DEVOLUTION CONFERENCE 2023

Celebrating a Decade of County-Led Health Service Delivery for Economic Growth in Kenya

Repositioning Primary Health Care and Harnessing the Power of Digitization as Drivers for Universal Health Coverage (UHC)

15th-19th August 2023
Uasin Gishu County

ABBREVIATIONS

ARC	Accelerated Response and Care
AWP	Annual Work Plan
CECM	County Executive Committee Member
CHA	Community Health Assistant
CHIS	Community Health Information System
CHMT	County Health Management Team
CHS	Centre For Health Solutions
CHW	Community Health Workers
CIDP	County Integrated Development Plan
COG	Council Of Governors
DESC	Digitally-Enabled, Equipped, Supervised, And Compensated
DESIP	Delivering Sustainable and Equitable Increases In Family Planning
EHR	Electronic Health Records
FCDO	Foreign, Commonwealth, And Development Office
HCW	Healthcare Worker
HRIO	Health Records Information Officer
ICCM	Integrated Community Case Management
IGRA	Intergovernmental Relations Act
IPC	Infection Prevention and Control
KEMSA	Kenya Medical Supplies Agency
MCPR	Modern Contraceptive Prevalence Rate
MOH	Ministry Of Health
MOU	Memorandum Of Understanding
MUAC	Mid-Upper Arm Circumference
NHIF	National Health Insurance Fund
ORS	Oral Rehydration Solution
PAF	Pharmaccess
PHC	Primary Health Care
QI	Quality Improvement
QIC	Quality Improvement Committee
QIP	Quality Improvement Plans
QIT	Quality Improvement Teams
RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
TB	Tuberculosis
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WIT	Work Improvement Teams

WORD FROM THE CHAIRPERSON, COUNCIL OF GOVERNORS HEALTH COMMITTEE

H.E Gov. Muthomi Njuki - Chair, COG Health Committee

A decade has passed since the inception of devolution in Kenya, marking a transformative journey of health governance and service delivery. The Council of Governors has played a pivotal role in shaping this evolution through its Annual Devolution Conferences, providing a platform for discussions, learning, and policy advancements. The Devolution Conference 2023 has purposed to celebrate achievements, learn from the past, and chart the course for a prosperous future.

The series of Devolution Conferences have convened diverse stakeholders, nationally and internationally, fostering discussions on the profound impacts of devolution on Kenya's governance structure and services to the citizen. Guided by a variety of themes, these gatherings have catalysed informed policymaking, improved accountability, and enhanced service delivery for health. This year the Conference bears the theme ***"10 Years of Devolution: The Present and the Future",*** with a compelling sub-theme, ***"Driving Transformation from the local level: County governments as the Centre of economic development."*** The conference underlines the pivotal role of county governments in steering the nation's economic trajectory. This conference provides an occasion to celebrate milestones, delve into complexities, and channel insights for a dynamic future.

At the heart of this discourse lies the health sector, which has planned for two breakout sessions running under the theme ***"Celebrating a Decade of County-Led Health Service Delivery: lessons for the future".*** The first breakout session will focus on Primary Healthcare with a sub-theme emphasizing ***"Repositioning Primary Health Care as a driver for Universal Health Coverage and economic growth"*** while the second breakout session will focus on digital innovations with the sub-theme ***"Digitizing Health to the last mile for economic growth".***

Primary Health Care (PHC) and Digital innovations are both central pillars in the Government's efforts to transform health. Kenya's health sector has a myriad of digital innovations. There is need to better coordinate these solutions and foster synergies between them and existing government systems, both at the national and at the county level. This conference provides a platform for innovators to dialogue with policy makers and health practitioners to harness strategic direction with regards to propelling innovations for holistic health service delivery.

It is my hope that this conference will deliver promising models, workable solutions and insights on how the health sector can be improved collaboratively with all stakeholders.

H.E Hon. Muthomi Njuki

Chairperson, Council of Governors Health Committee

WORD FROM THE VICE CHAIR PERSON, COUNCIL OF GOVERNORS HEALTH COMMITTEE

H.E Gov. Gladys Wanga, Vice Chair, COG Health Committee.

The devolved health system has seen Kenya record market improvement in health. For example, according to the 2022 Demographic and Health Survey, nine in every ten mothers who give birth do so under the care of trained healthcare workers, up from 66% in the year 2014. Over the same period, the under-5 mortality rate improved from 52 deaths per 1,000 to 41 deaths per 1,000, while the infant mortality rate improved from 39 to 32 deaths per 1,000. Digitalization of health services can help us reap more results as we move forward. It is this that informed the Council of Governors focus on digitizing health as a priority for health break out session 2 during this year's Devolution Conference.

The digital revolution has taken many sectors to brand new levels, and the health sector has not been left behind. Digitalization of health services has great potential to increase efficiency, effectiveness, quality and safety of health services and leap frog Kenya towards both universal health coverage and sustainable development goals.

Over the past decade, County governments have worked with the national government and other stakeholders to adopt and strengthen digitalization within the health sector. Efforts have been geared towards strengthening health information systems at community and health facility levels, logistics information management, data for decision making, telemedicine, and digital medical equipment among other innovative areas. Benefits of these investments have been many, including accurate diagnostics, better treatment outcomes, better management of health records, fast information processing, more effective and efficient data analysis for decision-making, reduced cost of operations, and improvement in management of health sector resources. Simply put, digitalization of the health sector has resulted in efficiency, effectiveness but also increased quality of health service delivery.

County Governments remain fully committed to fulfilling the requirements provided by the Constitution of Kenya that guarantee all citizens the right to affordable and accessible quality healthcare. As such, counties will continue to work with other stakeholders to drive digitization in Kenya's health sector.

H.E Hon. Gladys Wanga,

Vice Chairperson, Council of Governors Health Committee

INTRODUCTION

Kenya has undergone transformation in its governance structure, embracing a decentralised system with 47 autonomous county governments and one national government. Health was one of the functions that was devolved with the national government retaining policy formulation and regulation roles while the service delivery function was transferred to county governments. This shift to a county-led system has brought healthcare closer to the people, enhancing accessibility, accountability to the people, and elevating the quality of health services.

Primary Healthcare (PHC) embodies the promise of equitable, inclusive, and sustainable healthcare. The Government continues to reaffirm its resolute commitment to realizing every citizen's constitutional right to the highest attainable standard of health, devoid of distinctions. This commitment is particularly pronounced in the pursuit of a Universal Health Coverage (UHC) underpinned by sustainable financing for preventive and promotive primary healthcare, complemented by a robust referral system and a resilient health infrastructure capable of detecting, averting and responding to infectious diseases and outbreaks.

While many Counties have made substantial strides in healthcare, evident in restructured primary healthcare service systems, investments in functional primary healthcare networks, increased budgetary allocations, and support for community health promoters, health needs persist. Challenges in sustaining good health endure in numerous counties, fostering health disparities and non-communicable disease burdens. To avert premature loss of lives and to curb the escalation of diseases, immediate action is imperative. Counties must harness newfound knowledge and empower communities to manage their health. To achieve this, it requires collaborative and multisectoral approach to health systems strengthening as envisioned in 2018 Declaration of Astana.

Furthermore, in an era of technological advancement, digitization has presented unparalleled opportunities to improve service delivery, enhance patient outcomes, and optimize resource allocation thus efficiency gains. The adoption of electronic health records (EHRs) has streamlined the management of patient data, facilitating seamless information sharing between healthcare providers and enabling more informed and efficient decision-making. Additionally, innovations such as telemedicine and mobile health (mHealth) have transformed healthcare accessibility, bringing medical expertise to underserved communities which would otherwise not have access to specialised care due to inhibitive cost and inadequate specialists.

In this booklet, we highlight and celebrate the remarkable success stories of interventions being implemented by stakeholders as part of the progress made in Kenya's health sector with a focus on the 2023 Devolution Conference health sector breakout session sub themes on Primary Health Care (PHC) and Digital Innovations.

COUNTY-LEVEL HEALTH INSURANCE SCHEMES: SUCCESSES AND CHALLENGES

The Kenya government prioritised universal health coverage (UHC) in its Vision 2030 and chose to transform its national health insurance scheme into a social health insurance scheme to achieve UHC. In its quest, in December 2018, the government of Kenya launched a UHC pilot programme, *Afya Care*, that was implemented for one year in four counties – Isiolo, Kisumu, Machakos and Nyeri - to generate evidence that would make a case for UHC and establishing the national social health insurance scheme. The government of Kenya planned to scale up the scheme to the whole population by 2022. In addition, some counties have introduced their own SHI schemes or are paying NHIF premiums for households in their county e.g., Kisumu County's *Marwa*, Makueni County's *MakueniCare* and Nyeri County's *Bima Afya*. This evidence brief by the African Institute for Development Policy (AFIDEP) presents a rapid synthesis of published and grey literature highlighting select successes and challenges of these initiatives to inform ongoing and future County level SHI and UHC reforms and implementation processes in Kenya and other countries with a similar devolved governance structure.

SELECT COUNTY LEVEL SHI AND UHC SUCCESSES AND LESSONS

I. Service user level outcomes and impacts

The schemes recorded a number of successes. One was increases in utilization of services among beneficiaries of the schemes. For example, *Afya Care* pilot counties experienced increases in outpatient attendance (all the four counties), some Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services including fourth ANC attendance (Kisumu County), Obstetrics and Gynaecology clinic and breast cancer screening (Nyeri County) and major surgery (Nyeri County). One county, Isiolo, also recorded a reduction in maternal deaths due to improved availability of blood.

II. Provider/ Systems level outcomes and impacts

Public health expenditure savings: *MakueniCare* helped the county raise revenue from premiums, which resulted in the county making savings in their health budget. In the fiscal year 2016–17, about 87% of all monies allocated to *MakueniCare* came from the County Government. In FY 2017/18 and FY 2018/19, the County Government's contribution fell to 77% and 75%, respectively.

Facility upgrades and maintenance: The UHC pilot funds were used to upgrade facilities and for maintenance activities including: automating the health information system and developing a dashboard for monitoring real-time progress (Isiolo and Kisumu counties); repairing ambulances (Isiolo County); paying electricity bills for hospitals (Isiolo County); contracting cleaning and security companies (Isiolo County); procuring equipment such as dental equipment (Isiolo and Kisumu counties); constructing facilities for continuous medical education and CHMT offices (Isiolo County); setting up youth-friendly spaces to tackle issues such as teenage pregnancy and analyse and address the SRH needs of young people in the county (Machakos County).

Human resource capacity strengthening and incentives: In Isiolo and Kisumu counties, staff were trained to forecast the medicines and essential supplies and provide basic emergency obstetric and neonatal care. CHWs were trained on technical modules in Isiolo and Kisumu counties. In Isiolo County, eight new community units were formed, and the County used its own funds to provide monthly stipends to CHWs.

Reduced commodity stockouts: Kisumu and Isiolo counties reported reduced stockouts of medical supplies at health facilities.

III. Select lessons for improving ongoing and future SHI and UHC reforms and implementation

Registration and card verification process needs to be allocated sufficient time and resources: In Isiolo County, the time allocated for planning the *Afya*

Care registration process was not sufficient, which resulted in incomplete beneficiary information. Furthermore, the County Referral Hospital was the only facility equipped to electronically verify the UHC *Afya Care* card and patients had to pay for services in the absence of it. Lack of the UHC *Afya Care* card verification equipment in Isiolo sub-county hospitals resulted in them providing services without verifying the cards. Nyeri County's Bima Afya programme was also found to have an inadequate process for verifying beneficiaries because some of them were already covered by the NHIF.

