Economic & Social Rights Centre – Hakijamii

'Putting people first'

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THE IMPACT OF GOVERNMENT PROCUREMENT PROCEDURES ON AVAILABILITY OF PHARMACEUTICALS

THE CASE OF KAKAMEGA COUNTY

CHASP

Capacities for Health and Social Policy

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ABBREVIATIONS

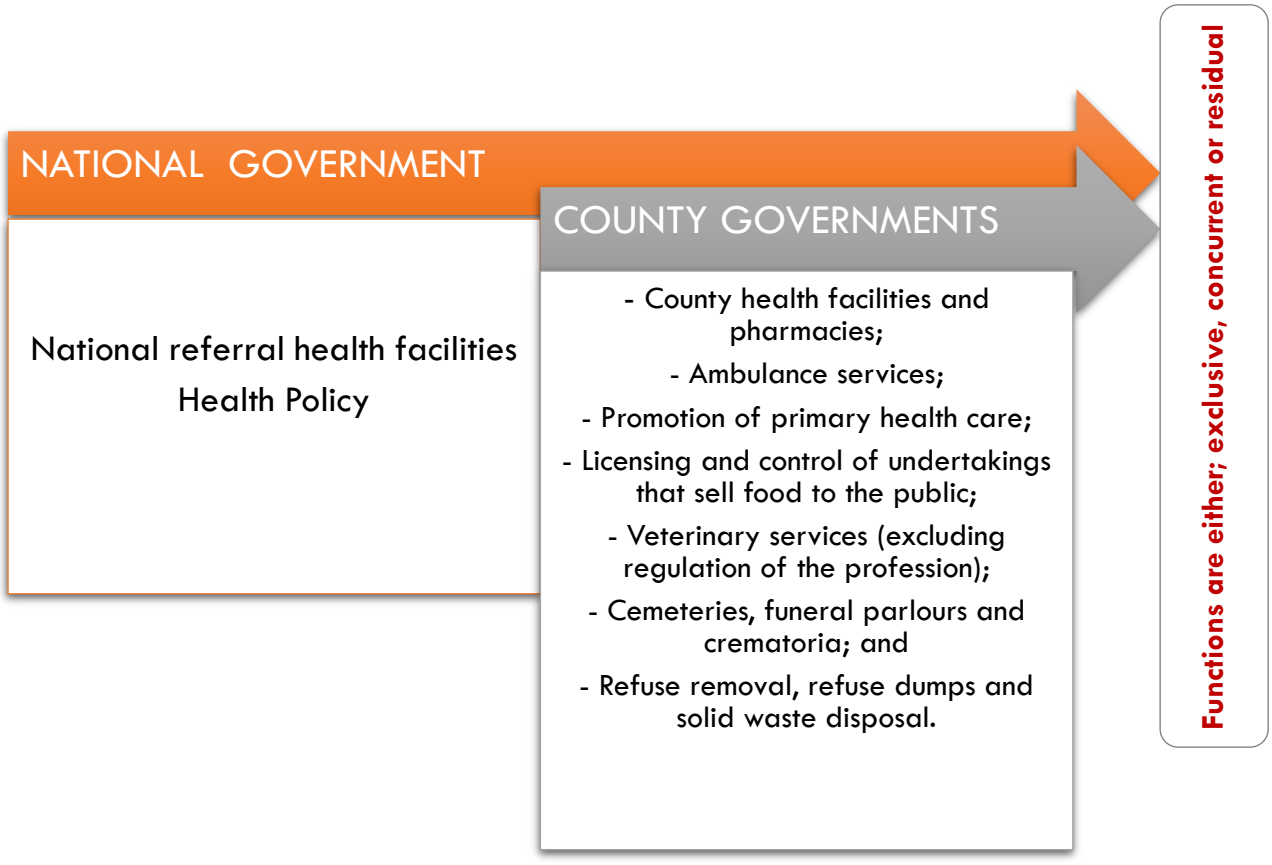
AOP	Annual Operation Plan
CBO	Community Based Organization
CBHA	County Budget Health Analysis
CBROP	County Budget Review and Operational Plan
CMH	Commission on Macroeconomics of Health
CME	Continuous Medical Education
ESRC	Economic and Social Rights Centre
FBO	Faith Based Organization
FP	Family Planning
GDP	Gross Domestic Product
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health Sector Service Fund
IFMIS	Integrated Finance Management System
KAIS	Kenya AIDS Indicator Survey
KEMSA	Kenya Medical Supplies Agency
KDHS	Kenya Demographic and Health Survey
KHPF	Kenya Health Policy Framework
KENAO	Kenya National Audit Office
MCH	Maternal Child Health
MOH	Ministry of Health
MTEF	Mid Term Expenditure Framework
MTP	Medium Term Plan
NACC	National AIDS Control Council
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHSSP II	National Heath Sector Strategic Plan II
OJT	On the Job Training
SDGs	Millennium Development Goals
SWA	Sector-Wide Approach
TB	Tuberculosis
UNICEF	United Nations Children's Fund
WASH	Water and Sanitation Hygiene
WHO	World Health Organization

1. EXECUTIVE SUMMARY

The constitution of Kenya (2010) devolved health services to counties to create a robust health system that is responsive to the various population health needs. The constitution guarantees health for all Kenyans;

- Article 26; Every person has the right to life
- Article 42; Every person has the right to a clean and healthy environment
- Article 43(1) Every person has the right— (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care
- Article 53. (1) Every child has the right—(c) to basic nutrition, shelter and health care
- Article 56. The State shall put in place affirmative action programmes designed to ensure that minorities and marginalised groups—(e) have reasonable access to water, health services and infrastructure.

The fourth schedule distributes functions between national and county governments as indicated below;



However, county level health systems face challenges that have far reaching effects on citizens' access to constitutionally guarantee the right to health. This study seeks to analyse Kakamega County health procurement procedures so as to identify the direct effect of lapses in county procurement systems on access to health services and suggest actions in the procurement processes that could lead to improvements in quality and access to health services.

According to the Kenya Population and Housing Census (2009), Kakamega County is one of the most highly populated counties in Kenya, with a projected population in 2017 of 2,028,324 distributed among 12 sub-counties. The county experiences high poverty levels at 57%, and some of the worst health indicators in the country, e.g., Maternal Mortality Rates of 880 per 100,000 live births and Neonatal Mortality Rate at 28 per 1,000 births. Poor environmental conditions add to the health burden with many incidences of diarrheal diseases. The Kenya AIDS Indicator Survey (KAIS 2016) indicates HIV prevalence to be4.8%. Although the county has well-distributed and balanced set of health institutions, they are under-funded, undermanned and under-equipped. Among the specific challenges facing the health sector are inadequate and erratic commodities supply, staff shortages, skill gaps, lack of specialised Medicare and equipment, weak management skills, and inadequate infrastructure.

1.1. Summary of Findings

1.1.1. Devolution of Healthcare

Devolution has been implemented for slightly more than four years and is performing relatively well in many respects. However, the health sector in the counties is facing many policy, administrative and fiscal constraints that impact on the provision of and residents access to health services. With respect to health supplies, a number of policy-level issues affect procurement processes and with implications on citizens' access to medical services, including

- Lack of guidelines on proportional allocations to the health sector;
- Poorly managed transfer of functions and contested mandates;
- Low absorption capacity of county governments;
- Poor or weak oversight institutions despite the high level of fiscal autonomy;
- Irregular and unpredictable transfers from the national Treasury;
- Erratic and centralised IFMIS system, with low political acceptance;
- Weak citizen participation in the supply chain, especially procurement, and;
- Weak capacity for complex health procurement.

There have been efforts to address most of these challenges through the pending Health Bill, but the bill is yet to be enacted by parliament.

