

The Kenyan health system after devolution: Setting priorities for community health and equity



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KEY MESSAGES

- The reason for devolution in Kenya was to ensure better equity of services at county level.
- Devolution has had positive ramifications for health equity in previously neglected counties and we can learn lessons from this best practice.
- The rapidity of devolution combined with limited technical capacity and guidance has meant that decision making and prioritisation for health can be captured for political and power interests.
- Less visible community health services, including health prevention, promotion, and referral risk being neglected in the prioritisation process.
- Addressing the gap in community health is important if health equity is to be achieved in the longer term and the benefits of devolution experienced by communities.

Ideally, health priorities should be set following a series of consultations among technical health decision-makers, local politicians, community members and other local stakeholders. Priorities should be guided by local evidence and community generated priorities. They should be bounded by available resources and national and county guidance documents using both cost-effectiveness and equity principles to identify context appropriate interventions which advance universal health coverage. Finally, there should be opportunity for appeal and revision.

Driven by the inefficiencies and inequities associated with the former centralised government, Kenya's devolution of planning, management and budgeting responsibilities to county governments aims to strengthen democracy and accountability, to increase community participation in decision-making, improve efficiency and reduce inequities. Global experiences have shown that the transfer of powers to lower levels does not always lead to the achievement of devolution's aims. Instead, there are risks that inefficiencies will multiply, inequities will widen and corruption will become more widespread. Health has been the most controversial of all services devolved in Kenya. This policy brief is focused on the impacts of devolution on health policy.

WHAT DID WE DO?

In response to the implications of devolution for community health, in 2015-2016, a REACHOUT sub-study was conducted to explore priority-setting for community health and equity across counties and health systems levels in Kenya post devolution. We explored health priority-setting processes, power dynamics and implications for health equity and community health services with respondents. Mixed qualitative approaches were used including interviews with county decision-makers (political, health, treasury, gender and children's representatives)

Figure 2 Counties studied for research with county decision-makers

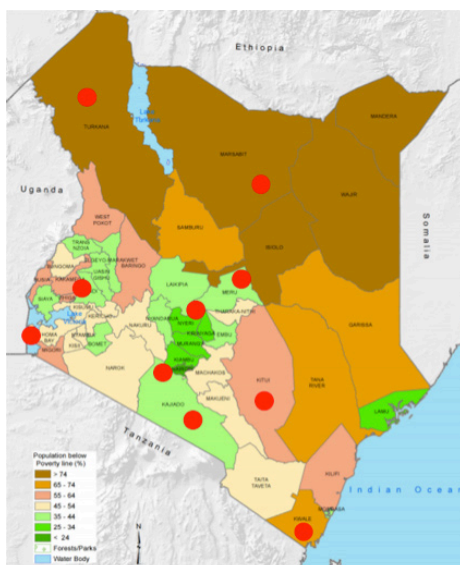
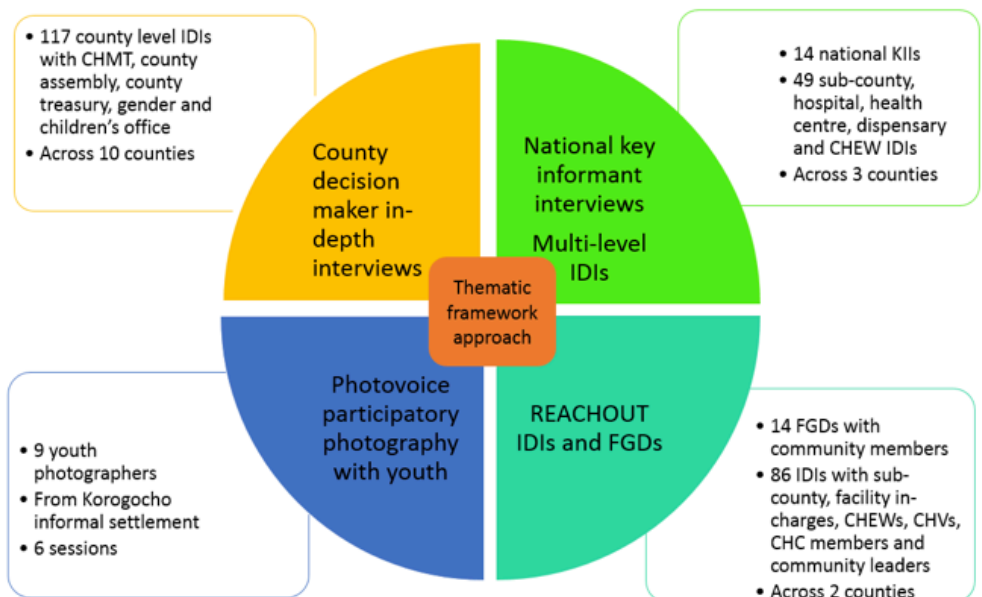


Figure 1 Study method chart



(ten counties), interviews with national key informants and health workers (three counties), interviews with Close-to-community providers and focus group discussions with community members (two counties) and participatory photography research (one county). See Figure 1 and Figure 2.

WHAT DID WE FIND?