Funding and funding flow bottlenecks need to be resolved: Isiolo and Kisumu counties reported challenges with the flow of *Afya Care* funds from the national government including NHIF. The funding flow challenges: included less than the allocated funding being disbursed to the counties, health facilities and community-based activities; delays in disbursement of the funding; and a cumbersome funding withdrawal process through the County Revenue Fund, as per the Public Finance Act. The Linda Mama programme was also interrupted in Kisumu County, and stopped in Isiolo County, which resulted in lost revenue, particularly in Kisumu County. In addition, some Isiolo County health facilities received funding increases that were not based on budget, workload, and catchment population.

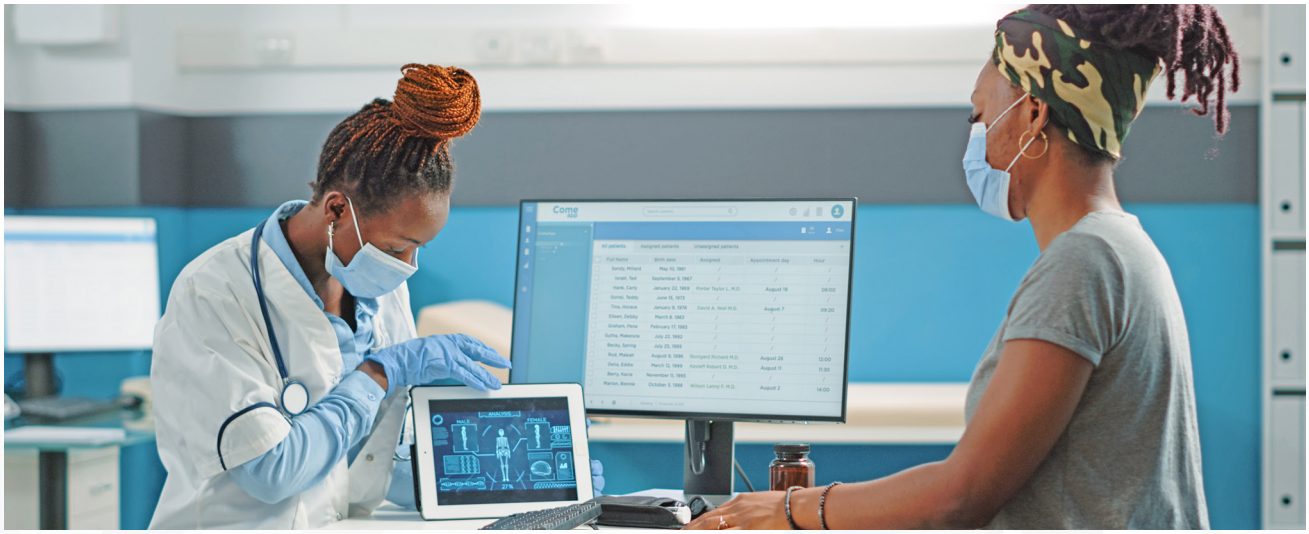
Having sufficient staff is critical for provision of quality of services: In Isiolo and Kisumu counties, the quality of services provided was compromised due to lack of sufficient staff to meet the increase in patient numbers. In Isiolo County, only 23 out of the required 135 new staff being hired due in part to the delay in the funds being disbursed to the County.

The persistent commodity supply challenges should be addressed more effectively: In Isiolo County, some health facilities reported delays in commodities from KEMSA, which improved with time except in specialized units including for dental and renal services. KEMSA also did not deliver all the CHW kits to Isiolo County. Kisumu County reported stockouts because KEMSA delivered commodities on time only in the first two quarters of the *Afya Care* programme implementation.

Provision of clear guidelines and tools is critical for effective programme implementation: In Isiolo County, unclear communication and lack of guidelines on how to implement the *Afya Care* programme contributed to planning challenges and programme implementation gaps. For instance, the programme intended for health facilities and health workers to be incentivised based on performance-based criteria, but this aspect was not implemented in Isiolo County because they were unaware of this requirement.

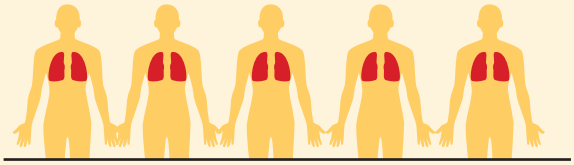
A strong governance and accountability mechanism should be established: Nyeri County's *Bima Afya* programme was found to lack an approved mechanism for overseeing and managing the programme.

A stronger monitoring, evaluation and learning (MEL) system should be established. Kisumu County was found to have a weak MEL system for generating quality data and using it to inform service provision.



FIGHTING TUBERCULOSIS IN MIGORI COUNTY: A STORY OF EFFECTIVE COLLABORATION

Migori County is among the high TB and HIV burden Counties in Kenya, reporting between 1000 and 2000 TB cases annually in the recent past. However, the County has faced challenges in improving overall TB treatment outcomes. Prior to 2019, Migori County had not achieved the 90% target for TB Treatment success rate.



1000-2000

Number of TB cases reported in Migori county annually

This performance is however changing as a result of stewardship by the Migori County Government, and enhanced collaboration effort with the National TB Program and its partner, the Centre for Health Solutions - Kenya (CHS), United States Agency for International Development (USAID), funded Tuberculosis Accelerated, Response and Care II (TB ARC II) activity.

"Before our collaboration with the National TB Program and CHS-USAID TB ARC II in the fight against TB, we experienced various challenges in the provision of TB services," says David Nyamohanga, the Migori County TB Coordinator.

Three major challenges were identified by the County TB coordinator including

- Inadequate knowledge on TB identification, treatment and management among health workers.
- Limited resources to conduct capacity building and training activities for health workers.
- Delayed rollout of new approaches in the county, e.g., new TB tools, new regimens, and new treatment formulations.

David recalls over time they have managed to tackle these challenges through the following ways;

Training of Health Care Workers
Capacity building of health care workers to provide quality TB services through didactic on-the-job training, regular facility-based and virtual continuous medical education, including sessions on the new integrated TB curriculum, paediatric TB, and non-injectable TB regimen, among others.

Continuous Medical Education (CMEs)
CMEs at the sub-county and facility level by targeting sub-optimally performing facilities and engaging them has enabled the healthcare workers gain skills and knowledge in TB case finding, diagnosis, and management, thus better quality of care to the patients.

This has resulted in a recorded increase in the index of TB suspicion among health workers and number of TB cases being reported and initiated on treatment. The county's quality of care for TB patients and treatment success rate has improved to 92% as per 2022 data.

Support for Timely TB Diagnosis
TB diagnosis in Migori County was a challenge; despite having access to GeneXpert machines these diagnostic tools were not fully utilised. Through a technical working group David and his team zoned the machines and networked the samples to the various hubs.

The county was further supported by a super-user who assists in the maintenance of the GeneXpert machines. All the GeneXpert machines are bundled monthly to provide real-time results to clinicians for early diagnosis and routine treatment follow-up to patients.

Initiation on TB Treatment
Efficient initiation of treatment and management of TB patients has been realised through the well-coordinated provision of reporting tools and TB medicine across the county.

Management of DR TB Patients
The county is supported to conduct clinical review meetings where various experts physically come together to review drug-resistant TB patients, case by case hence effectively monitoring the progress and response of a patient to treatment and in case of a challenge handling it as a team.

Targeted Outreaches
The National TB Program and CHS - USAID TB ARC II supported the county in carrying out targeted TB screening activities among TB vulnerable populations like the miners in the county hence finding missing TB cases and treating them.

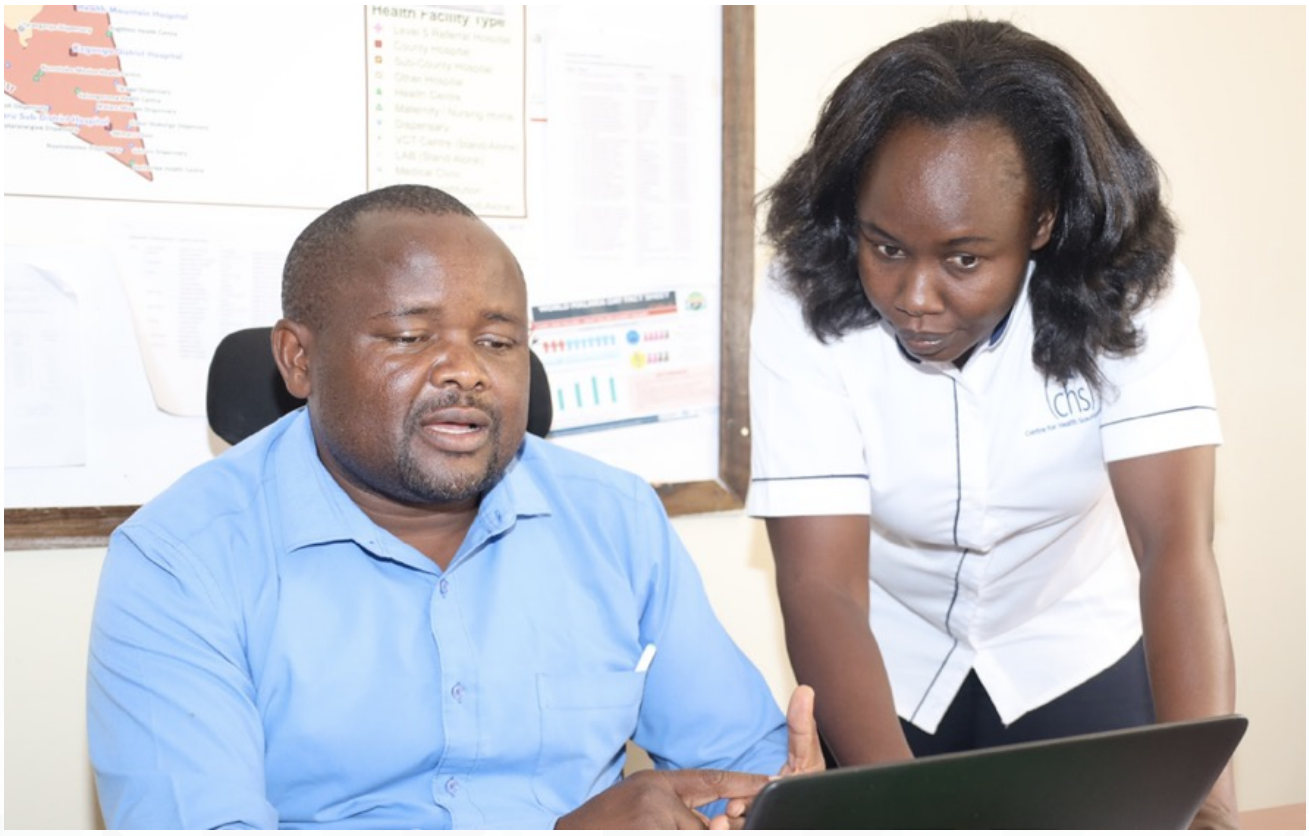
Documentation of Best Practices and Lessons Learnt
Some health workers providing TB services in the county have been supported in documentation of best practices for presentation in local and international conferences for adoption and scale up in TB control.