1.1.2. Findings on the Procurement System

- The financial infrastructure guarantees near complete autonomy, but oversight capacity of County Assemblies, Senate and KENAO as well as that of citizens themselves remain low. Procurement thus remains one of the areas most prone to abuse and corruption.
- Despite provisions stipulating that disbursements from Treasury are made by the 15th day of every quarter, actual transfers are often delayed. This affects cash flow planning and counties' obligations to suppliers and often leads to non-delivery of essential commodities.
- The procurement process is long, elaborate and bureaucratic. It faces other challenges, among others: delays of up to six months of projected quarterly dispatches; haphazard increase in the number of health facilities, often due to political expediency, and often lacking requisite budgets, facilities, equipment and personnel; lack of storage facilities, making it impossible to make long term supply plans or buy medicines in bulk, and; failure to conduct routine supervision/spot checks leading to poor monitoring and failure to identify capacity needs of pharmaceutical staff in smaller facilities.

1.1.3. Health Budgets

Kakamega County health system faces an acute budget shortfall, with a reported deficit of 53%. Total health care expenditure from all stakeholders amounted to Kshs 5 billion in 2015. Total county budget for health increased by 15% from 2014/15 to 2015/16 FY while that for pharmaceuticals rose from Kshs 289 million to Kshs 360 million between 2014/15 FY and 2016/17 FY. However, According to the National Health Accounts (2016), County expenditure on health as a proportion of total budget decreased from 25% to 22% between FY 2013/14 and FY 2014/15 although Kakamega remained one of counties with the best health sector allocations- this eventhough decreased, was still way above the 15% share of health budget as required by the Abuja Health declaration.Per capita health expenditure was USD 29.7 compared to WHO recommended USD 34 per year. It would be useful to note that the study team could not obtain the latest enacted budget (FY2017/2018) for analysis.

1.1.4. Recommendations

a) **Budget Allocation to Pharmaceuticals**: An average deficit of 53% in the quantities of medicines required means even with consistent dispatches to facilities, there would still be rampant instances of stock outs. The county government needs to purpose to progressively reduce this deficit.

b) **Personnel:** There is an inadequacy of pharmacists and pharm-techs yet this is a critical factor in the verification, dispensing and ordering for supplies. While the County government continues to mobilize resources to hire additional personnel, there should be deliberate efforts to conduct CMEs and OJTs for respective staff.

c) **Procurement Procedures:** It is possible for the county's financial structure to consider decentralizing procurement of medicines to the department without losing oversight authority. The other possibility would be to restructure the cycle of procurement from a period of 3 months (quarterly) to 6 months, to attempt to address the delays caused by a long procurement process.

d) **Storage Infrastructure:** For elements a, b and c above to be effective, it is imperative that the county government and partners support the improvement of storage facilities at the sub-county for the start but eventually also for the peripheral facilities.

e) **Strengthen Monitoring:** The commodity security technical working group and the County and Sub-County Health management teams need to be supported to conduct regular spot checks and to intensify backstopping to all health facilities. This has been documented to be one of the most effective ways of managing possibilities of pilferage of medicines at facility level.

INTRODUCTION AND BACKGROUND

2.1. Purpose of Study

The Constitution of Kenya 2010 recognizes the Bill of Rights with notable emphasis on devolution of political, administrative power and resources. Health services have been devolved at the county government with a view to create a robust health system that is responsive to various population health needs. The Constitution provides that at least 15 percent (15%) of the national revenue be allocated to the county governments to fund the devolved functions, including health – even though there is debate in the public space as to whether this percentage share needs to be increased.

County level health systems continue to face challenges that have far reaching effects on citizen's access to essential health services[1]. Health sector remains a major beneficiary of the national and county budgets despite potential gaps in the procurement procedures which continue to pose significant threats to the provision of these essential rights. This has led to inadequate health supplies, poor service delivery among others.

The essence of the study was to critically analyse government health procurement procedures **using Kakamega as a case County** with a view to unearth the direct effect of lapses in procurement systems on access to health services, and suggest actions that will contribute to improvements in the quality and access of basic health services.

The overall purpose of the study was to;

- Critically analyse public procurement policies including other related policies and legislations on procurement and disbursement process
- Analyse actual health funds received against actual/total health expenditure
- Examine challenges faced by health facilities in Kakamega as result of procurement procedures.
- Propose simplified health procurement procedure guide for effective procurement and disbursement of health supplies.

This study follows the National Health Sector Strategic Plan (NHSSP II), whose overall goal was to reduce inequalities in health care services and reverse the downward trend in health-related

[1] County Budget and Outlook Paper, October 2015

outcome indicators. It is a critical element in the planning process, in as far as it enables the County government to prioritize remedial actions (in improving health services) based on empirical evidence. It would be a useful guide for County Government budgeting process, so that resources are allocated and used efficiently for attainment of health outcomes. It also suggests how Non-State Actors and the Private Sector can support the County Government in addressing gaps in access of essential medicines and products.

2.2. Study Approach and Methodology

The study sought to generate useful information for use in improving operational efficiency in the procurement of essential medicines and devices, influence sector policy, and generate knowledge for use in health planning. The study was undertaken in three phases of Literature review, Field work (Key Informant Interviews and FGDs with health stakeholders), and Analysis and reporting.

2.2.1. Desk /Literature Review

Secondary data gathering was a continuous exercise throughout the assignment. The consultant sought information from existing literature from both the county government and other actors in the health and public procurement spaces. Literature from policy documents including but not limited to; Public Procurement policy, County Health strategy, County Integrated Development Plan, county level procurement laws were reviewed. The desk review provided the bulk of secondary information and was carried throughout in the three phases of the evaluation. Sources of secondary data are indicated in annex 2 of this report and form part of the references to the final report.

2.2.2. Focused Group Discussions (FGDs)

The consultant prepared discussion questions and conducted the FGDs. In each of the sampled locations, there was an FGD with the consumers of the health system. In total, 7 FGDs were conducted – the distribution of the FGDs was based on geographical considerations and socio-economic profiles. Overall, within FGDs, the consultant sought to build an understanding of the role and level of participation of community action groups on procurement of essential medicines, and gathered insights on the responsibility of the public in improving public pharmaceutical services. The FGDs were also used to assess the gaps in the access to essential drugs and related public health services.

2.2.3. Key Informants interviews (KIIs)

These were discourses on the procurement process for essential medicines and suggestions on improving future similar interventions between the consultant and the selected key informants (see annexed list of respondents). The process was an interrogation of the functionality of the Logistics Management Information System (LMIS), The focusting and quantification process, the participation of communities, the management of health budgets. Key informants included - Ministry of Health staff, policy makers; service providers (like KEMSA), County Administration, County Health Department (Chief Officer Health, County Pharmacist), and other agencies Implementing similar initiatives (Non-State Actors)

2.2.4. Rapid Health Systems and Budgets Review

In order to properly situate the procurement within the broader context of the health care system, it was important to develop a surface understanding of the other components of the system such as, Health Governance, Human Resources, Service Delivery, Information Systems, and Financing. While a large part of these reviews were part of desk work, it was important that these aspects be given prominence.

The budgets review included an analysis of the adequacy of the allocation as part of the overall county budget, and the broad lines of expenditure. The study was also keen to gather data on the percentage health budget dedicated for the purchase of essential medicines and analyse trends over the period of devolution.

2.2.5. Sampling and Coverage

The study covered (proportionately), the catchments of both Urban and Rural health facilities in Kakamega county. In these areas, FGDs and Key Informant Interviews were conducted as described above. Since this was a predominantly qualitative study, it was adequate to purposively identify respondents based on their knowledge of the subject of study.

