers, because the management of the Provincial General Hospitals (PGHs), procurement mechanisms, and fiscal transfer amounts and processes are not defined. Furthermore, health sector actors have limited knowledge about the effects of devolution on their work or the sector. These knowledge gaps present a significant barrier to the effective implementation of devolution.

## Building Knowledge, Finding Solutions: The Role of HPP Before the Elections

Devolution represented a major change from the system that existed before the 2010 constitution. In 2012, health sector actors had little information about their roles and responsibilities during devolution. Units of the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS)<sup>2</sup> proposed several organizational plans, consultants drafted health bills with little reference to constitutional structures, and minimal clarity existed on health worker distribution and management.

Recognizing the complexities inherent in devolution, HPP—with USAID/Kenya and Kenyan government support—brought together health system actors in various forums from June 2012 to March 2013 to develop a shared understanding of devolution, discuss common concerns, and find consensus on implementation.

## Consultations

In September and October 2012, HPP partnered with MOMS and MOPHS on two consultation events to develop a common understanding of the structures, opportunities, and challenges of devolution for health sector actors. The first event was held on September 20, and helped senior leaders from the ministries of health understand how devolution would divide authority and responsibility between the national and county governments, as outlined in the 2010 constitution and relevant subsequent legislation. The second event, on October 24, brought together representatives from both health ministries, non-health government ministries, development partners, and other stakeholders (Health Policy Project, 2012). The meeting focused on the national government's role in supporting the creation of counties in March 2013, and included expert presentations and consultation on human resources, fiscal allocations, procurement, and budget frameworks.



Prof. Anyang Nyong'o, then minister of medical services, discussing the devolution process at the October 24, 2012 policy dialogue event.

Photo by Health Policy Project

These meetings changed the way health sector actors understood the devolution process. By demonstrating the impact of various constitutional provisions, the presenters offered a convincing case that planning to date had been inadequate. For example, the constitution left several functions undefined, including referral hospitals, prevention services, and quarantine administration, among others. Health managers recognized the need to better prepare for these significant systemic changes by proposing definitions for national and county-level functions. The “unbundling” process would clarify functions, ensure that overlapping functions did not cause conflict, and guide the distribution of assets and liabilities. To drive decision making, the participants developed an eight-point “Road Map to Devolution” that outlined the actions stakeholders should take to prepare the health system for devolution (see Box 2).

## Road Map implementation

Following these events, HPP supported the ministries of health to implement the Road Map to Devolution. In keeping with its role as facilitator and technical assistance provider, HPP worked with senior ministry officials to identify participants for the Functional Assignment Competency Team (FACT) and support its work. FACT included both senior ministry staff and development partners, and was established under the guidance of the Transition Authority to spearhead, coordinate, and oversee the devolution of the health sector.

Guided by Transition Authority circulars, the Kenya Health Policy 2009–2030, the Kenya Health Sector Strategic and Investment Plan 2014–2018, and Vision 2030, FACT met regularly to discuss functions, determine assignments, and track progress from October 2012 to February 2013. During this process, FACT grappled with many contentious issues, including assigning functions to the two levels of government; developing formulas to determine health

### Box 2: Road Map to Devolution

- Form a team to propose functions for national and county levels
- Merge the two ministries of health
- Determine specific government functions flowing from the 2010 constitution
- Build management capacity at the county level
- Enumerate county-level assets
- Develop service delivery guidelines
- Create an infrastructure management plan
- Review the role of hospital management boards

Source: Health Policy Project, 2012

budget allocations, both among counties and between counties and the national government; clarifying the definition of a national referral facility; and organizing commodity procurement.

In February 2013, FACT completed the Function Assignment Transfer Policy Paper (FATPP), which addressed many issues from the Road Map to Devolution by classifying and assigning health sector functions for the national and county governments, developing reporting structures, and creating criteria for further function assignment. The two ministries, with HPP technical assistance, worked with stakeholders to implement the FATPP by integrating devolution issues into the 2014–2030 Kenya Health Policy (then under development), the Kenya Health Sector Strategic and Investment Plan, and the Draft Kenya Health Bill. HPP also provided technical assistance to the Ministry of Health (MOH) to generate County Health Fact Sheets containing county-level health information intended to inform decision making.

