# *Kenya CTAP*
# *Country Specific Health Sector Accountability Report*

CTAP COVID-19 TRANSPARENCY & ACCOUNTABILITY IN AFRICA | SIDAREC | Follow The Money

# Disclaimer

# Table of Contents

# *Table of Contents*

# List of Tables



# List of Figures

# List of Acronyms

| | |
|---|---|
| **AIDS** | Artificial Immune Deficiency Syndrome |
| **ARB** | Administrative Review Board |
| **CGA** | County Government Act |
| **CoB** | Controller of Budget |
| **CODE** | Connected Development |
| **CoG** | Council of Governors |
| **CRF** | County Revenue Fund |
| **DCI** | Directorate of Criminal Investigation |
| **EACC** | Ethics and Anti- Corruption Commission |
| **FBO** | Faith Based Organization |
| **GAVI** | The Vaccine Alliance |
| **GDP** | Gross Domestic Product |
| **GIZ** | Germany Development Agency |
| **HFMC** | Health Facility Management Committee |
| **HIV** | Human Immune deficiency Virus |
| **HPT** | Hyperparathyroidism |
| **HSSF** | Health Sector Services Fund |
| **ICPAK** | Institute of Certified Public Accountants of Kenya |
| **ICT** | Information Communication Technology |
| **IFMS** | Integrated Financial Management System |
| **KEMRI** | Kenya Medical Research Institute |
| **KEMSA** | Kenya Medical Supply Agency |
| **KENAO** | Kenya National Audit Office |
| **KEPH** | Kenya Essential Package for Health |
| **KHP** | Kenya Health Policy |
| **KHSSIP** | Kenya Health Sector Strategic and Investment Plan |
| **KMTC** | Kenya Medical Training College |
| **KNH** | Kenyatta National Hospital |
| **KPFMS** | Kenya's Public Finance Management System |
| **MES** | Medical Equipment Scheme |
| **MT&RH** | Moi Teaching and Referral Hospital |
| **NACC** | National AIDS Control Council |
| **NGO** | Non-Governmental Organization |
| **NHIF** | National Hospital Insurance Fund |
| **OAG** | Office of the Auditor General |
| **OECD** | Organization for Economic Cooperation and Development |
| **PFMA** | Public Finance Management Act |
| **PPA** | Public Audit Act |
| **PPADA** | Public Procurement and Disposal Act |
| **PPE** | Personal Protective Equipment |
| **PPOA** | Public Procurement Oversight Authority |
| **PPRCB** | Public Procurement Regional Competitive Bidding |
| **SAGA** | Semi-Autonomous Government Agencies |
| **SPA** | Special Purpose Account |
| **TB** | Tuberculosis |
| **US$** | United States Dollar |
| **USAID** | United States Agency for International Development |

# *Executive Summary*

**As part of efforts to bolster citizen engagement and promote change in the ways that governments use public resources, and increase the capacity of governments to meet people's needs, Transparency and Accountability in Africa Project (CTAP) through this study aims to evaluate accountability in health sector. The study is keen on evaluating the health sector governance through its different focus on participation of stakeholders and citizens' perception of healthcare in Kenya, health sector financing ,the legal frameworks under which the health sector is supported and opportunities for improvement.**

Commissioned under the Follow The Money (FTM) Initiative that advocates, visualizes and tracks government and international aid funds/spending across communities, the project is one of the many initiatives under Follow the Money and COVID-19 Transparency and Accountability in Africa Project (CTAP) in Africa. The study focuses on Kenya's national government and also the operation of the county government under the provisions of the constitution on health sector's mandates of the two arms of the government. The study documents citizen's and stakeholders' perception of healthcare through feedback from Focus Group Discussion and Key Informant Interviews. The qualitative aspect of the interviews were critical in providing a better context to the literature and presenting the experiences of stakeholders in a systematic way. The study was done via a guided desk research and primary data collection exercise using semi-structured questionnaires which were administered physically for the Focus Group Discussions(FGD) and telephone and online interviews for the Key Informants Interviews. The respondents engaged in the study included: community health workers, health officials, media practitioners, social protection officers, youth leaders, women group leaders ,private sector representations , and CSO representatives.

The findings from the study based on information available on information platforms

and collaborated by respondents participating in the study pointed to inadequacy of information ,poor quality of health care and lack of proper or failure of transparency and accountability measures in the institutional and policy frameworks established as well as in available managing resources. While it is noted there exists institutional and policy frameworks in the health sector to support service delivery, the same is not effective and citizens do not have trust in the systems and are not even aware of some of the measures put in place.
The study also notes that counties continue to struggle with service delivery noting that there continues to be challenges on resources available for basic commodities. As pointed out by the stakeholders including health workers, there is inadequate support from government and counties in provision of favorable working conditions and benefits thus affecting service delivery.

Access to information and citizen participation in key decision making including in the budget making process and decision in their health needs is still a challenge. While this affects all citizens, it has had a bigger impact on the most vulnerable population in the community including the old and people living with special needs. It is therefore critical to have measures in place to help address the challenges to ensure all are able to enjoy their right to health as envisioned in the Constitution.

While the policy and legal frameworks seek to address some of the identified gaps, there still remains a lot of work in implementation of the plans laid out as well as enhancement of systems to avoid loss of resources. Additionally, addressing the healthcare gaps requires multi-sectorial collaboration by different stakeholders with the support and goodwill of the national government. Embracing technology at the different levels will also help enhance service delivery within the health sector. The study outlines recommendations for different stakeholders.

# 1.0 Background of the Survey

**Kenya is a lower middle income country in East Africa with a population of 47.5 million and an estimated household size of five persons based on the 2019 population census. The country is in the middle of a demographic transition, with a still-high birth rate and a reducing mortality rate maintaining a high population growth rate (2.7 per cent per year)[1]. Life expectancy in Kenya in 2016 was estimated at 67.1 years in the year 2022, a 0.39% increase from 2021 up from 51 years in 2004. The high child and youth population bulges present unique opportunities and challenges to the provision of health care[2].**

Overall, Kenya is a resource-poor country that faces significant challenges to provide health services to its population, especially those living in rural and remote areas. It has an average of 16 doctors per 100,000 and 167 nurses per 100,000 as of 2018 which is far below the minimum of 21.7 doctors and 228 nurses per 100,000 people recommended by the World Health Organization (WHO) . Additional constraints to health care provision in Kenya include lack of adequate financing, poor health infrastructure, limited diagnostic resources and unaffordable health services.

On disease burden Kenya has made significant progress towards containing the threat of communicable diseases although prevalence is still significant. The country is, however, grappling with rising prevalence of non-communicable diseases due to changes in life styles and accidents. This combined double burden is projected to further escalate due to environmental changes and rising population, posing new challenges and pressure on the

1. *MOH, 2019. 'Kenya Health Financing Strategy 2020-2030' Nairobi. Government Printers*
2. *https://www.macrotrends.net/countries/KEN/kenya/life-expectancy*

already fragile health care delivery system. The situation is further aggravated by the high cost of medical care for such cases and poverty that result to inability to pay for health services rendered.

## *1.1 Problem Statement*

**In Kenya, it is estimated that 1.5 million people are forced below national poverty line resulting from out of pocket expenditure on health care. Only one quarter of the population is covered by a medical insurance; a situation that is soured by 12% medical inflation rate that is above 9.5% global rate. This implies that access to quality and affordable health services remain a top priority agenda in Kenya. As a priority sector, the health care system receives relatively higher funding from the exchequer and is the leading recipient of funding from donors.** However, a concern on whether these funds reflect to actual health care outcomes is determined by the strength of health governance and accountability system in the sector. The outbreak on COVID-19 exposed the major weaknesses in governance of Kenya health system as billions of funds meant to help contain the disease were embezzled. Recently, newspaper headlines were covered by revelation of stolen medical supplies from Kenya Medical Supply Agency (KEMSA) to a tune of tens of millions of dollars. It's worth noting that a health care system with strong accountability and governance reduce or eliminates misuse of public resources such as those that plague KEMSA. It also helps in improving citizens' trust in the system and enhances provision of better quality services.

One of the effective ways to improve accountability in the sector is to generate information that will guide citizens' and stakeholders' demand for it. Against this backdrop, Connected Development (CODE) through Follow The Money (FTM) commissioned research on Health Sector Accountability (HAS) as part of a larger initiative aimed at strengthening the governance system in the sector. Therefore, the survey is set to establish the status, practice and gaps that expose health care to malpractices.

## *1.2 Objectives of the Survey*

The study aims at achieving the following objectives;

i. Examine the governance of healthcare in Kenya including tiers of responsibility (management, funding and policy), accountability dynamics, and roles of health sector stakeholders.

ii. Assess the features and extent of reforms of the health sector in Kenya while unpacking the nature of political, bureaucratic and political-economy barriers, as well as an appraisal of the nature and extent of corruption in the country's health sector governance.

iii. Interrogate Kenya's health sector's laws, policies, procurement regime and legislative oversight.

iv. Examine health sector financing /general level of public health expenditure including private sector donations and financing at both national and sub-national levels.

v. Interrogate how citizens access healthcare and their perception of quality healthcare as a public good.

vi. Provide coherent recommendations alongside the findings from the above and highlight the possible and feasible interventions that Civil Society can adopt based on the premise that advocacy coalitions are potential candidates for bringing about policy change.

3. *Ministry of Health, The Kenya Harmonized Health Facility Assessment (KHFA) 2018-2019 (2020) https://www.health.go.ke/wp-content/uploads/2020/01/KHFA-2018-19-Popular-version-report-Final-.pdf*
4. *World Bank Databank(2022) https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=KE*

# 2.0 Methodology

The research was largely desk-based research with minimal fieldwork. It entailed doing a thorough review of secondary data and information especially health sector reports and those from oversight bodies including;

- Controller of Budget Annual Reports
- Office of the Auditor General Reports
- Reports from Health Committees of the National Assembly and the Senate
- County Assembly Health Committee Reports
- Council of Governance Reports on Health Care Management
- National Health Legal and Policies Review
- Health Sector Workgroup Reports and Performance Expenditure Reviews by the National Treasury
- COVID-19 Performance Reports
- KEMSA Governance & Management
- Similar Research Health System Accountability
- Other Related Literature

This revealed the trends and patterns in health care expenditure, irregularities in allocation of resources, corruption and effectiveness of services. It also gave insights to initiatives implemented to strengthen accountability and governance; citizen engagement, effectiveness and challenges.

*5. https://www.cdc.gov/globalhealth/countries/kenya/why/default.htm#:~:text=In%20Kenya%2C%20where%20over%2043,HIV%2C%20tuberculosis%2C%20and%20malaria.*
*6. https://www.health.go.ke/wp-content/uploads/2022/01/Kenya-SDG-Progress-Report_-April21.pdf*
*7. Waruru A, Onyango D, Nyagah L, Sila A, Waruiru W, Sava S, et al. (2022) Leading causes of death and high mortality rates in an HIV endemic setting (Kisumu county, Kenya, 2019).*

### *2.1 Field work*

Field survey was carried out in Nairobi where a group of participants were mobilized from different social economic and demographic backgrounds to participate in the field discussions.

### *2.2 Survey Design*

The survey adopted an explorative and participative approach where the views and perspectives of citizens, and stakeholders were captured. Data collection was done using mixed-methods research by collecting qualitative and quantitative data. The choice of this research strategy was informed by the unique nature of the questions that needed to be posed. For instance, expenditure, performance indicators and demographics were measured quantitatively while perception, attitudes and views requiring rich in-depth information were collected qualitatively. Notably, qualitative approaches are expansionist in nature; they recognize and capture complex views of human behavior, political and social-cultural perceptions relating to implementation of publicly funded projects and service delivery in a holistic manner.