2.3. The Context of Health Care

2.3.1. Geography, Demographics& Livelihoods

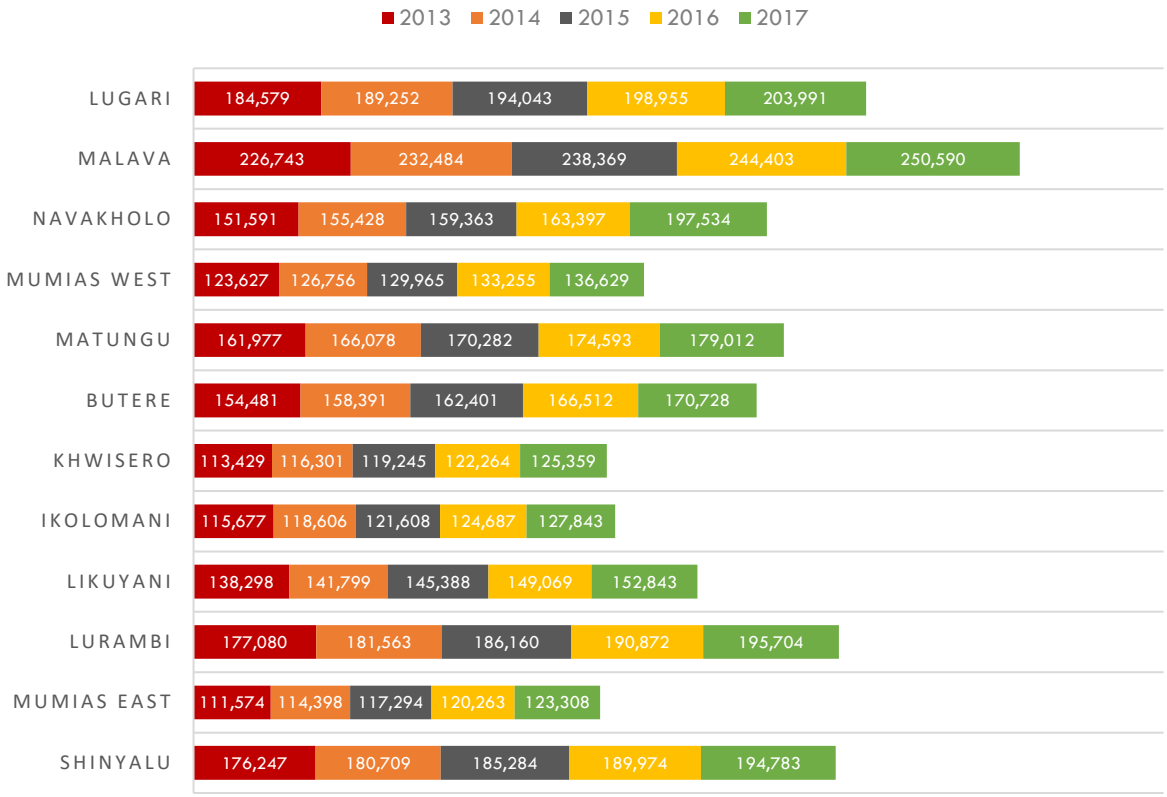
Kakamega County has 12 Sub Counties namely Lurambi, Ikolomani, Shinyalu, Malava, Butere, Khwisero, Matungu, Mumias West, Mumias East, Navakholo, Lugari and Likuyani. Its size is 3,050.3 Km^2 with a population density of 572 per square kilometre. More than 80% of the population lives in the rural, with 95% Luhyas, 2% Luos, 2% Kikuyus and 1% other tribes[2]. Christianity is the most predominant religion in the County at 75%, followed by Islam and others such as, Hinduism, Buddhism, Traditionalism and Atheism. According to the 2009 Population and Housing Census, the County population was 1,660, 651 consisting of 797,112 males and 863,539 females giving the population distribution of 48% male and 52% female[3].

The percentage population of children under 5 years in the county is 17.4 %, while Women of child bearing age consist of 26.3%. The largest population cohort is that of under 15 year olds which total to 47. 1%, while the composition of the elderly (>60yrs) is 4.7%.

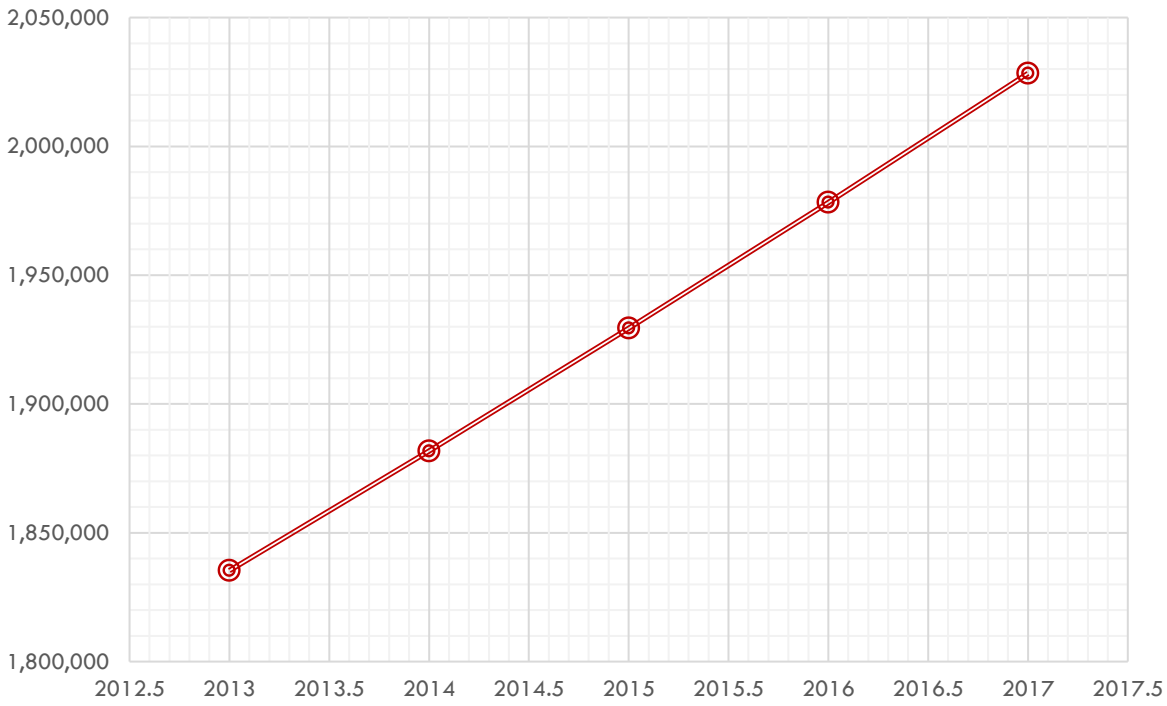
As shown in the table graphs below, the projected 2017 population is 2,028,324 based on a population growth rate estimated at 2.5%. This puts great pressure on socio-economic facilities; especially on health, education and land – Thus, resources which could have otherwise been utilized elsewhere, have been diverted to meet the health and education needs leaving very little for other investments.

[2] Kakamega County Integrated Development Plan
[3] KNBS – National Population Census 2009

Graph: Population growth by Sub-County



Graph: Growth in total population in Kakamega County



The main economic activity is mainly maize and sugar cane farming. Predominant subsistence farming includes maize, beans, ground nuts, sweat potatoes, cassava, millet, finger millet & peas. Other livelihood activities are small scale businesses, boda-boda business and gold mining.

2.3.2. Status of Healthcare

Kakamega County is one of the most populous counties in Kenya. According to the County's Integrated Development Plan, the county has a poverty level of 57%, and has also experienced some of the worst health indicators in the country. For example, **maternal mortality rate (MMR) is at 880 per 100,000 live births**, almost twice the national average; mainly due to the high number of unskilled deliveries. **Neonatal mortality is at 28 per 1000 live births**. The county has One (1) County General hospital, nine (9) sub-county hospitals, 9 mission/NGO hospitals, one (1) private hospital, eight (8) nursing homes and 27 public health centres. In addition, the county also has 1 private health centre, 66 public dispensaries, 31 private dispensaries and 107 private clinics. Previous Health situation and context analysis of the county reveal that access to,(and quality of) health services is faced by challenges related to inadequate commodity supply, irregular distribution of health personnel, skills gaps, lack of specialized Medicare and equipment, erratic/inconsistent commodities supply, and inadequacy of facilities.

