CONFERENCE PROCEEDINGS REPORT ON UNIVERSAL HEALTH CARE

CONFERENCE HELD AT KUSYOMBUNGUO HOTEL, MAKUENI COUNTY ON WEDNESDAY, 4TH & THURSDAY 5TH APRIL 2018

THEME: Meeting Kenya's Universal Health Care Challenge

Sub-themes:

Health Systems Strengthening

Experience Sharing

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Abbreviations & Acronyms

ART	Antiretroviral Therapy
ARV	Antiretroviral drug
CDC	Centers for Disease Control and Prevention
CEC	County Executive Committee
CIMES	County Integrated Monitoring and Evaluation Systems
CMT	Core Medical Training
CoG	Council of Governors
COMESA	Common Market for Eastern and Southern Africa
DHIS	District Health Information System
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
GAVI	GAVI, the Vaccine Alliance
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
HELB	Higher Education Loans Board
HR	Human Resource
HRH	Human Resources for Health
HWs	Health Workers
ICU	Intensive Care Unit
KEMSA	Kenya Medical Supplies Agency
KNH	Kenyatta National Hospital
KQMH	Kenya Quality Model for Health
MEDS	Mission for Essential Drugs & Supplies
MoH	Ministry of Health
MPs	Members of Parliament
MSM	Men who have sex with men
NCDs	Non-communicable diseases
NDMU	National Disaster Management Unit
NHIF	National Hospital Insurance Fund
NHIF	National Hospital Insurance Fund
NIMES	National Integrated Monitoring and Evaluation Systems
NSSF	National Social Security Fund
PDSA	Plan Do Study Act
PEPFAR	President's Emergency Plan for AIDS Relief
PPP	Public–Private Partnership
PS	Principal Secretary
PWDs	Persons with disabilities
UHC	Universal Health Care
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VDS	Kenya Vision 2030 Delivery Secretariat
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need

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Background

Vision 2030 recognizes health as an important anchor for improving the quality of life of Kenyans. This is clearly spelt out in the Vision's health sector goal of *ensuring an efficient integrated and high quality affordable health care to all citizens.* Among His Excellency the President's Big Four priorities in the next five years is the target of achieving 100 % Universal Health Care coverage for all. This will be realized through policy and administrative adjustments in key institutions of the health care sector. Since health is a devolved function in Kenya, a close collaboration between the Ministry of Health and the County governments as well as the private sector practitioners in the health arena is absolutely necessary to achieve transformation and realize Universal Health Care.

It is with this realization that the Kenya Vision 2030 Delivery Board (VDB) in conjunction with the Makueni County Government, Amref Health Africa, and Ministry of Health, organized a national Universal Health Care Conference themed, *Meeting Kenya's Universal Health Care Challenge*. Premised on carefully structured engagements, the overall goal was to identify clear implementation strategies for delivering Universal Health Care to the citizens of Kenya as the key beneficiaries. This forum brought together national and county governments, private sector and non-state actors in the health sector, as well as international actors, to dialogue and share best practices in providing affordable health care to all. A total of 337 people attended the conference.

The Conference which was sponsored by Leap Health, MEDS, Amref Enterprises, m-Jali Amref, Strathmore Business School, Centre for Health Solutions – Kenya and Uzazi Salama, was held on Wednesday 4th and Thursday 5th April 2018 at Kusyombunguo Hotel, Makueni County. The host county has implemented a model of Universal Health Care that invites attention. Indeed, it was the focus of much of the conversation at the Conference.

The Master of Ceremonies, Ms Wanjiku Njire-Mutua, welcomed participants and called on the Nyeri County Director for Health to give the opening prayer. She then welcomed all participants and proceeded to invite the Country Director of Amref Health Africa in Kenya, Dr. Meshack Ndirangu, to address participants on the objectives of the Conference and the expected outputs.

Conference objectives

Objectives of the health conference and expected outputs — *Dr. Meshack Ndirangu, Country Director, Amref Health Africa in Kenya*

Dr. Meshack Ndirangu began by emphasizing that access to healthcare is a constitutional right, which has not yet been achieved. He also mentioned that the debate on Universal Health Care should focus on realization of goals. He went on to state that affordable health care for all was one of the President's BIG FOUR priorities, hence, there was need to improve on collaboration between the National and County Governments, civil society organizations, development partners, faith-based organizations and the private sector, among other actors, to realize UHC for all. He noted that leadership and governance were key in health financing, pointing out that the norm in the country has been organizing for *Harambees* (fundraisers) to access treatment abroad. He noted that the forum was a platform to bring together key stakeholders to deliberate on strategies that can be applied to the delivery of affordable UHC. Hence, it provided an opportunity to develop a framework of action. He outlined the key objectives of the UHC Conference as follows:

- Deliberate on current national and county governments strategies on health;
- Create an enabling environment to address health systems;
- Develop a framework of action to realize UHC.

In conclusion, Dr. Ndirangu informed the participants that there would be an opportunity to visit healthcare centres in Makueni County after the closing ceremony.

The Master of Ceremonies, Ms. Mutua, took over and thanked Dr. Ndirangu for his remarks before introducing the moderator of the opening ceremony session, Prof. Judith Mbula Bahemuka to the podium.

Opening ceremony

When Prof. Bahemuka took over, she termed the conference a meeting of minds to come up with solutions and way-forward. She mentioned that the BIG FOUR [pillars of President Uhuru's vision for economic growth: food security, affordable housing, manufacturing and ***affordable healthcare****], were not new inventions but an opportunity to jog minds. Universal means all-inclusive, so the question was on the 'how' of making sure everybody is on board and of achieving UHC. She called on the speakers in the opening ceremony session to give their remarks, saying,*

in the interest of time, she did not need to read their bios, as the content they will share will give a clear indication of who they are.

First to speak was the host, Prof. Kivutha Kibwana, Governor of Makueni County.

Welcome remarks by Host Governor — *H.E. Prof. Kivutha Kibwana, Makueni County*

Prof. Kivutha Kibwana began by thanking the panelists and distinguished participants for attending the conference and acknowledged the sponsors who made the event possible. He then welcomed participants to Makueni County and mentioned that the County prided itself as being the capital of UHC and that other counties were learning from them. The Governor mentioned that when they embarked on UHC in the County, their vision was to provide quality UHC service; to deliver on positive health outcomes so that the system does not fail. Every citizen and resident who has been in Makueni for six months qualifies for the UHC package. He elaborated that the UHC was meant to improve the socio-economic wellbeing of Makueni by expanding equitable, affordable and quality healthcare.

The objective of *Makueni Care* being the implementation of the best healthcare package possible, given the county-level resource constraints and health objectives, was said to be a realistic package to deliver UHC. In Makueni County, 33.7 % of the annual budget goes to the healthcare package. The County has increased healthcare facilities from 109 to 232 greatly reducing the 9 km distance that people had to walk to get to the nearest health facility. He further stated that oxygen was now being manufactured in Wote town [within Makueni County] and they no longer had to incur the cost of purchasing oxygen. He elaborated some of their achievements as meeting targets beyond the national target. For instance, the county has recruited more healthcare workers from 977 in 2013/14 to 1,462 currently to meet the influx of patients even from other counties. Healthcare workers including specialist doctors, medical officers, dentists, nurses and clinical officers underwent training in various areas of healthcare.

The Makindu Hospital Trauma Centre was developed to serve the Nairobi–Mombasa highway trauma/accident patients from Voi to Malili and other cold cases across the country. The Makueni County Mother and Child Hospital has a 120-bed capacity; an autonomous Centre of excellence, which is a specialist hospital for mothers and children, with ultramodern facilities, including an aqua-bathing facility. Once complete, the hospital will officially be launched by First Lady Margaret Kenyatta. Healthcare facilities in the County were upgraded and newer facilities built to ensure the realization of UHC.

In his concluding remarks, the Governor noted that Makueni County has a nascent experiment in UHC, particularly at the sub-national level and that it offers a building block of the national UHC package driven by His Excellency the President.

The moderator picked up the conversation and called on Dr. Julius Muia to speak on behalf of Dr. James Mwangi, the Chairman of Vision Delivery Board (VDB), where he [Muia] was until recently, the Secretary and Director General of Vision Delivery Secretariat (VDS).

The Health Sector in Kenya Vision 2030 — *Dr. Julius M. Muia, PS, State Department for Planning*

Standing in for Dr. James Mwangi, VDB Chairman, Dr. Muia set off his talk by remarking that health was one of the most private goods one can think of, and that, "you can't pay anyone to be sick on your behalf", as health is individual. He noted that since the launch of Vision 2030 on April 20th, 2008 by His Excellency Mwai Kibaki, the Vision has received political support and gained gravity. Vision 2030 is working towards a globally competitive, prosperous nation, offering a high quality of life, including in healthcare. He pointed out that the Vision 2030 pillars (Economic, Social and Political) were affected by health. With the transformation of the six key social sectors, one of which is health, quality healthcare is important in achieving the highest standards of UHC that is affordable. The State Department for Planning is in the process of finalizing the Third Medium Term Plan (MTP III) 2018–2022 which will be shared with all stakeholders. In the MTP II, 12 flagship projects were identified in both the National and County governments pushing to achieve UHC.

Dr. Muia emphasized that clever public–private partnerships should be developed with universities, development partners, Council of Governors, the national government and county governments, among other players. He called for benchmarking with other countries on the same. He reminisced on a benchmarking trip he had made with the President to Singapore where he noted that instead of listing the date of starting a road project, they listed the completion date. Hence, citizens were able to hold the contractors accountable in case of delays. Such, he said should be the case in Kenya, to ensure accountability.

Looking at Kenya's global competitiveness, he stated that malaria has witnessed a considerable improvement, ranking 44th place in the world. However, HIV/AIDS was shown to be doing badly, ranking at 130 out of 140 countries. He further noted that NHIF registration has increased significantly, three times from 2013/14 to 2016/17. While speaking on the performance in the healthcare sector, he stated that the sector was ranked at 56 % above the national average, by seven experts who looked at the 24 sectors and ranked them according to performance.

A survey conducted on what people associated Vision 2030 with found out that 40 % associated the Secretariat with the Standard Gauge Railway (SGR) and only six per cent associated it with healthcare, more so because of the free maternal healthcare. He said this was because people associated development with infrastructural development. He noted that moving forward, innovations done by county governments will help in medical tourism, leaving referral and tertiary

healthcare facilities to referral cases. He also added that there will be special packages for the elderly and specialized people, and efforts to reduce outward bound medical tourism.

The moderator remarked simply that UHC is not new. She called the next speaker to deliver his remarks.

Remarks by Dr. Githinji Gitahi — *Group GEO, Amref Health Africa and UHC 2030 Co-Chair*

Dr. Githinji Gitahi began by congratulating Governor Kibwana on the performance of healthcare in Makueni County, more so the development of m-Jali platform piloted in Makueni County. He pointed out that Amref had been seeking for partnerships with county governments that would provide land for the development of Amref International University and only Governor Kibwana agreed by donating 50 acres of land in Makueni County. He said that Amref had now received a Letter of Interim Authority. He talked of plans to develop a trauma hospital in Makueni in the future. He further stated that the Conference was set right on time because it fell on the World Health Week whose theme was *Universal Health Coverage: Everyone, Everywhere.*

In elaborating what UHC is and what it is not, Dr. Gitahi stated that UHC is about providing the best healthcare package to Kenyans without impoverishing the people, irrespective of their background; it is not about constructing new hospitals, NHIF registration, or recruiting more doctors, all of which are necessary for strong health systems, but none of which define UHC. He provoked the participants by stating that, 'UHC is something that you do in order to become rich, not when you are rich'. Health is an investment for growth and the primary reason for UHC is a moral one, which is a good investment for future. He agreed with Prof. Bahemuka that UHC is not new, rather, it is the technology deployed that is new. Alluding to the rights-based approach, he noted that in the African setting, communities took care of everyone. The Constitution of Kenya 2010, provides for health as a human right. He stated that all the money spent on UHC conferences could go towards employing more people. He reminded participants of the 2016 Sixth Tokyo International Conference on African Development (TICAD–VI) held in Nairobi, that focused on UHC Africa Framework for Action and was signed by Kenya and the African Union.

In outlining the four things that are important in the realization of UHC, Dr. Gitahi asked about the services that were going to be made available under the UHC benefits package. No country has been able to provide for everything. America spends USD 10,000 on healthcare yet it doesn't provide for everything. Chile also defined its package in a national dialogue and came up with key elements that were necessary in achieving UHC as one that had maximum impact, was population-based, could be offered sustainably and was scientifically possible. Secondly, he asked participants to think about the mix of healthcare workers needed. He informed participants that Laikipia County had registered 19,000 residents on to NHIF through community health workers. Thirdly, was on deciding the financial model. And fourth, he stated that accountability, information-sharing and

transparency were fundamental to achieving UHC, noting that the most important office is the office of the citizen which should be engaged in creating accountability.

The moderator thanked Dr. Gitahi for speaking passionately about UHC and what Amref Health Africa was doing in partnership with communities. She had very kind words for the Chief Guest, Prof. Khama Rogo to give his remarks and also officially open the Conference.

Managing public expectations, health consumer rights and sustaining quality country health care delivery — *Prof. Khama Rogo, World Bank/IFC Global Health Specialist*

In presenting the keynote address, Prof. Khama Rogo begun by expounding on the situation in most Kenyan hospitals. He talked about there being no keys to doors and where there was, the equipment inside was most likely not functioning. He further lamented on the graveyard of equipment behind hospitals from the UN countries and the countries of the world which no longer functioned, stating that the health sector was the most wasteful. He emphasized that we should be meeting public expectations, not managing public expectations, further noting that Kenya has opportunities to be the best as it has some of the best training institutions, but wondered about its graduates. In addition, he noted that Kenya compared itself to its non-functional neighbours and therefore perceived itself to be doing well, rather than comparing itself with the economies of the world. He remarked that Kenya has a wealth of experience in both the demand and supply side, with NHIF at 50 years, yet we invite people to advise us, who come to learn from us and utilize the knowledge to advance their own countries. The region has 45 pharmaceutical manufacturers, 39 of which are in Kenya, yet most of the skilled workforce is unemployed.

He gave an analogy where one is able to deliver a parcel from New York and monitor its journey via their cell phone, yet we can't deliver medicine from Mlolongo [a town situated about 14 kilometres from Nairobi City on the Nairobi-Mombasa highway. The private sector is quite energetic, which is the reason that PPP is doing well in the country than in any other place. He suggested to the Governor of Makueni County that instead of the government building staff houses for its healthcare workers, the sons and daughters of Makueni should engage in that venture as part of the PPP collaboration. He noted that the health sector has not grown because of inadequate funding. Malaria has shown a considerable improvement because it is well funded by donors. While quoting Jack Ma [the richest man in China], he asked if we are like monkeys who choose bananas because we don't know that money can buy a lot of bananas. He pointed out that 10–15 % of the budget money can be recovered through efficiency, with more of it being used to pay for the 30 % of households that are unable to pay.

The biggest challenge in the health sector in Africa, he observed, lay in procurement of pharmaceuticals, of equipment and human resource. Everyone wants to buy equipment, yet no one wants to maintain it. On human resource, he said that Africa faced a major problem of productivity of its healthcare workers. On procurement of pharmaceuticals, he gave an example of Aspirin,

which is produced in Kenya yet sold at nine times the price than in India because it has to go through 9–15 middlemen who put up to 10 % mark-up before the drug reaches the consumer. He saw no need to talk about health rights as this is best captured in the Kenyan Constitution.