### *2.3 Target Population and Sampling*

The sample universe describes the inclusion and exclusion criteria in the survey. The survey included citizens and stakeholders selected based on the following criteria;
Citizens to participate in Focused Group Discussions, the following will be observed;

- Sex; Men and Women 40:60
- Age: Youth, Middle Aged and Old 40:30:30
- Persons with Disabilities.  At least 5%

The approach was compounded by specific consideration given by the CTAP team that directed the selection process. Purposive and snowball sampling was used to reach out to unique participants to broaden understanding.

Participants from the secondary category were based on their position and understanding of the subject matter. Workshop plenary participants were drawn from among the government officials and key stakeholders in the health sector.  These open discussions were semi structured to capture participant's opinion, attitudes and views regarding citizen generated data. They were conducted through note taking and audio recording to comprehensively capture the discussions. The consultant ensured that highest standards of research protocol and ethics were followed to the latter during data collection.

# 3.0 Health Sector Governance

This section presents findings on the structure and governance of healthcare system in Kenya. It includes a discussion on tiers of responsibility (management, funding and policy), accountability dynamics, and roles of health sector stakeholders

### *3.1 Overview*

In Kenya, over 43% of the population lives in poverty, health challenges include high maternal and child mortality, and a high burden of infectious diseases such as HIV, tuberculosis, and malaria . The country's health targets are aligned by those set under Sustainable Development Goal number 3 that aims to ensure healthy lives and promote well-being for all by reducing the burden of priority diseases, reducing mortality and achieving Universal Health Coverage (UHC). A review of SDG progress for the Kenya's health sector in 2019 indicated that the country's maternal mortality ratio of 342 per 100 000 live births, 39.2 under-5 mortality rate per 1 000 live births and 21 neonatal mortality rate per 1 000 live births .

On the general front, Kenya has an overall crude mortality rate of 550/100,000 population. Up to the year 2005, the main contributors to mortality rate in Kenya were Infectious diseases, driven largely by the impact of HIV. However, the last fifteen years have experienced epidemiological transition with non-communicable diseases and injuries claiming the biggest share as the leading causes of death. In the non-communicable category, Cancer is a major Underlying Cause Of Death (UCOD) even in rural settings. Indeed, cancer, pneumonia and malaria were reported as leading COD in Kenya in 2017. On the other hand, hypertension-related complications

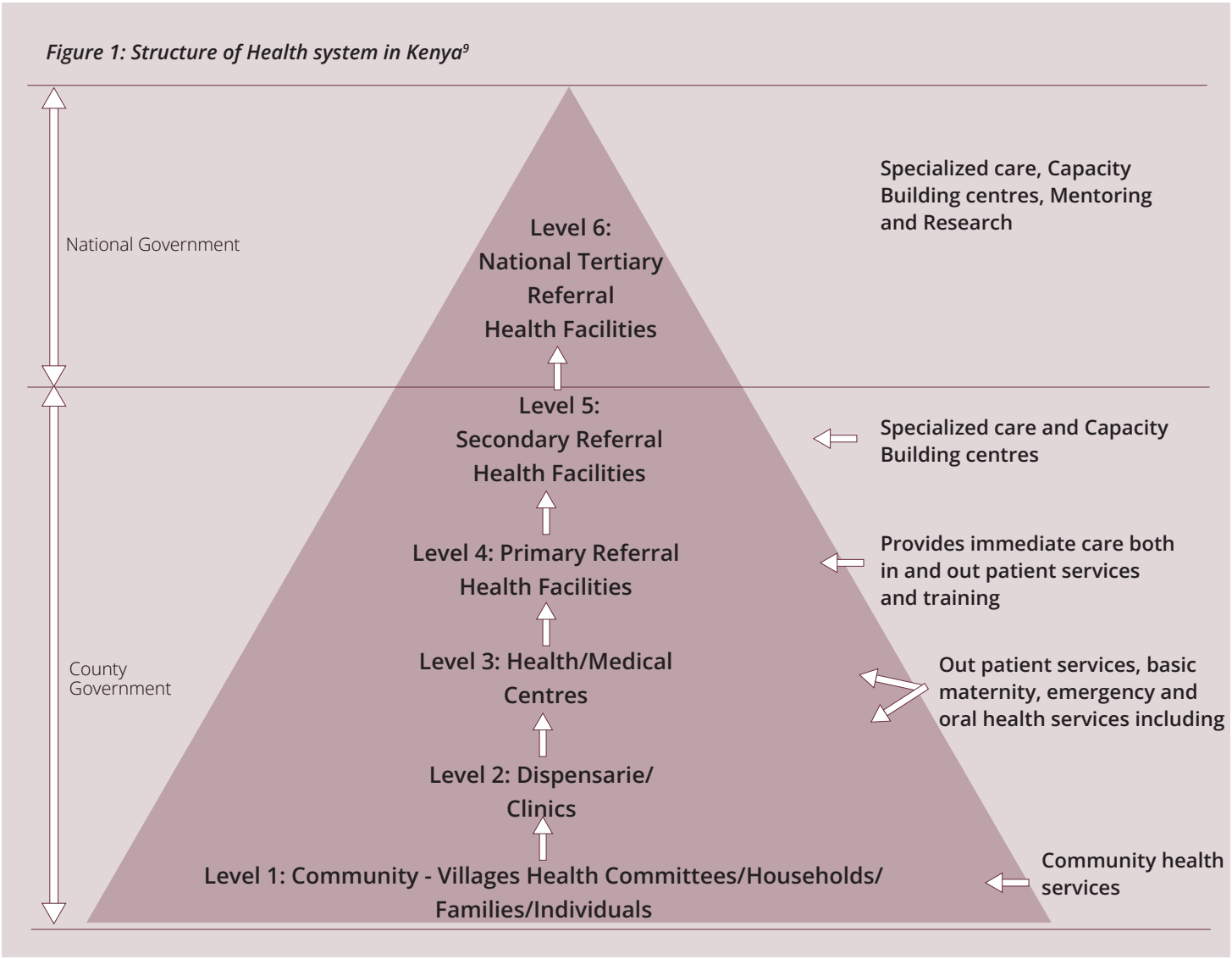
contribute to 50% of hospital admissions and claim an estimated 100,000 lives every year. **The leading recertified UCOD in Kenya are; HIV (11.0%), lower respiratory infections (9.1%), malaria (5.7%), non-HIV related tuberculosis (4.0%), diarrhea diseases (3.9%), prematurity and low birth weight (3.7%), digestive diseases (3.5%) and anemia (3.3%).** Changes in population dynamics, lifestyle and environmental factors in the country have contributed immensely to this epidemiological transition. In such a landscape, Kenya requires a robust health system that addresses both preventive and curative health care needs simultaneously to reduce the country's disease burden to manageable levels. The next section presents an analysis of the health system structure in Kenya.

### *3.2 Structure of Health system in Kenya*

Health system in Kenya follows devolved governance structure established under the Kenya Constitution 2010. The devolved system of government established 47 semi-autonomous Counties and 1 National Government. Under this system, health service function, especially provision of primary health care, was transferred to County government, while policy and regulatory functions were left under the national government . The Fourth Schedule of the Constitution on distribution of functions assigns the National government the role of leadership of health policy development, management of national referral health facilities; capacity building and technical assistance to counties; and consumer protection, including the development of norms, standards and guidelines. On the other hand, the County governments are assigned the responsibility of managing county health services including county health facilities and pharmacies, ambulance services, promotion of primary health care, licensing and control of undertakings that sell food to the public, and cemeteries, funeral parlors and crematoria. The operationalization of this framework was provided for through the enactment of the County Government Act of 2012 and Kenya Health Policy 2014-2030.

Devolving health care was informed by, among others, the need to promote accountability, foster efficiency in delivery of health care and enhance citizen participation in health based policy decisions. Through bringing health care closer to the population, the system aimed at promoting access to health care services to the underserved population in urban slums and remote rural areas. The devolved health system is four tiered - community health services, primary care services, county referral services, and national referral services. The Kenya health policy 2014-2030 that aim at assuring the attainment of highest standards of health in a responsive manner through development of comprehensive health investments, health plans, and service provision within the devolved healthcare system, describes and illustrates the structure of health system as shown in Figure 1 below;

*Figure 1: Structure of Health system in Kenya*[9]




As shown, the Kenya health structure is a six level system with the lowest level as community health services that focus on preventive health through health awareness campaigns. Above community health services are dispensaries and health centers which are designed to be the system first line of contact with the public on curative health care and are the majority. They provide outpatient services for simple ailments such as common cold and flu, uncomplicated malaria and skin conditions. Up in the pyramid, the levels are designed to handle more complicated health cases with level six handling specialized treatment in complex conditions such as neurosurgical and heart operations. The number of facilities reduces as you move up the pyramid but their capacity increases in terms of size, equipment and facilities. For instance, Kenya has five level 6 (referral) health facilities namely- i) Kenyatta National Hospital; ii) Moi Teaching and Referral Hospital; iii) National Spinal Injury Hospital; iv) Mathari National Teaching & Referral Hospital; and v) Kenyatta University Teaching and Referral Hospital) and 11 level 5 facilities. Table 1 further expounds classification of health service in Kenya.

9. https://www.dovepress.com/patients-access-to-medicines--a-critical-review-of-the-healthcare-syst-peer-reviewed-fulltext-article-RMHP

Table 1: Summary of the Levels of Health Service Delivery in Kenya[10]

***Table 1: Summary of the Levels of Health Service Delivery in Kenya[10]***

| Level | Population Served (Max) | Function |
|---|---|---|
| Level 1 – Community Health Unit | 5,000 | Mostly preventive and located at the community level aimed at creating awareness and enhancing participation between communities and health professionals. The level entails encouraging community members to initiate healthy behaviors alongside identifying problems and symptoms to be addressed. |
| Level 2 – Dispensaries/ Clinics | 10,000 (rural) - 15,000 (urban) | Follows community health units and links with health centers at a higher level. They promote both preventive and curative rehabilitative services. They also do micro planning, establish health records, and curative services for minor diseases. |
| Level 3 – Health Centers, Maternities, Nursing Homes | 30,000 – 40,000 | Help in supporting level 2 hospitals through provision of additional support infrastructure to the immediate catchment population of 30,000 to 40,000. They also offer higher level referrals, maternity services, minor surgeries, outpatient; and coordinate information across the health structure. |
| Level 4 –Primary Hospitals | 100,000 (rural) – 200,000 (urban) | They take referrals and provide clinically supportive supervision for level 1-3. Additionally, these facilities offer emergency obstetric care, surgery on impatient basis, oral health, specialize laboratory tests, radiology and oral health services. |
| Level 5 –Secondary Hospitals | 1,000,000 | Besides offering higher level and wide curative treatment services, these facilities have training wings that provide training to nursing and clinical officers. |
| Level 6 –Tertiary Hospitals | Over 1,000,000- National | National level facilities undertake complicated medical procedures, surgeries and scans. They also have training facilities for specialized cadre of health professionals, and conduct a wide range of health research. The catchment for referral hospitals in Kenya extends beyond the country's borders with Kenyatta National Hospital being the largest of its kind in eastern and central Africa. |

10. *Ministry of Health*

### *3.3 Structure of Health Sector Governance in Kenya*

Health sector governance in Kenya is an ecosystem that brings together actors from national and county government, semi-autonomous agencies, non-state actors and citizens. The central mandate of health care provision lies with the National and County government. Besides the non-state actors and citizens, there are eight allied Semi-Autonomous Government Agencies (SAGAs) under the National Health Ministry which complement it in discharging its functions through;[11]

- Health service delivery
- Procurement and distribution of drugs and medical supplies
- Financing under health insurance
- Medical research and training,

These SAGAs and a brief description of their role in the country's health system are as outlined hereunder;

i. The Kenyatta National Hospital (KNH): The largest referral hospital that offers specialized treatment to patients from other lower level hospitals and those from outside the country. KNH also offers medical education and research with the University of Nairobi, and collaborative health research with other health institutions in and outside the country. Additionally, it provides facilities for education and training in nursing and other health and allied professions and participate in national planning and policy formulation.

ii. Moi Teaching and Referral Hospital (MT&RH): Similar to KNH, the mandate of MT&RH is to receive patients on referral from other hospitals and institutions within and outside the country for specialized health care; provide facilities for medical education for Moi University, and for research in collaboration with other health institutions; provide facilities for education and training in nursing and other health and allied professions.

iii. Kenya Medical Training College (KMTC): KMTC is mandated to provide facilities for education in health manpower personnel training; facilitate the development and expansion of opportunities for Kenyans for continuing education in various disciplines of medical training; provide consultancy and technical advice in health related training and research; empower health trainers with the capacity to conduct research, develop usable and relevant health learning materials, and manage health-related training institutions; and provide guidance and leadership for the establishment of constituent training centers and facilities.

iv. Kenya Medical Supplies Agency (KEMSA): The Agency is mandated to procure, offer for sale and supply medicine and medical supplies; establish warehouse facilities for storage, packaging and sales of medicine and medical supplies to health institutions; conduct analysis of medicine and medical supplies to determine their suitability; advice consumers and health providers on cost effective use of medicine.

v. Kenya Medical Research Institute (KEMRI): Mandate of KEMRI includes; conducting research aimed at providing solutions for the reduction of the infectious, parasitic and non-infectious diseases and other causes of ill health in Kenya;

vi. National Hospital Insurance Fund (NHIF): The mandate of the NHIF is to provide accessible, affordable, sustainable and quality social health insurance through effective and efficient utilization of resources to the satisfaction of contributors. The core activities of NHIF include registering and receiving contributions; processing payments to the accredited health providers; carry out regular internal accreditation of health facilities and contract health care providers as agents to facilitate the Health Insurance Scheme.