## After the Elections: County Government Negotiation and Implementation

County governments came into being with the March 2013 elections, and devolution entered a new phase. Planning and preparation gave way to implementation, capacity development, and negotiation. These new roles required the inclusion of county-level stakeholders, and the Ministry of Devolution and Planning promoted a new coordination mechanism for the two levels of government to discuss common issues: the Health Sector Intergovernmental Forum (HSIF). HPP supported two HSIFs by developing discussion agendas, providing evidence to assist decision making, and facilitating supporting committees. The HSIFs have developed human resources, pharmaceutical, and financial management plans, to ensure that county-level health services are not interrupted.

Although the Transition to Devolved Government Act (2012) provided a three-year transition period to devolve government services—including capacity assessments and system audits—political pressures derailed these plans. Once governors and county assemblies were elected in March, they petitioned the president to devolve authority and resources to the counties as quickly as possible (Commission for the Implementation of the Constitution, 2014). As

a result, the Transition Authority devolved health services to the counties in Gazette Notice No. 137 of August 9, 2013 (Republic of Kenya, 2013).

## Strategic planning for county health management

As a result of this decision, HPP—along with the broader health system—had to adapt to a new reality. County politicians with limited legislative experience now controlled resources that they did not have the systems to administer. Additionally, many of them wanted to invest county resources in infrastructure improvements, including constructing new health facilities throughout their counties.

In partnership with the MOH, HPP sought to help county health management teams (CHMTs) allocate resources to ensure that priority services would not be neglected in the rush to build facilities. Along with the MOH and the World Health Organization, HPP organized strategic planning workshops for all 47 CHMTs in August and September 2013.

CHMTs also required access to accurate and reliable data so they could develop strategic plans in response to these challenges. HPP compiled data from several sources—including the Service Availability and Readiness Assessment Mapping (SARAM), County Health Fact Sheets, the Kenya Health Sector Strategic Plan, and the draft Kenya Health Policy—to inform the strategic plan development.

The workshops and data helped the CHMTs create county-level health strategic and investment plans, which were finalized in October 2013. These plans, in turn, provided CHMTs with justification for their budget requests to county assemblies. Discussions with CHMTs revealed that many teams were able to dissuade newly elected assemblies from building unneeded health infrastructure, thereby reorienting budgets toward essential services. By October 2013, the health strategic plans were integrated into the broader County Integrated Development Plans.

Also in 2013, the National Treasury of Kenya analyzed FY2012/13 spending to determine which line items would be devolved to the counties. When HPP and the MOH reviewed this analysis, we found that 30 percent of the devolved funding, as determined by the treasury, was allocated to health in FY2012/13. In the FY2013/14 budget, when county-level elected officials developed the first county budgets, the percentage allocated to health declined to 13 percent.

For FY2014/15, preliminary findings indicate that these allocations have increased—although they have yet to be confirmed by a second county health budget analysis—in part due to ongoing advocacy by CHMTs and the MOH highlighting these data.

## Aligning systems and structures

The CHMTs next asked for guidance on creating systems and structures to align their organizational structure with the principles and functions outlined in their strategic plans. Starting with Mombasa County in May 2014, HPP supported county leadership in establishing a CHMT Technical Committee to oversee restructuring. This committee discussed the integration of staff and functions, determined staffing requirements, created a staffing structure, and developed a change management plan. The committee submitted its proposal to the County Executive Committee Member for Health (CEC-Health) in October 2014. The CEC-Health approved the new structure in November 2014 and inaugurated the new CHMT. To capitalize on this momentum, HPP will work with the county to implement the change management plan and develop job descriptions for staff throughout 2015. Other counties need similar support; HPP will support seven in restructuring their CHMTs to better align structures with principles and functions.

The MOH and the counties were not the only governmental institutions that required technical assistance on devolution-related matters. Under the new constitution, the Kenya Medical Supplies Agency (KEMSA) lost its monopoly over health sector commodity procurement. As a result, KEMSA senior management wanted to reorient the agency to respond to county needs. HPP assistance provided two key inputs to support this process: facilitation of a strategic planning process and training for KEMSA staff on how the constitution affects their business model. The new strategic plan, covering 2014 to 2019, was based on an extensive desk review, key informant interviews, and a strategic plan development retreat. It outlines KEMSA's key organizational values, outcomes, and objectives as the agency seeks to address client requests. The training was the first opportunity for front-line staff to understand the importance of reaching out to county staff and strengthening their customer service.