Although the County is endowed with natural sources of water, access to clean water remains a challenge. This coupled with poor waste disposal, poor sanitation and unhygienic practices leading to diarrheal diseases which are a major cause of ill health and death. Viral enteric infections account for about 60% of all diarrheal cases, while other enteric infections contribute 40%[4].HIV Prevalence is at 4.8% (KAIS 2012) and an estimated 8.6% of children are underweight. The table below is a summary of the County's performance on various impact level indicators in comparison to global and national averages.

Impact level indicators	World (WHO)	National (KDHS)	County (Western)
life expectancy at birth (years)	59.7	58.9	48
annual deaths (per 1,000 persons) – Crude mortality	10.54	unknown	12.9
neonatal Mortality rate (per 1,000 births)	26.7	27.8	28
infant Mortality rate (per 1,000 births)	26	52	65
under 5 Mortality rate (per 1,000 births)	29	74	121
Maternal Mortality rate (per 100,000 births)	95	488	880
adult Mortality rate (per 100,000 births)	319	5.8%(F),	339
Crude birth rate (per 1,000 population)	37.4	34.8	38
Fertility rate (number of children per woman of child	2.3	4.6	5.6

[4] The Kakamega County Health Sector Strategic and Investment Plan 2013-2017

2.3.3. Causes of Morbidity and Mortality

Causes and Risk Factors for MORBIDITY			Causes and Risk Factors for MORTALITY		
#	Condition	Risk Factors	#	Condition	Risk Factors
1	Malaria	Exposure to infected vectors	1	Malaria	Inappropriate and late medical attention
2	Other diseases of the respiratory	Indoor air pollution	2	Pneumonia	Inappropriate and late medical attention
3	Disease of the skins including	Childhood & maternal malnutrition	3	Diarrhoea	Dehydration
4	Diarrhoea	Unsafe water, sanitation &hygiene	4	Anaemia	Inappropriate and late medical attention
5	Accidents– fractures, injuries etc	Reckless driving and driving under influence	5	abnormal clinical and lab findings	Misdiagnosis
6	Ear infections	Poor hygiene, excessive noise	6	Acute lower respiratory infections	inappropriate and late medical attention, non-adherence
7	Pneumonia	Poor ventilation and hygiene	7	Intentional self-harm	Drug and substance abuse
8	Rheumatism, joint pains etc	Unhealthy diet	8	Other heart diseases	Late detection &medical attention, non-adherence
9	Urinary tract infections	Unprotected sex with multiple	9	Gastric & duodenal cancer	Wrong diagnosis, non-adherence
10	Eye infections	Poor personal hygiene, dust and other allergens	10	Diseases of the genitourinary	inappropriate & late medical attention, non-adherence stigma

Source: Health Sector Strategic & Investment Plan

2.3.4. Status of Access and Quality of Health Services

Output Area	Intervention Area	Situation
Access	Availability of critical inputs (human resources, infrastructure, Commodities)	There is general staff shortage across all cadres, 51% of the population is not within five kilometres of reach of health facilities, and some existing health facilities cannot provide all essential services e.g. lack of maternity wings in some health facilities. supply of health commodities is inadequate & erratic in a majority of health facilities e.g. lab reagents, drugs, non-pharmaceutical etc.

	Functionality of critical inputs (maintenance, replacement plans, etc.)	Basic equipment is available in health facilities but some are in need of maintenance and replacement. However there is high need for additional critical inputs. example are microscopes, weighing scales and Blood pressure machines
	Readiness of facilities to offer services (appropriate HR skills, existing water / sanitation services, electricity, effective medications, etc.)	Though most health facilities have readiness to offer Services, some suffer inappropriate and inadequate HR skills, no reliable source of water, lack of electric power supply and inadequate staff housing.
Quality of care	improving patient/client experience	Facilitiesare sparselylocated within adequate equipmentand human resource. Supply of health products and technologies has been erratic. All these contribute to client low satisfaction.
	assuring patient/client safety (do no harm)	There is a fair degree of patient/client safety with established care committees and continued use of guidelines. Though, there is need to improve on infrastructure and Human Resources and ensure frequent supply of health products and technologies, coupled with strong health leadership and governance.
	assuring effectiveness of care	There have been efforts to ensure the effectiveness of care but there have been some limitations in terms of poor infrastructure, inadequate skills, irregular supply of health products and technologies and weak health leadership and governance.

Source: Health Sector Strategic & Investment Plan

2.3.5. Health Infrastructure

The County has a total of 251 health facilities of various categories as shown in the table below;

Type of health facility	#	Percentage
County hospital	1	0.4%
Mission/NGO hospitals	9	3.6%
Private hospitals	1	0.4%
Nursing homes	8	3.6%
Public health centres	27	10.8%
Private health centres	1	0.4%
Public dispensaries	66	26.3%
Private dispensaries	31	12.4%
Private clinics	107	42.6%
Total	**251**	**100%**

Source: Health Sector Strategic & Investment Plan

The facilities offer Essential Health services like Integrated MCH/FP Services, maternity services, services targeting elimination of Communicable diseases, services to control the rise of Non-Communicable diseases, Accident and Emergency Care, Laboratory services and X-ray/Imaging services among other essential services, etc.

Inadequate commodity supply, staff shortage, skills gaps, lack of specialized Medicare and equipment, erratic commodities supply and inadequate management skills were among some of the challenges identified. In addition, Facilities do not have adequate infrastructure like stores, Wards and Delivery rooms. Only10% of the facilities have access to computer services, and 67% of the facilities have some source of power/electricity.

Despite these significant gaps, the County Health Strategy indicates that 35% of the facilities have working service charters which demonstrate they are making efforts towards client satisfaction. There is need to improve on personnel, equipment and structures at level III downwards, in order to improve better access to health services, and promote health seeking behaviours. This will also enable better functioning of community units.

2.3.6. The Policy Environment

The 2013 elections marked the transition to the new governance system with the election of 47 county governors and Assemblies responsible. Aware of the challenges of the transition, the constitution provided guidelines for the transfer of functions to ensure continuity of service delivery. A key focus of these laws was the readiness of county governments to manage the functions devolved to them. Several laws were enacted to facilitate the transition and functioning of county governments, e.g., the County Governments Act, the Public Financial Management Act and Urban Areas and Cities Act. Older laws, such as the Public Procurement and Disposal Act, were amended to ensure they were in line with the new governance order.

The laws were intended to ensure transparency and accountability of county operations, enhance citizen participation, promote inter-governmental relations, in addition to facilitating effective and efficient delivery of services. But while in theory the county governments are closer to the people and can best understand and satisfy citizen needs, it's effect in the reach and quality of healthcare services remain subjective and a matter of conjecture. This study (in part) attempts to clarify the extent to which devolution has resulted in improved delivery of health services - even though a wider study engaging various counties would be necessary for better conclusions to be drawn.

The regulations on medical procurement provides that;

> (1) The procurement for the public health services of medicines, vaccines and vaccines and other medical goods shall be undertaken primarily by the Kenya Medical Supplies Agency
>
> (2) The classes of products procured by the Kenya Medical Supplies Agency shall extend to therapeutic feeds and nutritional formulations in addition to pharmaceutical and non-pharmaceutical goods
>
> 3) The Kenya Medical Supplies Agency may be the point of first call for procurement at the county level and it shall endeavour to establish branches within each county at such locations as it may determine
>
> (4) Notwithstanding sub section (3), counties shall have the right to procure these items incidentally from other sources where the Kenya Medical Supplies Agency is unable to supply them in good time or at a competitive price
>
> 5) National referral hospitals shall have a right to purchase medicines and vaccines from other accredited sources
>
> 6) National Government shall provide guidelines for the procurement, distribution and management of essential medicines at all levels of the national health system.