Logistical Support
The County and Sub County TB coordinators are provided with transport reimbursement to provide TB technical support supervision to various facilities and on job training. *"CHS-USAID TB ARC II goes to the extreme of providing its project vehicle and personnel to provide support supervision in the hard-to-reach areas. They have supported the distribution of commodities from the overstocked facilities to understocked ones. None of our facilities lacks TB reporting tools and with capacity building of our health workers, they can utilise them effectively improving data for decision making," David says.*
The county's collaborative effort with the National TB Program and USAID TB ARC II has played a pivotal role in making TB control relevant. TB control has been effectively prioritized at all levels, way from the county to the facility level.

"To ensure the sustainability of TB services in the county even after the exit of partners like CHS-USAID TB ARC II, there has been an increased allocation of TB resources. We are also partnering with other sectors and line ministries to ensure collaboration, David shares.

He adds, "Through the journey we have walked over the years, we are seeing positive results. Our indicators have improved, improving our county ranking as one of the best performing counties in TB control. In 2020, we were ranked position 19 but now we are position 2 nationally according to the National TB Program 2021, TB score card."

"Teamwork is pivotal in everything we do in health care. The synergy is the drive towards the accelerated fight against TB in Migori county," David concludes.



David Nyamohanga, County TB and Leprosy Coordinator Migori County and Stella Omulo, CHS - USAID TB ARC II Nyanza Regional Officer in a consultation meeting.

THE MAKING OF MARWA HEALTH INSURANCE SCHEME AS A PATHWAY TOWARDS UNIVERSAL HEALTH COVERAGE IN KISUMU COUNTY

James Okwiri from Seme in Kisumu County had a near-fatal accident that left him with broken bones. With no proper and consistent income, James would have seen himself waste away from ill health. But the Marwa Scheme was timely to his aid.

In December 2018, the national government launched the Afya Care Universal Health Coverage (UHC) pilot program in four counties, including Kisumu. The objective was to give Kenyans access to quality healthcare services without financial hardship. In this pilot, the government-sponsored 25,000 vulnerable households in each County with the National Health Insurance Fund (NHIF) cover.

At the close of the pilot phase, Prof. Anyang Nyong'o, the Governor of Kisumu County, felt the need to build on the lessons learnt and develop a locally grown and oriented medical scheme targeting disadvantaged members of the community. A collaborative initiative bringing together the county government, PharmAccess, and NHIF gave rise to **Marwa Kisumu Solidarity Health Insurance Scheme.** Launched in March 2021, it targeted 90,000 vulnerable households, with 45,000 in the first phase. The Marwa Health Scheme aimed to increase demand for healthcare services, improve the quality of services offered, reduce out-of-pocket payment for healthcare services, and increase the revenues generated at source within the public health facilities.

Although 90,000 vulnerable households had been identified, resources could only cover 45,000 households. The cover benefits a principal member, a spouse, and three children per household.

The making of Marwa Health Insurance Scheme

Kisumu County signed a memorandum of understanding (MOU) with NHIF to provide family-level insurance to 45,000 households. They were then registered onto the NHIF platform with PharmAccess funding the reimbursable subscription premiums valued at Ksh.67.5 million per quarter for two quarters. The County selected 49 health facilities to implement the Marwa scheme. They integrated the SafeCare quality standards in these facilities, trained 22 SafeCare champions, and introduced structured quality improvement assessments in each facility. This initiative aimed to deliver quality healthcare under the UHC banner.

"We created an end-to-end digitization process of our drugs and commodities through a program called Maisha-Meds where all the stock of drugs in our pharmacies in the government hospitals are on a platform accessible on a tablet. So, at a facility level, I can monitor my stock, my consumption, and so on. At the county level, there is a dashboard. We can look at this dashboard and monitor how different facilities are dispensing their drugs, identify patterns and trends in real-time, and make critical procurement or distribution decisions for the County," narrates Dr. Khizra Syed, Head of Health Financing, Kisumu County

In Phase 1 of the project, the County identified and enrolled vulnerable households for the cover. James Okwiri is a member of a family registered in the initial phase.

"I had an accident, and my leg was completely fractured. I was taken to Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH). Upon examination, I was admitted, and the doctor quickly advised that I needed some implants whose cost was more than Kshs. 100,000. Since I had registered with Marwa, it paid the costs. I was treated and discharged without paying a single cent from my pocket. The truth is that I couldn't afford that bill. The Marwa scheme has greatly benefited my family, personally and the many community members unable to afford healthcare who would suffer in silence," narrates James.

In phase 2, Marwa scheme changed tact to align with the vision of reaching 70% of the population with insurance coverage by 2027. PharmAccess hired a consultant to assess the ability and willingness of potential groups in the informal

H.E Prof. Anyang Nyong'o, the Governor of Kisumu County officially launching the Marwa Scheme.

sector to enroll in health insurance through Marwa. The informal sector makes up 55% of the County's population. It includes boda-boda riders, fisherfolk, rice farmers in Ahero, and sugar-cane farmers in Muhoroni. They identified and enrolled self-paying members from the informal sector and the rest of the community.

> *"We now have almost 60% increase in claims that facilities make from NHIF. We have created a lot of advocacy for NHIF regarding the facilities and their claims. For these facilities, what they get in the form of reimbursements is health financing, such that reimbursements from NHIF, Linda Mama, and others is a form of revenue generation at source," says Dr. Khizra.*

With the support of PharmAccess, the County integrated related programs such as Mom-Care and Linda Mama into their normal county health systems and facilities. This improved revenue streams from NHIF reimbursements leading to overall improvement at the health facilities.

Celebrating milestones

The Marwa health scheme compelled Kisumu County to enact health legislation and develop regulations to support and sustain the scheme. By anchoring the Marwa program within the Health Act (2019) of Kisumu County, the County ensured continuity beyond the 5-year election cycles. Additionally, they developed regulations that ring-fenced finances for the Marwa scheme to safeguard its funds from being diverted to competing priorities.

Public health facilities can now claim reimbursement from NHIF, resulting in steady financing streams and resources for improving service delivery. Public health facilities registered almost a 60% increase in insurance claims from NHIF. This is a form of health financing generated and used at the source. In addition, the SafeCare quality assessments in the Marwa registered facilities have ensured continuous quality improvement.

With these efforts, insurance penetration has risen from 12% to 23%, reducing incidences of catastrophic health expenditures for households. Dr. Phanice Ajore, Head of Health Insurance, County Department of Health, said, "My Health Wallet, a PharmAccess initiative, is encouraging County residents to save for their insurance. We are piloting this with the expectation that everyone will start saving some money in their wallet. This will encourage a saving culture for their health – which can then be pushed into premium payments to cover them extensively."

The Marwa dashboard provides the county health management teams with relevant, current data and information for making important decisions affecting the County's healthcare. As the Marwa Scheme takes root with progressive revenue streams ploughed back at the source, the county health management team, key partners, including NHIF and PharmAccess, and the beneficiaries are upbeat about what has been achieved and are optimistic that the County can progressively achieve context-relevant UHC.

NYERI COUNTY'S JOURNEY TOWARDS A SUSTAINABLE QUALITY HEALTH SERVICE DELIVERY

Before its selection as one of the four counties to pilot the UHC project in 2018, Nyeri County faced a significant burden of non-communicable diseases such as cancer, hypertension, and diabetes. The UHC conditional grants opened new doors, allowing the county to register 715,000 members from 250,000 households, leading to a surge in people seeking free medical services. However, when the UHC pilot ended, the financial and medical supplies support ceased, posing a challenge to sustain the quality of healthcare services.

The impact of the UHC project persisted through the community health service demand interventions that were supported during the pilot phase. The continuation of health service uptake posed new challenges as the public health facilities grappled with massive patient numbers without adequate financial support.

"Patients kept coming but there were no funds to run the hospital and provide quality care," notes Dr Benson Ngari, Medical Superintendent Karatina Level IV hospital.

Taking the first steps

To address the need for sustainability, during the UHC pilot, the National Hospital Insurance Fund (NHIF) subcontracted PharmAccess to provide technical assistance in Nyeri County, focusing on health financing, quality of care, and improving access to care. PharmAccess facilitated the biometric registration of beneficiaries and strengthened a network of health facilities with the option of referral to the county's referral hospital. Introducing SafeCare certification, PharmAccess promoted patient safety, infection prevention and control, and patient-centered care.

To coordinate implementation of SafeCare, the CHMT established two key positions County Quality Improvement Coordinator and Subcounty Focal Person. They instituted a quality improvement committee (QIC) led by the County director of health, the QI coordinator as Secretary, IPC coordinator, UHC coordinator, County Clinician, County HRIO, Physiotherapist, and County RMNCAH coordinator. The County committee coordinates all QI interventions from orientations, trainings, assessments, follows up on implementation of the quality improvement plan, reviews performance and re-assessments. At the hospital levels, Quality improvement teams (QITs) were set up, chaired by a QI chairperson and made up of departmental heads.

In mid-2020, Nyeri County rolled out the first phase of the SafeCare methodology implementation in 6 Public health hospitals – Nyeri county referral level V, Karatina level IV, Othaya level IV, Mukurweini level IV, Mount Kenya level IV, and Naromoru level IV hospitals. The county trained assessors who then conducted joint self-health facility assessments, developed quality improvement plans (QIPs) with action points and implemented them through the QITs and Work improvement teams (WITs). PharmAccess provided periodic supportive supervisory visits to strengthen learning and practice.

Counting the steps

Nyeri County implemented SafeCare in three phases. Starting with baseline assessments in 6 hospitals in mid-2020 and re-assessments in 5 health facilities except Mount Kenya level 4 hospital that was converted into a COVID 19 isolation centre.
As SafeCare spread its wings, phase two focused on training 100 health care workers (HCWs) from 50 high volume health centres and dispensaries in August 2021. The County is cascading SafeCare methodology to all the remaining 83 health centres and dispensaries through inhouse training of trainers. Re-assessments for the 50 health facilities in phase two is scheduled for 2023.

PharmAccess managed to register 86 percent of the County population to support roll out of UHC and support 33 health facilities with computers, internet and training on household registration and making NHIF payment claims. The Information Communication and Technology (ICT) coverage in health facilities is now included in the County Integrated Development Plan (CIDP) for financing by the County. This also enabled patients to access quality health care services closer to them without suffering financial hardship.

Milestones achieved to date

Milestones achieved so far include institutionalizing quality of care in the health system and incorporating it into the County's performance contracts. Notably, SafeCare standards and methodology brought tangible improvements, such as safe water availability, sanitation facilities with adequate hand hygiene equipment, and certified and trained healthcare workers with documented evidence.

Patient care and quality care is now an institutionalized priority in the County Integrated Development Plan (CIDP). SafeCare standards and methodology transformed the system, embedding quality of care as a key performance indicator.

> *"The SafeCare standards and methodology brought to reality and practice some of the things that we were used to reading in books and wondering if they can ever be done. But now we have established structures that have embedded quality of care into the system and is now a key performance indicator in my performance contract and that of the CECM for Health"*. - Dr. Muriu, Nyeri County Director of Health.

Today, Nyeri County proudly boasts improvements in health facilities including availability of Safe Water in sufficient quantities for patients and HCWs in all departments, increased and improved number of sanitation facilities. On human resource management, all health care workers are certified, licensed and trained with documented evidence in each of the health care workers human resources file. Nyeri County's journey towards sustainable quality health service delivery continues, offering hope and inspiration to others seeking transformative solutions in community health care.