11. *Health Sector Working Group Report 2014-15 to 2016-17*

vii National AIDS Control Council and the HIV&AIDS Equity Tribunal: NACC is a national coordinating authority for HIV and AIDS and her mandate includes: - Provision of policy and a strategic framework; Mobilization and coordination of resources; Prevention of HIV transmission; and Coordination of care and support for those infected and affected by HIV and AIDS.

***Constitutional structures***

| National Government | Intergovernmental Structures | County Government |
|---|---|---|
| ● Senate<br>● National Assembly<br>● National Executive (Cabinet, Ministry of Health, Health Sector Agencies-National Referral Hospitals<br>● The Judiciary | ● Summit<br>● Council of Governors (COG)<br>● Inter-governmental technical committee (secretariat)<br>● COG Secretariat<br>● Health Sector Consultative Forum Inter-governmental agencies<br>● Inter-county consultative forums (e.g. The regional consultative forums) | ● County Executives ( county executive Committee, County Ministry of Health, County health sector agencies, County Health Facilities, sub-county and community structures |

# 4.0 Health Financing And Fiscal Management In Kenya

### *4.0 Overview*

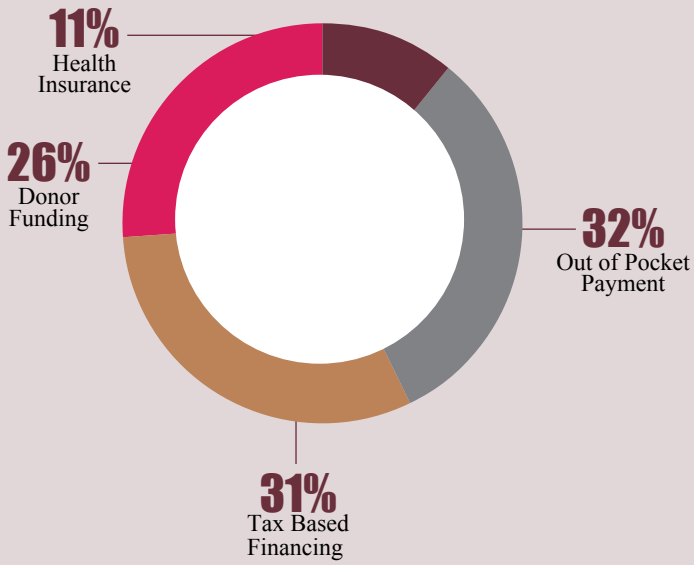
The section appraised the ecosystem of healthcare financing and expenditure in Kenya including private sector, donors and development partners' interventions etc. It considered all forms of expenditure at national and sub-national levels.

### *Health Financing*

Healthcare financing refers to the mobilization, accumulation and allocation of money for the provision of health services to citizens in a health system. Health financing is one of the six building blocks in a health system framework proposed by the World Health Organization (WHO) that also include Health workforce, Vaccines and Technologies, Service Delivery, Medical Products, Leadership and Governance, and, Information . This framework is widely used in health systems globally as it presents the key functions of a health system in a simple manner. As indicated in the health system framework health care, financing is a key input in the provision of quality health care. Financial resources are required for the provision of health facilities, purchase of drugs and health equipment, personnel remuneration and operations and maintenance.

**Health care financing structure in Kenya includes contribution from household out of pocket payment at the point of care, tax based financing, donor funding and health insurance (public and private). On this, household out of pocket contribution account to 32% of healthcare expenditure, tax based financing contributes 31% while donor funding and health insurance contributes 26% and 11% of health expenditure respectively.**

*Figure....Kenya Health Financing by Source*




Out-of-pocket payments (OOP), which comprise the largest proportion of health care expenditure, are direct payments made by individuals to health care providers at the time-of-service use. This subjects most people especially those at the Base of the Pyramid (BoP) to untenable financial hardship due to variation between cost of health and household's ability to pay for health care. Globally, over 100 million people are pushed below poverty line annually as a result of Out of Pocket (OOP) health expenditure[15]. Out of pocket health care payments increase the financial burden of a household especially where households have to borrow funds through social fund raising, liquidating assets or borrowing from financial institutions.

Without a properly designed social protection or health insurance system, the OOP model reduces access to health care, subsequently undermining the realization of Universal Health Care (UHC) and exacerbating health and socioeconomic inequalities. In Kenya, the Demographic Health Survey[16] indicated that health insurance coverage is low with about 17.1% of households reported to be in some form of prepayment health scheme. The survey also established that only 14.6% of women between ages 15–49 years have health insurance. Across income categories, the survey showed that only 3% of the poorest income quintile are covered by a Health insurance scheme compared to 42% in the richest income quintile. On the rural/urban divide, the survey reported that health insurance coverage is higher among the urban population (27%) than the rural population (12%).

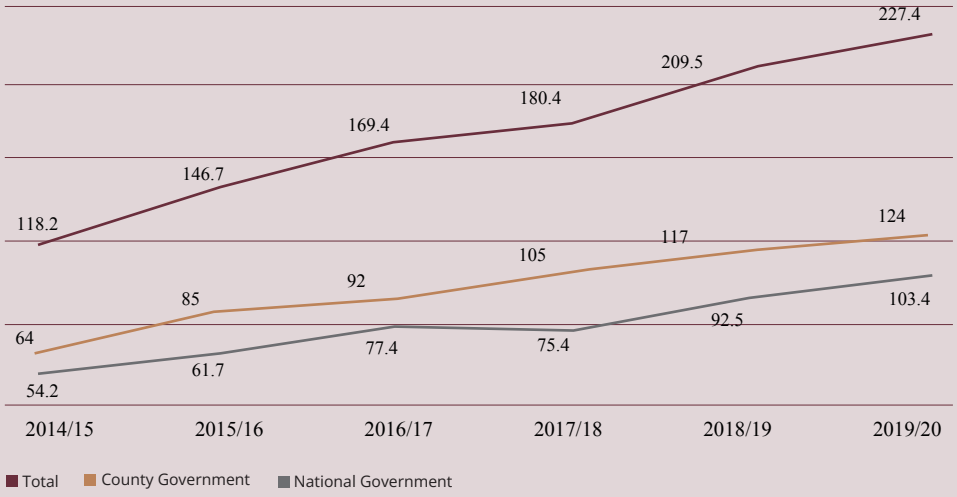
Nonetheless, Kenya is one of the few countries that have implemented mandatory health insurance through the National Hospital Insurance Fund (NHIF) that was established in 1966. Initially, it covered only formal sector employees and their dependents but it was expanded in 1998 to cover informal sector workers as well. NHIF is mandatory for all formal sector employees (public and private) and voluntary for those in the informal sector. Premium contributions are calculated on a graduated income scale for the formal sector and at a fixed rate for the informal sector. Currently, NHIF covers over 4.5 million Kenyans. Private health insurance covers a small proportion (4%) of the population (while) some rural areas have community-based health insurance schemes[17].

### *Government Expenditure on Health*

The trend of healthcare budgetary allocation to the entire sector, national and county government for 6 years preceding 2020 is as shown in figure.

15. https://ieakenya.or.ke/blog/can-people-afford-to-pay-out-of-pocket-for-health-care-in-kenya/
16. Kenya Demographic Health Survey 2014
17. Abuya, T., T. Maina, and J. Chuma. 2015. "Historical Account of the National Health Insurance Formulation in Kenya: Experiences from the Past Decade." BMC Health Services Research 15: 56

*Figure....Budgetary Allocations to the Health Sector (Ksh. Billion)*




*Source: Ministry of Health*

As shown (figure ..), budgetary allocation to the health sector in Kenya has been on an upward trajectory rising from a total of Kshs; 118.2 billion in 2014/15 to Kshs, and 227.4 billion in 2019/20. It's worth noting that the allocation to the health sector in the financial year 2019/20 was revised twice to accommodate the increased expenditure due to the pandemic. Despite the strides made towards increasing allocation to the health sector, the share of budget to national budget stood at 7-9%. The Abuja Declaration of 2001 gave a general guideline for health expenditure where member countries were urged to allocate at least 15% of their national budgets to the health sector. Notably, Kenya is yet to achieve this target allocation to the sector[18].

### *4.1 Kenya Health Financing Strategy*

This is the general framework that will guide health financing trajectories in Kenya. The journey to health sector financing strategy formulation began in 2009 progressing slowly to yield final version in the wake of the year 2020. The strategy aims at ensuring adequacy, efficiency and fairness in financing of health services in a manner that guarantees all Kenyans access to the essential high quality health services that they require. This will be achieved through mobilizing resources to afford the provision of essential health services to all citizens and ensure equity, and ensuring that available health resources are utilized with maximum efficiency to give tax payers value for money. However, before the finalization of the strategy, the government had made some progress on health sector reforms that included; abolishing of all user fees and allocating compensation in public dispensaries and health centers. The government also implemented a free maternity care policy that significantly subsidized access to maternal health care in public facilities. The two interventions called for annual appropriation averaging approximately US$ 60 million from the exchequer.

18. MoH, 2019. "Public Health Expenditure in Kenya: A Comparative Analysis of Nine Deep-Dive Counties" Government Printer. Nairobi

### *4.2 County Health Budget Allocation and Own Collection*

Kenya adopted fiscal decentralization following the promulgation of the 2010 Constitution of Kenya that established devolved units and decentralized health function to Counties. This provided for allocation of a significant portion of health finances to all the Counties. This allocation to all the 47 counties is based on a resource allocation formula that takes seven factors into account; including population, poverty, land share, and others. County allocations are given as block grants and counties determine the share to be allocated to health. County governments also collect some of their own revenue which are included as part of the county budgets before allocation to different sectors.

Analysis of budgetary allocations for national Ministries, Departments and Agencies (MDAs) between financial years 2017/18 and 2021/22 indicated that the health ministry received an average proportion of 5.64%. County health allocation for the year 2020/21 stood at US$ 3.7 billion which represented a proportion of 11.6% of the total national budget. The funds, which consisted US$ 167 million conditional grant meant for leasing medical equipment, compensation for user fees foregone by rural health centers and dispensaries, support level five hospitals, and support Universal Health Coverage (UHC). The allocation short fall of adequate resources required for expansion of health facilities and purchase of supplies which should be factored during budgeting.