He talked of quality from the people's eyes when accessing health services; they tend to focus on *three* things:

- *Cleanliness* — he compared the number of doctors to that of cleaners in African health institutions and quipped that cleaners are the majority, with those that clean while the rest dump dirt. People are used to dirty health facilities that they start speculating on what could be wrong when they visit a clean health facility.
- *Kindness* — people tend to visit private facilities more than public facilities due to the quality and kindness portrayed by the health workers there.
- *Care* — care is delivered through discipline. He gave an example of Cuba which is poor but the health sector works because of discipline. Locally there is no proper communication among the workers.

He pointedly emphasized that cleanliness and kindness cost nothing, and Makueni is a living example, and with [sound] management, the basics — money, human resource and service — can be better. He gave the examples below.

Basics:

- *Money* — while we don't get enough, we still don't have enough outputs. For example, if we took 10–15 % off the County budget, it is enough to pay NHIF for 30 % of the households that cannot pay. You get it back through efficiency — capitation and admissions. When the poorest people are already paid for, there will be no need for waiver. More money, more output.
- *Human resources* — why should Kenyatta National Hospital have about 400 consultants and 800 residents, translating into huge salaries, yet it hits the headlines for the wrong reasons, such as an outcome of opening the wrong head? Counties should be innovative instead of subsidizing KNH to train residents. Why should KNH have two administrations? Firstly, the best hospitals in the world are the teaching hospitals. Dual ownership is the problem in Kenya. Secondly, postgraduate training —train people for collegiate training in surgery and other areas. It doesn't cost money. It requires decision. The Master's programme in Kenya isn't okay. Thirdly, quality of care — in the perception of the ordinary person, quality is continual cleanliness, kindness and care.
- *Services* — quality of care is a little bit complex since it is a continuum of care from the community through to the secondary care. The sub-county hospital should be the most important in every County, and surgery should be done there. There is no need to go to KNH on capitation from counties for outpatient and other services. Sub-county hospitals should be properly equipped with health workers who love their work. Quality of care will be excellent because they know the people they serve. A spoke and ladle approach?

Ambulances are a rich place for PPP. In a light moment, he elaborated the difference between a hearse and an ambulance in Kenya, where the ambulance arrives after the patient dies, and the hearse arrives before the patient dies. With innovations, we should monitor the arrival of the ambulance.

Prof. Rogo cautioned against overlapping the NHIF mandate while trying to implement UHC at county level.

In his conclusion, he addressed several issues. He proposed that Kenyan citizens should be empowered with a medical insurance card where they will have the power of choice of preferred health facility. With the card, they can move to a health facility that actually offers UHC. In that way, all health facilities will style up, so that, surgery is done on the day it is needed, rather than when the doctors have time, and sometimes this would mean starving the patient day in day out while waiting for the surgery. He also suggested that health money from NHIF and elsewhere should be ring-fenced to secure it. He mentioned that the best way to lose weight in Africa is to undergo surgery in Africa, because you will be starved day in day out.

He cautioned that progress will not happen with business as usual, but through innovation. For example, in hiring health workers, he advocated for group contracting as done by Nairobi Hospital which does more with consultants, compared to employing on permanent and pensionable as is the case at KNH.

He also proposed that county governments should engage their citizens to build houses for medics. In addition, He wondered why donor-funded programmes succeed as opposed to locally-funded programmes.

Prof. Rogo then declared the Conference officially opened.

The moderator thanked the Professor and invited comments and questions from the audience to all panelists.

Q&A session

Comment by Dr. Ouma Oluga, Secretary General, KMPDU.

In what seemed to be a reaction to Prof. Rogo's suggestion on contracting, Dr. Oluga said contracting is only viable with better accountability, otherwise contractors will face procurement issues in payment, where they will not be paid by the government. He reminded participants that currently, government health workers don't get their salaries on time. He feared that, with contracting, the health sector will become a business opportunity for *tenderpreneurs*. He thus

indicated that Kenyan health workers in the private and public sectors are not open to contract employment.

He however agreed with Prof. Rogo on innovation around postgraduate training, terming the Master's programme archaic. He was keen to know what model Makueni County will use between the university model and the collegiate model.

Lastly, he argued that implementing good ideas is the most difficult, and therefore commended Makueni for starting UHC through public participation and public delivery. He nonetheless asked how the County intends to scale it up in terms of access and quality.

Ans. by Prof. Khama Rogo: On the question of contracting, one thing that you never do is close your mind to an idea, because if you close, then you won't negotiate. Both the payer and receiver will be happy to get the best out of the deal, and the receiver will have time to do other things that they are now doing anyway and are not properly accounted for. Let us not be afraid of the word entrepreneurship in health, because this sector needs it more than any other sector.

Qn. Was there a baseline survey done in Makueni to ascertain the needs of the County? And how do you plan to meet the ratio of health workers to the growing population? And what is Makueni doing to seal the loopholes of corruption to ensure that there is no leakage of funds? — *Allan Maleche*

Ans. by Prof. Kibwana: We do not tolerate corruption. We fire people who do wrong.

Qn. How does the Makueni Care compare with NHIF and other ways of health financing? — *Rita, Population Services Kenya*.

Ans. by Prof. Kibwana: Our UHC is like the primary care that covers most people. We are currently working with Amref to follow the Laikipia example to recruit as many people as possible in to NHIF, by getting people to pay on a monthly basis. Our system will be complemented by NHIF, and anybody who is unwell and pays the monthly amount of 500 Kenya shillings, gets instant coverage.

Prof. Rogo's perspective: Finally, with regard to NHIF, we owe it to ourselves as health professionals to understand NHIF. NHIF is a contributor fund, it is not government money. It is only now that we want the government to put in money. The issue of Linda Mama is not an NHIF issue. Linda Mama came up as a programme and in some area it overlaps with what NHIF is doing. Linda Mama money came from [the National] Treasury and went to the Ministry, only part of that money went to NHIF. It is important for us to know where the different pockets of money are and their use to avoid overlap. Community-based prepaid scheme is big, but it is bigger in Francophone Africa than it is in Anglophone Africa. A good way of getting people motivated on the idea of prepaying for care. As it grows, it grows outside the community as the

pool of money is difficult to handle outside an organised area and that pool is only as useful as its size. The key thing about insurance is that there is shared responsibilities. When you look at NHIF pay-outs now, counties like Makueni get very little out of NHIF compared to counties that have more facilities. Public hospitals only claim about 15% from NHIF.

Qn. Given the President's vision to have UHC by 2022, what is the projection for Makueni Care to achieve UHC by 2022? — *Dr. David Oluoch, Kakamega County*

Qn. Is Makueni Care entrenched in the county laws, or what will happen after the Prof. Kibwana's tenure? — *Dr. Oluoch*

Ans. by Prof. Kibwana: Centrally, we have county laws, policies, and guidelines, and we are working towards making sure that from the new Health Act, we will domesticate it into our county laws. I get the impression that Makueni Care is so popular that if a Governor came and wanted to abolish it, their government would be dissolved.

Qn. Given that counties inherited functions that were not costed, how are counties going to manage these functions? — *Dr. Oluoch*

Ans. by Prof. Kibwana: There is a basic problem that as a country we have not addressed, the national and county government functions that were never costed. So, in terms of health financing, that needs to be sorted out, so that both governments see themselves as complementary in terms of delivering UHC.

Qn. to the PS, Planning — Does NHIF have the capacity to deliver UHC? — *Dr. Oluoch*

Answer by Dr. Julius M. Muia, PS, State Department for Planning: From a health forum in Nairobi, NHIF was regarded as the driver for insurance for UHC. We are staring with what we have and what we have at the moment in terms of health financing is NHIF. It is with such discussions that we will be able to come up with the best financing mechanisms that are of world class standards and fitting in with what we want to do in terms of coverage and the income levels we have in the country. Health coverage in terms of insurance and NHIF is very low, and we need to focus on getting more funding from people through the insurance angle.

Qn. We spearheaded medical tourism in Kenya and about 10,000 patients came to Kenya, yet Kenya did not have the capacity to handle the numbers. Counties should look into tertiary health care and specialize in one speciality. Tenwek, in Bomet County does a lot of open heart surgeries than in major hospitals, yet it is a very small hospital. Specialization will help in promoting inter-county business. Is Makueni County thinking of specializing? — *Masinde Makhokha.*

Ans. by Prof. Kibwana: Indeed, people do come to Makueni County from neighbouring counties like Taita Taveta, Kitui and Machakos for medical tourism. Recently, I went to condole with a

health official in Machakos County whose relative had sought treatment in Makueni before passing on, but they could not disclose for fear of repercussions.

Qn. What budgetary challenges does the Makueni Governor experience when the county becomes the underwriter? — *James Mathenge, Laikipia County*

Ans. by Prof. Kibwana: Yes, Makueni County is an underwriter, but the idea was to raise money from the 500 Kenya shillings. We started off before there was a national conversation on UHC, but with a national conversation now we will be able to look critically at what we are doing.

Qn. to Prof. Rogo — Kenyans were known to prefer government health facilities, but something happened. What is the paradigm shift needed to get us back there? — *James Mathenge, Laikipia County*

Ans. by Prof. Rogo: The rain started beating us in 1979 when a pronouncement came from the government that doctors had to choose between public and private hospitals. On that day all the consultants at KNH sought to cross the road to Nairobi hospital. That is when we lost control completely and we never recovered. The medical profession is like the army; we need that level of seniority. The other problem is that the new consultants coming in started having more power than the matrons. The nurse must be brought back to become in charge again. We have perfected the art of inefficiency to a point of no return.

The MC, Ms. Mutua thanked and appreciated all partners supporting the conference. She informed that presentations would be availed to all participants who registered.

The following KIPPRA presentation was to be done on Day 1 but due to time constraint, it was pushed to Day 2.

Assessment of Health Care Service Delivery under the Devolved System of Governance, 2017 *— Dr. Eldah Onsomu, Researcher at KIPPRA, representing Dr. Rose Ngugi, Executive Director, KIPPRA*

In 2017, the Kenya Institute for Public Policy Research and Analysis (KIPPRA) undertook a survey in all 47 counties to assess the effectiveness of health care delivery following its devolvement to counties in 2013 by the new constitution. The survey sought to assess the changes brought about by key policy reforms which are aimed at improving the delivery and uptake of health care services since the accession to devolution in 2013.

Specific objectives included to assess:

- Compliance with the constitutional, policy and legislative provisions for citizens participation in planning and budgeting for health care;

- Availability of health inputs (human, capital, commodities) in primary health care facilities;
- Uptake of primary healthcare services;
- Level of citizens' satisfaction with the health services from health facilities; and finally draw policy

The survey was undertaken four years after devolution.

The researchers visited households and got adequate information from the counties. The response was high even in insecurity-prone areas.

Study findings

Briefly, the study findings included the following:

- The country had recorded positive progress in child survival and nutrition; and reduction in disease burden and deaths. There were low levels of child mortality.
- Nutrition status of children at county level in terms of stunted, wasted or underweight — the trends were going down. Counties with highest proportions of stunted children include West Pokot and Kitui at 46%, while those with lowest levels were Nyeri, Garissa and Kiambu counties. Wasting was concentrated in the northern part of the country (Turkana, Garissa, Wajir, Mandera, Marsabit, West Pokot and Samburu). Siaya and Kisumu had the lowest levels of wasted children at 1%. High levels of underweight children were observed in northern counties (Mandera, Marsabit, Turkana, West Pokot, and Samburu).
- High levels of wasting and stunting in early life affect productivity later in life. These are the long-term outcomes in health care. Kenya has an increase in number of years children are able to survive compared to Rwanda and Burundi, and thus should ensure the indicators are sustained at a lower level.
- The challenge of HIV/AIDS still prevails.
- Fertility rate is declining.
- Immunization has increased over time.
- Mortality varies across regions.
- Number of health professionals increased in some counties.
- Despite the various improvements and increase in human resource engaged by the counties, some counties had not achieved the WHO threshold of 30 doctors and 230 nurses to 100,000 population. There were disparities across counties with Kericho, Homa Bay, Muranga, Kajiado; Elgeyo Marakwet, Nairobi and Taita Taveta, having surpassed, while others like Nakuru, Bungoma, Kilifi, Meru Siaya, Trans Nzoia and Turkana are far below the threshold.
- Density of health facilities — Nyeri has the highest level of density compared to Mandera with lowest. People with emergency cases travel up to 52.6 km to get to a health Centre.

- Kenya attained a relatively higher level of life expectancy with a national average of 60 years compared to Nigeria, Botswana and Uganda at 53, 54 and 55 years, respectively. Life expectancy in Kenya has generally improved at 63 years and 59 years for women and men respectively. In 2013 it was 58 years. Finland, Japan and Switzerland are at over 80 years.
- Life expectancy is at 43 years in Siaya County and 68 years in Isiolo.
- There were major variations in proportion of mothers delivering with the assistance of skilled health workers. Interventions are not homogenous in counties. Kiambu County recorded the highest at 93 % while the lowest was Wajir at 22 %.
- There is a close link, if you are able to invest early you reap more in terms of human capital.
- Adequacy of legal frameworks — Kenya has a robust legislative framework, including the Constitution, County Act, PFM Act, and County Health Bills. For all counties to attain better outcomes, the main areas to focus on are enforcement and implementation.

Challenges

The main challenges included:

- Human resource management, facilities in rural areas still a challenge. There are weaknesses in deployment.
- High downtimes of the Integrated Financial Management Systems (IFMIS) in most counties.
- Limited level of citizen participation in high-level decision making — public participation is a key principle in effective devolution. The citizen who is the client in healthcare, must be satisfied. There is 70% general public participation. Discussing health issues participation is inadequate due to the way the participation is organized (no facilitation to attend meetings) or due to low levels of education attainment, making it difficult to grasp what is to be discussed.
- Poor information sharing — citizens do not get to understand what the policy entails, for example, legal framework, or budget, leading to low levels of quality participation. Communities participate through facility committees.
- How do our communities perceive healthcare? Households in urban areas had high uptake of healthcare — they have high levels of understanding through social media and the website. Only 32% of those invited (7%) were able to participate. Reasons given included not being facilitated financially to go to the sub-county health facility and content of discussion.
- Bookkeeping in low-level facilities was weak — the proportion of those managing is relatively low.
- Shortages in specialists and technical staff; issues of retention, progression.
- Infrastructure — most counties have invested in major equipment but there is no balance with provision, that is, idle facilities.
- Provision of power — there were major interruptions.
- Sanitation — 61 % able to access clean water.
- Waste management, sanitation were a challenge.

- Supply of medical supplies for mothers and children had increased (70 % improvement from 60 %), especially provision of equipment for obstetrics care and children.
- Quality of services — improvement on perception from 38.8 % to 52.8 %
- Availability — rating in general healthcare — 54 % healthcare good, but drugs (63 %) had to be bought. Access is at 80 %.
- Computed index on healthcare services delivery was at 59 %.

Key action areas

Key areas of intervention include improvements in public participation in healthcare, social accountability, establish a health scorecard, investing in community health workers, prioritizing community priorities, embracing technology, and M&E. Also, the Public Finance Management Act needs to take care of emergency procurement.

Theme 1: Health workforce: the critical path to UHC

Objective: *Towards the attraction, retention of competent, well-managed health workforce in counties*

Keynote speaker: *Dr. Charles Kandie, Head, Department of Health Standards, Quality Assurance and Regulations, Ministry of Health*

Implementing the National HRH Policy

Dr. Kandie begun by indicating that when assessing the situation analysis of human resource for health, it is important to consider the aspect of attraction and retention of competent, well-managed health workforces in counties. The HR strategy is undergoing audit to ensure that there is no wastage.

Looking at the HR situation analysis, he quantified the high investments in HR by counties which accounted for more than 50 % of the budget. Teething challenges due to devolved structures were now being sorted out. There is existence of county-specific needs, and policy/strategy documents have been developed outlining six objectives of health policy and the services for each county.