Nyeri County Referral Hospital takes a step toward SafeCare Accreditation

Nyeri County referral hospital is a level 5 hospital offering all health services including Cancer, Renal and intensive care special clinics. It has an inpatient bed capacity of 262 beds with a 95-98% bed occupancy rate. The facility has a daily outpatient department (OPD) workload of 450 to 600 patients with a 60 percent patient satisfaction score and a monthly revenue collection turnover of Ksh. 13 million. The baseline SafeCare assessment in 2019, revealed a level 1 certification of 40 points with the laboratory scoring the highest score. The facility implemented the QIPs. A second assessment of 20th September 2021 scored a level 3 certification of 48 points, a significant improvement. The hospital now has an emergency preparedness team in place, there are guidelines and standard operational procedures (SOPs) in all departments and there is adequate water and hand hygiene facilities within the hospital.

"SafeCare enabled us to acknowledge that some things we were doing were leading to loss of our resources in the long run. Without SafeCare we would have never seen this leakage in our system, so it is such an eye opener," Dr Pauline Kamau, Medical superintendent Nyeri County Referral hospital.

"At the baseline assessment we were shocked and embarrassed to realize that the hospital did not have a valid registration certificate, health workers did not know their job descriptions, and most had no valid practicing professional licenses. The Human Resource department lacked copies of certified professional documents. These have improved. The hospital certificate is renewed, each health worker is held accountable to renew their licenses and bring them for filing and each staff understands their job description. There is also improved record keeping for all workshops and seminars attended by the health workers thus improving documentation and record keeping in the hospital. The hospital has adopted practices that make it easier for patients to access different departments like signages along walk ways, citizen charters, initially missing at baseline. Patients are now well guided." Dr Stella Micheni, the Nyeri County Referral Hospital QIT Chairperson.

A key lesson is that the resources needed to improve quality service delivery in health facilities are not necessarily financial. In many instances, they include a commitment from the healthcare providers to analyze and think through the assessment results and establish and initiate change processes to implement the quality improvement plan. Additionally, creating the structures with responsible personnel and motivating them to perform is key.

"Everything is possible with a positive attitude, there are things we thought we needed magic to get done, but we have realized you just needed to be willing to do them, and with time, we did them without extra funds but by moving things around."
Dr Stella Micheni, Nyeri County Referral Hospital

Devolution and health services

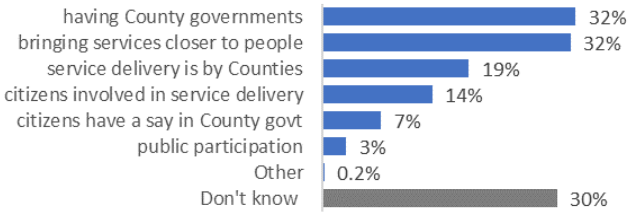
The opinions and experiences of Kenyan citizens

This brief explores the issue of devolution from the perspective of Kenyan citizens, with a particular focus of the impact on health services. The data comes from Twaweza's *Sauti za Wananchi* survey, a nationally-representative, high-frequency mobile phone panel survey of public opinion and citizens' experiences. Further details are available from www.twaweza.org/sauti.

Insight 1. Most citizens have some understanding of "devolution" in the Kenyan context

Most citizens (70%) have some understanding of the term "devolution" in the Kenyan context. Most point either to the presence of County governments (32%) and/or to intention to bring responsibility for public service delivery closer to the people (32%). Others point also to greater participation of citizens in service delivery and/or in decisions made by the County government.

In your own words, what would you say is the meaning of devolution in Kenya? (multiple responses permitted)



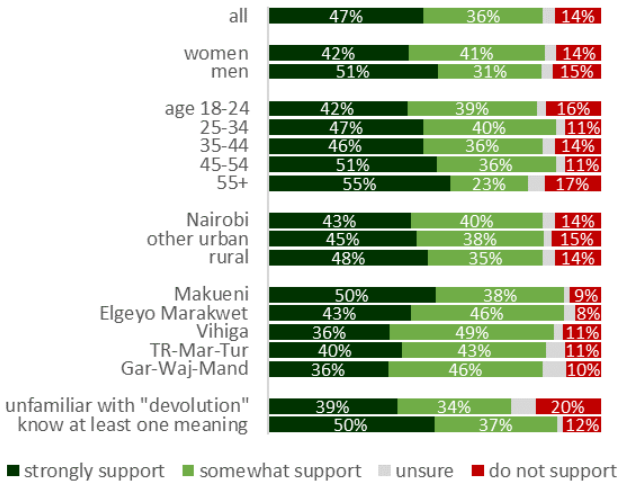
Source: Sauti za Wananchi special panel round 10, Jul 2023

Insight 2. Most citizens support devolution in Kenya, half support it strongly

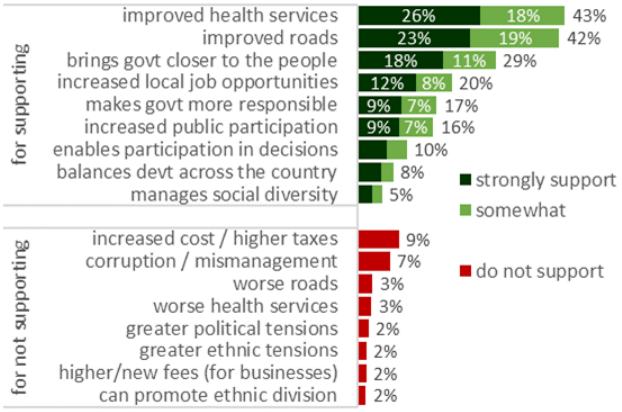
Most citizens (83%) support devolution in Kenya, either supporting it strongly (47%) or somewhat (36%). Strong support is more common among men, older citizens and those who have some understanding of the term "devolution".

The main reasons given for supporting devolution are that health services (43%) and/or roads (42%) have improved. The main reasons given for not supporting devolution are concerns around the cost and the potential for increased corruption.

To what extent do you support devolution in Kenya?



What are your three main reasons for supporting / not supporting devolution?

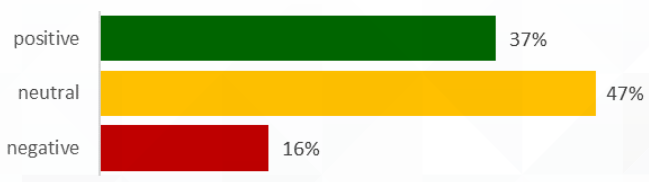


Source: Sauti za Wananchi special panel round 10, Jul 2023

Insight 3. Overall, Kenyans are more likely to see the impact of devolution as positive than negative, though many are unsure

Overall, more citizens see the impact of devolution as being positive (37%) than negative (16%). However, almost half (47%) are uncertain, concluding that the impact has been neither positive nor negative.

How would you rate the overall impact of devolution in Kenya?

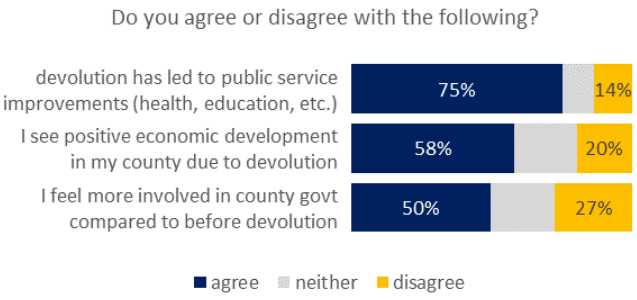


Source: Sauti za Wananchi special panel round 10, Jul 2023

Insight 4. Citizens are most positive about the impact of devolution on public services

Three out of four citizens (75%) agree with the statement that devolution in Kenya has led to improvements in key public services such as health, education and water.

Slightly fewer - though still a majority - agree with the statements that they can see positive economic development in their county as a result of devolution (58%) and that they feel more involved in county governance than before (50%).

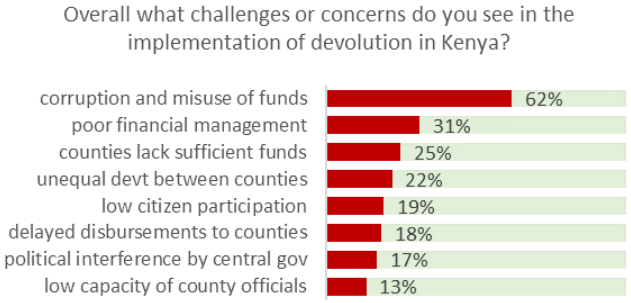


Source: Sauti za Wananchi special panel round 10, Jul 2023

Insight 5. The biggest challenge citizens perceive with devolution in Kenya is corruption and misuse of funds

Six out of ten citizens (62%) point to corruption and misuse of funds as among the challenges with devolution in Kenya, well ahead of any other area of concern.

This is followed by poor financial management (31%), lack of funds (25%) and low levels of citizen participation (19%). Others point to problems with disbursement of funds to counties or political interference by central government.

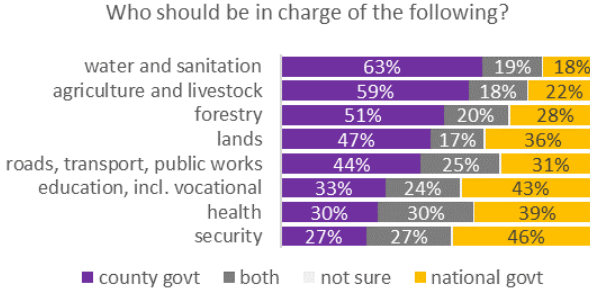


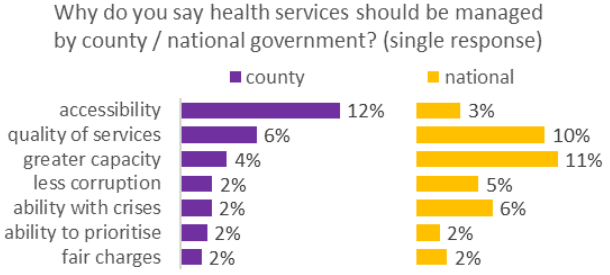
Source: Sauti za Wananchi special panel round 10, Jul 2023

Insight 6. Citizens are divided on which government functions should fall to county or to national governments

Citizens are generally divided on which functions of government should be handled by county or national government. They are most likely to say water, agriculture, forestry, land and roads should be managed by counties, and that education, health and security should fall to national government. However, in all cases, many disagree with this summary, or suggest roles for both.

On health services in particular, the main reason given in favour of county governments is accessibility, while the main arguments in favour of national government are quality and capacity.





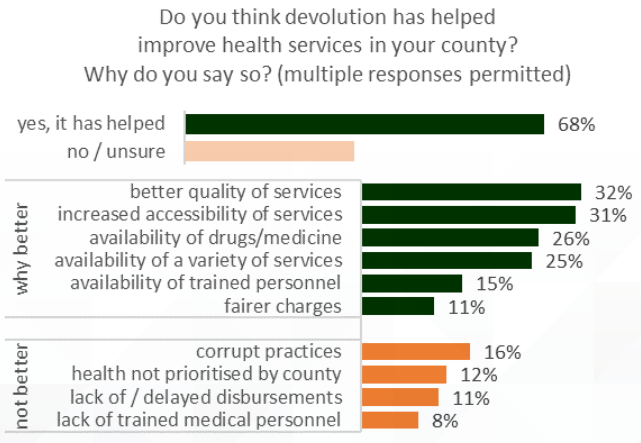
Source: Sauti za Wananchi special panel round 10, Jul 2023

Insight 7. Two out of three citizens think devolution has helped to improve health services in their county

A clear majority of citizens (68%) say that devolution has helped to improve health services in their county.

Specifically, citizens point to an improvement in the quality of health services, accessibility, improved availability of medicines and a greater variety of services.

However, significant numbers of citizens also express concerns, particularly around corruption, a lack of prioritisation of health services by their county government, and problems with disbursements to counties for health service spending.