Thus far, some of the policy, administrative, or fiscal constraints (within the arrangement of devolution) that can be said to have adverse effects on the provision of health services include;

- The constitution mandates that 15% of the national budget is transferred to counties for service delivery, including health. At the same time Kenya has committed to ensure that it allocates a certain minimum proportion of the budget to health to meet globally agreed targets. As a mostly devolved function, health has to compete with other priorities for funding, and there is no mechanism for ensuring that the collective national and county allocations meet the regional and global commitments. This is likely to impact on the resources available for procuring medical supplies.
  Suggested Solution: *Agree on national priorities and fund them directly through the consolidated fund or through conditional grants to ensure that national commitments are met.*

- Transfer of functions after the introduction of the devolved system of government was less than smooth, and roles are still being contested, with conflict over the ownership and management of health functions continuing nearly five years into the implementation of

devolution. This contestation has tended to obfuscate the real issues facing the sector and reducing discourse to "who controls what" rather than the quality of service delivery the citizens are receiving. In the absence of national consensus, priority areas such as procurement of essential medicines are likely to be affected. Suggested Solution: *Consensus on roles is reached and legislated to avoid ambiguity*.

- The Auditor-General's reports show a glaring challenge of Absorption Capacity in counties. For instance, the Kakamega County Ministry of Health budget outturn for the financial year 2014/2015 was a mere 45%, with the county spending only Kshs 284,682,596 against a budget allocation of Kshs 624,336,246. Suggested Solution: *A capacity assessment should be undertaken and capacity building programme initiated with assistance of the national government. Further, a clear disbursement timeline by the national government especially on matters health needs to be put in place to avoid end of FY disbursement leading to low absorption. Secondly prior procurement processes needs to have been done to ensure full utilization of funds despite late disbursements especially on health matters.*

- Counties have a high degree of financial autonomy, but oversight institutions, such as County Assembles, the Senate and Kenya National Audit Office (KENAO), are nascent and/or weak. The Auditor General's reports for Kakamega show numerous cases of less than optimal utilization of public funds; including unsupported expenditure, poor budget performance, unutilized funds and unaccounted for funds, among other irregularities. *Performance of oversight institutions should be assessed and a national programme to strengthen their role instituted, including strengthening legislations.*

- Disbursements (transfer of funds from national Treasury) are regulated so as to take into account inflows of revenues into the Treasury and to ensure predictability of financial flows at the counties. In reality, however, transfers to counties are irregular and late. This affects counties' ability to plan for their finances, and especially to meet financial obligations to contractors, including to their medical suppliers. Effects of this disbursement inefficiency were witnessed during this assessment when KEMSA was reported to have withheld supplies for several months due to non-payment by the county of previous deliveries. Suggested Solution: *Enforce disbursement schedules and punish institutions and individuals responsible for delays.*
- The Integrated Financial Management Information System (IFMIS) is intended to inject greater efficiency and transparency in financial management, particularly in budget

planning and execution. It can be argued that the system has succeeded to a certain extent in achieving those objectives. However, the system is erratic, and its use too highly centralized to the county headquarters. In addition, the system faces lingering resistance and has suspect political support at the counties' level. These challenges have a direct impact on procurement, as payments cannot be made outside the system.

Suggested Solution: *Strengthen capacity on IFMIS, roll the system to sub-counties and develop a change management strategy.*

- Citizen participation in the budget process is assured through the County Budget and Economic Forum through which citizens concerns are prioritized and budgeted for. However, the capacity for citizens to engage remains low leading to token representation and elite capture. In the absence of genuine citizen voice, residents of Kakamega felt that needs such as health do not get the high priority that they deserve resulting I low allocations and poor utilization of funds.

  Suggested solution: *Enhance citizen participation in budget process through partnership with CSO.*

- Public Procurement remains a complex area. The Health Bill allocates the national government the function of "Procurement of pharmaceutical and non-pharmaceutical goods for public health facilities through the Kenya Medical Supplies (KEMSA). Counties may however ignore KEMSA if they can find credible alternative suppliers. It was apparent during the review that the system has not worked smoothly for Kaka mega as KEMSA had withheld supplies due to non-payment of previous deliveries; this leading to severe shortages of critical drugs in the county. Another challenge facing procurement and the supply chain is corruption. Transparency International (TI) estimates that about 25% of government budget is lost on procurement related corruption in Kenya. In most areas visited, residents reported that cases of county drugs sold privately, amidst shortages in the public facilities.

  Suggested Solution: *Strengthen procurement capacity, guarantee payments; and introduce modern stock tracking system.*

It should be noted that the Health Bill of 2016 has attempted to address some of these challenges by, for instance, standardizing quality of service, controlling procurement and regulating health human resource management across the counties. This has however stalled on account of conflict with the constitution.

KEY FINDINGS OF STUDY

3.1. The Procurement System

Public procurement is a crucial pillar of strategic governance and service delivery. Since it involves huge volumes of public money, procurement is an important tool for achieving public policy goals. It plays a major role in fostering public sector efficiency and cultivating citizens' trust. OECD lists the key principles that should guide public procurement, among them: integrity, Access, Participation, Efficiency, E-procurement, Accountability and Integration. The Public Procurement and Asset Disposal Act provide a legal framework to achieve the goals and principles of public procurement, and stipulate the institutional arrangement for all public procurement. Counties are responsible for their own procurement.

Transparency International-Kenya estimates that government can save up to 25% of its expenditure by improving procurement processes. Capacity to undertake complex public procurement is weak, both within counties and those wishing to participate. Public participation is weak and thus the citizen oversight that is expected in procurement remains ineffective. In the absence of adequate capacity, effective citizen participation and strong enforcements mechanisms, procurement remains an area of extreme weakness in financial management. Procurement directly affects access to health care as gaps/inefficiencies in the system lead to delays in the acquisition of essential medicines and medical products.

3.1.1. Financial Infrastructure

Counties have a degree of constitutionally guaranteed financial autonomy. County resources are managed by the county Treasuries with the oversight of County Assemblies at the county level and Senate at the national level. The flow and management of funds is governed by the Public Financial Management (PFM) Act, while the independent Kenya National Audit Office (KENAO) undertakes the audit function. The county governments have complete autonomy in the way they plan, allocate resources and invest.

The arrangements for financial management guarantee counties fiscal and financial management autonomy. They have near complete independence from the national government over development planning and financial management; they can thus set own priorities and allocate funds to address them. However, the capacity of County Assemblies to play the oversight role is highly challenged. The national senate has also struggled to hold counties to account. Moreover, financial management capacity of counties - in terms of skills and numbers

of financial management personnel - remains inadequate, as is the capacity of KENAO to adequately audit the counties.