Devolution has brought improved equity between counties, through the allocation of funds via the equitable share from national to county governments (which

includes poverty related allocation and should benefit poorer counties more) and the introduction of equalisation funds. This has led to increased investment for health in formerly marginalised areas which was unheard of under the centralised government. However, lack of clarity surrounding priority setting has limited the opportunities for equity within counties. Devolution in Kenya is still new, with changes ongoing and challenges are to be expected following such substantial reforms. It is therefore vital that these challenges are identified early, with lessons learned to ensure the potential benefits of devolution are realised.

1. Understandings of equity and prioritisation of community health

Many respondents across health systems levels identified equity as a guiding principle for devolution. National and county level respondents tended to interpret health equity in terms of geographic and financial access to health services. Health workers and community members described equity more comprehensively, describing services which are effective, available, acceptable and used by those who need them. This difference in interpretation goes some way to explaining the current emphasis on infrastructure as a way to improve geographic access to health facilities, with varied prioritisation of community health services between counties. County level decision-makers, who were often found to hold greatest power for priority-setting, perceive building health facilities as the most appropriate way to achieve health equity. Community members who described a more holistic understanding of equity are not yet sufficiently empowered to establish the link between their understanding of equity and the priorities which they identify.



Ambulances and infrastructure are a priority for many counties

2. Examples of best practice

There are emerging examples of stronger, more equitable health priority-setting which fulfil devolution's objectives. For example, in one county where there is a large nomadic population the community health strategy has been modified to ensure that the community health volunteer moves with their community and has the ability to use a satellite phone (originally provided for reasons of insecurity) to communicate with members of the health team in the event of an obstetric

emergency. In another county, there have been extensive measures to educate and empower the community to understand health holistically and to inform 'powerful' decision-makers such as members of county assembly about the politically appealing aspects of community health interventions. As a result, equity promoting community health activities received funding from the county government for the first time. Meanwhile, in a county with high non-communicable disease burden CHVs have been trained to screen for and refer patients with hypertension.

Community health volunteers can promote equity and extend healthservices to hard-to-reach populations



3. Varying role of actors and the importance of power and process

Overwhelmingly the findings from this study relate to power dynamics. A range of actors are included within the decision-making process as indicated in Figure 3.

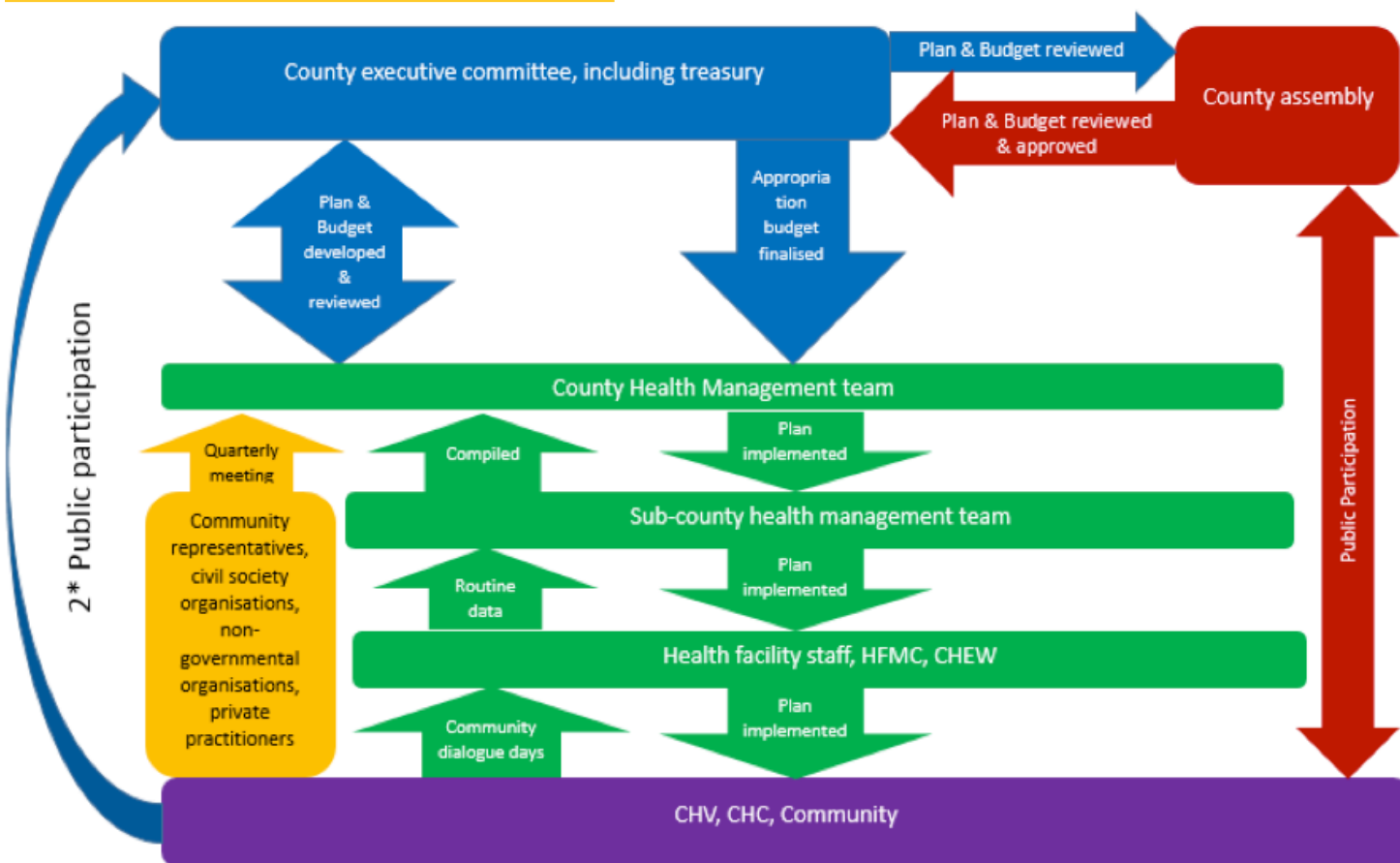
Despite a clear annual budget planning cycle there was lack of clarity about roles and responsibilities for decision-makers, with the absence of commonly defined criteria and processes to guide action. The communities studied are not adequately aware of their role and do not have the information they need to make informed, appropriate decisions. As a result, they often select visible priorities, such as new health infrastructure instead of services which meet underlying health needs, such as investment in health promotion or disease prevention. Within the confusion created by the lack of clear, specific guidance, opportunistic actors have seized available power. Some have created