He mentioned that the ministry of Health had reviewed various methodologies of staffing and settled on the Workload Indicators of Staffing Need (WISN), which provides an appropriate conceptual framework for staffing norms. He defined staffing norms as the minimum workers by cadre needed to assure provision of Kenya Essential Package for Health (KEPH). He stressed that all counties should reach the minimum. Optimal staffing is specific to each facility based on actual load. Thus, the workload differs even in health facilities that are on the same level, meaning that some facilities may meet the minimum, but will sometimes need more to cater for the higher workload. All counties are required to comply with the staffing needs during the implementation of the Kenya Health Sector Strategic Plan.

In the requirements by type of facilities, Dr. Kandie revealed that a catchment population of 5,000, requires around 8,808 community units, a far cry from the 439 existing community units. He pointed out that medical workers were needed up to health Centre level for the progressive realization of Vision 2030. He noted that nurses have the right numbers, but they tend to do extra work. Estimates of administrative staff required per facility also vary from facility to facility.

In his concluding remarks, he mentioned that the WISN tools should be disseminated to counties to help them recruit according to workload. The forthcoming Health Act will involve public participation.

The session moderator, Dr. Elizabeth Wala — Programme Director, Health Systems Strengthening, Amref Health Africa in Kenya, asked the panelists to give their presentations while commenting on the following:

- *Kenya has very nice documents. Have we executed them?*

- *Are we training for market or for service?*
- *Some cadres are trained without a destination for them, for instance Bachelor's degree for Clinical Officers.*
- *Are there counties that have achieved the required number of health workers?*
- *What are some of the constraining needs that counties face?*
- *How do we measure productivity of health workers in the public sector?*

The impact of health worker strikes on health service delivery and measures to prevent, manage and/or contain — *Dr. Olande Albert, Expert in M&E, Epidemiology*

Speaking on behalf of Mrs. Sarah Angima Omache, CEC Health Kisii County, Dr. Olande explained that the reason Kisii County handled the health workers' strike well was because there was political goodwill from the Governor who is the chair of the HR Committee. Through the goodwill, health workers have enjoyed certain benefits, including not suffering salary delays and better remuneration. For this reason, the health workers were obliged to give the county government more time to resolve the issue. He further elaborated that Kisii County has a robust CEC for Health, Mrs. Omache, who was very engaging in the process and represented the health workers who shied away from meeting with top management. She organised for meetings and it was agreed that services would continue. Furthermore, she held meetings with Sub-county teams. As a matter of fact, Dr. Olande pointed out that in Kisii County, managers don't go on strike. Lastly, he mentioned that in the County, referral hospitals operate autonomously and are detached from the administration. Revenues collected are put in a separate account and this allows the hospitals to continue offering services without strike disruptions. Mechanisms are in place to engage at facility level.

Improving the health systems through strengthening management of the health workforce for effective healthcare delivery — *Dr. Janet Muriuki, Medical Doctor, Public Health Specialist, IntraHealth*

Dr. Muriuki who represented Dr. Wasunna Owino the Chief of Party, HRH Project, IntraHealth discussed two key points, namely HR development, and HR management for health systems.

On HR for development, she asked two pertinent questions; who are we churning out? Are we training for the market or for services? She expressed the need to invest more in medical development so that the trainers are updated on the standards required in order to produce graduates that are market ready. The sector should apply technology for e-learning purposes. Amref and IntraHealth, among others, have mounted online courses to deal with absenteeism, which will be utilized by centralized learning institutions. Highlighting on collaboration, she emphasized the need for county governments and training institutions to dialogue as there seems to be some disconnect. She asked whether faculty were engaging in Continuous Medical Education (CME).

On the issue of HR management, she pointed out the irony of management of equipment services being put before human management. She asked the national and county governments to provide for resources for specialized training for running the equipment and plan for skills trainings. Equipment needs human capital; nurses have to undergo 18 months for the training. Dr. Muriuki, mentioned that while HELB [the Higher Education Loans Board] provided loans at 4.3 %, IntraHealth was working with HELB, the private sector and counties to develop the Afya Elimu Fund at pre-service and in-service levels. So far 13,000 students have been supported, with 3000 looking for employment. Workforce is being produced, but there is a challenge of adoption.

In her recommendations she provided for in-depth solutions on how to recover:

- *Induct health workers into public service* — all civil servants go through an induction process on the work ethics of public servants, something the health workers do not benefit from. Hence, the national and county governments need to budget for induction.
- *Performance contracting vs. Performance management* — how do we get our workers accountable as individuals? There are productivity challenges on the implementation of performance management. Accountability needs to be held at every moment not periodically.
- *Incentivize* — counties need to incentivize health workers to go to the remotest areas to work. IntraHealth has supported a number of counties in hardship allowances. The incentives need not to be monetary, but could be in the form of recognition, for example, awarding employee of the month as is the case in the private sector as this will highly encourage the health workers.
- Emphasis should be put on safety in the health environment. She gave an example of women health workers having to work in unlit corridors.
- *Supervision* of health workers — there should be three HRs for management, development/training and data around the health workforce.
- *Strikes* — in 2017, 300 man-days of healthcare provision were lost due to the doctors' and nurses' strikes. Mechanisms should be put in place around strikes; there should be minimum service agreements where critical services like ICU, Renal unit and maternity cannot be compromised. People should not die during strikes.
- *Data integration* — there should be a backup of data to the physical file. Intra-health has trained focal staff who can now generate reports in real time.
- Retirement — UHC works when the provider is at the dispensary level. Hence health workers need to be distributed from county to sub-county to the dispensary level.

By way of introduction, the moderator, Dr. Elizabeth Wala, called on Dr. Oluga, to explain whether people go on strikes only because of salaries.

Health worker unrest and strikes: Role of Health Workers Unions in improving employer–employee relations — *Dr. Ouma Oluga, Secretary General, KMPDU*

Dr. Oluga affirmed that the Union exists to improve employee-employer relationships. In a twist he also stated that the health sector wastes a lot of man-hours and finances on conferences, further stating that nowadays health conferencing is turning out to be a major tourism movement. He indicated that the trust conferred to health workers by the consumers is a powerful indicator of trust in the institution, citing that they are the most trusted of all workers. He was concerned by previous utterances about HWs not providing adequate care and informed that health workers are health consumers too and are not removed from the system. Health workers are not a commodity to be managed, but have lives to live too. They can work with you or not work with you. Holding health workers accountable starts from the management and needs both a supervision and a support system. He turned the heat on management by asking whether they lead by example by being at work, or being accountable. He lamented that ideas from health workers are seen to be less important.

Dr. Oluga mentioned that in 2015, the Union met with the Council of Governors (CoG) and tabled a Minimum Service Agreement (MSA), but the document is yet to be signed. Ironically, during the 2016/2017 strikes, the governors were calling on doctors to provide minimum services. He informed that the Union has one with KNH.

Dr. Oluga asked management to look at Unions as centres of development and insisted that health workers cannot work when there are austerity measures. He said that there were few partnerships between Unions and other entities and asked for more collaborations. Unions can provide advisory services by partnering with service providers instead of them hiring external consultants. He mentioned that Kakamega County had constituted a board and the Union had nominated Prof. Ayaya to the board. Health Workers and Unions must be looked upon as ambassadors of UHC. He argued that in spite of the negativity, 67 % of the population that goes to health facilities passes through a health worker, and that a study by Ipsos Synovate indicated that health workers were the most trusted of all professionals at 78 %. He noted that existing insurances are only effective up to 17 % and asked that there be deliberations around effective insurance. In his final comments, he remarked that there are 1,000 doctors in the Union who are unemployed and urged the participants to get in touch with the Union and offer them jobs.

Q&A session

Dr. Wala invited questions from the audience to the panelists.

Qn. 1: There is a 3.5% increase of older people which will increase fourfold in 2050. Are there any mechanisms for client orientation to ensure that health workers are able to deal with older patients? — *Doctor from Help Age International*

Qn. 2: We often focus on number of workers vis-à-vis the population. How about in relation to infrastructure needed? It is very common to find 20 dental surgeons with only four dental chairs — *Dr. Matiku, Health Economist and Policy Researcher.*

Answer by Dr. Kandie: Having more personnel than the equipment affects workloads of health facilities. The issue of aligning HR needs with the infrastructure is being addressed.

Qn. 3: Are we being realistic to have staffing target by 2030, while the population is growing? And are we thinking about the concept of health in all sectors, including education, security and so on? — *Dr. Kizito Lubano, KEMRI*

Answer by Dr. Kandie: On the question of staffing targets, there is a team in place that continually advises MoH on emerging issues and the changing environment. MoH policies are available online and participants should review them and provide comments for them to be aligned to needs.

Answer by Dr. Muriuki: IntraHealth is working with HR for health departments. This year they will be going to Nakuru and Migori to redo a segment to inform on standards and norms, where the counties experiences will be included. Bridging the gap cannot be done in one or two years. Lamu County has a higher workforce to a population at 13%, being one of the highest, mainly because they have a lower population. There should be cross-sharing of specialists between public and private entities across counties. Counties should set up centres and share the workforce, while the national government should maintain specialists to support counties. Specialists could be contracted, though contracting is not for all. Other health workers can be on permanent and pensionable terms. Contracting will help with decongesting our referral hospitals. Nurses who are specialized can be contracted to decongest referral hospitals, which could also be a form of undergoing training.

Dr. Wala mentioned that Amref offered cross-sharing of specialists.

Qn. 4: Since no county has met the expected ratios of health workers, are the issues of norms and standards being met by the different health facilities? — *Dr. Frank Mwangemi, CEC Health, Taita Taveta County*

Answer by Dr. Kandie: The norms and standards for 2018 are to be reviewed. Previous deliberations reported the need to come up with a skills list for each category of staff. In some counties, some hospitals were upgraded, but are still of a lower level 3. Plans are underway to come up with short-term and intermediate number of staffing.

Comment: Advise other ministries on health workers' needs for them to be able to respond to changing needs. — *Dr. Rose Bosire, KEMRI*

Answer by Dr. Oluga: Universities are not seen as stakeholders in the healthcare discussions, and are therefore, not invited to meetings. There is no alignment between what universities are doing and the government or the workforce. Universities run parallel to the sector. MoH should map all stakeholders and include universities which should be able to pick training needs. Since health devolved, it is still not absorbing more health workers, and universities are still training. The country suffers hugely from unemployment, hence, the country should start looking at solutions now that UHC is an important agenda. The country should think about incubating cottage industries. When hospitals work, the economy around that region also works. For example, at KNH you will always see people selling products, be it flowers, fruits, gifts, and so on. Human Resource Information System (HRIS) is an investment.

Dr. Mulwa, CEC for Health Makueni County, then welcomed delegates to the Conference. He recognized the attendance of UN agencies, development partners, CEC from various counties, NHIF, and the team from the government of Makueni County. He further recognized and appreciated several dignitaries, among them, the Deputy Governor, Adelina Mwau; Daniel Maanzo, MP for Makueni Constituency; Sylvia Kasanga, Senator Makueni County; Dr. Meshack Ndolo of CoG and Prof. Bahemuka.

Theme 2: Health service delivery

Objective*:* *Healthcare strategies on service delivery systems and processes*

The moderator, Ms. Irene Omogi, Quality Management and Accreditation Coordinator, GIZ, called upon Dr. Kandie to give his keynote address.

Implementing the Kenya Quality Model of Health and tracking performance in health services — *Dr. Charles Kandie, Head, Department of Health Standards Quality Assurance and Regulations, Ministry of Health*

In his opening statement, Dr. Kandie highlighted that the health sector exists to improve the healthcare system, where the ultimate goal is reduced mortality and reduced morbidity. He elaborated that quality should be driven by strategy and policy. When discussing strategy, he highlighted five key points in Kiswahili for achieving quality as: *Kusasambua, Kuseti, Safisha, Fanikisha* and *Shikikia*. The Kenya Quality Model for Health (KQMH) is inspiring health facilities to go beyond the minimum. KQMH is related to the ISO standards and has 12 dimensions. It has been piloted in Kilifi, Meru and Kakamega counties where inspections have been intensified. The MoH has gone to every county and trained on KQMH. To access NHIF funds, one must be law compliant. The accreditation system is measured continuously for quality improvement. There are various compliance categories provided. For non-compliance, one's certificate is taken away. He further mentioned that PDSA tool is necessary to improve various sectors. In his concluding remarks, he indicated that each discipline needs to self-regulate.

Towards a Patient-centred Care and People-Centred Health Systems — *Stephen Murathe, Deputy CEO, Morris Moses Foundation*

Mr. Murathe started by informing the Conference that the reason why health systems exists is because of the patient who receives the care. However, the patient often gets lost in the system, where the focus is on everything else except the patient. If the patient is not forgotten, then most likely the care is not to their liking. The medical curriculum is mostly disease-centred, capable of providing clinical solutions; but if there is to be a shift to patient-centred care, focus needs to be on human interactions. Faith healers and pastors make a breakthrough with the people they serve because they listen to them and give them ample time to open up. He indicated that during a recent health forum in Nairobi he asked the question, "Does the quality of training affect the quality of healthcare?" If the curriculum does not offer patient-centred approach, then it will be difficult to provide for the same. Mr. Murathe noted that every health person needs to be involved to provide care to patients. To illustrate his point, he told an anecdote where patients feared bed number seven in a certain hospital because all patients allocated bed number seven died. On investigation, the

hospital management found out that a certain cleaner would come every morning and unplug the machine on that bed to charge his phone.

He emphasized that there should be a collaborative approach among everybody in the health sector, and not just the physicians but every other person who is involved. Everybody is a player in the healthcare system, including the patient. Faith healers have specialised data on what is ailing patients because they listen to the patients who open up to them. In his concluding remarks, he mentioned that visits to inspect health facilities on patient safety should not include the superintendent only, but the entire workforce involved in offering healthcare, from the watchmen, cleaners and the patient themselves who are the receivers of care. Furthermore, he concluded by pointing out that citizens needed to have information of the different medical courses available, further stating that nothing goes wrong, it simply starts wrong.

Policy and programmatic experience of Task-shifting/Task-sharing — *Agnes Waudo, Country Director, Emory University Kenya Projects*

Speaking about the task-sharing policy that Emory University supported the MoH to develop, which was launched and is now being disseminated, she indicated the rationale for the policy was to promote equitable and enhanced access to UHC at the national, county and sub-county levels to improve the utilization of the Human Resources (HR) and financial resources. Utilizes available resources to ensure that they can still provide quality service to clients. For Kenya they embraced the task-sharing component as opposed to task-shifting. She gave the definition for task-sharing as a systematic delegation of tasks where appropriate from more highly skilled professional cadres to less specialized cadres in order to improve efficiency and maximize use of existing HR for health.

She further gave another definition from WHO guidelines 2007 as, specific tasks are shared between highly qualified HWs and those with shorter trainings and less qualifications to enhance efficiency of use of available HR information system. Task sharing is necessary for the scale-up of UHC in Kenya.

Ms. Waudo elaborated the principles of the policy by stating that high standards of ethics should be upheld and the policy should be adapted and formalized to ensure adequate productive HWs, creation of an enabling healthy regulatory environment by aligning rules and regulations to adapt as theory. Some of the regulations are inhibiting to certain cadres to perform certain tasks. Ensure quality of care during implementation and improve skills and competencies. The task-sharing policy calls for all at different levels of government to ensure that health cadres are taken through some kind of training on the new skills. The policy is currently formalizing those tasks and enabling the HWs to achieve their tasks for sustainability. She mentioned that there was need to organize clinical care services and regulate, coordinate and integrate the system. The guiding principle for the task-sharing policy is to determine the prohibited legislation and scrutinize the job descriptions and the scope of practice as endorsed by regulatory boards and see how they can

be made possible for HWs. For individual HWs, their competencies need to be scrutinized for them to perform their activities safely. The study focused on HIV/AIDS as it was supported by PEPFAR but can be generalized. It also looked at how task-sharing can be implemented in the area of communicable diseases, non-communicable diseases, reproductive health, immunizations, nutrition, mental health and quality improvement.