Source: Sauti za Wananchi special panel round 10, Jul 2023

A PEEP INTO THE FUTURE: TELEMEDICINE BREAKING BARRIERS IN ACCESSING SPECIALIZED CARE IN ISIOLO COUNTY

In the vast County of Isiolo, a ground-breaking initiative was set in motion to revolutionize health service delivery. Isiolo County, like many other regions in Kenya, faced numerous challenges in providing quality healthcare to its people. Over 70% of the population resided in rural areas, far from adequate and accessible health facilities. The shortage of skilled healthcare workers and the need for specialized care further compounded the healthcare crisis.

However, amidst these challenges, hope emerged in the form of telemedicine, a revolutionary technology that had the potential to break distance barriers and provide efficient and effective healthcare services. Kenya's recognition as one of the most technology-savvy countries in Africa, coupled with its commitment to improving digital connectivity, laid the perfect groundwork for this transformative intervention.

In December 2018, Isiolo County was chosen as one of the pilot counties for Universal Health Coverage (UHC). As part of this ambitious agenda, the county adopted telemedicine through a partnership with Kenyatta National Hospital, Huawei, and Safaricom. This strategic alliance aimed to make specialized care accessible to Isiolo's residents, even in the remotest corners of the county.

The implementation of telemedicine began with the signing of a vital Memorandum of Understanding (MoU) between Isiolo County and Kenyatta National Hospital in May 2022. The objectives of the MoU were ambitious and multifaceted. Firstly, the goal was to increase access and utilization of specialized care for residents of Isiolo County. This required the set-up of a teleconnection between the County Teaching and Referral Hospital and Kenyatta National Hospital. This three-way linkage between the subcounty facilities, the County facility, and the national referral facility aimed to ensure that even the most remote health centres could access expert medical advice and support.
To facilitate this, Huawei, a leading technology company, partnered with Isiolo County to deliver healthcare through telemedicine. High-resolution cameras and monitors were procured and installed in four level 4 and 5 health facilities, transforming these facilities into modern telemedicine hubs. Safaricom, a major telecommunications provider in Kenya, facilitated network coverage to ensure effective communication via 4G internet. When a medical officer in one of the health centres ascertained that a certain illness was complicated and required specialized care, a teleconference was configured between the health centre, Garbatulla Referral Hospital (which was telemedicine-enabled), and the Isiolo County Teaching and Referral Hospital. For cases that could not be solved at this level, further configuration was done from the County Referral Hospital to Kenyatta National Hospital.

Beyond establishing the telemedicine infrastructure, the MoU also focused on capacity building. Health workers and managers were trained on the effective use of telemedicine and electronic health management systems. The County's Health Department scheduled weekly medical education sessions to ensure that health service providers were well-equipped to make the best use of the technology.

In addition, the MoU targeted installation, usage and interoperability of a comprehensive electronic management system in 31 health facilities (levels 2 to 4) and community units (level 1) in the County. This completion of the hub-and-scope model was critical for proper referral of conditions, which aided the treatment and management of complicated cases in facilities that had few staff and were located in far-flung areas.

What the results show

The results have been promising, with a marked improvement in accessing specialized care. Through the telemedicine approach, 19 cases were referred to Isiolo County Teaching and Referral Hospital, while four complex cases that couldn't be handled at the County level were referred to Kenyatta National Hospital. The advanced teleconferencing facilities, including high-resolution equipment and telemedicine rooms, were set up in Isiolo and Garbatulla Sub-County hospitals.

Referring facility	Receiving facility	No. of cases referred	Consultant's speciality
Garbatulla Sub-County Hospital	Isiolo County Teaching and Referral Hospital	19	Obs/Gyn- 5; Physician- 13; Paediatrician – 1 Psychiatry – 1
Isiolo County Teaching and Referral Hospital (ICTRH)	Kenyatta National Hospital	4	Obs/Gyn – 1 Cardiothoracic – 1 Renal – 1 Urologist/ Paediatric Nephrologist – 1
Total		**23**	

What can work better

Despite these successes, some challenges surfaced, calling for continuous improvements and investments. The scheduling of telemedicine consultations needed better coordination to avoid appointment overlaps. Technology and ICT challenges in certain health facilities required additional support and training to ensure seamless telemedicine operations. Moreover, the storage of digital medical records and teleconsultation recordings posed new challenges in ensuring patients' confidentiality, necessitating plans for secure data storage.

To ensure the sustained success of telemedicine, the County needed to invest in deploying staff to interlinked facilities and provide training in the effective use of ICT for tele-medicine. Inter-sectoral collaboration with health actors, non-health actors, and private-sector partners was deemed essential for the seamless implementation of telemedicine. Additionally, clear legislation, policies, and standards around telehealth practice would enable easier implementation by all health actors.

All in all, the future of Isiolo County's health service delivery shines brightly with the transformative power of telemedicine breaking barriers and bringing quality healthcare to every corner. With commitment and innovation, the county paves the way for healthier communities and accessible healthcare for all.

Chief Officer for Health Services, Hon. Ibrahim Chulu and Head of Telemedicine at Kenyatta National Hospital, Dr Amina Guleid listening to Jillo Ali Jillo consulting from Isiolo County Teaching and Referal Hospital.

EMPOWERING LIVES, TRANSFORMING COMMUNITIES: INCLUSIVITY AND ACCESS TO ESSENTIAL SERVICES IN HOMABAY COUNTY, KENYA

In a nation brimming with potential, the program on Delivering Sustainable and Equitable Increases in Family Planning (DESIP) emerged as a beacon of hope, dedicated to empowering communities and transforming lives. For five extraordinary years, this innovative initiative has left an indelible mark on the lives of countless individuals, fostering progress, inclusivity, and access to essential services. Since its inception, the DESIP program recognized the pressing need to address the low modern contraceptive prevalence rate (MCPR) in selected Kenyan counties, where percentages ranged from a mere 2% to 45%. With a vision to create positive change, the program focused its efforts on these regions, ready to uplift the underserved and marginalized communities.

One county that stood at the heart of the DESIP program's focus was Homabay. This region faced significant challenges, grappling with a high number of unplanned pregnancies among young people, those living with disabilities, and rural women. The program's concerted efforts in Homabay gave rise to a transformation that surpassed expectations. Venturing forth with passion and purpose, the Foreign, Commonwealth, and Development Office (FCDO) and DESIP teams worked hand in hand to visit several healthcare facilities in the county. From the Homabay Referral Hospital to Rangwe Sub-County Hospital and the Faith-based St. Teresa Nagoya, the program left no stone unturned in its mission to bring about change.

Richard Lelei, a male Community Health Promoter, engaging with FCDO and PS Kenya-DESIP team

Inclusivity was a cornerstone of the DESIP program's vision. At St. Teresa Nagoya Hospital, the program exhibited its unwavering commitment to inclusivity. By conducting support supervision and advising on structural adjustments, the program facilitated the installation of wheelchair ramps, ensuring smooth accessibility for persons with disabilities. This marked a pivotal step towards eliminating barriers to sexual and reproductive health services for persons living with disabilities, exemplifying the program's vision of a truly inclusive society. Embracing a multifaceted approach, the DESIP program addressed negative perceptions among both healthcare providers and the wider community. By fostering a culture of acceptance and understanding, the program ushered in an era of empowerment for people with disabilities, granting them access to vital services, including family planning.

Understanding the limited accessibility to healthcare facilities by young people due to distance and topographical challenges in Suba sub-county, the program took proactive steps to ensure that sexual and reproductive health services were brought directly to the communities. Integrated Mobile clinics were set up in strategic locations, coupled with door-to-door outreach and awareness campaigns. The program leaders, recognizing the deeply embedded cultural norms and stigmas surrounding sexual and reproductive health, prioritized sensitization services closer to the target audience by organizing targeted integrated health outreaches.

Digital initiatives also played a pivotal role in strengthening communication via digital technologies and social media, which created a positive impact on information dissemination to youth and adolescents in hard-to-reach areas. Linet, one of the audiences reached with intervention, attested to the effectiveness of online engagement, saying, "*online engagement has made information access easy to me; when I need information, I don't need to go and line up in a facility for long just to consult; I get it in the palm of my hands and can still book a real-time appointment with the nurse or clinician*".

This was made possible through trained youth peer providers in hard-to-reach settings engaging their peers in online weekly sessions, WhatsApp, Facebook, and SMS to convey relevant and appropriate messages about family planning and reproductive health. Access to health services is critical, but so is the quality of those services. With the implementation of youth-friendly services, marginalized adolescents felt more comfortable seeking reproductive health services, leading to significant improvements in healthcare access and outcomes.

> *"Some of us stay within the hospital, and I can tell you, nowadays they even come check us in our houses during weekends or late in the evening, and we are flexible and attend to them. Personally, weekends used to be my resting days, but currently I understand how dealing with youths requires flexibility"*

DESIP's adolescent-responsive contraceptive interventions were further enhanced through improved health information systems, mobilizers, and service providers' capacity building, service delivery, access to essential medicines, financing, and governance. This comprehensive approach ensured that young people from hard-to-reach areas received information and services without interruption, empowering them to make informed decisions about their reproductive health.

As DESIP enters its fifth and final year, its vision remains steadfast. The program aims to collaborate with other existing partners in the county's health sector for Technical Working Groups and commodity redistribution initiatives. DESIP embodies the unwavering commitment of visionary leaders to leave no one behind in the pursuit of progress and inclusivity. Together, with the power of unity and determination, the DESIP program has created a brighter future for Kenya, transforming lives one empowered individual and one transformed life at a time.

BUILDING SUSTAINABLE COMMUNITY HEALTH SERVICES IN KISUMU COUNTY

The health sector runs on data, preferably real time data. Yet the history of the health sector and record keeping in general has not been a good one in Kenya, especially in the public health sector. Cases of missing records are common. The over reliance on manual systems in the public sector has compromised health service delivery. One county in Kenya is changing that narrative - Kisumu County. The county has found a worthwhile partner, Living Goods to advance lifesaving, cost effective community health services.

Living Goods and Kisumu County are implementing a Digitally-enabled, Equipped, Supervised, and Compensated (DESC) community health approach to ensure sustainable and durable health impact. This is a first of its kind co-financing and co-implementation partnership with County Governments to provide high-quality comprehensive health services in the local community. Kisumu is the second county after Isiolo to implement this approach with the government in the lead while Living Goods offer support. They are building a case for government-led community health and hope to inspire other governments and funders to invest in effective community health approaches.

Building on the proven DESC Approach to deliver high quality services

The statistics show more of quantity of staff rather than quality of service delivery. Kenya has more than 95,000 CHWs with 3,000 located in Kisumu County. The sad reality is that these CHWs are not efficient in their service delivery. This affects the effectiveness of their work. Most of them perform and report their activities through unreliable paper-based tools. Others are not well trained and lastly, they lack management support and are not compensated for their work.

The DESC Approach

Digitally-Enabled	Equipped	Supervised	Compensated
Digital tools and Data for Decision-Making are important engines of our strategy. In fact, digital technology enables all other aspects of the DESC approach. Data for decision-making is used at every level of the health system, including CHWs, supervisors, managers and leadership teams	Ensuring that CHWs have access to supplies of essential medicines and digital resources, as well as the training and kits they need to succeed.	Increasing accountability of supervisors and managers in primary healthcare to ensure CHWs are adequately supported.	Effectively compensating, motivating, and empowering community health workers.