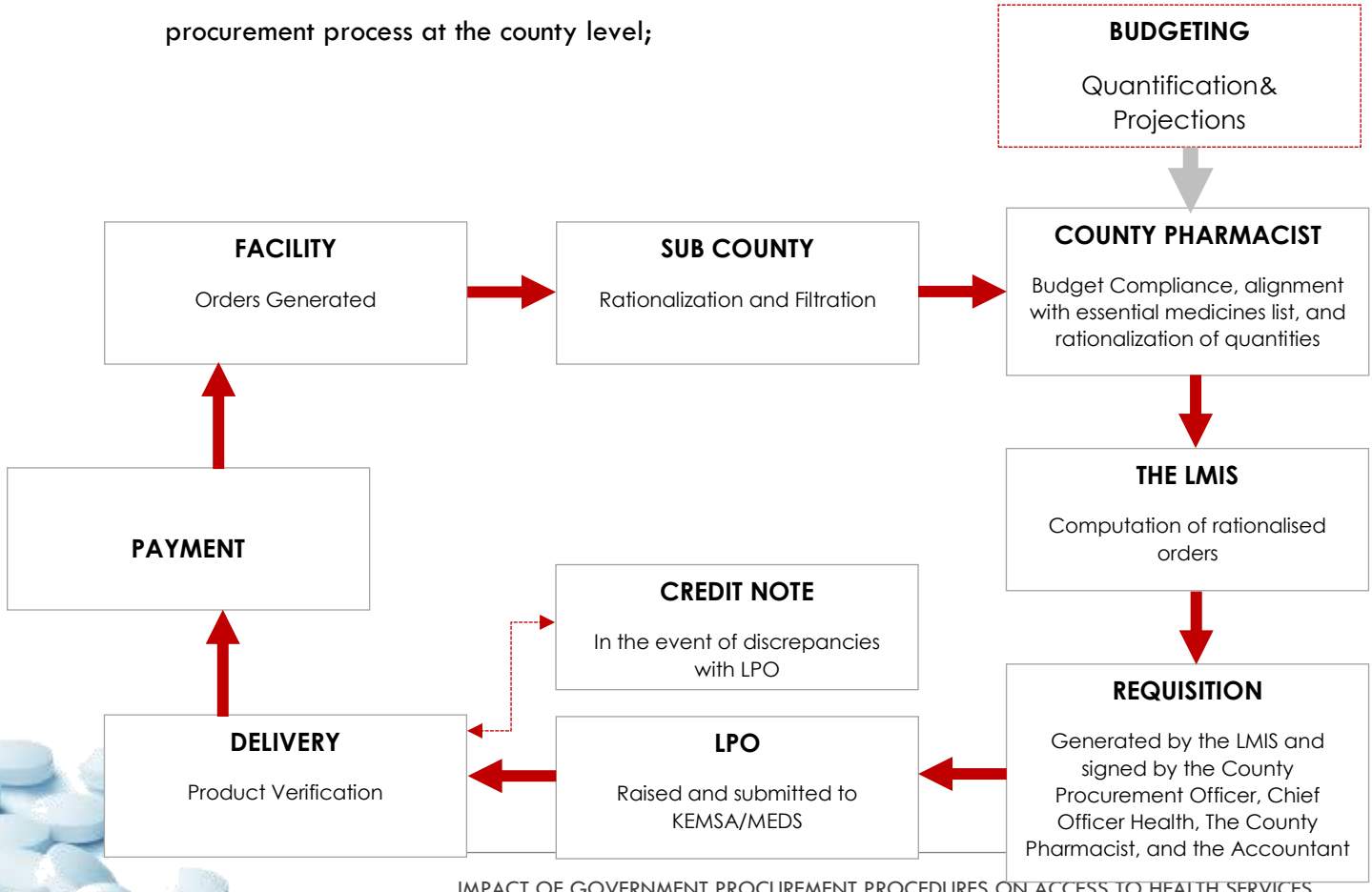
3.1.2. Disbursement of Funds

To ensure certainly and predictability in county financial management, the National Treasury is mandated to transfer funds at the beginning of every quarter, and no later the 15th day of the quarter. The actual amounts are specified in a schedule prepared by the National Assembly in consultation with the Intergovernmental Budget and Economic Council (IBEC). The schedule of transfers should reflect the realities of the national government's cash flow. However, the system has not always worked as expected.

Counties have on many occasions complained of irregular and delayed disbursements. It is not clear where the problem lies, or who is to blame for these delays. A blame game has often ensued in which counties accuse the National Treasury of bad faith in funds disbursements while the Treasury accuses counties of lacking the absorption capacity. Possible factors include the counties absorption capacity, financial management preparedness/capacity, flow of funds into the national government or political bad faith. Whatever is the case, delayed transfers affect county government's ability to meet financial obligations and provide services to the citizens.

3.1.3. The procurement process for essential medicines and medical products

In essence, the procurement process for pharmaceuticals and Non-Pharms is designed to run full cycle every quarter, even though this is not realized in practice. Below is an illustration of the procurement process at the county level;



From the process illustrated above, it is evident that the county has a well thought through process of procurement and that the challenge is certainly not the theory of process but rather the gaps in practice. However, it is worrying that in the flow of the procurement processas illustrated above, there are no prescribed timeframes beyond a broad indication that it's a quarterly process. Some of the other gaps identified within elements of the system include;

- **Delays in Quarterly Dispatches:** At the time of the study it had been 6 months since some of the facilities received consignments of medical supplies, and all the health facilities visited did not have the adequate medicines. There were however reports of a recent dispatch much of which was yet to reach the facilities. In engagements with facility in-charges and the communities around (including groups of Community Health Volunteers) it emerged that there are frequent stock outs, and that patients are often referred to private chemists even for drugs that should be in the essential drugs list like Malaria.

  It is our informed opinion that the delays in supply are caused by a combination of various systemic and structural factors that that can easily be addressed through a combination of policy, administrative and infrastructural alignments. The most notable cause of the delay being delays in remittances to the supplies (KEMSA/MEDS) – without which they are often unable to honour the LPOs. Further, the overall inadequacy of the budget allocation towards Pharmaceuticals and Non-Pharms remains an even bigger challenge. For instance, in the 2016/2017 Fiscal Year, only KES 360million was allocated despite a demand projection of KES 760million. In principle, this means that even if the medicines and products were to be supplied consistently, they would still only meet about 47% of the demand.

  Since the delay in payments to suppliers of medicines is the major reason for the inconsistencies in dispatches, the management of the county might need to consider an alternative procurement model. For example, it might be possible to have county level policy conversations around creating special arrangements for managing the allocation to pharmaceuticals and non-pharms outside the county's consolidated account, or to create provisions to process bulk orders every 6months rather than the existing quarterly process (though this would be subject to investment in storage and distribution infrastructure). The above notwithstanding it is even more critical for the county health team to consider increasing expenditure on pharmaceuticals either through higher budget appropriations or by mobilizing additional resources through partners (appropriations in aid).

- **Haphazard increase in the number of health facilities:** Kakamega County already has a total of about 251 facilities yet there is continued pressure (often from the Members of the County Assembly) to establish more facilities – there were reports of structures constructed as health facilities but which remain unfunctional due to lack of staff and equipment, notwithstanding the

fact they do not meet the structural requirements for a health facility. The balance between the existent need to improve coverage of health services, and the capacity of the county to resource and manage additional facilities is one that is certainly challenging to find. In the end, the county's health resources (personnel, infrastructure, and budgets) are stretched thin across the facilities.

Going **forward it is critical that the county conducts elaborate health systems assessments in order to measure its performance on the various health system components** *(Governance, Human resources, financing, service provision, Information Systems, and essential medicines and medical products)* against national and global benchmarks.

- **Storage Facilities:** Most peripheral facilities do not have adequate storage facilities and equipment for the storage of medicines and products that may last longer than 3 months. In essence, the facilities visited clearly outlined the limitation of space as one of the constraints. To counter this challenge, **it would be beneficial for the county to invest in a central, or sub-county level storage facilities (and distribution infrastructure) with the capacity to bulk large amounts of drugs, for onward supply to peripheral facilities.** While additional consultation and resources needs to go into establishing this distribution model, it has considerable potential to help circumvent the delays occasioned by a prolonged county procurement process.

- **Routine Supervision/ Spot checks:** In order to manage any incidences of pilferage at facility level, and for purposes of sustaining technical support to facility pharmacist is important to support county teams to consistently conduct support supervisory visits. These visits not only help in monitoring usage of medicines and products but also provide an opportunity for trained pharmacists and to offer on the job training for staff in smaller facilities who are often not qualified pharmacists or pharm-techs. It was not clear from the study if the staff in charge of the pharmacies within the peripheral facilities undergo some form of training (OJT or CME) before or in the cause of discharging such responsibilities.