**At the county level, the governments allocate an average of 25% of their budget (from the national government and own collection) towards health expenditure that included spending on medical supplies, equipment, structure and facilities, and payment of salaries and wages. A 2019 report by the ministry of health[19] across 9 Countries in Kenya revealed that they allocated an average of 25.8% of their budgets to finance the health budget in FY 2017/18. Nakuru allocated the largest share at 38 percent, and Turkana the least at 11 percent. The survey also noted that the counties had an average budget utilization rate of 91.7% which showed an improvement from the 2017/18 fiscal year's utilization rate of 78 percent. The increase in absorption was attributed to expenditure growth in personal emolument while spending on drugs and related non-pharmaceuticals improved marginally.**

### *4.3 COVID-19 Financing*

Coronavirus or COVID-19 caught the world unprepared. The first case in Kenya was reported on 13 March 2020. Similar to situation across the World, the outbreak ushered in a new and unique challenge in the Kenya's health sector management. The outbreak that threatened the entire health sector called for targeted interventions to contain its spread and take care of rapidly rising infection without compromising conventional healthcare support. Private health insurance firms were quick to declare that they would not pay for healthcare costs related to the pandemic and by November, 2020 National Health Insurance Fund (NHIF) followed suit excluding COVID-19 related illnesses from its cover.

In response to the outbreak, the government introduced a raft of measures including banning all passenger flights, temporary closure of bars, suspension of learning in all education institutions, dusk to dawn curfew, cessation of movement in and out of high-risk areas, among others. These crippled the economic

19. MoH, 2019. "Public Health Expenditure in Kenya: A Comparative Analysis of Nine Deep-Dive Counties" Government Printer. Nairobi

performance yielding far reaching ramifications beyond the health sector. Notably, Kenya's 2020/21 national budget presented to parliament in June of 2020 was prepared at a time when the country was grappling with the health, social economic impacts of the COVID-19 pandemic and containment measures. In the budget, the government reduced expenditure across all the ministries, adjusted its fiscal management through establishing economic stimulus strategies to cushion the economy, and increased health allocation to help in fighting the spread and managing COVID-19 cases. Health sector faced unprecedented strain resulting from limited availability of equipment, testing kits, Personal Protective Equipment (PPEs), ventilators, and oxygen among others. There were other related challenges that included availability of water and sanitation services as well as overcrowding in urban slums that were classified as hotspot areas for spread of the virus[20].

**Government's response to the health emergency entailed creation of COVID-19 contingency plan to support early detection and response preparedness. The plan was cost at US$ 82 million, 61% of which came from the World Bank Financing. One month after the pandemic was reported, the International Monetary Fund (IMF), under the Rapid Credit Facility approved the disbursement of US$ 739 million to Kenya to enable the government bridge the country's urgent balance of payment needs. COVID-19 Surveillance was included in the second supplementary budget estimates for the 2019/20 financial year to facilitate emergency response.**

*20. https://devinit.org/resources/kenyas-covid-19-budget-funding-for-health-and-welfare/*

# 5.0 Accountability In The Health Sector

Accountability in the health sector is an ethical principle of good governance that requires government institutions and public officers governing the health sector to proactively take responsibility for explaining their policy focus, decisions, commitment and performance. It requires visible responsive action if standards and commitments are not met. The government should proactively explain to its citizenry the causes of actions relating to financial utilization, hiring of health workforce, procurement of medical supplies and equipment among others. Accountability in the health sector comprises public participation and establishment of oversight institutions.

### *5.1 Public Participation*

Health accountability system in Kenya is anchored in the country's 2010 Constitution that requires the government to ensure access to the highest attainable standards of health to all while ensuring a health system is people-driven and rights–based. The Constitution under article 10 underscores public participation as the key pillar of accountability in the governance system. Further, the Constitution is cognizant of the fact that decentralization of the governance system was meant to promote community participation and accountability, and enhance technical efficiency and equity in the management of public resources including health, which is largely devolved. Article 174(c) of the Constitution notes that devolution serves to *"enhance the participation of people in the exercise of the powers of the State and in making decisions affecting them."*

### *5.2 Accountability through Representation*

Health, just like all other public sectors, is required to provide explanations on demand or part of regular reporting to parliament, (i.e. Senate, National Assembly) or County Assemblies. Through respective health committees, parliament and county assemblies

are required to conduct investigations into particularly important aspects of health policy, expenditure and administration .

### *5.3 Oversight Institutions*

The 2010 Constitution of Kenya established a legal framework to ensure accountability, transparency and efficiency in utilization of public resources. Under chapter six on leadership and integrity, the constitution calls for legislation to establish the Ethics and Anti-Corruption Commission (EACC) under Article 79, while Articles 228 and 229 established the offices of Controller of Budget and Auditor General respectively as independent finance officers. These three organs form the oversight institutional framework that is meant to promote accountability in utilization of public resources.

### *5.4 Health Sector Political-Economy and Bureaucratic barriers*

The health sector was the largest service sector to be devolved under the new constitutional dispensation in Kenya. The overarching aim was to bring healthcare closer to the people, enhance transparency and social accountability in management of the sector. A reflection back to the 10year journey revealed that though great strides have been made to establish structure, policy and legal framework, the transition is still married with significant governance challenges that affected the sector's efficiency. These include;

i. The health sector at the county level suffers from inadequate capacity in terms of human, equipment and supplies.

ii. Delays in disbursement of funds from National treasury to the counties leading to accumulation of pending bills and increased number of stalled projects.

iii. KEMSA monopoly (KEMSA Act, 2013) to supply drugs, medical equipment and kits to all the 47 counties. County governments are not allowed to procure drugs and medical supplies from suppliers other than the Authority. This has led to delays in numerous cases that cause shortages of supplies in county hospitals.

iv. Failure of counties to meet their part of bargain on salaries and welfare of health workers leading to regular strikes that affect service delivery.

v. Conflict between national and county government, transfer of functions from the national government to county governments, and resource allocation to counties as provided for in the 2010 constitution are core to the implementation of functions such as healthcare. However, there is regular conflict with the national government appearing to insubordinate or frustrate implementation of devolved functions.

vi. Lack of adequate critical legal framework and institutional infrastructure.

vii. Cronyism and nepotism affect efficiency of county health operations. There are numerous cited cases of favoritism in job promotion, transfers, and political interference over health worker management and disruptions in salaries payment. Ineffective negotiation and conflict resolution mechanism as manifested by the 2014 Council of Governors's (CoG) failure to resolve health workers' grievances and agree on a return to work arrangement; instead, made a joint political decision to lay off all striking workers within their counties.

### *5.5 Nature and Extent of Corruption in Health Sector Governance*

Health sector in Kenya has been characterized with accountability challenges resulting in loss of hundreds of millions of shillings both at national and county level. This is manifested by the frequent street demonstrations by health practitioners pushing for salary payments and protesting ill governance, corruption and poor service delivery. Such was the case that informed the 2017 suspension of approximately US$ 21 million meant to support the health sector by the US government. While announcing the suspension, the U.S ambassador to Kenya noted that the measure was in response to the increasing concerns of corruption and weak accounting procedures within the ministry.

### *5.5.1 Irregular Expenditure/Procurement*

A review of the Auditor General reports revealed that the health sector at the national and county levels are marred with questionable expenditures year in year out. Much of this irregular expenditure occurs under procurement and allowances. Table 2 presents an analysis of questionable expenditures from four counties according to the Auditor General Report

*Table 2: Questionable Health Expenditures in four Counties*

| County | Flagged health expenditure amount (Ksh.) millions per FY | | |
|---|---|---|---|
| | 2016/17 | 2017/18 | 2018/19 |
| Nairobi | 819.70 | 1,718.10 | 1244.00 |
| Mombasa | 398.00 | 381.00 | - |
| Kakamega | 227.00 | 153.00 | 247.80 |
| Kirinyaga | 174.60 | 171.20 | 146.10 |

**Management of COVID-19 allocations and donations exposed major systemic weaknesses in the country's health sector. According to the EACC, US$ 78 million was irregularly spent while procuring supply of COVID-19 equipment and medical supplies by the Kenya Medical Supplies Authority (KEMSA). The Commission questioned the procedure used in procuring these supplies noting that most procured items were of low quality and inflated prices. Indeed, it was observed that despite heavy expenditure on COVID-19 emergency supplies, medical practitioners were protesting over low pay and poor quality protective equipment. A report by the Public Procurement Regulatory Authority noted that Paracetamol tablets sold at 40 shillings per pack were bought for 66.50 shillings during the pandemic, while alcohol-based sanitizers priced at 313 shillings were purchased at 495 shillings.**[22] Other notable procurement irregularities included the fact that tenders were retrospectively negotiated and evaluated after the deliveries, while some of the negotiated prices were not as high as proposed prices.

### *5.5.2 Inadequate Public Participation*

Adequate public participation remains a significant social accountability concern in the health sector. While it is required that all governance decisions be first subjected to public participation, a report on influence of governance and corruption in health sector[23] observed that only a predetermined number of selected people were invited to the meetings and were paid to approve, without questioning, every proposal in the meetings. Issues raised by the citizens during the meetings were never treated with the urgency and priority they deserve. Further, time that was allocated for the whole process was hardly enough to read through and understand the complexity that came with legislation or budgeting. The booklets were also written in English, which is a language not understood by the majority of citizens. A number of health policy interventions in Kenya are largely driven by policymakers with very little public participation. One such example is the Medical Equipment Scheme (MES) 7 which was designed and executed by the National Government and had very little participation by the counties and the public in general. This has

22. https://www.reuters.com/article/uk-kenya-corruption-idAFKCN26F3C8
23. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-08975-0

resulted in very low utilization of the leased equipment largely due to lack of required infrastructure and human resource[24].

### *5.5.3 Access to Information*

Closely related to public participation is the access to information on health system governance and the extent to which the system is structured towards ensuring the realization of the highest attainable health standards including ensuring equitable, affordable and quality health care for all citizens is not properly enforced.[25] Article 35 of the Constitution for Kenya (2010) and the Access to information Act (2016) provide for the right of public access to information. It is important to note that the key information about health financing including budgetary allocation, disbursements and expenditure is imperative to citizens if they have to hold duty bearers to account on how they utilize public resources. Such kind of information however is limited to the public. For instance, most counties do not post information pertaining to budgets, allocations, disbursements and expenditures on their websites.

Lack of timely information impairs effective public participation. The accounting and reporting on healthcare spending by the government (National and County levels) has always fallen short of the set standards as reported by the Auditor General. Promotion of social participation is a key driver of health equity because it supports governance mechanisms that provide opportunities for greater health equality: raising awareness and recognition of the rights of groups with the highest level of health disadvantage; transforming vulnerable groups into agents and protagonists of the policies and Programmes that affect them; producing new collective knowledge that challenges dominant narratives; promoting coherence, responsiveness, transparency and the rule of law; facilitating the implementation and evaluation of strategies, Programmes and activities; and promoting population consciousness of the private sector strategies used to promote products and choices that are detrimental to health.[26]

### *5.5.4 Resources Access and Utilization*

As a largely decentralized function, the health sector lines up for devolved funds from the national government. However, the allocation to county and from county to health sector has not been sufficient to meet its budgetary requirements. On the other hand, the sector is characterized by underutilization of county health budgets due to limited capacity to intensify and expand the depth and scope of resource utilization monitoring

### *5.5.5 Disruptions, Delays, and Discrepancies in Payments of Health Workers' Salaries*

County governments were given the mandate to process and pay health workers salaries. However, this is characterized by several challenges including general delays in salary payments, payroll discrepancies and missing allowances; and some staff missing from the payroll altogether.