Living Goods is aware of these handicaps and is intentionally leveraging on the existing public infrastructure to improve the service delivery of the CHWs. It is implementing the DESC approach together with the county government as follows:

Digitization: Designing, implementing, and scaling context-appropriate digital solutions so that CHWs can provide consistent and accurate assessments, diagnosis, treatment, referral and follow up. Together with the Ministry of Health (MoH) and the Kisumu County Government, Living Goods

piloted Kenya's first electronic community health information system (eCHIS). Both the CHWs and supervisors in Kisumu are now actively using digital tools to deliver health services, with dashboard data informing monthly performance reviews and program planning.

Equipping: Providing CHWs with the trainings, tools, and commodities. CHWs follow an initial 13-day of ICCM (Integrated Community Case Management) and digital tool training with Living Goods' support. They then receive monthly refresher and some specific trainings to perform other tasks and campaigns (for example, WASH, supported by UNICEF). Once trained, CHWs receive a "CHW Kit" containing an initial batch of supplies including Amoxil, zinc, ORS, dewormers (Albendazole), Paracetamol, condoms, thermometer, MUAC tape, teaching aids. They then receive monthly replenishments at their link facility which receives commodities from KEMSA (Kenya Medical Supplies Authority). The county manages the supply and ensures stock up of essential medicines that CHWs prescribe.

Supervision: Increasing quality and accountability of supervisors and managers. All CHWs are closely managed by Community Health Assistants (CHAs) who meet them twice a month and can follow up on their performance using the supervisor App. The CHAs supervise 10-20 CHWs each. Living Goods deploys a team of peer coaches who provide support to the government supervisors by coaching them on how to use data to drive performance and make decisions.

Compensation: Motivating and empowering CHWs with financial and non-financial incentives that include monthly stipends. For example, CHWs in Kisumu receive a monthly stipend of 2,000 KES (approximately USD 15) paid quarterly. In addition, the county passed community health legislation in 2022, which ringfences resources for community health.

The county has seen positive results: The story is good so far in Kisumu County. The county government has seen improvements in health indicators and service delivery at the community level. Living Goods supports government supervisors, CHAs, through a 'Trainer of Trainers' model. For instance, they support them in leveraging best practices including setting clear targets for key performance indicators such as pregnancies registered, and sick children assessed and treated. The close collaboration through colocation at county and subcounty levels is essential. It ensures alignment and makes it possible to transfer skills and learnings, including coaching on how to use data to drive performance and make decisions.
Since the inception of this partnership in 2021, the Kisumu County has achieved the following results.

Increased the number of active CHWs. By the end of 2022, they had trained 2465 Community Health Volunteers (CHWs), serving 1.2 million people. **Diagnosed, treated, and referred** pneumonia, malaria, and diarrhoea diseases which are among the leading causes of under-five (U5) mortality. For example, CHWs on average provided 7.3 under-5 sick child treatments a month in 2022, compared to 4.4 the year before. **Sensitized and improved** referral on family planning and ensured pregnancy identification and follow-ups. A marked change from the past indicators which have lagged over the past decade. For example, they advocated for facility deliveries, ensuring on-time post-natal follow-ups for 50% of them by September 2022. **Built a stronger supply chain** with in-stock rates of essential medicines rising from 34% at the end of 2021 to 63% by December 2022. Subsequently, Kisumu County **managed to decongest** health facilities while maximising access to care with 96% of Under-5 referrals completed in September 2022.

Some of the **CHWs interviewed were unanimous in showing confidence in the approach** and advocated for expansion of their scope of work to include management of non-communicable diseases.

Buoyed by the fruits of the partnership, since 2021, the County government has progressively increased financing of its community health initiatives from 30% to 60% by 2022. It has provided overall leadership, systems, and human resources. Gradually, Living Goods has tapered down its contribution from 70% in 2021 to 40% by end of 2022 through specific responsibilities (notably the distribution of phones and technical assistance through peer coaching at all levels). The objective is to create a durable and sustainable community health system where governments are in the lead to ensure buy-in and ownership so that the gains are sustained even after Living Goods' departure.

BRIDGING BORDERS OF CARE: PCN NETWORK IMPLEMENTATION IN DADAAB REFUGEE CAMPS

In Garissa County lies the Dadaab refugee complex, a place that has become a solace for those fleeing turmoil in neighbouring Somalia. Established in 1991, this sprawling refuge has witnessed flow of lives seeking safety, now sheltering a population of **343,249** registered refugees and asylum seekers as of the year 2023. Within this complex, there are three camps; Dagahaley, Ifo, and Hagadera.

The first two camps, Dagahaley and Ifo, rest within the borders of the Dadaab sub-county, while Hagadera finds its place in the arms of Fafi sub-county. The region's harsh reality of recurrent, prolonged droughts and the threatening shadow of insecurity in Somalia's continue to drive the desperate influx of new arrivals into the Dadaab camps.

Understanding the interconnectedness of the camps and their host communities, the Garissa County's Department of Health embarked on a mission of collaboration by rallying United Nations High Commissioner for Refugees (UNHCR) and its dedicated implementing partners behind the cause of providing essential healthcare services to both the refugee residents and the communities that shared their lands. This partnership forged the foundations of a plan - to extend the Primary Care Networks (PCN) to include the NGO-managed hospitals within the refugee camps.

The concept of PCN emerged through the lessons learned from a previous endeavour. The first year of PCN modelling in Garissa Sub-County had exposed weak engagement efforts with non-Ministry of Health (MOH) service providers in the network design and implementation. The Dadaab initiative recognized the vital role of the NGO hospitals and wanted to make sure that they were a central part of the plan, alongside the county facilities.

Dagahaley, Ifo, and Hagadera refugee camp hospitals, managed by Médecins Sans Frontières (MSF), the International Rescue Committee (IRC), and the Kenya Red Cross Society (KRCS), were welcomed into the encirclement of the PCN. These refugee-run medical facllities served as the hub, their services radiating outward to the spokes linked to them. Their contributions extended beyond the ordinary, embracing not just basic health services but also the specialized spectrum:

- Theatre Services
- Specialized Laboratory Services
- Radiological Services
- Specialist Reviews
- Non-Communicable Diseases Clinic
- Comprehensive Obstetric Care Services

The refugee camp hospitals' proximity to the host communities proved to be strategic, easing transportation time and granting better access to essential healthcare. The once-distant lights of the camp hospitals now illuminated the path to timely, life-saving care. These hospital hubs wove a fabric of compassion, bringing together not only refugee lives but also the lives of those who welcomed them into their fold.

COMMUNITY HEALTH AS A PATHWAY TO UNIVERSAL HEALTH COVERAGE: THARAKA NITHI COUNTY EXPERIENCE

H.E Gov. Muthomi Njuki interacts with CHPs in Tharaka Nithi County

Community health services are a critical component of Kenya's health system given the country's current population and health dynamics. The community health approach is based on the Primary Health Care concept, from the Alma Ata declaration of 1978 that focuses on the principles of equity, community participation, intersectoral action and appropriate technology and a decentralized role played by the health system. Since the formulation of the Community Health Strategy, Kenya's community health services have undergone rapid development, from identifying a gap between the formal health system and communities in 2006 to a developing fully recognized level one services with Community Health Volunteers.

Tharaka Nithi County Government deliberately committed to institutionalizing the Community Health strategy in 2018 and established a total of 127 Community Health Units manned by 1,265 Community Health Promoters (CHPs) supervised by Community Health Assistants (CHAs) and Community Health Extension workers(CHEWs). This strategy delivers health services at level I, within communities and even within the family set up. There is been established a good link between community health units and health facilities. Communities have also been sensitized to own their health *(Afya Yetu Jukumu Letu)* meaning (Our Health Our Responsibility) through following simple basic health practices. The CHPs perform various roles, including:

- Create demand for Antenatal and Postnatal Health services
- Promote delivery in health facilities currently standing at 95% in 2022 compared to the previous 44% (2017)
- Participate school health activities, Deworming and Vitamin A supplementation in ECDE centers during the biannual MALEZI BORA weeks
- Call Ambulance team for evacuation of very ill mothers and children or any other critically sick patients
- Health Education and health promotion, Screening for high blood pressure
- Referring mothers for Maternal Child Health services among others
- Immunization defaulter tracing improving immunization coverage to 95% (2022) compared to 65.8 (2017)
- Conducting Home visits for post natal mothers and acting as treatment companions that has improved drug adherence for TB and HIV patients
- Participating in the Triple Threat campaign-monitoring and reporting of underage pregnancies so far 899 cases reported and followed up in the health facilities
- Participating in integrated community outreaches together with the link health facilities
- Participating in school health and Community based Disease Surveillance
- Participate in NHIF recruitment
- Participated in Covid-19 screening and education on containment measures.

TIME TO SAFEGUARD DEVOLUTION GAINS IN HEALTH

By H.E Gov. Muthomi Njuki, Chair COG Health Committee

The 2010 Constitution was a turning point for Kenya. It reconfigured the balance of power by devolving power and responsibilities from the national government to 47 elected county governments, and recalibrating powers between executive, legislative and judiciary. In addition to this, the constitution strengthened right based approaches to health through providing that every citizen has a right to the highest attainable standard of health. The biggest health gains in Kenya have been made during the devolution era. County Governments' progressive investment in the health sector has resulted in the improvement of key health indicators. Today, many more Kenyans are able to access high quality health services within their counties as compared to the pre-devolution era. Let me highlight some key progress areas:

First, through devolution, access to high quality health services for Kenyan citizens was improved. During the first 5 years of devolution, County Governments heavily invested in developing and upgrading health infrastructure after inheriting a vastly dilapidated health facilities from the national government due to decades of under-investment in health. Today, counties have built and operationalized hundreds of health facilities across Kenya, enabling most Kenyans to live within a 5 km range of health services as recommended by the World Health Organization. In addition, counties have significantly expanded the scope of services available to citizens. For instance, renal dialysis for patients with renal failure previously only available in a few national hospitals is now provided at county level. Specialized surgeries, cardiology services, neurology are just but a few specialized services that counties have scaled up.

The capacity of a health system to effectively deliver services is commonly measured against its capacity to ensure that no woman dies while giving life. The devolution era has yielded significant results in this regard, increasing access for mothers and reducing morbidity and mortality for both the mother and baby. With 89% of mothers currently delivering under skilled care as compared to 66% before devolution, there has been a rapid decline in maternal and child mortality rates. Between 2014 and 2022, Kenya's under-5 mortality rate reduced from 52 deaths per 1,000 to 41 deaths per 1,000, and the infant mortality rate from 39 to 32 deaths per 1,000. While noting that early investment in effective prevention strategies enhances good population health, reduces morbidity and mortality including from lifelong chronic illnesses, and saves resources in both healthcare and social services, county governments stepped up these interventions.

Second, let me talk about the **health workforce**. One of the biggest successes of devolving health has been the health workforce. Devolution has allowed Kenya to rapidly build up a large pool of highly qualified health workers across all cadres, and at the same time ensured that this important resource is more equitably distributed across the country. In the past 10 years, county governments have hired a large number of health workers causing the total health workforce to more than double compared to pre-devolution numbers. Between 2016 and 2021 alone, the total number of health workers in counties improved by 61% from **59,726** to **96,453.** In addition to this, the distribution across Kenya also improved, as county governments executed customized strategies to attract, develop and retain high quality healthcare workers.