In her final remarks, she mentioned that they expected that the MoH will oversee the implementation, revise the scheme of service and job descriptions, while the counties should manage the policy implementation process and ensure that trainings are conducted, that regulatory bodies have amended that which is necessary. The intergovernmental regulation agencies should do the oversight policy implementation process, while the health professionals' agencies should initiate and review harmonization of existing rules and regulations. Public, private and faith-based health facilities will comply with the policy where possible. The process has to be inclusive of all community HWs, families and everyone for the achievement of UHC.

Disaster preparedness and response strategy in Kenya: Are we there yet? — *Amos Onchiri, National Disaster Management Unit*

Mr. Onchiri confirmed that the National Disaster Managements Unit (NDMU) is an inter-agency institution that was established by a presidential directive in 2013 after a series of emergencies and disasters. Emphasizing that the question, 'Are we there yet?' was a big one, he asked delegates to define some terms, including disaster preparedness. He defined disaster as an occurrence that affects a given population, where the consequences maybe adverse or diverse and that the affected population is unable to cope with the impact. An emergency is a sudden occurrence, while disaster preparedness is the pre-disaster activities including capacity building, resource mobilization, hazard assessment, resource mapping, emergency drills and so forth. Finally, he defined disaster response as the actual offering of emergency services in the imminent occurrence of a disaster. He noted that within the disaster management cycle there were five major phases as defined in the National Disaster Risk Management Policy, 2017 as prevention, preparedness — where he stated that each dollar invested in preparedness, saves seven dollars that would have been used in the response and recovery phase. Arguably, no country in the world is effectively prepared to respond to emergencies, because one cannot quantify the magnitude of a disaster that is to strike and when.

The third cycle is response and recovery. He noted that the ultimate goal of disaster risk management (DRR) is a resilient nation, county and sub-county. He further pointed out that UHC is a DRR strategy. Disaster management is a shared mandate between the national and county governments who are the key stakeholders. Emergency medical care policy which is at the legislation level provides guidelines on the coordination of ambulances, pre-medical care and establish effective response through evidence based strategies. Mr. Onchiri indicated that they had operationalized the emergency Centre at the National Police Service, at the NDMU and at the

National Disaster Operational Centre (NDOC) and many others. In future, they intend to link up these centres through an integrated online system for information sharing. The mass casualty incidence protocol provides for guidelines on maters incident management. Partnerships include with the COMESA Resilience Academy, the Humanitarian Leadership Academy and the Masinde Muliro University which provides undergraduate program on DRR and International Diplomacy.

There exist opportunities for counties to tap into and invest in DRR for resilience in matters concerning UHC, as it needs a DRR perspective. He pointed out to emerging issues including Chemical Biological Radiological Nuclear and Explosives Emergencies (CBRNEE), and mentioned that HWs should be sensitized and trained in handling CBRNEE casualties. He encouraged that partnerships between the national and county governments should be strengthened in DRR issues for resilience. Capacities along DRR should be built to ensure for a multi-hazard approach which is a best practice in the Sendai Framework for DRR 2015–2030. He asked the national and county governments to invest in decontamination units and isolated wards for casualties affected by bio-hazards. There is also a need to conduct drills and exercises to ascertain that systems are working. He gave an example of the conference room which had no marked emergency exists and fire extinguishers and noted that the hotel administration were not prepared in case of an emergency.

Finally, he concluded with a quote from Valerie Amos, the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, "We can't prevent disasters, but preparedness can help prevent the human tragedies they cause".

Advancing Global Health Security Agenda in Kenya through strengthening of information systems and reporting? — *George Owiso, Country Representative, I-TECH Kenya*

In his opening remarks, Mr. Owiso began by quoting W. Edwards Deming, "In God we trust, all others bring data." Electronic information systems will not solve system problems in the health sector. He suggested that we need to figure out what the solutions should be and how information systems can enhance the solution. It is called human centred design, which is the only time information systems work. Safaricom invented M-PESA because we needed to move money. When digital health investments are used correctly, there will definitely be an improvement in patient care and the quality of data collected which will aid in policy decision-making. He mentioned that while looking at vaccine coverage for the country and what was in the KDHS report, he noted that the statistics showed that Kenya was doing so well at over 90 % in most of the parameters. However, when they looked at DHIS 2, they noticed that it was much lower. He urged counties that wanted to solve such problems to put an information system to observe concurrence between their administrative data and the data reported at the national level. Data used for decision-making will rely on data that is routinely generated from health facilities, hence, the need to strengthen the system that collects the data. In elaborating on the products he asked, "How

many information products or digital health investments do you know that exist within your jurisdiction?"

Mr. Owiso indicated that people should understand what the systems do. First off, he asked that the process begins by taking stock, and understanding the products and the data that they generate, whether it is longitudinal or cross-sectional data which only takes stock of people that are served at that time. He mentioned that it was also imperative to ascertain whether the data will be available beyond the health facility that produces the report or if the data will be available only at the facility. Secondly, he asked that certification systems be built around the systems. There was a process to develop standards for information systems, but it was never implemented. He noted that probably with devolution of health, enforcing of the guidelines might be possible. Lastly, he asked of the number of people who had accessed services, how many were unique? When registering people, use what people are — their biometrics, what they know — their demographics or what they have — their NHIF card or ID to uniquely identify them across facilities or within the same facility. He pointed out that we always complain that we do not know how many HIV patients we have, or how many people have malaria and this is simply because we are just counting services and not people. With the unique national identifier, we can build data from the counties up.

Q&A session

Comment: The issue of task-sharing/task-shifting presents us with a dilemma because we are giving unskilled professionals' tasks they don't know how to do. It also brings about the issue of overwork, as at most times it is the nurses who end up doing the bulk and can also lead to looking down on other professionals. This practice is unsafe for patients. I recommend that we have clinical officers at dispensary levels — *Rachel Kamau*

Comment: Emory University cannot allow their own state to have a policy like the task-sharing policy. The policy is wrong — *Dr. Oyuga, Secretary General KMPDU*

Answer by Agnes Waudo: Emory University came to support MoH at their request, not the other way round. CDC Kenya had requested PEPFAR for Emory to provide the support. The university helps to strengthen health professional bodies. Task-sharing is used to scale-up UHC using available HR. Many good doctors learnt from nurses. In terms of policy; many people have died because nurses are not allowed to put intravenous catheters (IV-lines). We should appreciate one another.

Qn. 1: How come every time there is a disaster, we only hear of Red Cross, who mobilize resources and respond? Where is the NDMU in instances of disaster? What have you done to empower the counties to be able to respond to disasters?

Answer by Amos Onchiri: On the issue of incident management, NDMU has been growing over time. Since 2014, at the inception of NDMU there has been some level of sanity in incident management. The NDMU adapted the incident command system from the United States. The incidence management team can deploy Red Cross to for instance deal with the emergency or disaster. NDMU also conducts sensitization trainings for free and we can be invited to train on incidence management in the counties. DRM is a shared function, hence, we can only advise the county governments and offer support for them to develop Acts and policies. We have trained West Pokot, Nairobi, Mombasa and Turkana counties on DRM. The Ministry of Education has safety guidelines that they enforce through the regulators and auditors.

Qn. 2: Every partner wants to implement their own information system; why can't we have few partners implementing so that there is uniformity and we are not constantly taken back?

Answer by Dr. Charles Kandie: On the question of information systems and partners, we've had similar problems and so we decided to put all our systems on DHIS 2 so that it is managed by our own officers. We are currently in the process of ensuring that all our systems are integrated on one database. Our department works with counties to capacity build them and help them improve quality. There is a current plan to work with the County Health Director, Dr. Ndolo, and his CEC so that in the next two-year period, every facility is mentored on QY [Quality Improvement] at no cost. KQMH, has a component for measurement that focusses on patient-centred care.

Answer by George Owiso: When there is duplication of information systems in facilities or counties, it is the management that should be held responsible. We should not allow partners to burden us with new information systems.

Qn. 3: It seems that as government you have many tested, proven, expensive solutions and for some reason, we at the county level are not able to access those solutions. Where is the problem?

Qn. 4: In the spirit of universality, are we able to think around the issue of disaster preparedness and how it affects the whole spectrum of the human being? — *Judith Nyakawa, National Treasury*

Comment: We need to inculcate UHC into our education system because we spend so much money treating ailments when we should be preventing through education, a case in point when dealing with lifestyle diseases — *Judy Nyakawa, National Treasury*

Comment: The Kenya Quality Model for Health (KQMH) is one of the best policies ever developed, but is also one of the silent policies. As Africans, we have to value ourselves; if cancer is to be treated by an oncologist in England and in California, then let cancer be treated by an oncologist in Africa.

Comment: The Integrated Population Registration System (IPRS) is a unique identifier which should capture name and number from birth, which will also be the same number for the ID, passport, driving licence, NSSF, NHIF and PIN. The project is currently ongoing between Ministry of ICT and Ministry of Interior. In the medium term planning process of the government 2018–2022, Disaster Risk Management (DRM) has been identified as a new sector that was not considered in government planning. Hence, there will be a lot of work by the national government in this area trickling down to the counties — *Dr. Julius Muia, PS, State Department for Planning*

Qn. 5: Quality costs money and has to be a deliberate effort. What kind of investments is Makueni County making to ensure that the quality provided is of the highest attainable standards? — *Irene Omogi, Quality Management and Accreditation Coordinator, GIZ*

Note: The above question directed to H.E. Prof. Kivutha Kibwana, was deferred to be tackled at another session.

Qn. 6: What impact does task-sharing have on the satisfaction of employees? How does KQMH address issues on patient-centred care? — *Irene Omogi, Quality Management and Accreditation Coordinator, GIZ*

Answer by Stephen Murathe: There should be structures to support the patient, for example, suggestion boxes and a Patient Affairs Officer in the hospital, who patients can complain to. Patients should be able to lodge complaints with the Patient Affairs Office, which should be operational at every health facility. We need to focus more on the human relations aspect of UHC.

Theme 3: Innovations in logistics and supply chain

Objective: *Strengthening Kenya's healthcare supply chain to deliver Universal Health Care*

Session Moderator: *Dr. James Kanyange — Director, Health Commodities and Technologies, Makueni County*

Dr. Kanyange announced that the Pharmacy and Poisons Board representatives had sent their apologies. He then welcomed the panelists present to make their remarks, starting with the keynote speaker, Dr. James Riungu.

Keynote speaker: *Dr. James Riungu, Supply Chain Director, Afya Ugavi, Chemonics International, Kenya*

Using last mile distribution to increase access to health commodities

In his introduction, Dr. Riungu regretted that the last mile is not taken seriously. He volunteered that the biggest challenge as a child was being sent home because of lack of drugs. He noted that the two levels of government [national & county] must work in harmony to achieve UHC, seeing that the mandate of the national government and Ministry of Health includes: policy development; capacity building; provision of standards and regulations; and technical assistance, while that of the county governments is service delivery.

He gave highlights of what is ailing the supply chain:

- The transport system is a major problem. Some patients live in deplorable conditions and cannot easily access health care facilities. How do we reach them?
- Some facilities keep drugs in deplorable conditions, hence managing the quality of the drugs is a challenge.
- Unavailability of drugs because of ineffective and inefficient supply chains. With no commodities, there cannot be health services. Why should people continue to die of treatable diseases like malaria, simply because the medicines are not available in the health facilities due to ineffective and inefficient supply chains?

While emphasizing that health supply chains are critical to the provision of health services, he offered that, using technology, there can be proper flow of information, financing and most importantly health products. It is possible to have better supply chains, from manufacturing to delivering to health facilities.

Supply chain objectives include:

- *Balance between supply and demand* — do good supply planning. Ensure there is sufficient supply and provide consistent uninterrupted supply available to meet demand.
- *Cost* — minimize company cost and cost implications to counties and patients.
- *Quality and safety* — systems management to ensure supply of quality medicines till the last patient, ensure drug safety in each step of the supply chain.

The supply chain can be divided into three streams:

- *Upstream:* the whole procurement process, including the initial scope, procurement, selection of manufacturers and through to delivery to the first port of entry into a country.
- *Midstream:* starts at country level, either port or Central Warehouse and covers the distribution of commodities from the port of entry or central warehouse to the regional or sub regional levels. Examples of midstream players are KEMSA and MEDS.
- *Downstream:* covers the transportation and distribution of the commodities to their final destinations, the health facilities, from the County/Sub-county level warehouses. It includes delivery to the final and most remote Service Delivery Points (SDP) to ensure that the end users can access commodities when they need them. Distribution from the warehouses to end-users is part of service delivery and not supply chain. This is the last mile.

Last mile delivery may be defined as the movement of commodities through the midstream and downstream stages of the supply chain through to the service delivery point.

The last mile is one of the most fragile parts of the supply chain because it depends on a range of different aspects.

Factors affecting successful delivery to the last mile

- Infrastructural challenges (transportation breakdowns, unreliable electricity supply, need for refrigeration, bad weather challenges).
- Poor skills to do demand and supply planning, thus ordering too much or too little; low-skilled staff; wrongly recorded or missing stock levels; and consumption data.
- Low staff morale — some say they forgot to order medicines. Nobody forgets. It is a case of disinterest due to low salaries, overburdened health workers and lack of motivational incentives.
- Limited resources, say, transportation costs not budgeted for.
- Questionable quality of products at the facility level.

The key issues in supply chain are price and quality. At the upstream we may buy a tablet for 1 Kenya shilling but at the downstream it ends up costing 20 Kenya shillings, coupled with poor storage. Variability in quality and price increases downstream.

How supply chains can improve UHC

- Strong supply chains are essential in effective health care delivery in all sectors. KEMSA is able to deliver to difficult-to-reach areas.
- They define the ultimate cost and accessibility of medicines.
- They provide broad geographic access to affordable, high-quality products

Well-designed supply chains guarantee health care delivery, and thus UHC.

Success factors include:

- Quality of medicines at the last mile;
- Reliability of suppliers;
- Availability of medicines; and

- Price is a relative consideration — it is best to start with the three above.

Improving quality

- Quality — substandard medicine is costly and should be reversed by investing in quality control laboratories (the country has two so far); and post-marketing surveillance. In this country, we have a problem of counterfeits which cause more harm.
- Price — health commodities form the second largest driver of costs in the health sector. There is need to improve price by adapting differential pricing, that is, having different prices for different markets and barring unscrupulous business people from buying the cheap commodities to resale at a higher price.
- Reliability — Kenya has medicines for most diseases. Patients die of manageable diseases because our supply chain systems are not reliable.

Conclusion
UHC requires supply chain systems that are designed for devolved units. It is therefore necessary to redesign existing supply chain systems. Kenya has the resources with which to do this. To achieve UHC health commodities security, price should be a relative consideration.

County experiences in procuring health products — a look at the gaps — *Dr. Claver Kimathi, Chair, County Pharmacists Caucus and County Pharmacist, Isiolo County*

Before devolution, procurement of essential medicines was done centrally at Afya House. One would do requisition and wait for the supplies. With the onset of devolution in 2014, KEMSA was blamed for erratic supply, yet this was due to funding challenges. Some counties did not want to continue with KEMSA, opting to deal with new suppliers who proved to be corrupt and did not guarantee quality, safety and favourable costs. In the long run, County pharmaceutical officers mooted a forum to ensure quality and safety of products from suppliers and to avoid audit issues. So they stuck with MEDS and KEMSA who auditors had given a clean bill of health. They also prefer suppliers with all products under one roof, to save on costs. KEMSA is to stock cancer, renal management drugs and lab commodities; MEDS is already doing it.