24. https://actionfortransparency.org/wp-content/uploads/2020/05/Transparency-and-Accountability-in-Kenyas-Health-Financing-Models.pdf
25. Masaba, B.B. et al. 2020." Devolution of healthcare system in Kenya: progress and challenges" Public Health, Volume 189, Pages 135-140
26. https://apps.who.int/iris/bitstream/handle/10665/324909/9789289054126-eng.pdf?sequence=1&isAllowed=y

# 6.0 Health Sector Legislative Framework

### *6.1 Overview*

This section appraised operations of legislative oversight and procurement regime regarding the healthcare sector at both national and sub-national levels. The section also gives an analysis of key legislations that underpin the health sector and their importance and also limitations. The interest is on legislative responsibility/oversight and procurement practices in delivery of quality healthcare in the country and if there's an opportunity to build our advocacy on such.

***Critical Laws Governing the Health Sector in Kenya***

| S/N | Legislation | Critical provisions | Impact | Limit/Delimit |
|---|---|---|---|---|
| 1 | The Constitution of Kenya | Section 43(1)(a) (The Fourth Schedule of the Constitution of Kenya, 2010). -Article 2 | Explicitly provides for the right to healthcare services and reproductive care, as well as the highest attainable standard of health, Distribution of functions between the national and county governments. National health referral facilities fall within the ambit of the national government and the county government is responsible for county health services | The constitutional provisions have helped develop jurisprudence on the right to health. There is however much to be achieved especially under Fourth Schedule of the Constitution to help address devolution, public finance management and access to information. |

| S/N | Legislation | Critical provisions | Impact | Limit/Delimit |
|---|---|---|---|---|
| 2 | Public Finance Management Legal Framework (PFMA, 2012)<br>● Supplementary budget<br>● National budget, division of revenue and budget appropriation laws<br>● County Governments Act, 2012 | Chapter 12 of the Constitution Article 204(1) read with Article 204(3) | To provide for additional resources before the next budget cycle making provision for resources<br><br>Counties to develop sectoral plans | There are demerits emanating from challenges in this stage of planning for resources that eventually affect provision of health services including inadequate resources, delays in disbursement of resources etc. A lot of opportunities in monitoring of budget, resource allocation, and expenditure. |
| 3 | Public Health Act | General Provisions | Guarantees the public's right to health including the prevention and suppression of infectious and communicable diseases<br><br>Also provides for Restrictions of Movement, Prevention and Control; | Poor regulation has led to some consequences such as medical malpractices and negligence; low health standards, corruption etc. Transparency and accountability gaps need to be addressed to enhance service delivery |
| 4 | Kenya Health Financing Strategy 2020-2030 | General Provisions | Ensure adequacy, efficiency and fairness in financing of health services in a manner that guarantees all Kenyans access to the essential high quality health services that they need. | Increased focus on health as well as funding by the government. Focus on the gaps. |
| 5 | The Health Act, 2017<br>&<br>Intergovernmental Relations Act, 2012 (provides a framework for the relationship between county and national governments (Republic of Kenya, 2012c). | Fleshing out the right to health as provided for in Article 43 of the Constitution of Kenya | It formalizes collaboration between national and county governments, obliges Kenya to address the health needs of vulnerable groups, and mandates the provision of emergency and specialized care including free maternity care, vaccinations for children under age five, and workplace breastfeeding facilities. | The journey to devolution has been a difficult one with few challenges including lack of appreciation by national government–: The consultative aspect, especially on matters finance has affected the operation of the counties as there are delays in disbursement of resources thus affecting operations at that level<br>There are also significant capacity gaps within county political and management structures and lack of accountability mechanisms allowing abuse and misappropriation of fund[27] |

27. *Global Corruption Report (2006)*

| S/N | Legislation | Critical provisions | Impact | Limit/Delimit |
|---|---|---|---|---|
| 6 | Kenya Health Policy (2014–2030) | Provides for Key components of a well-functioning health system: (I) leadership and governance; (ii) service delivery; (iii) health system financing; (iv) health workforce; (v) medical products, vaccines and technologies; and (vi) health information systems and health research. | To guide the transformation in the health sector include addressing the following constraints seen in the health sector: decline in health sector expenditure, inefficient utilization of resources, centralized decision-making, inequitable management information systems, outdated health laws, inadequate management skills at the district level, worsening poverty levels, increasing burden of disease, and rapid population growth | Despite the provisions, some of the areas are yet to have significant improvements and achievements. Advocacy on these areas to push for achievement of target within the period. |
| 7 | The NHIF(Amendment) Act 2022 | General Provisions | Supports social protection reforms for the poor and vulnerable. | Increased access to services. Regressive contributory mechanism for the informal sector<br>However, there are concerns on some of the proposals including implementation and financing due to lack of systems to address the provisions. |
| 8 | Kenya Medical Supplies Authority Act (Republic of Kenya, 2013a), | | Enacted to make provisions for the establishment of the Kenya Medical Supplies Authority and for connected purposes. | There has been concerns around management of the entity emanating from misappropriation of resources leading to calls for disbandment. Enhance Transparency and accountability in running of roles as provided. |
| 9 | The Pandemic Response and Management Bill, 2020<br>&<br>Ministry of Health COVID-19 Protocols and Guidelines | General Provisions | Act of Parliament to provide: a legal framework for a coordinated response and management of activities during a pandemic; temporary measures and relief during a pandemic | Critical during the COVID-19 period. Would it be applicable under a different emergency? |

### *6.2 Procurement in Public Sector*

It is noteworthy that procurement is one of the concepts that have vast variations in definition. However, the Procurement Code of Maricopa County, Arizona (Article 1, Section 1-101-83) defines procurement as buying, purchasing, renting, leasing or otherwise acquiring any information, Materials, Services or Construction. It also includes all functions that pertain to the obtaining of any Material, Service, or Construction, including description of requirements, selection and Solicitation of sources, preparation and Award of Contract, and all phases of Contract administration.[28] This definition therefore covers the broad spectrum of activities and responsibilities related to procurement including HPTs. Procurement means the acquisition by purchase, rental, lease, hire purchase, license, tenancy, franchise, or by any other contractual means of any type of works, assets, services or goods including livestock or any combination and includes advisory, planning and processing in the supply chain system.[29]

Public procurement refers to the purchase by governments and state-owned enterprises of goods, services and works. As public procurement accounts for a substantial portion of the taxpayers' money, governments are expected to carry it out efficiently and with high standards of conduct in order to ensure high quality of service delivery and safeguard the public interest.[30] Procurement is a key component of Kenya's Public Finance Management System. Article 201 of the Constitution of Kenya 2010 provides for openness and accountability including public participation in financial matters. Article 227 of the Constitution 2010 provides that when a state organ or any other public entity contracts for goods / service, it shall do so in accordance with a system that is fair equitable, transparent competitive and cost effective

In Kenya, procurement in the health sector is carried out within the confines of applicable laws, policies, regulations and good procurement practices as provided for in the Public Procurement and Disposal (PPAD) Act 2015 and PPAD Regulations 2020 to ensure transparency, accountability and efficiency of its processes. The process can be done at three levels;

- National
- County
- Facility/organization

KEMSA is the national procuring entity for HPTs in the public sector as provided for in the KEMSA Act 2013 and in the Health Acts amendments for May 2019.

#### *6.2.1 Procurement Process*

This entails a series of essential steps on how to get products or services. They include;

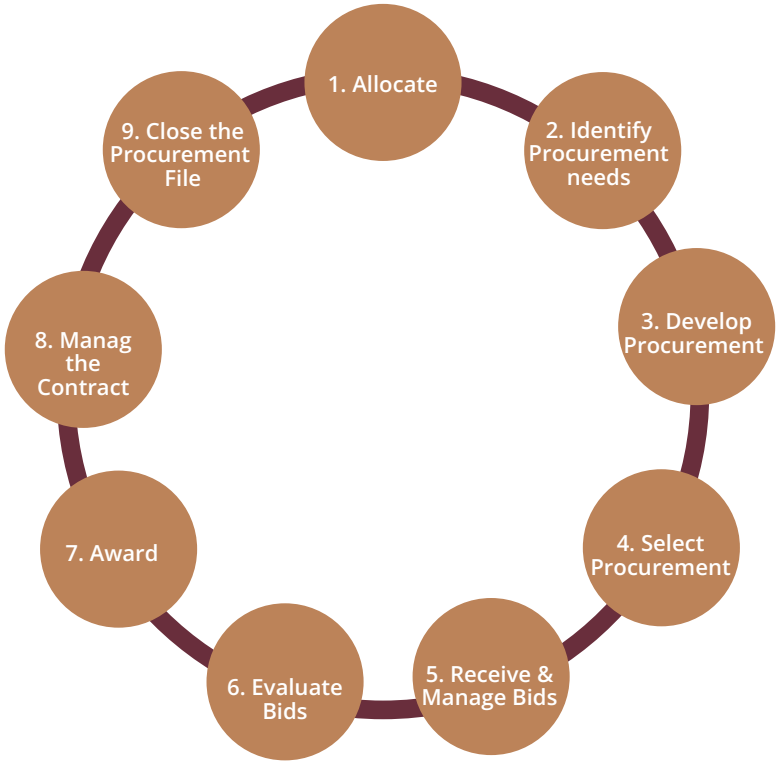
1. Needs Recognition
2. Purchase Requisition
3. Requisition Review
4. Solicitation Process
5. Evaluation and Contract
6. Order Management
7. Invoice Approvals and Disputes
8. Record Keeping

#### *6.2.2 Procurement Cycle*

The procurement cycle is a multi-layered process that involves all the elements related to purchasing from vendor selection and strategic vetting to contract negotiation and the purchase of goods and services. It is therefore a cyclic process that saves time and money, optimizes pricing and reduces delivery time. The nine steps are presented in the flowchart below;

28. *(http://www.maricopa.gov/materials/p-code/HTML_code/Code01.htm)*
29. *Section 2 of the PPADA 2015*
30. *OECD definition of public procurement accessed at https://www.oecd.org/gov/public-procurement/*

*Figure 2: Public Procurement Process in Kenya*




### *6.2.3 Principles of Procurement*

[31]There are certain fundamental principles that guide procurement processes. In the realm of the public sector, they guide the public servants and duty bearers to account on how effective and meaningful they are.

1. **Value for money:** the procurement process must be both efficient and economical. If need be, cost-benefit analyses and risk assessments must be conducted to ensure goods and services are obtained at an optimal cost but greater quality and durability.

2. **Fairness:** objective assessment of all bids and impartial treatment of individuals or organizations that meet the prescribed criteria must be strictly adhered to.

3. **Competition:** Organizations should seek competitive bids from multiple suppliers unless there are specific reasons not to do so. Single sourcing should only happen when goods or services can only be available from a single supplier.

4. **Efficiency:** Procurement processes must be carried out efficiently to help maximize value and avoid delays.

5. **Transparency:** Access to procurement information to both the suppliers and public is imperative. Information to be treated in confidence must be validated through a court order or legal prohibitions.

6. **Integrity:** Those who practice public procurement should always strive to be perceived as trustworthy, reliable, honest and responsible. Funds must be used for their intended purpose and in the interest of the public.

7. **Accountability:** People involved in the procurement process are accountable for their actions and decisions. They are required to report procurement activities accurately, including any errors.

### *6.2.4 Legal Framework of Public Procurement in Kenya*

1. **The Constitution of Kenya 2010**
   Article 227(1) of the Constitution expressly provides that when a state organ or any other public entity contracts for goods or services, it shall do so in accordance with a

31. https://www.netsuite.com/portal/resource/articles/accounting/procurement.shtml

system that is fair, equitable, transparent, competitive, and cost-effective.

2. **The Public Procurement and Disposal Act 2015**
   This is an Act of Parliament which gives effect to Article 227 of the Constitution. It is the primary legislation governing public procurement and asset disposal. The Act provides for guiding principles of public procurement and Asset disposal in line with the Constitution of Kenya 2010.

3. **The Public Procurement and Disposal Act Rules 2020**
   The purpose of the regulations is to give effect to the implementation of the Public Procurement and Disposal Act 2015 and for connected purposes.