Today, counties in hard to reach areas have significantly more health workers compared to the pre-devolution period. For example, Turkana County had less than 10 medical officers before devolution, a number that has increased six fold to 61 doctors in 2023 – and this is a similar story in most many counties. It is also important to note that through supporting health workers to take further studies, county governments have driven a rapid emergence of health specialists, even in areas where there were none before, which fosters a better skill mix. This has allowed counties to provide a wide range of specialized health services even in areas where these services were not available before devolution. Before devolution, opportunities for health workers to undertake further training were limited. It is also important to note that counties also increased the number of community health volunteers to 107,839 in 2023, covering most villages. With some counties

already paying stipend for this cadre, counties are now making concerted effort to remunerate all CHVs in recognition of their important roles in healthcare.

Third, I note that **Essential medicines and other medical commodities** are central to a good health system. Although county health authorities put in effort to ensure all health facilities have adequate supply of medicines and commodities, these efforts are largely hampered by inefficiencies and lack of transparency at the Kenya Medical Supplies Agency (KEMSA). Most counties pay KEMSA timely, but delivery of medicines is done both late and in inadequate quantities.

Fourth, **financing health** remains a key priority of County Governments, with most counties allocating more than 30% of their total budget to health despite having 14 devolved functions. Despite this, there has been disproportionate allocation of funds for health between the two levels of government, especially given that the national government has significantly less roles compared to county governments. For instance, in the financial year 2022/23, the government allocated KES 146.8 billion to the Ministry of Health, while all counties put together received an estimated KES 102 billion for health, given that the total equitable share for counties was KES 340 billion. Kenya's investments in health are below 15% in line with the Abuja declaration, thus there is need to both devolve more funds for health to follow functions, but also increase resource allocation to the health sector. We know that many times, disease comes alongside physical, psychological and financial burdens that often leave families in poverty. The majority of families never recover from these shocks. County Governments continue to push for a more accountable National Health Insurance Fund that covers citizens from catastrophic expenditure of health, is priced at a cost that citizens can pay, makes timely reimbursements to service providers and is sustainable.

In **conclusion**, I note that gains made under devolution have happened under very difficult circumstances. Health functions were devolved without requisite resources causing huge underfunding of counties. The National Treasury frequently disburses equitable share funds late; and some functions were not fully transferred. As such, there is urgent need to conclude unbundling of health functions, transfer all the remaining devolved functions to county governments, and ensure that resources follow functions. The national and county governments also need to strengthen their collaboration and partnership.

CALL TO EXPAND INVESTMENTS IN PREVENTIVE CARE

By Mary Mwiti, CEO, Council of Governors

In recent decades, Kenya's population has rapidly grown, life expectancy improved, and an ageing population emerged despite the fact that the majority of Kenyans are aged below 35. The disease profile has also changed from a context where communicable diseases comprised a majority of priority diseases, to a new norm where communicable diseases, non-communicable diseases and injury all pose a big strain to the health system. In addition to this, the prevalence of chronic lifelong conditions continues to increase. To respond to this situation, both the national and county governments have stepped up health investments, expanded health facility infrastructure, equipment, human resource capacities and other critical resources with a focus on ensuring that all Kenyans have access to high quality health services, when they need them and at a cost they can afford. Indeed, this remains a critical pillar of the President's big 4 agenda which seeks to among other priorities, ensure Kenya attains universal health coverage.

Most Kenyan leaders, policy makers, health managers, healthcare workers and communities agree to the slogan *Prevention is better than cure.* Early investment in effective prevention strategies has been found to enhance good population health, reduce morbidity and mortality including from lifelong chronic illnesses, and save resources in both healthcare and social services. A shilling invested in preventive health has been found to save 5 shillings in direct medical costs and up to 11 shillings on the overall costs, factoring in other potential loses like individual's productivity and caretaker costs. Overall, countries that do not invest in preventive health have been found to spent much more per capita cost for health, in both direct and indirect costs, than those who invest in preventive health.

Further, a critical review of Kenya's demographic and disease profile transitions suggest that if the country does not prioritize preventive health, the cost of health will

significantly increase due to both direct and indirect health costs. Despite this, investments in primary disease prevention remains sub optimal at individual, community, county, and national levels. As such, there is need to critically review options for increasing investment in preventive health. But as we do this, there is need to acknowledge that county governments remain strained on health resources - spending more than 30% of their total budgets on health despite having 14 devolved functions. In addition to this, there is reducing donor funding to health as most development partners reduce their funding obligations given Kenya's rebasing to a middle-income economy in 2015. As such, it remains critical to ask - is it possible to increase resource investment to preventive health in a health resource limited context? In answering this question, we explore two pathways.

First and foremost, the scope of preventive health options available has rapidly expanded in recent years, providing a robust range of interventions available to programmers to uptake. Recent decades have seen scientific and technological advances that rapidly expanded and accelerated understanding of disease causes, progression and transmission. This has resulted in making available innovative preventive, curative and rehabilitative approaches. Once a preserve of classical public health interventions, disease prevention currently encompasses a wide range of activities – both clinical and non-clinical – that are aimed in some way to reduce the acquisition, transmission or progression risk of any disease. As such, in scaling up preventive health services, governments should seek to step up disease prevention and health promotion through both classical public health interventions, as well as innovative approaches, some which can be integrated in the provision of routine health services of Public health workers, clinical staff, community health volunteers among other health services cadres.

Secondly, it is key to note that increasing investment in disease prevention potentially free ups resources for health care services by reducing avoidable health problems, thus saving resources that can be re-ploughed in prevention, care, treatment, and rehabilitation services.

Rather than reduce investments, preventive health has been found to allow the health sector to optimize the its full spectrum of services in the

mid to long term basis as a cost-effective solution. For instance, effectively preventing diseases like malaria and diarhoea at community level could cut off large number of patients seeking healthcare at health facilities, which in addition to saving disease associated direct and indirect costs, frees up time for the already overwhelmed clinicians and saving on other resources. This will allow better patient – clinicians interactions, improving not just the quality of diagnosis for complex conditions, but also foster the patient clinician relationship, making health facilities more socially accountable. It should also be noted that there are wider and longer-term cross-sectoral benefits of disease prevention beyond the health sector.

A disease successfully prevented means more hours of productivity for would be patients and their caretakers, alternative utilization of medical costs by families (especially off-pocket health spending) and a reduction of days learners are absent from school among other benefits. Improving school attendance has been found to have lifelong benefits to learners, their families and the broader national development agenda.

As we strengthen preventive health, it is necessary to note that this goes beyond activities done within the health sector. There is a wide range of activities and actions that promote and protect health that are delivered in other sectors outside mainstream health system. Whilst in a few cases the mother sectors either underestimate or under-prioritize the importance of such interventions to health, the most common scenario is insufficient capacity in understanding and maximizing cross sectoral health benefits. Agriculture, education, physical planning, infrastructural development, water and sanitation as well as many other sectors directly drive health outcomes. In certain contexts, interventions that affect health but delivered outside the mainstream health sector suffer from fragmented funding structures. For instance, much as the current Kenya national sanitation function is delivered under the Ministry of Water, Sanitation and Hygiene, there still a sizable sanitation workforce under the Ministry of Health. There is thus need to strengthen intersectoral collaboration to maximizing intersectoral benefits in preventive health.

We suggest that the Ministry of Health and County Governments: a) Showcase non-health sector specific benefits associated with health promotion and disease prevention to the mother sectors, while making a case for investment; b) Identify potential shared objectives and goals and highlight 'win-win' situations for both the health and mother sectors by investing in disease prevention; and c) Seek opportunities to co-locate relevant health and other sectors to help establish working relationships and trust.

Kenya needs to refocus its policy and legislative structures to prioritize investments preventive health. In doing this, there is need to itemize and keep track of funding investments on disease prevention, including classical public health interventions; as well as improve the measurements and documentation of benefits accrued by the nation due to these investments.

POSITIVE SCORECARD FOR COUNTY GOVERNMENTS: THE KENYA DEMOGRAPHIC AND HEALTH SURVEY 2022

By Khatra Ali, Director, COG Health Directorate

This year, the Kenya National Bureau of Statistics (KNBS) and various partners released the Kenya Demographic and Health Survey 2022 (KDHS 2022). This is the 7th Demographic and Health Survey ever to be implemented in Kenya, with the first such study having been done in 1989. The primary objective of the 2022 KDHS was to provide up-to-date data on key demographic, health, and nutrition indicators to guide planning, implementation, monitoring, and evaluation of health and population related programs at both the national and county levels. As such, it is important for all health in the country to critically review the results of this survey and to improve planning. It is key to note that the last KDHS was done at the onset of devolution. As such, this demographic survey provides a good scorecard for County Governments and the devolution family at large.

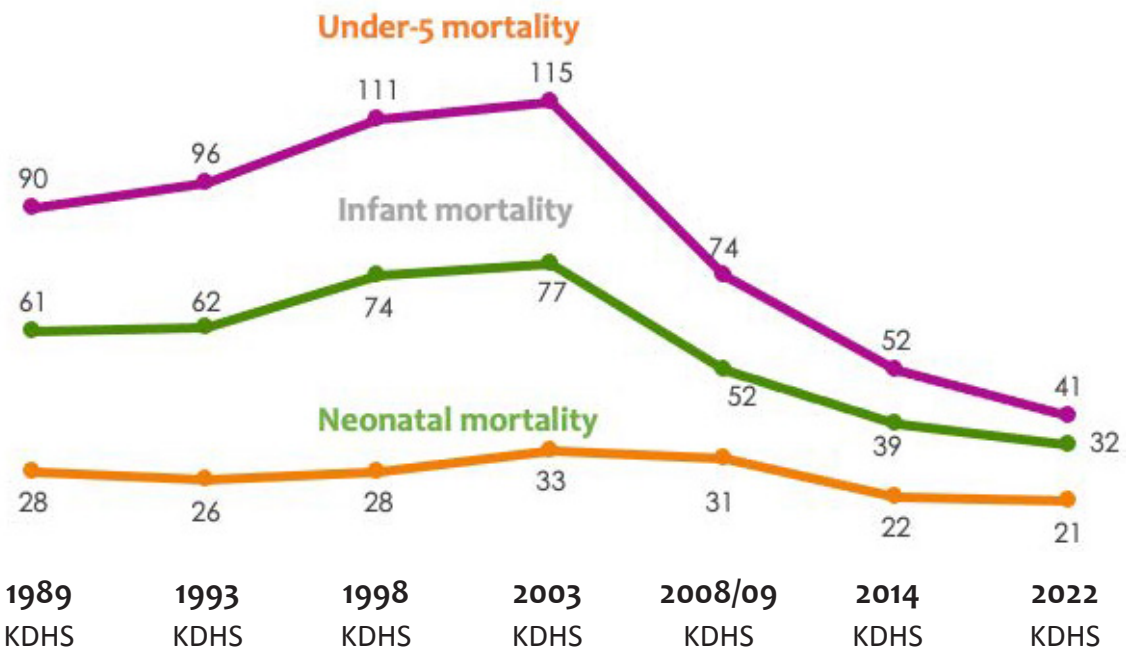
No women should die to give life, and every baby born should live. In order to achieve this, every country must first and foremost have an effective Family Planning (FP) program that ensures that only mothers who want to get babies get pregnant. Secondly, you need a maternal health program that ensures the mother and baby are safe and healthy throughout pregnancy and delivery, and finally, you need programs that effectively take care of mothers and babies post-delivery. The KDHS 2022 found that Kenya's FP program was working well. Two in every three currently married women (63%) were using a contraceptive method, with 57% using a modern method which is an improvement from the 53% observed in 2014, underpinning the successful county government's efforts in FP. The most commonly used methods were injectables (20%), implants (19%), and contraceptive pills (8%). Despite this progress, there was a huge inter-county disparity. The percentage of currently married women using contraception was lowest in Mandera (2%), Wajir (3%), Marsabit (6%), and Garissa (13%), and highest in Embu (82%), Nyeri (81%), Meru (76%) and Tharaka Nithi (75%).