Challenges

- County governments do not pay for supplies. KEMSA is owed 2.4 billion Kenya shillings by counties. It is important to pay KEMSA to avoid hiccups in supply.
- There is the challenge of getting reliable quality data to inform the budgeting process which is essential for forecasting and quantification. It is prudent to invest in data collection and management.
- Storage is not ideal. Arid counties lag behind because of geographical challenges as well as storage challenges such as storing medicines in hot conditions or on dusty shelves.
- Expiry of drugs is prevalent in the country. Expired drugs not only occupy space, they may be resold by unscrupulous business people. NEMA complicates the destruction of the expired drugs. Nevertheless, there is need to mop up expired drugs. He called for a holistic approach, and suggested that, perhaps we could engage KEMSA and MEDS to do the mopping on our behalf.

He finished by saying that he had a lot more to share but was limited in time. He invited participants to feel free to approach him to discuss further during the breaks.

The moderator, Dr. Kanyange thanked Dr. Kimathi for his sharing. He then introduced the next speaker, Dr. Jonathan Kiliko from MEDS.

Policies on medicines procurement that specifies the most cost-effective medicines in the right quantities — *Dr. Jonathan Kiliko, Head of Customer Services, Mission for Essential Drugs Supply (MEDS)*

Dr. Kiliko spoke on behalf of Dr. Jane Masiga, the Managing Director, MEDS.

He started by acknowledging the fact that Makueni County is leading in UHC and in keeping its promises to citizens and partners, and for this, he led the participants in applauding the County leadership. *[Applause]*

He then described MEDS as a faith-based organization which is not for profit or loss making. It operates with a small budget in terms of supply chain, called drug revolving fund. MEDS works towards an efficient and cost-effective supply chain system. MEDS specializes in supply chain, quality assurance (MEDS has a WHO-prequalified quality control lab), and health advisory services to counties and all other partners.

Back to his topic, Dr. Kiliko sought to highlight the following areas that a county would need policies in, to achieve the UHC dream:

- Proper product selection — health needs should drive this, and these are unique to each county. Each county should thus prepare an essential medicines list as per its specific needs.
- Forecasting and quantification to avoid stock-out and stocking of drugs that are not consumed
- Efficient procurement to ensure cost-effective supply of essential medicines and equipment. Products should be sourced from reputable institutions that have available stock and that offer good process.
- Paying promptly to avoid commodities interruption
- Inventory management

In ending his talk, he supplied that the success of UHC lies in strategic partnerships between public and public or between national/county and county, or private–private partnerships (PPP), to bring down the cost of essential commodities. Counties should pull together to take advantage of economies of scale that make a difference; they improve purchasing power and enable consumers to attract several volumes, especially for commodities that are very expensive in the private sector market.

The moderator thanked Dr. Kiliko for his timely talk. He then welcomed Dr. Allan Mackenzie to tackle the next topic.

Modalities for improving treatment access — *Dr. Allan Mackenzie, Regional Government Affairs Manager, Astra Zeneca*

Dr. Mackenzie informed participants that he oversees operations across sub-Saharan Africa, and they look at ways to work with countries and governments to increase access to treatments.

He too lauded the Makueni Governor for the UHC programme and gave a short story to illustrate the impact it had, in terms of the factors that affect the seeking behavior of patients. One time his casual worker named Mutuku requested him to help him take his sick relative to hospital. Instead of choosing to be taken to the nearest health facility within Masii in another County where they lived, he asked to be taken to a facility further away in Makueni County, due to the affordable cost of treatment there. Their County had very good health facilities, yet they were out of his reach. He acknowledged that, yes, patients may choose to go to a particular health facility because of the cleanliness, kindness or care, as was shared earlier, but they may also make a choice because of cost. He thus asked participants to applaud the Makueni Governor. *[Applause]*

He then proceeded to talk about Astra Zeneca's efforts in improving access to treatment. Astra Zeneca is a science-led pharmaceutical company involved in the discovery, development and commercialization of human medicines that focus on tackling some of the biggest challenges facing Kenya, and these include largely the non-communicable diseases whose data is not usually available compared to diseases like pneumonia, malaria, tuberculosis, and others whose data is known since there has been investments in recording the cases. We all are aware of cases of non-communicable diseases such as hypertension, diabetes or cancer, but we don't highlight them because we don't have the numbers. Luckily, Makueni County is keeping records, as was evident from the Governor's presentation. The numbers are essential, for example in bringing social care at affordable costs. Since Kenya is a free market economy, meaning we can't control the pricing; suppliers may put huge markups to their products. Astra Zeneca finds ways to reduce costs by shortening the distribution chain where they ship directly from the manufacturer to MEDS, which then supplies to the facility, thereby having only two players. So, for example, for a monthly dose that would cost patient 3,000 Kenya shillings in private facilities, they would end up paying 200 Kenya shillings for the same dose.

Still on affordability, Dr. Mackenzie quoted a certain bishop who is in charge of a project, who when looking at affordability at the household level, gave the example of a farmer who has a chicken that is laying eggs; he can afford to sell the eggs and pay for his monthly anti-hypertensive treatment.

Besides the cost of care, it is important to look at the value of health. The Constitution of Kenya talks of [every person having the right to] the highest attainable standard of health; it doesn't talk about health care. Health is a state, while health care are the activities done to achieve health.

We need to put a value to a person or partner who is providing a more holistic package of care, from involving communities in health care to improving their health wellbeing, to health promotion activities, to improving their diagnostics and health worker capacity building, to providing medicines through procurement. The usual practice in Kenya has been to look at cost reduction by awarding tenders to the lowest bidder that is probably not concerned about you or your population. But there may be a different partner who may be slightly more expensive but is investing in the entire continuum of patients' pathway (of care), who you should instead consider.

He gave an example of a county that Astra has been working with for the past three years on a hypertension programme. That county has seen a significant reduction in the number of patients presenting with stroke in outpatient care. Patients presenting with complications of these conditions are consuming a lot of health care budgets because they will require inpatient critical care such as dialysis, and so on, whereas if the investment had been done earlier, in providing a more continuum of care, say, bringing care closer to where this patient lives, works or does leisure activities, maybe these complications could have been prevented or delayed and that would mean lower cost of care for the county.

Other initiatives that increase access to treatment include devolving healthcare to lower levels of care. A lot of care, especially for non-communicable diseases is given in higher levels of care yet it is locally it is possible to capacity build local health centers and dispensaries to be able to offer care for non-complicated serious conditions, thereby significantly reducing the cost of care. This requires embracing partnerships that support capacity building, and that encourage local innovations like community pharmacies. These were actually initiated a while back but failed due to lack of political will. However, isolated incidences of effective models of community pharmacies still exist. For instance, Amref has such models in Nairobi and other counties, while AMPATH is implementing such models in Western Kenya where health centers are able to expand the basket of care and get into innovative models that contribute to affordable and accessible healthcare. Thus, counties should ensure that the care delivered rides on, or is integrated into existing programmes such as HIV/AIDS.

Astra's Healthy Heart Africa programme aims to improve access to hypertension care sustainably. Counties should avail treatments in very low levels of care so that patient do not need to travel far, and that medicine is assured of quality, is at an affordable cost and the people in that facility are actually capacity built to provide individual care. Clinical officers need to show up in community meetings to offer health messages and offer reviews and treatment for those patients with conditions such as hypertension and diabetes.

Lastly, Dr. Mackenzie noted that care has been delivered in vertical programing, and Astra is looking into innovations such as pooling the demand to drop the prices. He advised counties to 'pool demand' for supplies, to be able to approach manufacturers together and negotiate for significant discounts for bulk orders. He said Astra piloted this by pooling the demand by 700 facilities across Kenya, and they were able to attract discounts, which minimized costs. He said this is the strategy private facilities use to buy supplies cheaply.

The moderator interrupted the programme to give the area MP and the Senator a chance to make some remarks.

Remarks by Hon. Daniel Maanzo, *MP, Makueni Constituency*

Hon. Maanzo admitted he had learnt something new from the conference proceedings and remarked that there are a lot of health bills in Parliament yet there are only four doctor MPs and they only get 10 minutes each to speak. Not surprising, the Chair of the Parliamentary Health Committee is not a doctor. MPs should be invited to health forums to sensitize them on the issues

that need Parliament's intervention in terms of passing relevant laws. He also invited participants to visit Makueni again, even privately, as it has a lot to offer.

Monitoring the health of foetus and mothers during pregnancy — *Senator Sylvia Mueni Kasanga, Nominated Senator, Makueni County*

Senator Kasanga started by congratulating the Governor of Makueni for the progress evidenced in UHC. She said in her work as a Senator, she focuses on the built environment, and is an architect and arbitrator by profession. She challenged participants to discuss the built environment since health officers make part of the approval process for built environment issues, and food issues that have a big impact on health.

She informed participants that Senator Mutula Kilonzo had published a bill in parliament on disaster preparedness, and since senators get more time in parliament than MPs, lobbying and championing bills becomes easier.

She said she works with a group of young doctors who have come across a portable foetal monitor for maternal health produced in Poland; it gives real-time results on what is going on. It doesn't need electricity. She bought one and would like to present it to the Governor of Makueni to complement his efforts in UHC.

Here, the moderator presided over the handing-over moment, and in a light moment, he asked participants if they had witnessed their politicians donating anything from their pockets, like is happening in Makueni.

The Senator presented the gadget to the Governor who was flanked by his Deputy and the MP for Makueni. There was a photo moment. The Governor thanked Senator Kasanga for her gesture and promised to use the gadget and see how to get more if it proves to be effective.

Experiences sharing session

Objective*: Share strategies towards universal health coverage in counties*

Moderator*: Dr. Meshack Ndolo, Health Advisor, Council of Governors*

Dr. Ndolo said UHC is the trending issue, and invited panelists from Makueni, Kwale, Kiambu, Kakamega and Laikipia counties to share the strategies they are using to implementing UHC in their respective counties.

Lessons from HIV situation to manage UHC better — *Dr. Nduku Kilonzo, CEO, National Aids Control Council (NACC)*

Dr. Kilonzo started off by giving a brief on the HIV situation in Kenya. The HIV prevalence rate in Kenya is more than 5 %. In Kenya, a 90–90–90 treatment policy is used where the target is to ensure that 90 % of the people living with HIV are identified; 90 % of those identified receive sustained ART; and 90 % of those on ART are virally suppressed. Currently, over 1 million people are on ARV treatment which is used to strengthen immune response and enable an extended life.

There is need to increase coverage through increased efficient and effective treatment of related diseases such as TB, and non-communicable diseases like cancers, diabetes and heart diseases. NCDs are the new co-morbidities of HIV. The period from 2005–2016 has seen a 61 % decline in HIV incidences, with 57 % increase in non-communicable diseases. There is lack of investment in prevention.

Dr. Kilonzo regretted that NHIF does not offer HIV services cover for people living with HIV as it is not paid off of the insurance, hence the sustainability of treatment costs is in jeopardy.

Opportunities and recommendations on UHC:

- Include HIV as part of the basic health care package; UHC is to be missed by 1.5 million if HIV is not covered.
- Adopt mechanisms for channeling HIV treatment resources through national health insurance schemes.
- Extend HIV primary prevention model and infrastructure to NCDs.
- Insurance companies should start covering HIV patients, not the diseases.

HIV services cover should include testing and consultation services, ART and viral load. We should extend the AIDS model for estimation of STDs and infrastructure of NCDs, and reduce long-term costs to health. We need off-budget financing through development partners and foundations. The cost of ARV per person per year is 42,000 Kenya shillings, besides other costs such as mother-to-child transmission. The urban roads project generated 2.1 billion Kenya shillings for HIV mitigation, money which should be used in counties for social protection and reducing numbers of new infections.

In leveraging available resources for results for response, NGOs do self-reporting. Treatment funds should be leveraged to contribute to risk pools.

To extend HIV primary prevention model and infrastructure to non-communicable diseases (NCDs), we need better investment in data, and curriculum review — we need to address HIV and NCDs in our education system by, for example, embedding health knowledge and better health choices in the curriculum.

Opportunities for NCDs prevention in order to safeguard our risks pools and insurance schemes include estimation of NCDs, which may bankrupt insurance schemes if not checked. The health sector needs to invest in indicators and routine diagnosis, that is, wellness screening for High Blood Pressure (HBP), BMI, cancer screening, and others, so as to channel prevention better.

On the way forward, Dr. Kilonzo stated that HIV is not an enemy, and therefore, we should look at resources and determine how to channel them better; use the HIV prevention model and infrastructure to leverage experience to strengthen prevention; and take total advantage of UHC resources.

Community-based health insurance as an option towards UHC — *Dr. Patrick Musyoki Kibwana, Chief Officer, Health Services, Makueni County*

UHC in Makueni is a journey that is ongoing. He underscored the interest that Makueni County government has in the health of its citizens; it heavily incurs expenditure on the people to provide primary health care. The County has engaged in building operational health facilities in the local area, from the community-level dispensary, to healthcare units — patients find a physician and there are drugs. He lauded the national UHC conversation happening in the country, saying that, if primary healthcare is not working, everyone will be flocking the sub-county referral hospitals.

To implement UHC, Makueni County has invested in:

- *HR recruitment and motivation*. For example, the staff are on Madison insurance and Makueni Care. There is also timely remittance of salaries and statutory deductions. The County Assembly passed an Act that allows hospitals to keep the money they collect instead of remitting it to the County revenue account. All they require is Authority to Incur Expenditure (AIE). Decisions are made at the hospital management level.
- *Health commodities investment* — the drugs procurement budget increased to 400 million Kenya shillings, and since 2013, no facility has had stock-outs. The County has built a county depot from where the local facilities conveniently get their supplies.
- *Infrastructure expansion* — there are 8 sub-county hospitals, complete with maternities, operational theatres, dental services, radiology services, and training institutions.
- *Leadership and governance* is key — if you are getting a salary you must work. The Governor leads by example; he works hard.
- *Accountability* — you can't steal public coffers in Makueni; you will suffer the consequences immediately.

The County is basically making improvements in all areas in line with the Constitution of Kenya which guarantees access to quality health.

Implementation of Kenya Quality Model of Health — *Mr. Francis Gwama, CEC Health, Kwale County*

Mr. Gwama first thanked Amref and GIZ for supporting Kwale County towards UHC, saying that Kwale County has quality improvement teams in place at sub-county level and facility level. The teams articulate facility level needs.

Improvements in the health strategy include:

- Strengthening community casuals in primary health care.
- Developing a health strategies policy —for example, all community health assistants are getting monetary incentives. They are the direct link to the community in sending health messages.
- Mapping — to locate facilities within the county and the services offered.
- the health facilities also hold periodic meetings to share best practices, and organize recognition and motivation of facilities and health workers that have performed well
- There is coaching and mentoring at all levels, which has led to improved utilization of facilities.
- The GIZ collaboration helped in streamlining health partners and allocating each partner the activities to do and the exact location, thus clearing out duplication.

- The County health sector has worked with GIZ and Amref to get political buy-in, resulting in allocation of 10 million Kenya shillings for malaria through PPP. There is also an ICU and a Renal Unit in Kwale, courtesy of the Governor.
- The health sector is designed to look for solutions from within. There is a County Blood Bank Centre and an operational CT scan.
- There are 1,620 health workers currently compared to 400 previously.

The moderator appreciated the use of partners that resulted in the good experience for Kwale, especially on how to deal with malaria.

Using community health workers to recruit households into NHIF — *Dr. Donald Muthui, CEC Health, Laikipia County*

Dr. Muthui stated that the UHC journey started in 2017 with the new Governor who wanted to transform the county by providing universal health care. This was as a result of the experience he had as the local MP where an estimated 40 % of community members would go to see him seeking financial help to access medical services. When he became Governor, he called a leaders' meeting that resulted in a leaders' charter to get NHIF membership for Laikipia citizens. The County called on stakeholders to help enhance health care services, which saw Amref and NHIF coming on board to help enroll citizens to NHIF.