4. **The Public Finance Management Act 2012**
   This is an Act of Parliament to provide for the effective management of public finances by the national and county governments, including Parliament and County Assemblies in conducting their oversight roles.

   The Act places responsibility on accounting officers for the proper and efficient management of finances both at the National and County Government entities. Furthermore, the said sections place responsibility on accounting officers to ensure procurement practices are according to the Law, whilst ensuring Value for Money.

5. **Executive Order no 2 of 2018**
   This is a directive which mandates all public entities to maintain and continuously update and publicize (through the websites of the Public Procuring entity, citizens, Public Procurement Regulatory Authority platforms, public notice boards) complete procurement information.

6. **Chapter 12, Part 6, Article 229 of the Constitution of Kenya 2010** establishes the Office of the Auditor General whose mandate is to offer financial oversight on all public finances.

### *6.2.5 Problem in Health Sector Procurement*

Each year, governments around the world spend significant sums of public funds on health-related contracts for everything from medicines to major infrastructure projects such as hospitals. Given the vast sums of money committed to procurement by the State, it is not surprising that the Organization for Economic Co-Operation and Development (OECD) cites procurement as government's greatest corruption risk. In 57 per cent of the 427 bribery cases concluded under the OECD Anti-Bribery Convention, bribes were paid to win public contracts.3 Ensuring effective procurement processes can result in high-quality and cost-effective products being purchased in the correct volume, at the right time, at the right price, and in alignment with health needs. This is crucial to provide citizens with access to essential, affordable and quality healthcare.

**The procurement process is one of the largest corruption risks for the health sector. Estimates suggest that 10% to 25% of global spending on public medicine procurement is lost to corruption. When procurement goes wrong, the quality of health services decreases, and in many countries, citizens end up paying for their healthcare out-of-pocket. Corruption in healthcare procurement can result in medicines shortages, inflated drug prices and theinfiltration of falsified and substandard medicines into the health system.**

Corruption in public procurement takes place when officials collude with suppliers and contractors and break the law for their own personal interests. Both small and larger procurements can be exposed to corruption, and it can take place at any stage of the procurement cycle. During the pre-tendering and tendering phases, officials or political representatives may favor preferred bidders in exchange for bribes. During contract implementation, officials and representatives may demand bribes in order to approve time extensions or defective work.

### *6.2.6 Oversight Institutions and their Effectiveness in Enhancing Public Procurement in the Health Sector*

Health care is one of the economic sectors in all countries, and procurement of medicines and other essential commodities necessarily creates economic linkages between a country's health sector and its overall contribution to the GDP growth. Procurement in this sector is therefore crucial as it determines whether populations are able to access quality healthcare services that would in turn lead to a productive nation.

[32] A report by OECD has identified procurement as one of the government activities that are vulnerable to corruption. This is due to the fact that the volume of transactions and financial stakes are high, and the process is complex as well. In most OECD countries, conflict of interest in decision making undermines the allocation of resources through the procurement process and exacerbates the scourge of corruption.

There are many reasons to carry out performance audits on public procurement. Due to the great financial value of the procurement and the risks involved, an effective procurement system plays a strategic role in avoiding mismanagement and waste of public funds. Among the costs of corruption identified in the report include distortion of competition, limited market access and reduced business appetite for foreign investors. To create an enabling business environment, there is a need for various reforms in the procurement processes to restore the principles of transparency, efficiency and fairness.

In Kenya, oversight and control constitute the fundamental foundation for effective integrity systems in the public sector and procurement processes. Internal control ensures the efficient fulfillment of a public procurement process while safeguarding integrity-related goals and objectives. Oversight also verifies whether legal, administrative and financial procedures are followed and include financial controls, internal audit and management controls.

The Public Procurement and Disposal Act 2015 establishes the Public Procurement Regulatory Authority whose among other functions is to monitor, assess and review the public procurement and Asset Disposal system to ensure they respect the National values and other provisions including Article 227 of the constitution on public procurement. Section 9 of the PPADA 2015 confers the PPRA the following functions, which include but not limited to monitoring the public procurement system; reporting on the overall functioning of it; presenting to the Cabinet Secretary and the county executive member for finance in each county, such other reports and recommendations for improvements; preparing issuing and publicizing standard public procurement and asset disposal documents and formats to be used by public entities and other stakeholders; Providing advice and technical support upon request; investigating and acting on complaints received on procurement and asset disposal proceedings from procuring entities, tenderers, contractors or the general public that are not subject of administrative review; and researching on the public procurement and asset disposal system and any developments arising from the same.

Article 157 of the Constitution of Kenya 2010 establishes the Office of the Director of Public Prosecutions. The Ethics and Anti-Corruption Commission (EACC) is a public body established under Section 3 (1) of the Ethics and Anti-Corruption Commission Act, 2011, pursuant to Article 79 of the Constitution of Kenya 2010. Article 79 provides that Parliament shall enact legislation to establish an independent ethics and anti-corruption commission, which shall be and have the status and powers of a commission under Chapter Fifteen, for purposes of ensuring compliance with, and enforcement of, the provisions of this Chapter.

In Kenya, the Supreme Audit institution is the Office of the Auditor General. The Office of the Auditor General is an independent institution established under Art 229 of the COK. Article 248 (3) expressly states that the Office of the

32. *https://www.oecd.org/gov/ethics/Corruption-Public-Procurement-Brochure.pdf*

Auditor General is an independent office under the COK. Furthermore, Section 4 of the Public Audit Act 2015 establishes the Office of the Auditor General. Section 10 of the Act provides that the Auditor General hereinafter referred to as OAG shall not be subject to direction or control by any person or Authority in carrying out his functions under the COK or the Act.
In the health sector, the government has embarked on a program of Universal Healthcare Coverage as one of the Big Four Agenda items. UHC is an important pillar with the aim of transforming the country's health sector for enhanced service delivery. This implementation brings together different players undertaking different roles within the value chain to ensure that all citizens have access to safe, effective, quality essential health care services, including affordable essential medicines and vaccines without suffering catastrophic expenditure. To guide the achievement of UHC, the government of Kenya released the Kenya Universal Health Coverage Policy 2020 – 2030 which gives direction towards ensuring significant improvement in the overall status of health in Kenya in line with the Big Four Agenda, the Constitution of Kenya 2010, Kenya Health Policy 2014-2030, Kenya Vision 2030, regional and global commitments. It demonstrates the health sector's commitment under the Government's stewardship to ensure that the country implements health plans in a manner responsive to the needs of the population. However, it is devastating to note that when COVID-19 pandemic struck, the government spent a lot of resources in containing and mitigating the risks of the disease. There were various reports pointing out that public resources were lost due to non-compliance with procurement guidelines.

### *6.2.7 Procurement Irregularities; Case study of COVID-19 Pandemic Procurement in Kenya*

Even before the COVID-19 pandemic, there were pre-existing challenges that have faced public contracting systems for many years, with governments struggling with low levels of transparency, digitization, and coordination[33]. The public sector is one of the victims of lack of transparency in procurement, due to political interference in procurement and demand for bribes from technical staff responsible for procurement and management of contracts. A lack of transparency results in a distorted playing field, where some players engage in illicit activities to do business, to the detriment of others. Emergency medical procurement is even riskier due to rushed processes, complex requirements, sole sourcing, prepayment, and a general lack of scrutiny. The COVID-19 pandemic required an unprecedented public health response, with governments dedicating massive amounts of resources to their health systems at extraordinary speed. KEMSA is one of the legal entities at the heart of procurement in Kenya. Sadly, it has been shrouded with incessant allegations of violation of procurement processes and other attendant laws.

The Health Act, 2017 requires that the procurement of HPT for public health services be undertaken in line with the Public Procurement and Asset Disposal (PPADA) Act No. 33 of 2015 and agreed intergovernmental arrangements. Similarly, KEMSA Act, 2013, KEMSA has the mandate for procuring, warehousing, and distributing essential medicines and medical supplies in Kenya. It also provides guidance for procurement of health products for the public sector both at the National and county levels. This implies that KEMSA has a big role to play in ensuring successful implementation of the UHC guided by the aforementioned principles of procurement.

The Parliament of Kenya through the various Standing Committees has an oversight role in collaboration with other oversight institutions to ensure prudence in the utilization of public resources. The Public Investment Committee as mandated by the Standing Order 206 of the National Assembly examines the working of public investments with a particular focus on financial oversight on the use of appropriated public funds.[34] The Public Investment Committee's Report of COVID-19 Fund by KEMSA put the Authority on the spot following reports of alleged malpractices. Owing to the devastating

33. https://ti-health.org/improving-covid19-procurement-to-increase-equitable-access-medicines-medical-equipment/
34. http://www.parliament.go.ke/sites/default/files/2021-09/PIC%20report%20on%20utilization%20of%20covid%2019%20fund.pdf

effects of the pandemic and its impact on the healthcare systems in Kenya, allegations of malpractices invited public interest and the Special Audit Report by the office of the Auditor General was submitted to the House on 1st October 2020. It formed the basis for PIC inquiry. The elements that were interrogated included;

1. Adherence to the Public Procurement and Asset Disposal Act, 2015 (PPADA, 2015) by KEMSA in the procurement of medical supplies for purposes of combating the COVID-19 pandemic;

2. Adherence to the Public Finance Management Act, 2012 (PFMA, 2012) by KEMSA in the procurement of medical supplies; and

3. Value for Money in the procurement of medical supplies for purposes of combating the COVID-19 pandemic.

The outcome of the report indicated that there was lack of consistency in the procurement processes that led to irregular procurement of items amounting to over 8 billion shillings. Payment to suppliers also showed a skewed pattern. Other issues of concern included procuring COVID-19 facemasks at a higher price than what other entities were buying at the same period. These brazen violations were committed by KEMSA despite the existing procurement guidelines and policies. They eventually led to loss of public funds and compromised the service delivery in the health sector. This was also experienced at the county level where it was established by the Auditor General that counties lacked the capacity to fully implement the Public Procurement and Disposal Act 2015 in emergency procurement. This was highlighted by the Auditor General in the Special Audit Report on Utilization of COVID-19 Funds by the County Governments, where it was widely noted that amongst the 47 counties in the Republic of Kenya there were widespread procurement irregularities, inclusive of absence of approved work plans, procurement plans and training plans for COVID-19 appropriation activities. To decisively deal with the problem, the Special Audit Report recommended as follows'

i. The DCI and EACC to conduct further investigations and ascertain the criminality on procurement process for COVID-19 related items and those found culpable to face the full force of the law

ii. The management of KEMSA to halt any processing of COVID-19 related claims until an independent audit is carried out to confirm the legitimacy and veracity of such claims

iii. KEMSA to overhaul its business model that failed to ensure the principles of procurement such as transparency, efficiency and prudence are upheld.

iv. Individuals or organizations that perpetrated the misappropriations as highlighted in the Audit report to face the law as provided for.

These findings point to the gross violation of Section 68(1) of the PFMA 2012 on procurement by irregular utilization of UHC and capital budget.

### *6.2.8 Challenges with Kenya's Control systems*

A study jointly carried out between Kenya and OECD dubbed "Assessment of the Procurement System in Kenya" reveals the following weaknesses;

1. Poor enforcement and follow-up on external audit recommendations: The Kenya National Audit Office (KENAO) carries out annual

external audits, a mandate that derives its mandate from the Constitution and is further governed by the Public Audit Act of 2003 (PAA). Some of these audits include financial audit, systems audit and performance audit. Procurement is included in the latter. Unfortunately, implementation of the audit recommendations remains a challenge.

2. Lack of procurement proficiency among auditors: Both internal and external auditors are trained in procurement as part of their regular in-house training. However, they are not procurement experts. Currently, procurement specialists are not called in to form part of the control and audit teams.