The KDHS 2022 report is evidence of significant improvement antenatal care, delivery and post natal care services. Antenatal care (ANC) is the care from a skilled provider to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, delivery, and the postnatal period. KDHS 2022 found that nearly all women (98%) received ANC from a skilled provider at least once for their most recent child, while 66% of women had the recommended four or more ANC visits. The proportion of women who had four or more ANC visits for their last birth was lowest in Garissa (31%) and highest in Nyeri (82%). In regard to safe delivery, **nine in every ten (89%) babies were born with the assistance of a skilled provider, up from 66% in 2014.** It is key to note that delivering a baby under a skilled care worker is associated with wealth, with the study finding that this increasing with household wealth, from 69% among births in the lowest wealth quintile to 99% in the highest quintile. As such, by having significant impact on skilled delivery, County Governments have reached the very poor, in line with the Kenya Kwanza manifesto. At the county level, the proportion of live births delivered by a skilled provider is lowest in Turkana (53%), Mandera (55%), Wajir (57%), Samburu (57%), and Tana River (59%).

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, prompt postnatal care (PNC) for both the mother and the child is important to treat any complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child. Safe motherhood programs recommend that all women receive a check of their health during the first 2 days after birth. KDHS 2022 found that on the overall, 73% of women who delivered received a postnatal check within 2 days after delivery, with this being lowest in Wajir (37%), Marsabit (41%), Meru (41%), Garissa (45%), and Mandera (46%).

Trends in Childhood Mortality

Deaths per 1,000 live births for the 5-year period before the survey



This study found that 80% of children aged 12–23 months were fully vaccinated with the basic antigens. But when looked against the Ministry of Health expanded vaccination schedule, the study found that only 55% of children age 12–23 months and 38% of children age 24–35 months are fully vaccinated. Although the vaccination coverage rate for basic antigens increased has dramatically improved since 1989, we note that there was no improvement in this critical indicator between 2014 (79%) and 2022 (80%). It is key to note that vaccination is one of the services that were not devolved based on fears that counties could lose gains accrued, but 10 years after devolution, areas like skilled delivery that were devolved are doing much better than vaccination.

It is not possible to close our discussion without looking at child health. In the 5-year period prior to the survey, the under-5 mortality rate declined from 52 deaths per 1,000 live births in 2014 to 41 deaths per 1,000 live births in the 2022 survey. The infant mortality rate declined from 39 to 32 deaths per 1,000 live births, while the neonatal mortality rate declined from 22 to 21 deaths per 1,000 live births. Neonatal deaths account for 66% of infant deaths and 51% of under-5 deaths.

On the overall, county governments have helped Kenya to significantly improve its health indicators. It is important to better invest in county health services as Kenya seeks to attain health components of sustainable development goals, vision 2030 and Universal Health Coverage.

DEVOLUTION CONFERENCE 2023

Theme:

10 Years of Devolution: The Present and the Future.

Sub-theme:
Driving Transformation from the Local Level: County Governments as the Centre of Economic Development.

Objective:
Reflect on the 10 years of devolution and explore locally and internationally recognized methodologies for strengthening systems to enhance transformational service delivery in Counties

Date: August 2023 **Venue:** Uasin Gishu County

HEALTH BREAK OUT SESSION PROGRAMME

Theme:
Celebrating a Decade of County-Led Health service Delivery: lessons for the future

Health Sector Breakaway- Primary Health Care (PHC)

WEDNESDAY, 16TH AUGUST 2023

Sub theme:
Celebrating a Decade of County-Led Health Service Delivery: Lessons for the Future

1. ***Objective:*** *To discuss and propose policy adjustments that foster implementation of Primary Health Care (PHC) and share best and promising practices on PHC over the last decade.*

Time	Speaker/Moderator	Sessions
3:00 pm – 5:00 pm	**Session Chair:** **Governor Muthomi Njuki** Chairperson, CoG Health Committee **Key note speaker:** **H.E. Amb. Ole Thonke** Ambassador to Denmark **Moderator:** **Ms. Irene Choge** Media Advocacy Manager, JHPIEGO	**Video Clip:** Success and Challenges: Celebrating 10 years of Devolution in the Health sector – Citizen experiences on PHC **Presentation: Strategy to Strengthen PHC to attain UHC -** Dr. Gregory Ganda, County Executive Committee Member Kisumu County **Panelists** 1. **Hon. Susan Nakhumicha** Cabinet Secretary, Ministry of Health 2. **Sen. Jackson Mandago, EGH, M.P.** Chairperson, Senate Committee on Health 3. **Hon. (Dr) Pukose Robert** Chairperson, National Assembly Health Committee 4. **Dr. Tim Theuri** Chief Executive Officer, Kenya Health Federation 5. **Mr. John Kuenhle** Chair, Development Partners for Health in Kenya (DPHK) 6. **Dr. Ann Kihara** President Elect, International Federation of Obstetricians and Gynecologists 7. **Mr. Irungu Nyakera** Chairperson, Kenya Medical Supplies Authority (KEMSA)

Health Sector Breakaway- Digitalization

THURSDAY, 17TH AUGUST 2023

Sub theme:
Celebrating a Decade of County-Led Health Service Delivery: Lessons for the Future

2. ***Objective:*** *To discuss County experiences with digital health innovations and examine digitalization as an enabler to fast-track attainment of inclusive, sustainable and scalable UHC models.*

Time	Speaker/Moderator	Sessions
3:00 pm – 5:00 pm	**Session Chair:** **Governor Gladys Wanga** Vice-chair, CoG Health Committee **Keynote Speaker:** **Hon. Ruchika Singhal** Int. President Medtronic LABS. **Moderator:** **Elizabeth Ntonjira** Communication Expert Malaria No- More	**Video Clip:** on Patient/Client experiences with Digitization and innovations **Presentation:** Potential of Digitalization in driving Universal Health Coverage Agenda **Mr. Erick Angula**, strategic Partnerships and government relations Medtronic LABS **Mr. Kwasi Boahene**, Health system strengthening Director Pharm Access **Panelists** 1. **Ms. Mary Muthoni, HSC** Principal Secretary, State Department of Public Health and Professional Standards - Ministry of Health 2. **Ms. Rita Okuthe** Executive Board Chair, CarePay Kenya (M-TIBA) 3. **Caroline S Mbindyo** CEO, Amref Health Innovations - Amref Health Africa 4. **Mr. David Munyendo** Chief Executive Officer, Christian Blind Mission 5. **Dr. Susan Ontiri** Country Director, International Center for Reproductive Health 6. **Ms. Harriet Kongin** Policy and Strategy Advisor, UNAIDS 7. **Mr. Brian Rettmann** PEPFAR Coordinator -Kenya

PARTNERS

MINISTRY OF HEALTH

MEDTRONIC LABS

PharmAccess

amref health africa

PEPFAR
20 YEARS OF IMPACT

USAID
FROM THE AMERICAN PEOPLE

UNAIDS

SDG PARTNERSHIP PLATFORM

World Health Organization

PARTNERS

AFIDEP
African Institute for Development Policy

LivingGoods
Delivering Data-Driven Health Care, Door to Door.
15 YEARS

JACARANDA HEALTH

cbm
Global Disability Inclusion

Options

DSW
Deutsche Stiftung Weltbevölkerung
youth car

ps Kenya
Healthy lives. Measurable results.

Twaweza
ni sisi

ZERO MALARIA | CAMPAIGN COALITION
KENYA

jhpiego
Saving lives. Improving health.
Transforming futures.

COG HEALTH COMMITTEE LEADERSHIP

1. H.E Muthomi Njuki - Tharaka Nithi – Chairperson
2. H.E Gladys Wanga - Homa Bay – Vice Chairperson
3. H.E FCPA Ahmed Abdullahi-Wajir
4. H.E George Natembeya –Trans Nzoia
5. H.E Dr. Moses Badilisha - Nyandarua- member
6. H.E Prof. Anyang' Nyongó - Kisumu- Member
7. H.E Ochilo Ayacko - Migori- Member
8. H.E Fatuma Achani - Kwale- Member
9. H. E Wilber Ottichilo – Vihiga- Member
10. H.E Irungu Kang'ata - Murangá- Member
11. H.E Mohamud M. Ali - Marsabit-Member
12. H.E. Susan Kihika- Nakuru -Member
13. H.E Mohamed Adan Khalif - Mandera- Member
14. H.E Wisley Rotich- Elgeyo Marakwet- Member
15. H.E Mutahi Kahiga - Nyeri- Member

CECM Health Caucus leaders

1. A.g Chairperson - Ms. Ruth Koech - Nandi County
2. Secretary General - Dr. Timothy Ombati – Nyamira County
3. Whip Dr. Andrew Wamalwa - Bungoma County
4. Treasurer Ms. Beatrice Nakholi- Busia County

Chief Officers of Health Caucus leaders

1. Chairperson - Dr. Kevin Osuri – Homabay County
2. Vice Chair - Ms. Jane Mwaniki – Embu County
3. Secretary - Mr. Sheikh Abubakar – Mandera County
4. Whip - Mr. Tache Elema – Marsabit County
5. Treasurer - Mr. Tom Nyakaba – Nairobi County

County Directors of Health Caucus leaders

1. Chairperson - Dr. Gordon Okomo - Homabay
2. Vice Chair - Ms. Betty Langat – Kericho County
3. Secretary - Mr. Oscar Endekwa – Tana River County
4. Whip - Dr. Baasba Abubakar – Lamu County
5. Treasurer - Dr. Ronald Kibet – Bomet County

COG Health Secretariate Members

1.	Khatra Ali	Director, Health Directorate
2.	Meboh Abuor	Advisor, Adolescent Sexual & Reproductive Health
3.	Jemimah kuta	Senior Officer, Monitoring and Evaluation
4.	Peris Njibu	Program Officer, PHC and Partnerships
5.	Linet Kerubo	Assistant Program Officer
6.	Dr. Mutakha Kangu	Advisor, Legal and Intergovernmental Relations
7.	Dr. Emmanuel Wamalwa	Advisor, Public Health
8.	Robert Rapando	Lead, Health system Strengthening
9.	Zahra Hassan	Assistant, Health Systems Strengthening
10.	Vincent Odini	Coordinator, THS (Component 1)
11.	Maureen Khaniri	Cluster Coordinator, THS
12.	Michael Nyale	Cluster Coordinator, THS
13.	Steen Larsen	Senior Financial Advisor, DANIDA PHC
14.	Kirstine Nojgaard	Senior M&E Advisor, DANIDA PHC

COG Health Committee members during their induction in Diani, Kwale County

CECMs Health induction at PrideInn Paradise Resort, Mombasa County

COH Caucus during the induction of County Chief Officers for Health in Naivasha, Nakuru County

Council of Governors, Ministry of Health and Development Partners of Health Kenya (DPHK) during 20th Health Sector Intergovernmental Forum at Kenya School of Government

COUNCIL OF GOVERNORS

The Council of Governors,
Delta Corner, Oracle Wing, 2nd Floor,
Off Waiyaki Way
P.O. Box 40401-00100 Nairobi, Kenya
Tel: +254 (020) 2403313/4

Email: info@cog.go.ke
Website: https://www.cog.go.ke/

ISBN 978-9914-9638-9-2

9 789914 963892