## Challenges to Devolution

Services and resources were devolved rapidly, but a number of outstanding questions and concerns remain for the Kenyan health system.

Unsurprisingly, significant capacity gaps are common within county political and management structures. When resources were devolved, few counties possessed the administrative capability to absorb the available funding or plan for its use. Although the national government was concerned about these capacity gaps, it had not outlined training and mentoring plans for the counties, as it expected to use the full three-year transition period originally allowed by law.

## Negotiation solves some challenges...

The 2010 constitution did not specify whether national or county governments would manage the PGHs or how counties would procure pharmaceutical products. In keeping with earlier requests for more resources and authority, county governments wanted both control over PGHs and procurement flexibility. However, the national government tried to keep PGHs under its control by designating them as national referral hospitals, with KEMSA as the sole procurement option for counties. HPP worked with the MOH to explore the possibility of funding PGHs through various conditional grants, and circulated a policy brief (Chen, Mulaki, and Williamson, 2014) on the subject to county teams.

As a result of this ambiguity and political maneuvering, the Transition Authority negotiated with the Council of Governors to transfer PGH management to county governments, with directed funding from the national governments to ensure service continuity. Negotiations between the MOH and county governments also yielded a compromise on pharmaceutical procurement: all 47 counties agreed to procure pharmaceuticals from KEMSA through 2014.

These issues reflect some of the political and technical challenges associated with devolution. Counties sought to expand the scope of resources transferred from the national government, increase their authority over services, and reduce national government restrictions. However, the national government fought to retain centralized control.

During these negotiations, HPP provided technical guidance and options to various stakeholders, including analysis of county-level finances, evaluation of potential granting mechanisms, and support for negotiation forums and meetings.

### ... but many persist

Although some issues have already been resolved, major human resource management questions remain, such as personnel transfer, salary payment, and terms of service. These questions highlight ongoing conflicts among three major interests—MOH civil servants, county political leadership, and health workers—each of whom would like to retain or expand their influence over the health system. Counties seek the authority to hire, release, and set standards for health workers, in order to maximize both power and autonomy. Health workers, seeking to preserve their terms of service, ensure timely payment of salaries, and retain control over their professions, have petitioned the national government to create a Health Services Commission to allocate health workers to the counties. Finally, MOH civil servants, seeking to preserve their positions in Nairobi, have tried to limit health worker transfers to CHMTs or health facilities. They fear that certain counties will have poor social services and infrastructure, that they will lose political power outside of Nairobi, and that their work will be subject to greater political interference.

Currently, counties pay salaries for health workers who were seconded to them. However, human resource files remain in Nairobi, and counties are unable to fully manage health workers due to limited information on discipline, training needs, promotions, and retirement. These disputes over health worker supervision have led to delayed salaries and, in some cases, health worker strikes.

The national MOH has also been slow to restructure. Without adequate political will, it is unlikely that MOH headquarters staff will be reassigned to assist

CHMTs or provide health services as originally envisioned.

## Conclusions

The Kenyan health system has undergone significant changes in the last two years. Devolution has radically changed the fabric of procurement, human resources, financing, and governance mechanisms, with more changes yet to come. HPP has worked with a variety of health system actors to shape these new structures, adapt to change, and create space for dialogue. Technical assistance to stakeholders has resulted in concrete outcomes, such as national and county-level plans to respond to the changing environment, policy guidance on health sector devolution, and county-level institutional reform to enable better responses to health challenges.

Devolution is a political process. The future of Kenya's health system relies on negotiation among stakeholders that can operate in this new political environment. HPP's support of these stakeholders to recognize political dynamics, navigate obstacles, and facilitate policy discussions has been, and will continue to be, critical to the future success of health sector devolution.

## Notes

1. The Local Authority Transfer Fund (LATF), Constituency Development Fund (CDF), Constituency Bursary Fund, Constituency Roads Fund, Constituency HIV/AIDS Fund, Rural Electrification Fund, Free Primary Education, Youth Enterprise Development Fund, Women Enterprise Fund, Free Secondary Education Fund, Water Services Trust Fund, National Development Fund for Persons with Disabilities, and the Poverty Eradication Fund.
2. Between 2008 and 2013, there were two ministries of health in Kenya: the Ministry of Public Health and Sanitation and the Ministry of Medical Services. In 2013, these two ministries were merged into a single Ministry of Health.

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