In addition, **there is an opportunity for partners/Non-State Actors to invest in strengthening the Commodity Security Technical Working Group.**

3.1.4. Community Participation

Community participation is an important aspect of the Kenya vision 2030 and the Constitution of 2010. It is expected that policy-making, public resource management, revenue sharing/budgeting, and oversight are grounded on public participation.

Community participation in health has been singled out as an important pillar in stabilising health. Community health strategy implementation as an important vehicle for achieving community participation is a priority in the county's health strategic plan with 100% community unit coverage as an important milestone. Household challenges of access to clean water supplies, hygiene, sanitation and nutrition are better addressed through organised community-based structures.

During the Focused Group Discussions, it emerged that most communities do not feel sufficiently involved in the management of health facilities despite the presence of active community units. Improving the process of selection of Facility Management Committees, and occasional community health engagement forums could be useful processes in improving community participation and providing health education.

3.2. The County Health Budget

Based on the County's expenditure projections, **the county health sector would annually require an average of KES 971,796,992 for Pharmaceutical Supplies and KES 95,876,509 for non-pharmaceutical supplies.** This is a huge resource demand that the County government has not been able to cope with and which reinforces the need for continued investment by other players. The Health strategic and Investment plan has a partnership framework that allows participation of all stakeholders to support efforts that contribute to the health outcomes. The plan offers avenues to partners and other health stakeholders to seize opportunities for investing in health and to contribute towards realization of sector goals and commitments.

Even with such gaps in financing, it would be useful for the county government to interrogate absorption rates for each of its departments and seal possible lags in procurement process.

While it was not possible to obtain quantification figures for pharmaceuticals and non-pharms for the previous years, interactions with key county officials revealed that the budget inadequacies have been consistent and that it is important to direct efforts to fill the resource gap. It is therefore expected that the recommendations of this report should trigger a county level discourse on identifying opportunities and actions required to bridge this gap.

In FY 2016/17, the budget deficit on medicines and medical products was 53% which was way higher than the national average deficit of 46.2%[5]. It was immediately not clear how the county performed in the appropriations for the previous years. In order to best understand

[5] Source:

the conduct of health budgets within the County, it is important to generate analytical perspectives based on history of health expenditure. A good place to begin would be to begin would be the outlook of the Total Health Expenditure (THE) in absolute values for FY 2013/14 and FY 2014/15 – broken down by health function, health providers, and financing agents.

Some of the major constraints faced in budget implementation include; Acute shortage of human resource, insufficient and delayed disbursement of funds, and Long and tedious procurement procedures. These challenges could be addressed by recruitment of human resources, and the by the decentralization of procurement entity (away from the consolidated fund).

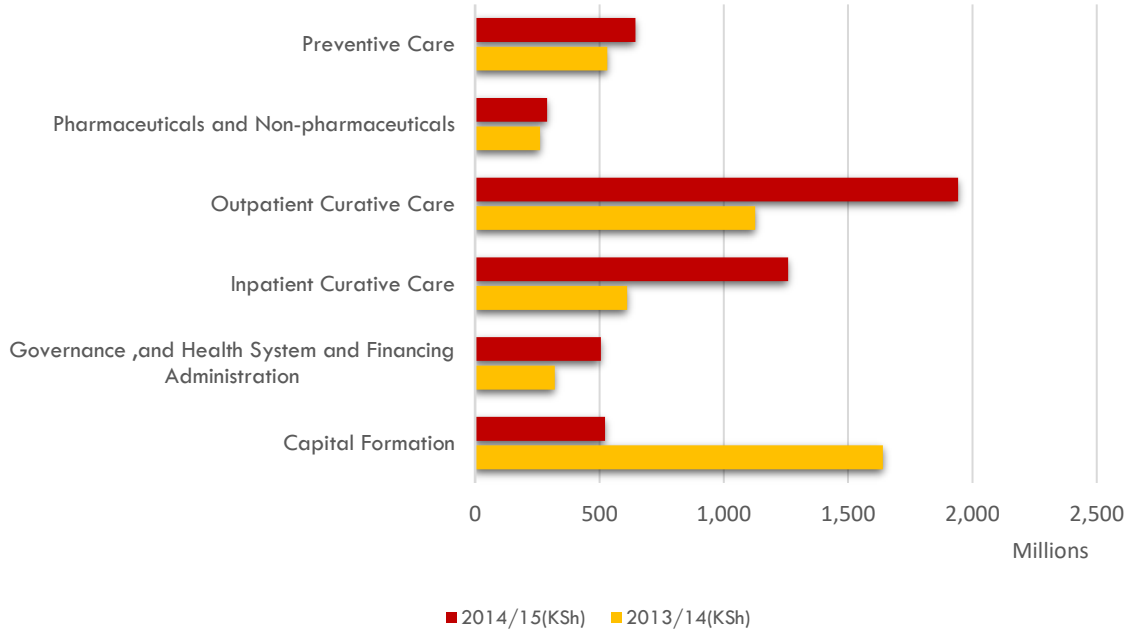
It is not expected that either of these solutions would be easy to pursue based on budget and planning realities, and entrenchments of policy but they are definitely achievable with the good will and commitment of the office of the governor and all the critical players.

3.2.1. Absolute Values of Total Health Expenditure by functions

Health Care Functions	2013/14(KSh)	2014/15(KSh)	% Change
Capital Formation	1,639,393,838	522,288,487	-68.1%
Governance, Health System and Financing Administration	320,813,294	505,987,611	57.7%
Inpatient Curative Care	611,789,217	1,258,482,364	105.7%
Outpatient Curative Care	1,125,799,841	1,942,550,296	72.5%
Pharmaceuticals and Non-pharmaceuticals	261,622,436	289,194,639	10.5%
Preventive Care	531,919,312	644,593,230	21.2%
Grand Total	**4,491,337,937**	**5,163,096,628**	**15.0%**

Source: Kakamega County Health Accounts

As indicated in the table above, and visualised in the graph below, it is evident that Pharmaceuticals and Non-Pharmaceuticals expense the lowest within the continuum of functions, and there is a general feeling that **the county government and stakeholders could better rationalize the existing budgets to increase the allocations to medicines**.



3.2.2. Absolute Values of Total Health Expenditure by Health Care Providers

According to Kakamega County Health Accounts, it is estimated that the total investment in health care is about KES 5 Billion in 2015. It is however expected that this amount has increased over the years. For example, the government allocation to Pharmaceuticals has increased to KES 360million in FY2016/17 from KES 289million reported in FY 2014/15 – accounting for about 8% increase in expenditure. The table below is a breakdown of health expenditure by the various health providers;

Health Care Providers	2013/14	2014/15	% Change
General Hospitals-Government	642,963,302	1,636,389,578	154.5%
General Hospitals-Private for Profit	212,322,293	326,102,919	53.6%
General Hospitals-Private Not for Profit	21,223,860	23,462,828	10.5%
Government Health Centres and Dispensaries	552,131,226	914,344,119	65.6%
Pharmacies	261,62		
Private for Profit Health Centres and Dispensaries	254,896,601	241,168,083	-5.4%
Private Not for Profit Health Centres and Dispensaries	35,277,497	39,036,985	10.7%
Providers of Health Care System Administration	1,848,322,318	912,396,035	-50.6%
Providers of Preventive Care	635,701,244	750,770,124	18.1%
Other Health Care Providers	26,877,162	30,231,316	12.5%
Grand Total	**4,491,337,937**	**5,163,096,628**	**15.0%**