opportunities to manipulate county health priorities to align with personal objectives, such as seeking political re-election. The resulting increased complexity creates a situation that makes progress beyond a single elected term challenging, blurring lines of accountability with the result that certain activities are delayed or cut from plans. This has led in turn to an increased focus on tangible curative services such as ambulances and health facilities, further stunting opportunities for strengthening quality service delivery and holistic care. Because political offices have more power than health workers at sub-county and health facility levels there have been mixed results for the delivery of health services.

Infrastructure was a common area for investment with rehabilitation of facilities across all counties studied. This was a

politically charged area, which at times led to construction of facilities which lacked the staff, equipment, and drugs to provide services. Supply of drugs and commodities varied hugely between counties, with some describing the improvement in drug supply chain as the county's greatest success. While in other counties supply chains deteriorated leading to frequent stock-outs which has affected client care-seeking practices. Many county governments have sought to invest in human resources. However, there have been repeated controversies with recurring health worker strikes as a result of delayed payment of salaries, slow career progression, and lack of engagement with health workers throughout the devolution process leading to disillusionment by many.

Figure 3 Actors in priority-setting process for health



WHAT SHOULD WE DO?

Devolution has brought a period of colossal upheaval with changes in roles and power within the health system. This has created considerable opportunities to improve equity, but findings from the early years after devolution reveal these have not yet been fully realised. In response eight key recommendations are identified:

National Level Recommendations

1. Clarify guidance: National and county level governments should collaborate to align standards and to identify clear guidance about processes for the filtering and selection of public inputs. This should include what aspects of services are non-negotiable and must be provided and which are open for re-invention to better meet county, sub-county, and local communities' needs, roles and responsibilities.
2. Monitoring key indicators: Stakeholders should monitor key public health indicators (such as immunisation and family planning) with an equity focus, with introduction of measures to ensure adequate funding towards public health, community health and primary health care services as needed. This should include targeted capacity building for wise decision-making and use of conditional grants to encourage public/community/primary health approaches.



County Level Recommendations

3. Capacity building: Stakeholders should share best practices for county-to-county capacity building. County technical decision-makers need to build capacity (in technical actors, politicians and at community level) to understand health holistically, community health, equity, and universal health coverage principles.
4. Strengthen community governance and empowerment: Stakeholders should ensure accountability measures are meaningful by providing community members with easily understood information about the range of choices available to them. This should include innovative approaches to ensure participation in priority-setting from those considered 'marginalised', such as women only meetings in certain contexts or the use of social media platforms with youth.
5. Maintain a quality focus: Stakeholders should use existing accountability mechanisms to monitor quality, so that as coverage extends functionality is maintained. For example, county decision-makers should seek to incorporate community feedback about the effectiveness of services provided (community dialogue days, complaints boxes) in priority-setting processes.
6. Build county level human resource management capacity: Recruitment of trained and experienced human resource managers within county public service boards, with earmarking of funds for staff salaries within the county is needed. This should be accompanied by the creation of stronger platforms to engage health workers (community and health facility level) in priority-setting and in demanding fair treatment from county public service boards.
7. Continued decentralisation: Counties need to consider further decentralisation to sub-county, health facility, and community unit level, by developing laws which give these levels greater control over selected management functions and resources, to accommodate local problem-solving and ensure funding for needed activities currently neglected in many places under devolution. They should ensure functioning governance mechanisms are in place at these levels before decentralising these functions.
8. An equity focus: Stakeholders should ensure that equity is a focus when tracking service coverage and uptake, by expanding high-priority services for everyone and ensuring that vulnerable groups are not left behind. County government should identify vulnerable groups within their county and build capacity for data collection and use, such as community score cards, community health workers should be tasked with ensuring participation of vulnerable groups.

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