Among the low-hanging fruits is the use of community health volunteers who move into households getting data for community-run health information systems and to enroll the same households to NHIF.

Amref developed m-Jali to assist in collecting data, register citizens to NHIF, and to help the communities determine what other economic activities the households would engage in to be able to get them out of a subsidy programme to paying for themselves. These include contract farming and enterprise fund.

The other strategy is to have volunteers use technology, that is, mobile phones which have been installed with necessary data; IBM has nice analytical tools to determine relationships in health and sanitation issues. Through volunteers, Laikipia has visited 75 households and taken socioeconomic data and enrolled the citizens to NHIF. Barring NHIF structural issues which need to be resolved, Laikipia uses technology to register community members at their homes instead of them having to visit the NHIF office.

The County is in the process of getting more health workers and constructing 2 mother-and-child hospitals. To expand service delivery, most facilities are accredited to NHIF. Last year alone, Laikipia got NHIF to accredit 39 more health facilities. The challenge now is to upgrade those facilities.

The moderator thanked the speaker for sharing the rich experience in Laikipia and invited Dr. Joseph Murega to speak on PPP impact on UHC, especially when the community is involved.

Philips Community Life Centre aimed at strengthening primary health care and enabling community development — *Dr. Joseph Murega, CEC Health, Kiambu County*

Dr. Murega started by declaring the total population of Kiambu County, which stands at 1.9 million people, who need UHC. Added to this, 50 % of patients come from outside Kiambu County. The County has 70 dispensaries and 80 level 4 hospitals. All level 4 and 5 hospitals are NHIF-accredited. Ruiru Sub-county with a population of 300,000 people and an influx from outside, has 1 hospital and 2 dispensaries.

The Governor's manifesto focuses on prevention.

In the Langata-Githurai area, Philips set up community life centres to integrate health care services to economic activities. Philips lights the roads leading to the facilities and helps align infrastructure to reduce delay.

Results of the PPP include:

- *Safety* — Philips put up a health facility on a one-acre piece of land and provided green energy that provides lighting, and powers equipment in the lab and the pharmacy. It provided equipment for connectivity so that there is no delay in service delivery.
- *Free water* — Philips is set to drill a borehole in the facility for the community to get water from. They will only pay a negligible maintenance fee.
- *ANC* attendance has increased four times over the time.
- *Outpatient* numbers reach 400 daily
- *Child welfare* has been given maximum consideration
- *Night service* — services are offered even after 18:00 because there is lighting.
- *Increased utilization of facilities* since all services are operational.
- Philips introduced a *community life Centre bag* with a medical toolbox that includes a portable ultrasound, and stethoscope, among other essential tools.
- *Vibrant commercial enterprises* have emerged around the facilities.
- *Increased social interaction* between health workers and communities around.
- Philips provided an *IT system* to help keep better health records.
- On the basis of *Learning on PPP* — other counties visit Kiambu for benchmarking.

Challenges faced in implementing the PPP initiative include recent stealing of some computers mushrooming of illegal health services; the need for referral ambulances for mothers going to deliver; the influx of patients from other counties; and the need to recruit more community health workers.

The moderator stated the fields to focus on as: social determinants of health, inter-county relations and enterprise.

Effects of incentive use of 'Oparanya Care Services' in improving skilled delivery of mothers *— Dr. David Oluoch, representing Rachel Okumu, County Director of Health, Kakamega County*

Dr. Oluoch started off by mentioning that Kakamega is the second most populous County in the country, after Nairobi, with up to 2.73 million people.

He talked on the Oparanya Care Program that was started by Governor Wycliffe Oparanya on realizing that the facilities in the health centres were low and that poverty contributed to the delivery of mothers elsewhere other than a health facility. The programme funded by the County at 1 million US dollars per year, was thus used to support poor pregnant mothers The County is focusing on putting up a 6-billion facility that is to be the second largest after KNH.

The programme was later renamed *Imarisha Afya ya Mama na Mtoto Programme* because many people mistakenly thought it was the Governor's way of enticing the citizens to maintain his position.

The programme is supported by UNICEF and their goal is to decrease maternal and under-five year mortality, and also decrease mother-to-child contraction of HIV during birth. It is implemented on a web-based e-platform to maximize on the eligible persons that are auto picked. As a mode of encouragement, they pay women 12, 000 Kenya shillings in six instalments, that is, 2,000 Kenya shillings each time they go to seek medical attention and checkup during the period of pregnancy, delivery and after delivery. Their key achievement so far has been 45,511 mothers registered and 38,000 verified beneficiaries.

The Maternal, Child and Family Planning Act 2017 created a fund for this programme — 3 % of approved health budget.

The challenges the programme has faced so far include increased demand, thus overwhelming the health centres; underage mothers without IDs who cannot be paid through M-PESA; influx of mothers from Uganda without IDs; and depoliticizing the programme from Oparanya Care to Imarisha Afya ya Mama na Mtoto.

M&E includes review of the e-platform; improvement of coordination; and linking mothers to registration for the programme.

The moderator, Dr. Mulwa, noted that statistics help to show where we have come from and that the sustainability agenda is on course, given the experiences shared. The challenge seems to be in the flow of funds, and the influx of foreigners, which brings an international dimension to it.

Noting the time as 19.53pm, the moderator, Dr. Mulwa observed that the Conference conversation was very interesting, judging from his estimate that the attrition rate is at 10 %.

He took the time to recognize county officers who had joined the Conference, and advised participants that a networking dinner would be served by the pool side after the session.

He requested the Makueni Deputy Governor to give a vote of thanks.

Closing remarks by Hon. Adelina Mwau, Deputy Governor, Makueni County

Hon. Mwau thanked all presenters, panelists, participants for gracing the Conference.

Theme 4: Health systems governance for UHC

Objective*:* *Indicators for measuring health systems governance*

Tackling corruption: towards an effective oversight, coalition building, regulation, and accountable public health system — *Dr. Julius Muia, Principal Secretary, State Department for Planning*

Dr. Muia set off his talk by asking delegates to think about corruption in their mother tongue. He asked members to domesticate the English word 'corruption'. Transparency International defines corruption as 'the abuse of entrusted power for private gain.' He asked participants to feel bad about corruption even as he was making the presentation. There is a lot of petty corruption that goes unreported and political corruption is a major issue. Corruption is evil, unethical, wrong, undesirable and *mbaya kabisa* [very bad].

In the legal and institutional frameworks, there are many attempts internationally, regionally and nationally to deal with corruption. The Constitution of Kenya, Article 10 has 15 national values and principles of governance indicated. The main institutions in the country that deal with corruption directly are the Ethics and Anti-Corruption Commission (EACC), Directorate of Cohesion and National Values — which spearheads and coordinates mainstreaming of national values, Kenya National Commission for Human Rights (KNCHR), and Transparency International (TI). Dr. Muia offered that if Kenya was to deal with national values and ethical behaviour, there will be less struggle dealing with the symptoms of lack of ethical behaviour. Corruption is symptomatic to lack of good values and unethical practices in a society.

He highlighted the cost of corruption according to TI which has divided the cost into four categories: political, economic, social and environmental costs of corruption. He dwelt on the political cost, saying that when governance is right a lot of things fall into place. As a political cost, corruption is an obstacle to democracy and the rule of law. Offices and institutions lose legitimacy as a consequence of corruption. A corrupt climate deters investment by hindering the development of fair market structures and distorting competition, hence affecting the economic stability of a country. As a social cost, corrupt officers' prioritize high-profile looking projects such as dams, power plants, oil refineries, and so forth, over less spectacular but more urgent projects like schools and hospitals, because of opportunities of corrupt gains in the grand projects.

Dr. Muia disclosed that TI conducts a measure of perceived corruption annually in 180 countries worldwide and suggested that Kenya should benchmark with the countries with the least corruption perceptions index. There is a negative correlation between corruption and the level of development, hence, the more corrupt a country is, the less developed. From the study, the most

corrupt countries were South Sudan, Syria and Somalia, among others, countries that Kenya should not compare itself to.

Due to corruption, people put up with official indifference when seeking redress from authorities. Corruption is a violation of human rights. Corruption breeds when there is less access to information about public expenditure. The Kenya Police Service and the Judiciary were found to be the most prone to corruption. According to TI, where anti-corruption laws exist, they are often ignored, hence structures should be made available to enforce the laws. Corruption also results into little or weak press freedoms. Since 2008, at the inception of Vision 2030, Kenya's performance on the issue of corruption has improved, according to TI. The World Economic Forum (WEF) which evaluates the competitiveness of various countries in the world, found corruption to be the leading problem in Kenya. The Kenya Institute for Public Policy Research and Analysis (KIPPRA) was commissioned by EACC to find out the reasons given for the prevalence of corruption in Kenya, and bribes demanded in public offices was among the reasons.

The study also found out that the Health Department was the worst in corruption, and that most people do not report corruption because they do not know where to report it. According to Dr. Muia, mitigating or ending corruption requires dealing with it gradually and in a non-confrontational manner. He also called for collaboration to deal with corruption from the governments, both national and county, private entities, universities and other stakeholders. He asked that information be provided to hold governments accountable. For example, on a trip to Singapore he observed that in constructing their roads, they do not indicate when the project began but when it is due for completion. This, he says allows citizens to hold governments accountable.

Leadership, Management and Governance: Capacity building for health managers — *Dr. George Kimathi, Director, Institute of Capacity Development, Amref Health Africa*

Dr. Kimathi affirmed that an emerging issue from the Conference was consensus on the power of leadership. He mentioned that UHC will develop with firm leadership and governance. Leadership, Management and Governance (LMG) is a key factor in UHC. Lack of development can be attributed to the 40 % of leaders who perceive themselves as not ready for their roles. Focus should be on capacity building of health workers so that they are competent in what they do. Strategic partnerships with training institutions, corporates and development partners are very crucial, even for consultation. He noted that there were few institutions that offered courses on health systems management and stressed that there should be a shift from instilling knowledge to competencies. He asked institutions, the national and county governments to plan and invest in capacity building of health workers. Dr. Kimathi, emphasized that health workers should be the champions of UHC.

Noting the importance of mentorship, he challenged participants to bring up better young people. Dealing with young people who serve as health workers can be a difficult endeavour. He gave an example where a young person is attending to a patient and at the same time is on social media

conversing on WhatsApp, claiming to be multi-tasking. Further affirming the value of mentorship and coaching, he noted that, 'the greatest burden in life is not having any burden at all'. He quipped that one should not expire before they inspire; in Africa those with power have no ideas and those with ideas have no power. He called for leaders who inspire and create momentum for delivery.

While elaborating on management as a principle, he stated the need to think through structures and people and the importance of a shared vision/direction. Leaders look at capacities/competencies to be able to scan the environment.

In his concluding remarks, he noted that as technology is evolving, we should be able to tap into it.

Indicators for Universal Healthcare — *Dr. Samson Machuka, Director, Monitoring and Evaluation, State Department for Planning*

Dr. Machuka acknowledged that if corruption is managed, then there would be no need for development assistance, and we can even lend to other countries. He gave an example of Japan where people queue to pay taxes because they know what their taxes do for them. He stated that Kenya needed to embark on tax evaluation to note the amounts that are lost on tax leakage.

In a brief background on the National Integrated Monitoring and Evaluation System (NIMES), he mentioned some of the objectives of NIMES as: to build an M&E system at both the county and national levels; to promote a culture and practice of M&E; and to provide for cost and timely feedback.

He mentioned that counties should develop a County Integrated Monitoring and Evaluation System (CIMES). He observed that only a few counties had developed policies for M&E. Giving the benefits of CIMES, he mentioned that it creates equity, protection from financial risk of target and that it is a variable used to track the targets set. He indicated that reporting on health indicators should be done by picking the high-level indicators.

As he concluded, he stated that the Department will be launching an e-NIMES to report achievements on real-time basis. He pointed out, that the tool will be transparent and will be able to achieve outcomes. Under SDG Goal 3, Dr. Machuka informed that Kenya has identified 16 indicators out of the 27 provided which will be monitored.

The role of National County governments in advancing quality management and compliance with the Health Act, 2017 — *Allan Maleche, KELIN*

Mr. Maleche began his presentation on the premise of health being a fundamental human right and that delivery of human services should be seen from that approach. To be able to appreciate the issue of accountability in the health sector, certain frank discussions must be made. These

discussions include, what are the problems? And why are they happening and to whom? Is it the patient, the health worker or management? Why are they happening? Is it lack of training, funds, leadership, corruption or an 'I don't care' attitude? He pointed out the need for governments to provide civic education and empower citizens to hold the leadership accountable, citing Section 100 of the County Governments Act, 2012. He mentioned that there should be a remedial mechanism to handle the issues that crop up once evaluation is done.

He mentioned lack of access as a poignant issue, stating that the Kenya Health Policy is not available in braille for blind people to access, and that most Acts of Parliament, laws and policies are not available in the diverse languages of Kenyans. He also called for the amendment of the Act stating that it was in violation of other parts of the Constitution of Kenya (CoK), 2010. For example, the provision of the Kenya Health Human Resource Advisory Council (KHHRAC) in the Health Act, 2017 negates what the Constitution says.

In his recommendations, he called for intergovernmental agreements on health issues in the country, which the Constitution provided for in Article 187. The Intergovernmental Relations Act, 2012 Section 26 makes for provisions around the intergovernmental agreements. There are no intergovernmental agreements on health in the country. The section dealing with reproductive health in the Health Act categorically requires health workers to acquire a separate licence to handle such cases. Section 3 of the Health Act stipulates that vaccinations shall be free and compulsory, and maternal health services shall also be free and compulsory, which provides for individual interpretations that could lead to legal and budgetary issues.

Mr. Maleche then gave an example where in 2016, Kenya paid back Kshs. 160 million to GAVI because they could not account for the funds which were misappropriated. The GAVI audit report which is on their website clearly indicates who has not yet accounted by name and company. The Ministry of Health has not yet responded on how the funds were lost and no one has been prosecuted yet. Questions were also raised to MoH as to where they got a budget line to pay back the funds, and also if there was an intergovernmental agreement that shows if counties ceded back the functions of vaccinations since it is a primary health function. The issues were also raised with the Office of the Ombudsman. Citing the lack of accountability, he asked how they would account to the children who did not get the vaccines and were at risk of contracting polio, tetanus, measles and other diseases.

He also noted that some of the County laws were going against what the Constitution stipulated. For instance, the Kilifi County Maternal, Newborn and Child Health Act, 2016, allows for abortion only during emergency, while the Constitution allows for a wider parameter. He called for linkages with the county governments and the Senate, to allow for the drafting of proper laws. He indicated that the Makueni County Maternal, Newborn and Child Health Bill was in line with the Constitution.

In his concluding remarks, he called for consultation between the national and county governments to avoid proliferation of funds. He also reiterated on the aspect of having accountability at all levels and empowering people to engage in public participation for the achievement of UHC.

Data for transparency: strengthening the generation and use of intelligence, focussing largely on health financing — *Dr. Alex Awiti, Director, Aga Khan East African Institute*

Dr. Awiti begun by describing intelligence-based delivery of UHC and how it responds to local disease burden. He mentioned that equitable access to affordable quality healthcare to the population can be achieved. It is important to have differentiated care at the different levels of government and horizontally at the county levels. Intelligence- based delivery is sensitive to socio-economic conditions of the population as it shows where the most vulnerable, hard to reach segments of populations are distributed. Dynamic delivery models respond to shifting demographic, epidemiological and technological trends, as well as people's needs. For instance, he stated that the population demographic of over 65 years is seeking more care, which means that morbidity is an age-determinant process. He informed that the shift was from mere data to intelligence and ability to make decisions based on triangulating various aspects of data. The population of the North Eastern region of the country is rising due to higher fertility rates.