3. Limited access to ARB decisions: While review of complaints generally takes place within the legally established time frames, access to PPRCB decisions is limited. Although complaint review decisions are available at the PPOA/ARB premises, they are thus currently not published in any official gazette nor on the PPOA website or any other government websites

4. No Code of Ethics addressing procurement related issues: While the Public Officers Ethics Act does provide a general Code of Ethics for Public Officials, this Code does not include specific provisions for those officials involved in public financial management, including procurement

5. Procurement audits are non-existing: While both the IAG and the KENAO undertake audits of procurement, none of these institutions are able or see it as their clear-cut mandate to conduct procurement audits; thus, at present, procurement audits are not being conducted.

6. Public Procurement at the County level: It has been established that there is lack of automation of procurement processes. In addition, the procurement departments are perceived to be reluctant to embrace e-procurement preferring to use manual systems.

### *6.2.9 Advocacy Initiatives by Non-State Actors in Enhancing a Robust Procurement Process*

To achieve effective service delivery, CSOs and other non-state actors should build the capacity of citizens to exercise their constitutional right of public participation in the entire chain of procurement process. This should include but not limited to;

1. maximizing efficiency and effectiveness (getting the right goods, services and construction projects at the right cost to the right quality and at the right time);

2. They should also help Promote a well-functioning market (e.g., promote competition and ensure that competitors are treated fairly and equitably);

3. Participating in the investigation of public audit system to ensure that it offers a robust protection against corruption and whether the major actors have fulfilled their roles and responsibilities within this system;

4. Improving inspection and monitoring documentation and transparency about projects being undertaken;

5. Instituting a mechanism to review the designs and estimates of the projects as they are prepared by the consultants before implementation for the good of the public;

6. Engaging with the necessary stakeholders to address the problem of delays in payments

to contractors due to bureaucracy and poor documentation, which sometimes affects the timely delivery of services by limiting the contractors' cash flow and causing works to stall. There are many hospitals that have stalled due to either late disbursement of funds or pending bills owed to contractors and suppliers;

7. The use of emergency procurement must also be justified, recorded, and made public. This can be achieved through the adoption of open data on emergency procurement, as well as with cooperation with civil society and the media. One method in which this can be achieved is through full adoption of open contracting principles. The principles of open contracting seek to transform how public contracting is undertaken by engaging stakeholders across government, private sector, and civil society to drive systemic reforms. Moreover, open contracting generates greater understanding of what is working and what is not working in the health sector, allowing government departments to visibly progress and ultimately save lives; and

8. There is a need for automation of all procurement processes and enhancing the capacity of county staff involved in procurement and supply of goods and services on the automated system.

# 7.0 Accountability In The Health Sector

### *7.1 Overview*

Timely access to quality healthcare is widely acknowledged as key to reducing the global burden of morbidity and mortality. Quality of health care service is an imperative to the realization of Universal Health Care. This implies that even if the world achieved essential health coverage and financial protection, health outcomes would still be poor if services were low-quality and unsafe. Evidence suggests that substandard care wastes significant resources and harms the health of populations, destroying human capital and reducing productivity. Quality of care, especially patient safety, is essential to creating trust in health services. It is also key to global health security, which starts with local health security, and in turn depends on high-quality frontline health services. Quality health services not only prevent human suffering and ensure healthier societies, but also ensure better human capital and healthier economies.

### *7.2 Citizen Perception on Quality of Healthcare in Kenya*

Citizens' perception was evaluated through discussions with community in relation to four dimensions used to measure healthcare quality, i.e. Availability and Accessibility; Affordability; Adequacy and Appropriateness.

#### *7.2.1 Availability and Accessibility*

Participants were asked to indicate where they sought health care information. The results revealed that, even though the majority expressed their confidence on the information from doctors in health facilities, the first instance source of their information is relatives or friends who have had similar problems followed by pharmaceutical shops (chemists). On why they prefer chemists, participants noted that chemists tend to be centrally located therefore are easily accessible. Furthermore, chemists do not require lengthy procedures and are cheap

since they don't charge consultancy fees compared to hospitals. Health facilities, as a source of information, are a remote option.

On the length of time it takes to access healthcare service from a facility, the majority of participants noted that it takes them less than 10 minutes to get to the nearest facility. Indeed, Ministry of health[35]. The report estimated that 70% of urban dwellers have access to health facilities within 4km, while such access is available to only 30% of the rural population. Even though health facilities are at close proximity especially in the urban setting, it takes much longer time, sometimes 3-6 hours to receive healthcare in a facility. This is due to lengthy procedures, limited staff and equipment, and general poor/slower service delivery. One participants explained;

*... you find that in public hospitals there are so many procedures from registering through a checkup card, pay for doctor consultations, consult the doctor, laboratory testing, waiting for test results, providing results to the doctors for assessment and diagnosis, getting prescription and queuing for medicine.*

In some certain scenarios, for one to access health care he/she has to pay a bribe. One participant noted;
*"...you find long queues in hospitals where some patients who are in critical conditions have spent many hours waiting to be attended to. One time I got into a discussion with one patient and they told me that unless you know an insider in the hospital or "peana kitu kidogo (give something small)" you might end up dying even before you get to the doctor".*

On access to health care during the COVID-19 peak period, respondents stated that it was very hard due to restrictions, especially quarantine requirements and getting tested for the virus due to stigma associated with it once detected. They noted that, first one would analyze themselves for any COVID-19 symptoms before accessing health care services. One respondent explained that she feared visiting a hospital while nursing a flu fearing that it would automatically be interpreted as COVID-19. However, the situation has changed after mass vaccination and relaxation of measures. They noted that the situation now is relaxed, the associated stigma and fear the of visiting hospitals is no more.

### *7.2.2 Affordability*

As noted under the health financing discussions, a large proportion of health expenditure in Kenya comes from household out of pocket spending. With the aim of ensuring access to affordable quality health services and reduce the out-of-pocket cost by Kenyans, several initiatives have been enforced. In 2004, the elimination of user fee at primary health care facilities, with the exception of registration fee, was introduced. The user fees at health facilities were used as an additional source of revenue to fund healthcare services. This was improved in 2013 when all user fees including registration fees were abolished. This was necessitated by the finding that there was low adherence to the policy at most health facilities and Kenyans continued to pay higher fees. The National Government compensates County Governments for the user fees foregone in the form of conditional grants and is budgeted for in each financial year.

Despite these strides, affordability of health care services in Kenya remains a challenge as pointed out by FGD discussants. They noted that cost of accessing health services keeps going up in every aspect from consultation fee, lab charges, medicine etc. one participant retorted,

35. Ministry of Health, The Kenya Harmonized Health Facility Assessment (KHFA) 2018-2019 (2020) https://www.health.go.ke/wp-content/uploads/2020/01/KHFA-2018-19-Popular-version-report-Final-.pdf

*I am asthmatic and so are some of my family members. The tablet that I used to buy at Ksh.5 has priced up. Today, I spend more on medication than before. Consultation fee has also gone up. For example, we used to pay Ksh 100 but now we pay Ksh. 250 to see a doctor*

Another response indicated that a drug they used to remedy stomach pains has more than doubled in price in the last three years. Participants also pointed out that X-ray charges in a nearby hospital inflated from Ksh 1000 to Ksh 1500.

Two indicators are used to track the extent to which out of pocket healthcare payments present households with financial difficulties. The first is the incidence of catastrophic expenditures and the second is impoverishment. Incidence of catastrophic expenditure measures the levels of OOP healthcare payments that present financial difficulties to households whereas impoverishment measures the levels of OOP payments that push households into poverty. Statistics show that in 2018, high out of pocket health care expenditures led to 7.1 percent of households that used health care facing catastrophic expenditures, an increase from 5% in 2014. In 2014, 39% of households reported that OOP payments pushed them into poverty, an increase from 32% in 2008. This illustrates that Kenya still lags behind in protecting its people against financial risks associated with ill health and health care seeking behavior.

### *7.2.3 Participant's Experience with Insurance and National Health Insurance*

There are 32 private health insurers that collectively cover only 1 percent of the Kenyan population. On the other hand, financial protection by NHIF is quite weak since it only offers limited financial protection for the poor, those over 60 years' old, and patients with chronic illnesses having lowest access. Insured members (non-civil servants) still need to pay out of pocket fees for treatment, diagnosis, and pharmaceuticals. This implies that a majority of Kenyans access health through out-of-pocket payment.

On NHIF, participants noted that the cover was as reliable as it was equally unreliable. Those who gave positive experiences noted that they got medical assistance using the card on an incidence that they could not have otherwise afforded. The cover, according to participants, needs to be updated in a year ahead so that it can help in settling medical expenses. One of the participants cited an incident where her friend's husband was admitted at Kajiado general hospital and had not paid NHIF premiums for a while. When he (the husband) got seriously ill, through the assistance of local MCA, they paid up premiums of about Ksh 6000 for the period that the husband had not remitted monthly dues and were able to cater for hospital expenses. NHIF has also helped expectant mothers to access maternity services. One participant cited an example of a case where NHIF covered all her niece' expenses during child delivery. Participants also noted that the Linda Mama scheme under NHIF has been of great assistance to expectant mothers during delivery as it holistically covers all expenses.

However, participants expressed their disappointment with NHIF customer care services especially when one has challenges in using the card. They noted that helpline operators are usually non empathetic and often not able to offer assistance as and when it is required. They also pointed out that NHIF does not always cover all the medical expenses resulting from out-of -pocket payment, especially for medicine. Lastly, it also emerged from the discussions that the affordability of monthly payments is untenable to most senior citizens, poor widows and vulnerable low income groups.

### *7.2.4 Adequacy*

Adequacy in healthcare refers to provision of all services needed at the point of delivery. According to participants, this depends on the

facility although in most to level facilities one is likely to miss some services including laboratory and medicine. They also noted that in some cases, access to medical services requires one to give a bribe or know someone working in the hospital. One participant stated that most people bribe in order to get the comprehensive child medical report required during admission to school. Another participant noted;

*"...a hospital worker or health personnel will ask whether you want to continue queuing or you provide something small to be attended to in no time. Since one may be in a hurry and have witnessed long queues, they end up opting for the easier way out by paying a bribe".*

The other concern raised by the discussants was service delivery where they expressed their disappointment by health practitioners especially nurses. One participant cited an incident where she experienced a nurse hurling insults at a patient and finally telling them "wewe umetusumbua sana, si ukufe haraka". They noted that nurses, especially those working in the maternity wing, lack empathy when handling patients. "In Public hospitals one does not die because of the ailment, they die because of the kind of human (mis)treatment they receive". A majority of health care professionals lack the requisite interpersonal relation with patients.

On health care providers' opinions regarding treatment, participants indicated that in public hospitals it's rare for a doctor or nurse to listen to suggestions from a patient. This is attributed to the fact that, first, most patients fear doctors thus take their word as indisputable truth. Secondly, poor people lack literacy skills such that when a doctor could diagnose and give prescription to a patient and the patient would not check the medications before taking them. One of the respondents cited an incident where she wanted to assist a friend who had a broken arm to get transferred to another hospital. Reason for transfer was that she was asked to purchase medical equipment and medicine required for the treatment from a different health facility and let the patient be treated in a different hospital. She inquired about the kind of procedure that was undertaken to the patient but no one explained to her. She forwarded the case to the hospital superintendent and requested to withdraw the patient but was also reluctant to take action thereby forcing her to reach out to the ministry of health who issued an order to release the patient. This creates a picture of lack of freedom of expression when seeking medical assistance. They know patients lack awareness of their rights and they end up being exploited.

### *7.2.5 Appropriateness*

The World Health Organization defines appropriateness from a system's perspective as care that is effective, efficient and in line with ethical principles of fair allocation. Building quality health services requires a culture of transparency, engagement, and openness about results, which are possible in all societies regardless of their income level. Around the world, lessons abound on what works and what does not, providing a rich foundation from which to rapidly scale up a quality revolution.