Source: Kakamega County Health Accounts

Source: Kakamega County Health Accounts

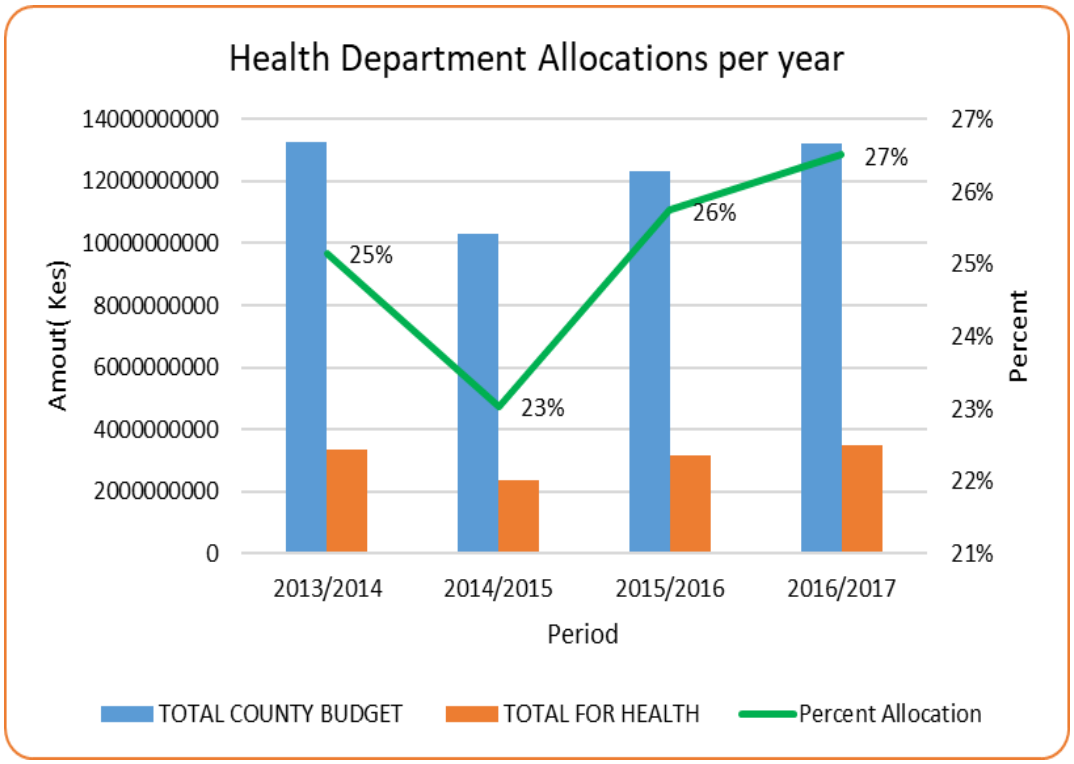
3.2.3. Health Financing

In FY 2014/15 the county government budget allocation was Kshs.2.584B yet in the allocation for FY 2015/16 amounting to KES 2,969B – which represents an increase of 15 percent[6]. This increment has enabled the county government to (in addition to routine services) increase access to emergency and rescue services by investing in a referral system/infrastructure, and to develop master plans for the facilities, which is pivotal in visionary health planning.

According to the latest County Health Accounts report, the Per capita expenditure on health was KES 2422 (USD 27.9) and KSH. 2716 (USD 29.7) in 2013/14 and 2014/15 respectively – which are still lower than the USD 34per capita recommended by WHO's Commission on Macroeconomics of Health (CMH).

Despite the fact that the County government expenditure on health (CGEH) as a percent of total County government expenditure (TCGE), decreased from 25 percent in FY 2013/14 to 22 percent in FY 2014/15, the county still remains one of the best health sector allocations nationwide.

The graph below shows the trend of allocations to the health sector over the last 4 years;



[6] Programme Based Budget of The County Government of Kakamega for The Year Ending 30th June, 2016

County government was the dominant financier of health services in contributing nearly half (48%) of the total health expenditure. The table is a breakdown of THE by financing agents;

Financing Agents	2013/14(KSH)	2014/15(KSH)	% Change
Commercial Insurance Companies	313,879,126	455,486,047	45.1%
County Health Department	2,081,278,754	2,464,453,345	18.4%
Households	1,019,910,563	1,127,503,989	10.5%
NGOs	759,644,557	801,275,433	5.5%
Parastatals	102,334,042	103,440,217	1.1%
Private Employers	80,891,465	58,078,929	-28.2%
Social Health Insurance Agency(NHIF)	133,399,431	152,858,669	14.6%
Grand Total	**4,491,337,937**	**5,163,096,628**	**15.0%**

Source: Kakamega County Health Accounts

4. RECOMMENDATIONS: An Alternative Procurement Paradigm for Pharmaceuticals and Non-Pharmaceuticals

4.1.1. Structure, Conduct and Practice

In suggesting an alternative procurement model, the fundamental questions would often be; what are the gaps in the existing model? What improvements should be made? And who should take what role in the process?

With these questions in mind, it is the opinion of this study that the procurement system for pharmaceuticals and non-pharms is not broken but certainly has gaps that could easily be addressed through a combination of policy level engagements, investments in the supply chain, and intensified involvement of stakeholders (including communities) – subsequently contributing to improvements in the mobilization and management of health resources.

Specifically, an alternative model should involve discussions around improving each of these elements;

- **Budget Allocation:** An average deficit of 53% in the quantities of medicines required means even with consistent dispatches to facilities, there would still be rampant instances of stock outs. The county government needs to purpose to progressively reduce this

deficit. Besides, the growth of health infrastructure, and the purchase of medicines and medical products, it is important that the county also allocates adequate resources towards the maintenance and servicing of hospital equipment on regular basis - preferably on a quarterly (or as need may arise)

- **Personnel:** There is an inadequacy of pharmacists and pharm-techs yet this is a critical factor in the verification, dispensing and ordering for supplies. While the County government continues to mobilize resources to hire additional personnel, there should be deliberate efforts to conduct CMEs and OJTs for respective staff.

- **Procurement Procedures:** It is possible for the county's financial structure to consider decentralizing procurement of medicines to the department without losing oversight authority. The other possibility would be to restructure the cycle of procurement from a period of 3 months (quarterly) to 6 months, to attempt to address the delays caused by a long procurement process. Since the 3 months process does not seem to be working for far more complicated reasons like the IFMIS System and delays in treasury disbursements, it is probable for the county to make 6month orders to KEMSA instead of the usual 3 months. This will ensure the availability of medicines and medical supplies at the health facilities even as the payment processes drag on.

- **Storage Infrastructure:** For elements a, b and c above to be effective, it is imperative that the county government and partners support the improvement of storage facilities at the sub-county for the start but eventually also for the peripheral facilities. In essence, equipping the primary health facilities (low level hospitals) will certainly decongest higher level hospitals and control aggravation of preventable and diseases.

f) **Strengthen Monitoring:** The commodity security technical working group and the County and Sub-County Health management teams need to be supported to conduct regular spot checks and to intensify backstopping to all health facilities. This has been documented to be one of the most effective ways of managing possibilities of pilferage of medicines at facility level.

g) **Focusting and Quantification (F&Q):** In addition to the budget for epidemiological emergencies, there is need for accurate and regular (annual/bi-annual) medical supply projections to inform timely replenishment of supplies. Accurate projections ensure suitable prioritization, and facilitates evidence based budgeting.

h) **Community Participation:** In Kakamega, there should be a well-structured, adequately funded, participatory and people oriented policy on public participation, that the public should be made aware of, so as to enhance their participation. Similarly, both pre and post budget hearings should be done so as to sensitize stakeholders on budget proposals and implementations in order to help them understand the budget process, facilitate development and adoption of sound budget policies in addition to enhancing integration of county priorities into the budget (including health). There is also need for a grassroots driven Community Health Technical Working Group (CHTWG) to facilitate continuous collaboration between the communities and the county government. This CHTWG can also serve to support the processes by which Facility Management Committees are identified, and subsequently hold them accountable. On its part, the county government should be ready to incorporate the views of the community representatives, and stakeholders in the budgeting process so as to level their expectations and harness their resources.

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