Intelligence-based delivery makes us think about data in a very different way. For example, he noted that the density of healthcare and skilled birth attendance were among the driving factors of child mortality. By critically analyzing this data, numerous mechanisms can be put in place to intervene on child mortality which is very high in Siaya, Homabay, Busia and Kisumu counties, for instance. The education level of the mother is a key factor when addressing UHC issues. Kenya is a hugely divided country in many ways and it is devolution that helps us to spotlight and to think of ways we can raise the levels and equalize. Dr. Awiti broke down the disparities by stating that if one lived in Turkana County, they were four times likely to be poor than in Nairobi County. Also, a person living in Turkana was more likely to be out of school than the one living in Kirinyaga County. He further stated that one was more likely to die due to complications related to child birth six times more in Turkana than in Kiambu County.

In his concluding remarks, he gave the three dimensions of UHC as population, services and direct costs that can be driven by data to create the intelligence for correct decision-making. The dimensions are heterogeneous and can be manipulated to be county-specific. He mentioned that URT was a big topic at the G8 forum. UHC should go beyond coverage to quality of service.

Q&A session

Comment: Corruption is two-way; it includes the one giving and the one receiving, and thus to control it, people should change their attitude and behavior — *Mr. Onchiri*

Qn. 1: Is there an M&E data inclusion of indicator measures for the disabled? — *Dr. Rabera from Spinal Injury Hospital*

Answer by Dr. Machuka: It is captured in the NIMES handbook of indicators and will be disseminated at a convenient time.

Qn. 2: Can wealth declaration forms be made public? Why is there no law on audits for public officials? — *Prof. Kibwana*

Answer by Dr. Muia: The process of wealth declaration was started way back but its usage is erratic. After submission, the acquired data is not published but after dealing with corruption, such information, including lifestyle audit, should be available, to show where people are benefitting correctly and where they are not.

Qn. 3: Is the M&E Department monitoring exclusive breast feeding which is known to be a poverty reduction and NCPD prevention strategy? How is the M&E Department developing the national and county health systems to cater for the old, that is, 65+ and not 60+?

Answer by Dr. Machuka: We capture 6 categories of indicators, including nation, county, human rights, gender, SDGs and climate change, thus all is included.

Qn. 4: Can NIMES be intertwined with DHS2

Answer by Dr. Machuka: NIMES is the central point and it is fed by all the systems so as to link information.

Qn. 5: Corruption is in our DNA; what radical steps can be taken to eradicate it?

Answer by Dr. Muia: It is an act that requires everyone to take part in order to bring it. We need to find where the gaps are and make targeted interventions.

Answer by Mr. Maleche: We need to hold the people liable and have them pay for the money unaccounted for from their pockets and not the staff fund.

Theme 5: Health care financing

Objective: *Financing Universal Health: Global and Local Strategies*

Moderator: *Dr. Angela Gichaga — CEO, Health Access Financing*

To start off the conversation around health care financing, Dr. Gichaga stated that the pillars around health care financing include revenue generation — health is still significantly underfunded; pooling resources — prepaying populations; and strategic purchasing.

She said that Financing Alliance is in the business of UHC as it supports the Ministry of Health and other insurance funds to set up sustainable finance and crowd in different players to ensure a healthy nation, domestic mobilization of resources, and better leverage of NGOs and others. Noting that knowledge is power and that sources of financing for government are available, she disclosed that Financing Alliance helps point to sources of financing for government and has developed a financing compendium indicating revenue generating financing across different categories. This information is available on the Financing Alliance website. She warned that not all existing instruments such as grants and debts, are suitable for all organizations.

She also noted that UHC is not free; it might be free at the point of service, but someone is paying for it. She said that the value for money is not equals to cheap; it means getting value for the money one pays. She commented on the role of NHIF as a role of risk pool for health in Kenya.

Having said that, she invited the panelists to make their presentations around health care financing.

NHIF healthcare financing model to achieve 100 % UHC *— Mr. Gilbert Osoro on behalf of Mr. Geoffrey Mwangi CEO, NHIF*

Mr. Osoro began by quoting Winston Churchill:

The further you look into the past, the further you see unto the future.

He stated that, out of the 48.46 million Kenyans (World Bank, 2016), only about 6 million had registered for NHIF. Their target is to reach 13 million. The NHIF aims to achieve 100 % universal health care through purchase mechanism and strategic planning.

He outlined the functions of NHIF as per the NHIF Act No. 9 of 1998. They include:

- To register and receive all contributions and other payments
- To make payments out of the Fund to declared hospitals
- To set criteria for declaration of hospitals and to declare such hospitals
- To regulate contributions payable to the Fund
- To protect interests of contributors to the Fund
- To advise the government on the national policy with regard to national health insurance.

He defined UHC as a health system that provides healthcare services and financial protection, including promotive and preventive health and rehabilitative services. A UHC should be strong, efficient, well-run, and affordable, avail essential health commodities, and have sufficient capacity.

The main components of the healthcare financing system in Kenya include general tax financing; national hospital insurance fund; private health insurance; employer self-funded schemes; community-based health financing (CBHF) schemes; out-of-pocket (OOP) health spending; and donors and non-governmental organizations.

The NHIF health financing model to achieve UHC is to attain 100 % cover. So far, the following have been put to practice:

- Partnerships with the county and national governments to register people
- Simplified registration via *USSD* (Unstructured Supplementary Service Data) — dial *263# to register
- Cost reduction
- Increase of rates to cushion members on out-of-pocket expenditure
- Pooling of resources and managing mechanisms.

NHIF intends to extend coverage to the non-covered items and services, such as optical, dental and renal dialysis.

The scope of purchasing services has been:

- The defined structure of purchasing services — what services, who provided the services? Which facility can do which procedure? Level 6 hospitals can perform specialized transplants.
- NHIF covers 36 % of Kenyans; county governments should pass legislation to require a certificate of compliance from NHIF by way of registration of people doing business.

NHIF requires support in:

- Legal reforms — gaps in the NHIF Act to align with agenda four of attaining UHC
- Platinum cover subscriptions for VIPs
- Review of the Insurance Regulatory Act to categorize private insurers as primary insurers and NHIF as secondary insurers
- County engagement towards promotive and preventive health care
- Additional funding from the National Treasury — progressively increase funding from 7 % to 10 % by 2022
- Three-phase power, stable and reliable power
- Mobilization and enforcement of NHIF registration

Suggested initiatives to drive NHIF scale-up include adopting agency model; activating CHWs network to register persons who have not registered; legal reforms to align NHIF to UHC; redefining NHIF to multi-tier benefits package; and digitizing NHIF to leverage on technology.

Mr. Osoro concluded by giving an SMS number 21101 to enable one check their contribution status.

The moderator, Dr. Gichaga, commented that NHIF has 50 years' experience, and recommended that Makueni and NHIF should engage to remove overlaps and for synergy, adding that UHC requires resources and accountability for the money, that is, more health for the money.

Role of the private sector in health — *Dr. Amit Thakker, Chairman, Kenya Health Federation*

Dr. Thakker started off by commending Kenya, saying that it is in a good spot considering its journey towards providing health care for its people. He also commended the job done by NHIF and said that NHIF expenditure was about 75 % on administrative issues 11 years ago and would have gone bankrupt save for) improved efficiency and cost reduction over the years. He talked about the Rapha Hospital in Makueni that has experienced growth as a result of self-funding.

Dr. Thakker gave five mechanisms which the private sector uses in financing UHC, and the areas they need to work on, including financing; stakeholder engagement; healthcare provision; and enablers.

Saying that, "if you think healthcare is expensive, make it free", he gave an example of Medical Outpatient Clinic (MOPC) patients where the volume of patients has increased as a result of better facilities. Many individuals will take advantage of free services.

Under financing, he mentioned that Private Medical Insurance (PMI) collects 38 billion Kenya shillings annually, whereas NHIF collects 30 billion Kenya shillings. Medical claims have surpassed motor vehicle claims in the non-life insurance class. He added that, it is difficult to find a low-cost scheme in Kenya for as low as 6,000 Kenya shillings per annum. By law, individuals must first pay NHIF from salary before paying private insurers. He cautioned that the current mixed model of private and public risk pooling schemes is disastrous.

He then said that NHIF covers only 'the rich', and that it does not cover the 48 % population below poverty index that cannot afford the NHIF cover of 6,000 Kenya shillings annually, and challenged the sector to rethink NHIF, UHC and coverage of the poor. He urged to digitize Makueni Care Card Application Form and incorporate a Unique Person Identifier to stem fraud since at the moment many people can use the same card. He also promised to give pro bono services on robotics to ensure Makueni continues to develop UHC.

On stakeholder engagement as a mechanism to finance UHC, Dr. Thakker said that there is need to improve the model of Makueni and also advocacy in forums such as the Presidential roundtable that takes place in every two months to share innovation ideas. He also encouraged the need to ensure a good public–private dialogue initiative by the national government.

He mentioned that KHF supports appropriate regulation to promote UHC and that a neutral overarching regulator, that is, a Health Benefits Regulatory Authority, should be set up to regulate NHIF and other insurance funds to protect the people. He reiterated that, if it is good for the private sector, it should be good for the public sector; everyone should be regulated.

On the mechanism of health care provision, he said that 36 factories producing medicines in Kenya come from the private sector. He chided the state officers who go to private health facilities, unlike the Makueni Governor who goes to Makueni general hospital — a sterling example of what leaders should do.

The concluded with the fifth mechanism based on enablers whereby the private sectors are trying to provide solutions around tele-health (with tele-radiology, tele-diagnosis already started), m-health, HMIS, e-Health, artificial intelligence (robotic), and administration processing in order to help counties to determine how much they collect, how much they use and how much they retain.

The moderator, Dr. Gichaga, hinted that private and public sectors are working well together.

Health infrastructure development and service provision through PPPs — *Judith Nyakawa, Senior Deputy Director, PPP Unit, The National Treasury*

Ms. Nyakawa who was representing Eng. Stanley Kamau, the Director of PPPs in Kenya, began by giving two quotes:

> Everything rises and falls with leaders and people rarely go beyond their leaders.
>
> Leaders are the people who hold umbrellas, and depending on how high you raise the umbrella, the team will rise high — *John C. Maxwell 'in his book 'Be a people person'*

Rationale for PPPs in Kenya

Speaking on the challenge of infrastructure in Kenya, Ms. Nyakawa said the funding gap in the development vote is 3 billion US dollars per annum for the next decade, an amount that is way beyond the annual Treasury budget. She added that for us to transform the country into a middle income country, there is need to fund infrastructure. Still, in order to develop, we need to deal with the many legacy issues in Kenya, including corruption; poor design; poor project selection; and poor maintenance and completion. These she said are all as a result of erratic funding. She also talked about reducing the net ratio to up to 45 % in order to utilize private sector initiatives to help deliver services.

She gave the core tests for PPP as follows:

i. Value for money — the sectors that have sunk billions of shillings are health, education and roads.
ii. Affordability

iii. Risk transfer — a locative efficiency — we should determine who is best able to deal with the risk of the project.

Because PPP focuses on health, roads, energy, and education sectors, it is important to engage across sectors for synergy. There exists a cross-sectoral PPP Committee made up of PSs in government. The PPP cycle is a six-step process and the community is involved. Ms. Nyakawa thus extended an invitation to participants to visit her in her PPP Unit office located at the Kenya Reinsurance Plaza to progress the PPP discussion.

So far, through PPP, the Unit has provided for a 300-bed private hospital, accommodation and shopping mall for training at KNH; KMTC student hostels and tuition centres; referral hospitals in Homa Bay, Nyamira, Kisii and Masai Mara; cancer management centres in Nakuru, Nyeri and Mombasa; strengthened clinical services in Kirinyaga; and a feasibility study supported by Ernst & Young.

She mentioned that they do PPP through competitive bids and privately solicited investment proposals. The PPP Unit's work is to support counties by giving technical support, capacity building and transaction advisory services.

She concluded by saying that PPP is new in Kenya, thus the following challenges:

- Cost of land — she gave the scenario where during the construction of the second Nyali Bridge to Mombasa, the cost of land went way above the cost of the project.
- Value gap funding — she said that the government has to step in to fill the gap.
- Contingent liabilities
- Politics and political calendar

The moderator, Ms. Angela Gichage, picked the conversation and commented that health needs significant investment and that health is an investment. She said that there is a 9 to 1 return on investment for investing in HR, and that community health is a critical building block in providing primary health care.

She welcomed the next panelist to continue the conversation.

The role of CHWs in achievement of UHC — *Dr. Frasia Karua, General Manager, Amref Enterprises*

Dr. Karua started her presentation by asking how it would be possible to link patients to the formal health systems. She then said that Amref had for the last 60 years trained over 12,000 CHWs annually and currently Amref uses the mobile phone to register people into insurance funds via SMS and voice recording with the help of trained CHWs, who also collect health-seeking behavior and health practices data.

She talked of the Amref m-Jali tool that is used by CHWs to enroll households in NHIF, which is the social health insurance product in Kenya. The CHWs also help citizens to see the benefits of NHIF and to pay for NHIF using M-PESA by converting items such as eggs and milk into money. She commented on the conversion rate in Laikipia which she said was not high as a result of lack of knowledge. She emphasized that health coverage must start at the homestead rather than the hospitals by use of the patient's phone to access health care. So, for us to achieve UHC, CHWs must be central.

She concluded by urging all counties to use CHWs to enroll people in NHIF, educate them on promotive and preventive health, and how to use their phones to manage their health.

Moderator: she was eager to know how counties like Laikipia entrenched equity in resource allocation at the sub national level.

Beyond national health allocation: innovative ways of health allocation — *Governor Ndiritu, Laikipia County*

Governor Ndiritu started off by mentioning that 24 ethnic communities live in Laikipia, meaning they require different approaches. He then mentioned the method they use to incentivize maternal delivery in a health facility where Traditional Birth Attendants get goats for delivering a mother, and they get another goat for encouraging the mother to deliver at a health facility.

He talked about the access of health centres and commended NHIF which accredited 36 additional health centres in Laikipia.

He said that financing is critical in developing UHC.

He shared data showing households living on less than 2,500 Kenya shillings per month are the majority enrolling for NHIF cover. He also shared that out of the 75,000 households visited, 29,000 were either registered or already under NHIF or in a form of insurance.

Lessons from Laikipia include:

- Use of CHWs is proving effective as they understand the people
- Ease of payment
- Easy registration — Form available on mobile phone and door to door visits
- The poor are more receptive

He mentioned that Laikipia is looking at subsidy, and is collecting socioeconomic data to determine who can pay, and to link UHC to economic activities to enable the members to afford to pay.

The moderator, Ms. Gichaga, concluded the presentation session by asking questions to determine if learning took place. She asked about the numbers:

- **263# — NHIF registration*

- *30 million — NHIF and private sector each*
- *USD 3B — development funding gap*
- *20/- per day — it is to cumulatively pay 500/- for Makueni Care;*
- *2 goats — for TBAs referrals*

Q&A session

The following questions were submitted in writing but many were not addressed due to time constraints.

To Mr. Osoro, NHIF

1. What is NHIF doing about the inconvenience caused by the frequent system failures?
2. What steps have been made to fulfill the presidential directive of enrolling secondary schools into NHIF?
3. What is NHIF's reaction to the proposal by COG to include a governor in its board?
4. Why doesn't NHIF allow members to select multiple hospitals for outpatient treatment?
5. How will the proposed NHIF coverage for older persons who are beneficiaries of the cash transfer (OPCT + Inua familia) be funded and managed, bearing in mind that this year over 840,000 older persons are enrolled?
6. How financially stable is NHIF, because last year the management was restricting hospital visits to 4 per year before politics overruled you?
7. How do you ensure equity in services offered at both private and public healthcare facilities?
8. Aren't you facing a conflict of interest to accredit and regulate?
9. Why does NHIF reimbursement seem to favor private providers in place of government hospitals?
10. What can we do differently under NHIF and private insurance to cover those in the informal sector and farmers?