On use of health facilities and equipment, participants noted that there is a practice where private hospitals are benefitting from public laboratories at the expense of the public using the laboratory facility. For example, if one visits a public hospital for testing he/she is redirected to a private clinic which tends to charge higher. This causes collusion between public and private clinics. Another common problem cited for public hospitals was that healthcare providers lack commitment in their work in the facility since they operate private clinics. In certain circumstances where the doctor is absent, you find public hospitals being operated by medical students who are not qualified to attend to patients.

There is a higher chance of getting misdiagnosed in public hospitals due to low morale. One of the respondents pointed out that there is a major problem in hospitals where even doctors have no idea of what they are doing and go ahead to diagnose a patient without proper screening. She gave an example where a doctor administered a certain drug which triggered her curiosity and asked the doctor what the drug does, shockingly the doctor had no idea and could not provide a reasonable explanation of

the drug and its dosage. This explains why there are cases of patients dying due to doctors' misdiagnosis.

One of the participants stated an experience in the health sector that breeds commercialization of this sector. For instance, pregnant women who deliver through Caesarean Session are charged differently from those who undergo natural labor. In addition, if a patient is admitted to an inpatient center he/she lacks the knowledge of what charges incurred due to a lack of inquiring. You find that one is charged beyond the service the patient is seeking for. This presents a lack of being provided adequate information while being admitted. On the other hand, due to the patient's lack of inquisitiveness, exploitation takes a toll.

### *7.2.6 Rating of Kenya's Achievement towards Universal Health Coverage*

The government has made significant strides towards realization of Universal Health Care in terms of policy and investment in health infrastructure and personnel. Participants indicated that while this is plausible, a lot needs to be done especially in improving health care service delivery in urban centers. In terms of infrastructure and equipment, participants noted that Nairobi is ahead of rural counties, however, in terms of service delivery, most hospitals in the city perform dismally. There are some factors such as improved infrastructure in terms of accessibility to electricity which makes it easier for hospitals to operate in and aiding mothers during child delivery, emergency response in terms of additional number of ambulances that target a wider geographical location. These are some of the factors that indicate improvements among hospitals in the Nairobi region. They added that even though health facilities in counties such as Kisumu and Makueni cannot match those in the city, their services, in terms of attending to patients, are excellent.

**When asked to score, one participant stated that Nairobi County would rate at 2 on a scale of 1-10.**

*"Reason being, if you attend a public hospital there, is a certain way that the healthcare providers will give cold reception. Further, most hospitals have created an environment of bribery where one is required to bribe to skip the queue, get medical assistance and medicine. For a County like Kisumu, there has been notable improvements in the last 5 years. Health care service delivery in terms of cleanliness, reception, hospital outlook, efficiency, and emergency response has tremendously improved. Therefore, I would rate Kisumu at 7 on a scale of 1-10".*

The difference in health care service delivery across the county is determined by political leadership. In Kisumu and Makueni, governors committed towards enhancing health care as a priority in policy and resource allocation.

## *CONCLUSION AND RECOMMENDATIONS*

The feedback, discussion and findings from the respondents and this study point to a number of challenges that the health sector is experiencing in Kenya. These challenges have proved a big set-back to proper service delivery and the bigger goal of enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being as envisioned in the Kenyan Constitution. The biggest set-back seems to be implementation of laid down policy and legal provisions to avert some of the challenges including in appropriation of resources ,poor service delivery , high cost of provision of basic services and needs, minimal access to information and participation, and lack of goodwill from the government to tackle some of the gaps and challenges. To address most of the challenges, it will be critical to have all stakeholders' participation and inclusion to forge a way forward in addressing pertinent issues within the health sector. Governments' goodwill and support remain key in all these. A number of recommendations are highlighted below;

**Government:**

- Government should be keen to reduce health inequalities related to gender, age and disability. The goal to reduce health inequalities can only be achieved effectively by involving the population itself in decisions on priority setting and consequently in the allocation of the resources. This requires a fundamental change in the existing governance structures in order to allow such a community ownership to take place.

- Active involvement and partnership with other stakeholders in the provision of healthcare is needed. A functioning health system that would rely on collaboration and partnership with all stakeholders, and whose policies and services would have an impact on health outcomes should be established.

- There should be enhanced frameworks for resource allocation and disbursement to avoid delays. Additionally, the budgetary allocations should be able to address the identified gaps and needs. This should be coupled with enhancement of the working relationship between the national and county government when dealing with the health sector.

- A review of the National Health Insurance Fund to ensure it is affordable to the vulnerable groups (criteria for vulnerability to be developed) as well as enhance its operation to cover everything and ensure it is effective at all times.

- More funds and investment in the health sector budget should be raised while the government continues to make efforts to fund the health sector. There are still gaps in funding that need to be addressed to ensure achievement of the highest attainable right to health.

- Government needs to address the dwindling trust and confidence from citizens that have seen service delivery affected. Government should give support to healthcare workers and encourage them to put up good attitude and morale in order to make the positive impact needed. It is important that the government show goodwill in partnering and addressing challenges in the health sector.

- Enhance and establish transparency and accountability measures within the health sector, and eradicate misappropriation of available resources by corrupt government officials. Lay down strict measures and penalties for those found guilty.

- To tackle corruption at lower levels, the government should improve working conditions and good payment packages and salaries for health workers. Enhance human resource manage-

ment. Similarly, there should be a mechanism to deal with unwarranted referrals of patients that provide for opportunities to corrupt. These mechanisms should also provide harsh penalties for anyone found practicing these vices.

- A comprehensive review of the health sector to ensure regular quality, control check- ups of health facilities, enhancement of capacity, and knowledge of health practitioners.

- Development of appropriate malpractice laws to address medical errors that amount to negligence. There should be a strong ethical framework for monitoring doctors' and other health practitioners' conduct in order to protect the patients' rights and enforce the observance of medical ethics.

- Put in place mechanisms to address relations and partnerships between the county and national government as well as address grievances from the different players and stakeholders including healthcare workers to avoid instances of unrest and strikes.

**Civil Society and Citizens:**

- Support research on different areas including available resources/infrastructure within the sector, gaps in funding and utilization of resources, gaps in human resource, gaps on available medications etc. This will help the national and county governments to know areas of priority and focus.

- Participate and support in development and review of frameworks (county and national government policies, laws and regulations) that will support protection and attainment of the right to health as provided under the constitution.

- Partner with the government to provide civic education to groups and communities to raise concerns on violation of their health rights with the relevant complaints mechanisms as well as raise concerns on any violations or threat to the violation of the right to health.

- Monitor and support the community in the development of the health sector plans and budgets at the national and county levels and participate in forums to influence the integration of rights based approaches and the allocation of adequate resources for the implementation of the right to health.

- Advocate for the inclusion of the health needs of marginalized and vulnerable populations in the planning and implementation of the health sector Programmes.

- Use the evidence to advocate for equitable access to quality health infrastructure by the people.

- Citizens should push for access to information on some of the public resources and procurement .There is a need to pile up more pressure on the government entity to ensure they provide information that allows for checks on transparency and accountability in the public resource spending.

- Generally, Public and community participation in decision making remains key to ensuring that the country has a framework of accountability for realizing the right to health and meaningful engagements.

**Private Sector:**

- Private sector should be keen to participate and partner with stakeholders in decision making. In addition, they should be interested in reviewing and developing frameworks to support the attainment of right to health within the health sector.

- To ensure inclusion, there is a need for a policy framework of engaging the private sector in Kenya's health sector. This will help address critical areas such as beneficial ownership and how private entities work or do business with government entities and also what kind of support the private sector can offer to the health sector.

- Support and invest in the health sector and capacity building for stakeholders in the health sector; this will help in their capacity to manage available resources.

*REFERENCES*


1. MOH, 2019. 'Kenya Health Financing Strategy 2020-2030' Nairobi. Government Printers
2. https://www.macrotrends.net/countries/KEN/kenya/life-expectancy
3. Ministry of Health, The Kenya Harmonized Health Facility Assessment (KHFA) 2018-2019 (2020) https://www.health.go.ke/wp-content/uploads/2020/01/KHFA-2018-19-Popular-version-report-Final-.pdf
4. World Bank Databank(2022) https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=KE
5. https://www.cdc.gov/globalhealth/countries/kenya/why/default.htm#:~:text=In%20Kenya%2C%20where%20over%2043,HIV%2C%20tuberculosis%2C%20and%20malaria.
6. https://www.health.go.ke/wp-content/uploads/2022/01/Kenya-SDG-Progress-Report_-April21.pdf
7. Waruru A, Onyango D, Nyagah L, Sila A, Waruiru W, Sava S, et al. (2022) Leading causes of death and high mortality rates in an HIV endemic setting (Kisumu county, Kenya, 2019).
8. https://www.sciencedirect.com/science/article/abs/pii/S0033350620304431
9. https://www.dovepress.com/patients-access-to-medicines--a-critical-review-of-the- health-care-syst-peer-reviewed-fulltext-article-RMHP
10. Ministry of Health
11. Health Sector Working Group Report 2014-15 to 2016-17
12 World Health Organization (WHO). 2007. "Everybody's business - strengthening health systems to improve health outcomes: WHO's framework for action". WHO; Geneva.
13. Manda D.K et al. 2020. "Health Expenditures and Health Outcomes in Kenya) European Scientific Journal Vol.16, No.22
14. https://aphrc.org/blogarticle/how-much-is-spent-on-healthcare-in-kenya-and-where-does-the-money-come-from/
15. https://ieakenya.or.ke/blog/can-people-afford-to-pay-out-of-pocket-for-health-care-in-kenya/
16. Kenya Demographic Health Survey 2014
17. Abuya, T., T. Maina, and J. Chuma. 2015. "Historical Account of the National Health Insurance Formulation in Kenya: Experiences from the Past Decade." BMC Health Services Research 15: 56
18. MoH, 2019. "Public Health Expenditure in Kenya: A Comparative Analysis of Nine Deep-Dive Counties" Government Printer. Nairobi
19. MoH, 2019. "Public Health Expenditure in Kenya: A Comparative Analysis of Nine Deep-Dive Counties" Government Printer. Nairobi
20. https://devinit.org/resources/kenyas-covid-19-budget-funding-for-health-and-welfare/
21. https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-seven-creating-national-institutions-to-implement-and-monitor-the-convention-4.html
22. https://www.reuters.com/article/uk-kenya-corruption-idAFKCN26F3C8
23. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-08975-0
24. https://actionfortransparency.org/wp-content/uploads/2020/05/Transparency-and-Accountability-in-Kenyas-Health-Financing-Models.pdf
25. Masaba, B.B. et al. 2020." Devolution of healthcare system in Kenya: progress and challenges" Public Health, Volume 189, Pages 135-140
26. https://apps.who.int/iris/bitstream/handle/10665/324909/9789289054126-eng. pdf?sequence=1&isAllowed=y
27. Global Corruption Report (2006)
28. (http://www.maricopa.gov/materials/p-code/HTML_code/Code01.htm)
29. Section 2 of the PPADA 2015
30. OECD definition of public procurement accessed at https://www.oecd.org/gov/public-procurement/

*REFERENCES*

31. https://www.netsuite.com/portal/resource/articles/accounting/procurement.shtml
32. https://www.oecd.org/gov/ethics/Corruption-Public-Procurement-Brochure.pdf
33. https://ti-health.org/improving-covid19-procurement-to-increase-equitable-access-medicines-medical-equipment/
34. http://www.parliament.go.ke/sites/default/-files/2021-09/PIC%20report%20on%20utilization%20of%20covid%2019%20fund.pdf
35. Ministry of Health, The Kenya Harmonized Health Facility Assessment (KHFA) 2018-2019 (2020) https://www.health.go.ke/wp-content/uploads/2020/01/KH-FA-2018-19-Popular-version-report-Final-.pdf


CTAP
COVID-19 TRANSPARENCY & ACCOUNTABILITY IN AFRICA
SIDAREC
Follow
The Money