To Dr. Amit Thakker, KHF

1. Why do we have physicians carrying out clinical functions even in health facilities?
2. Any study done in Kenya on the value (cost-benefit analysis) of the numerous face-to-face conferences?

To Governor Nderitu, Laikipia

1. Do you encourage the TBAs to take the pregnant ladies to ANC visits? — by Gov. Kibwana
2. What is the future of the leased equipment that were sent to counties yet they do not have relevant technical personnel to run them?
3. What is the compensation mechanism for the CHVs enrolling people in health insurance?

To Dr. Frasia Karua, Amref Enterprises

1. How much are the CHWs paid per month as subsidy? — by Gov. Kibwana
2. Can the UHC pilot funds be sent directly to counties?
3. What is the attrition rate for those who pay for one month then default subsequently?
4. What plans does AMREF and other development partners have in rolling out the same programmes done in Laikipia and Makueni to other counties?

To Ms. Judith Nyakawa, PPP Unit

Can the social protection capitation be categorized into two sub-components; for health insurance and for consumption?

To Dr. Nduku Kilonzo, National Aids Control Council

Are there specific programmes within the broader UHC targeting the key populations (PWDs, MSMs, sex workers) to mitigate the spread of HIV/AIDS and ultimately reduce mortality related to these kinds of disasters?

Comments

1. NHIF should not be in the business of accreditation but in insurance. Leave accreditation to relevant regulatory bodies.
2. Gov. Kibwana to Dr. Amit, "Thank you for the [pro bono services] offer. We shall take it".
3. Thank you NHIF and Laikipia Government for thinking of and engaging community health workers — a group that does so much but rarely thought of; do it more.

Conclusion: UHC in Kenya — a framework for action

Objective: *Accelerating progress toward UHC: opportunity, directions and the way forward.*

Keynote speaker: *Mr. Siddharth Chatterjee, UNDP Resident Representative*

An average of 3,000 Kenyans die daily, translating to a million plus Kenyans in one year. The primacy of sexual reproductive health and rights, and the future of universal health coverage in this country, especially the preventative part of it is absolutely crucial.

UNDP, UNICEF and WHO made a projection that the focus should be on preventive health. It is important to get the primary health care part right first, by ensuring the *big five* ticket items:

i. Ensure 100 % immunization of every woman and every child;
ii. Ensure the primacy of reproductive health and rights features in universal health coverage;
iii. Ensure prevention of water borne diseases, vector-borne diseases; and HIV and sexually transmitted infections and TB;
iv. Do behavioral change in two non-communicable diseases — hypertension and diabetes;
v. Ensure the nutrition of mothers and the under-five.

In five years' time, Kenya will become a blueprint of UHC, minus the learning curve of the Asian tigers and the western countries. With technology such as telemedicine and artificial intelligence, Kenya has the potential to be the hub of the medical industry throughout Africa. By 2030, the medical industry will be worth 300 billion dollars in Africa and will create 16 million new jobs.

The issue of community health workers is going to be crucial. Kenya like the rest of Africa is 50 % short of doctors and nurses. Building a medical school in every county, will not bridge this gap, given the rising population. In 1956, Kenya's population equaled that of Sweden at 7 million. Today, Kenya's population is 46 million while that of Sweden is 10 million people. By 2030, Kenya's population will be at 65 million and by 2050, it will have risen to 90 million. The population of Africa will be 2.3 billion; it will not be possible to keep up.

The viable solution is to equip an army of community health workers drawn from among the school leavers aged 15–17 years, with vocational skills and tools/equipment fitted with the most advanced technology on a backpack to be able to do all the basic vital statistics and checks, and at the same time deliver vaccines and immunizations, as we incentivize them with 100 Kenya shillings a day or 3,000 Kenya shillings a month. Africa requires 2 million community health workers to take care of its population. This target that can be achieved within the next 2–3 years. Such a move can set Kenya on the path of good health, bearing in mind the big five ticket items earlier mentioned. More importantly today, over 70 % of Kenya's population today is aged below 30, meaning women should join the labour force. The total fertility rate in some counties is between 6 and 8, while Kenya's national average is about 4. All countries whose economy actually took off achieved a total fertility rate of 2.1. For example, Malaysia achieved a total fertility rate of 2.1 and achieved universal health coverage at the primary health care level and from 1987 her economy skyrocketed.

We need to do the same for us to reap a demographic dividend, and this means that universal health coverage is going to be even more crucial.

The vision of the government of Kenya, and in particular the President of Kenya, in identifying four critical issues that could transform the Kenyan economy is commendable. The transformation agenda of universal health coverage; food security; affordable housing; and manufacturing will happen when the young ones have basic health, which includes good nutrition, considering that Kenya has a big caseload of stunting and wasting. It also means that Kenya is producing a million young people in the age group of 15–24 that are joining the workforce every year, and this will be the case for the next 10–15 years. For every 1 million young people, there are about 150 jobs being created, mostly in the informal sector. The large number of young unemployable people is due to the fact that in the first 100–200 days of life, they lacked proper nutrition required to develop cognitive skills. And cumulatively, this is a large number. And so, Makueni Care is laudable and critical. Through innovating financing and the available technology, Kenya can collect enough revenues without incurring debts. Even 100-dollar or 100-shilling tax at border points, if properly ring-fenced or properly collected can actually bring in close to half a billion Kenya shilling a day. With this Kenya can transform NHIF into the best insurance system and also have the best quality care.

So, public–private partnerships are today more crucial because no institution, country, or government can do it alone, and we can chart our own path and succeed. If a country like Singapore can get rid of malaria, which is endemic in the country built on a swamp, why can't we? The potential is huge but focus is key, say, 5 or 6 items per county. There's already a sustainable development goal platform. Some 9 counties have already been done, 47 counties will be completed, to have a diagnosis of the critical need of each county, how much it is going to cost, and how it will be implemented.

Kenya can lead the way in universal health coverage in Africa and perhaps become the benchmark as well as the blueprint for the rest of Africa.

The United Nations family congratulates the Makueni Governor and assures him of support.

At this juncture, Ms. Ada Mwangola. VDS Director, Social & Political Pillars took to the podium to read the Summary Report (here below) and to give a vote of thanks on behalf of VDB and VDS.

Summary report

UHC Conference held at Kusyombunguo Hotel, Makueni County on 4–5 April 2018

DAY 1

Opening Ceremony

- We should move from *managing* public expectations to *meeting* public expectations in healthcare.
- Health offices should move from health county players to the patients/consumers, hence empowering them.
- Universal Health Care (UHC) should focus on management, manpower, and money for effectiveness and efficiency.
- Quality of healthcare should focus on **cleanliness, kindness** and **care**, which do not require finances, but a compassionate Human Resource (HR), discipline and communication among workers.
- Comparing Kenya with neighbours makes us seem to be doing well. Kenya should compare itself to the economies of the world that come and take our ideas and excel.

Theme 1: Health Workforce: the Critical Path to UHC

- Health workers are a critical path to UHC. Focus should be on HR development — are we training for the market or for service?
- HR management which includes providing the right environment and cordial employee relations is critical. Focus is on relationships.
- We should adopt systems that enable us to manage performance for human health in the public sector.

Theme 2: Health Service Delivery

- Emphasis should be on patient-centred healthcare, where the patient is the key stakeholder.
- The health sector should consider implementing task sharing policy — sharing staff rather than shifting staff.
- The health sector should use data to inform decision making.
- The health sector should develop systems with unique patient identifier.
- The health sector should adopt a multi-sectoral approach to manage health disaster preparedness. Counties must develop systems to manage when emergency occurs.
- The health sector should hold conversations with other sectors for a holistic approach to health.
- Counties should develop policies and systems for sustainability of UHC.

Theme 3: Innovations in Logistics and Supply chain

- The health sector needs to improve procurement mechanisms in order to deliver health services to the last mile patients with efficiency and effectiveness.

Experience Sharing

Kakamega, Kiambu, Kwale, Laikipia, and Makueni Counties shared their experiences towards UHC.

Emerging issues were on:

- Public participation
- Partnerships
- Leadership
- Technology
- Holistic approach to healthcare
- Sustainability of county initiatives

DAY 2

Theme 4: Health Systems Governance for UHC

- Corruption is hugely affecting achievement of UHC.
- The health sector is ailing from corruption — the public health sector is among the top hot-spots for corruption.
- If we manage corruption to manageable levels, we will not require assistance from development agencies and other countries.

Way forward

- Adopt a collaborative approach to tackling corruption.
- Review the Health Act, 2017 to align with the Constitution.
- There is need to sort out leadership, management and governance issues — there is need to plan and invest in Leadership, Management and Governance (LMG).
- M&E should be conducted to address gaps.
- The State Department for Planning is to launch e-NIMES that will report achievements in real-time basis. The tool is transparent and one can achieve outcomes with it.
- The health sector should have accountability measures across all levels.
- The health sector should have strategic partnerships with training institutions, corporates and others.
- There is need to move from knowledge acquisition to competencies.
- The health sector should have value mentorship and coaching.

- The health sector should have use data/intelligence to come up with targeted interventions within counties.

Way forward after the conference today

- Prepare a robust and very instructive way forward that will include detailed conference proceedings which have very clear proposals on innovative, targeted and technology-supported interventions.
- The draft conference proceedings will be ready on the 20th April 2018 and will be presented to the **Technical Committee** for validation and forwarding to the leadership of **MoH, Makueni County, VDB and Amref**, and for approval. The proceedings will then be disseminated. There will also be an engagement with Council of Governors and CS Ministry of Health to inform them on efforts towards UHC.

Theme 5: Health Care Financing

- The private and public sectors should create synergies for UHC and insurance for the poorest populations.
- There should be an overarching regulator for sustainability in the health sector. A neutral regulator provides prosperity.
- The health sector should leverage technology for wider coverage.
- Adopt PPP — private sector helps reduce Government sovereign borrowing.
- Lack of information is a key contributor to low uptake of insurance registration.
- To achieve UHC, community health workers must be central as they ensure the last mile.
- UHC is to be missed by 1.5 million Kenyans if HIV is not covered.

Closing ceremony

The closing ceremony was presided over by Dr. Andrew Mulwa, CEC Health, Makueni County.

He led participants in applauding all presenters, moderators and panelists for attending the Conference and devotedly participating in the discussions. He also thanked the Kusyombunguo Hotel management for its hospitality. He then invited Dr. Meshack Ndirangu to make his closing remarks on behalf of the entire Amref family.

Closing remarks by Dr. Meshack Ndirangu, Country Director Amref Kenya

Dr. Ndirangu expressed his gratitude to leaders — Governors, Member of Parliament, County officers and MCAs; panelists, presenters, and all other guests present, including those from the private and public sectors.

He disclosed that Amref Health Africa recognizes that no one can do it all alone, thus UHC achievement needs all players on board, adding that health insurance is important for the peace of mind of the individual and the family.

He ended by saying that Amref appreciates all the sponsors who came on board at just five weeks' notice, a demonstration of the passion they have for the country.

Dr. Mulwa invited the Makueni Deputy Governor, Hon. Adelina Mwau to make some remarks after which she was to invite the Governor of Makueni.

Closing remarks by Deputy Governor, Makueni County - Adelina Mwau

The Deputy Governor started by admitting that she had learnt a lot from the Conference and that Makueni County will borrow the idea of the use of Community Health Workers and Traditional Birth Attendants in implementing Universal Health Care.

She was also grateful for the repeated recognition of County government's efforts towards Universal Health Care.

She then invited the Governor to deliver his closing remarks.

Closing remarks by Prof. Kivutha Kibwana, Governor, Makueni County

The Governor said he found it impressive that young people had organized the event, and pointed out that the dissemination of the conference proceedings will be useful even to the President with regard to the *Big Four* priorities.

He excited the audience when he intimated that he had experienced intellectual stimulation over the two days of the Conference. He also offered that villages and counties have a lot of data that would be useful in informing interventions on Universal Health Care.

Among the things he believed people would take home is the notion that Universal Health Care is possible and that senior decision makers would gain largely from the information collected during the conference. For him, lessons learnt were on experience sharing on developments in UHC and on the building blocks of UHC, saying it will be important to implement the learning. He acknowledged the sentiments earlier made by the UNDP Resident Representative that when one realizes UHC, one progresses developments in a significant way. On the same note, he stated that UHC required strategic partnerships like the national/county governments, private/public, and multi-sectoral partnerships.

He noted as well that the event was the first big international conference Makueni County had hosted. He quoted the remarks of Khama Rogo, a medical Professor working with the World Bank who said that the most powerful office in the land is the office of 'Wanjiku', the citizen.

He gave special thanks to Dr. Julius Muia [PS, State Department for Planning] who was very integral in planning the event while at VDS.

Lastly, on behalf of the Chairman of Council of Governors, he invited Governor Ndiritu Muriithi who would later invite the representative of the PS for Health.

Closing remarks by Governor Ndiritu Muriithi, Laikipia County

Governor Ndiritu started off his speech by asserting that everybody must be on health insurance adding that when he was a Member of Parliament, nearly 40 % of citizens would visit his office to seek help with health financing.

He disclosed that, in a Council of Governors' meeting with the Ministry of Health, the Ministry had proposed to pilot 100 % cover for citizens in just four counties though the Council of Governors found it right to pilot in all counties. He added that having learnt some lessons, Kenya is capable and has what it takes to implement UHC.

He then congratulated Makueni County saying they have shown them the way, and welcomed them to Laikipia County.

The Governor welcomed Dr. Peter Cherotich representing the Cabinet Secretary for Health, Ms. Cecily Kariuki.

Closing remarks by Dr. Peter Cherotich

Dr. Cherotich thanked Governor Kivutha Kibwana for extending a hand of collaboration and for the invitation. He mentioned that the Ministry of Health was aware of his great initiative on UHC.

One of the lessons he had learnt from Kakamega, Makueni and Laikipia UHC experiences was that it is time to move. He also shared that he believes that implementation drives policies, and the Ministry of Health is taking lessons and is keen to make sure the entire process of UHC is launched countrywide. He further mentioned that there would be challenges but by walking together, achievements would be made, adding that piloting is the Ministry's desire even with financing challenges.

The Ministry's goal is to make Kenyans healthier, and in the next 3–4 years, certain diseases have been targeted for elimination. He said the ministry eliminated kidney worm disease and next in line will be maternal and neonatal tetanus, trachoma, congenital syphilis, and many others. In the same respect, he asked the County government to step in and help.

He also recognized the discussion on non-communicable diseases at the Conference, but cautioned that the NCD epidemic is back and has to be dealt with. He saw a great opportunity to make service delivery for blood pressure, diabetes, cancer screening to be part of primary health care.

He noted that international partnerships dynamics in finance are changing, and he looks forward to using UHC resources to fill the arising gaps. The doctor thanked those supporting the government to mobilize resources and said that the engagement of county governments on the

Global Fund proposal will be appreciated. He urged the county governments to continue building their accountability systems to be able to manage funds effectively.

He termed the challenges around cholera as shameful and that they needed to be done away with through proper sanitation and technology use.

He also mentioned that the frequent industrial strikes have been derailing programmes and therefore a dialogue was needed to come up with solutions.

On matters concerning health emergencies and epidemics, he said they divert resources and urged all to continue investing in monitoring surveillance systems to give early warnings.

He welcomed the proposed membership of the Council of Governors in the NHIF and asked all to pay NHIF contributions for their workers.

In his final remarks, he assured on the liquidity of NHIF saying that NHIF has the capacity to deliver UHC.

With that, he declared the Conference officially closed at 15:09.

The CEC Health for Nandi County made the closing prayer.

Annexes

programme2.pdf

UHC Conference Attendees.xlsx

PRESENTATIONS.rar (Command Line)