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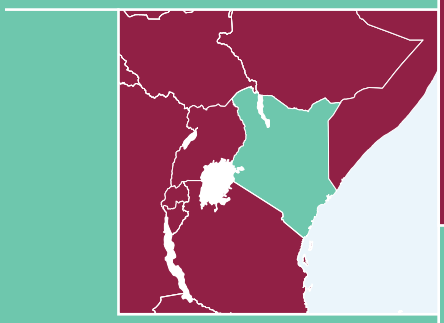
POLITICAL WILL FOR HEALTH SYSTEM DEVOLUTION IN KENYA:

INSIGHTS FROM THREE COUNTIES



Brief

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INTRODUCTION

The enactment of Kenya's new constitution in 2010 devolved most functions previously held by the central government including health sector functions to 47 newly established counties. The health sector is particularly important for Kenya's devolution—it receives the largest share of the budget in most counties and is a frontline sector, meaning Kenyans use health sector performance to judge the government's overall effectiveness (Hope, 2014).

Because devolved units are now responsible for critical government functions, devolution's success relies heavily on ongoing political will at all levels of the Kenyan government. Assessing what drives political will can help shed light on decisionmakers' action or inaction and allow the Kenyan government to better formulate sustainable, long-term strategies to effectively implement devolution in the health sector (Williamson and Mulaki, 2014). Further, this kind of analysis can identify points of leverage for nonstate actors seeking to improve political will for the devolving health sector.

Box 1: What Is Devolution?

"Devolution is a form of decentralization, or the transfer of authority and responsibility from central to lower levels of government for a range of public functions" (World Bank, 2001). Kenya's national government has shifted power, responsibility, and budgetary authority to locally elected and appointed officials (Williamson and Mulaki, 2014).

Political will can be defined as, "the commitment of actors to undertake actions to achieve a set of objectives … and to sustain the cost of those actions over time" (Brinkerhoff, 2010, p. 1). However, this broad definition hides many complexities. Breaking down the concept into seven factors clarifies the meaning of "political will" (Brinkerhoff, 2010; see Box 2). Ultimately, it is driven by incentives, and Kenya's

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devolution process has created new incentives for national and subnational actors.

To improve understanding of political will for the devolution of Kenya's health sector, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted a series of semi-structured interviews with key informants in January 2015—involving the national government, three county-level governments, and consultants—to explore what incentives are driving political will for the devolution of Kenya's health sector. HPP found that the desire for improved health outcomes is one of many factors driving political will for health sector devolution. The need to meet constituents' and political stakeholders' expectations also influences political will. A greater understanding of the various factors that influence political will can help the national government take a leadership role to incentivize and encourage counties to make decisions for improving health outcomes, and move devolution forward.

Box 2: Seven Factors of Political Will

1. Nature of government initiative
2. Country-led policy and program selection process that is technically sound
3. Stakeholder mobilization
4. Public commitment and allocation of resources
5. Application of accountability mechanisms
6. Continuity of effort over time
7. Learning and adaptation

Source: Adapted from Brinkerhoff, 2010

FINDINGS

The following dominant factors were identified in the key informant interviews: having a country-led policy and program selection process that is technically sound, stakeholder mobilization, and public commitment and allocation of resources.

A Country-led Policy and Program Selection Process That Is Technically Sound

While the Constitution of Kenya was signed in 2010, implementation of devolution did not begin until March 2013, after general elections took place. Because it is too early to assess the effectiveness of policy and program choices made under the devolved system, this analysis examines the processes used to make decisions, a topic that came up frequently in the informant interviews. It is more likely that country-level actors will be committed to and take action on their choices when they lead the decision-making process, as opposed to those processes being led by external influences (Brinkerhoff, 2010). Commitments are supported when decision-making processes allow for technical debates on policies and programs, and when country actors base decisions on their own assessments of the anticipated outcomes and benefits of policies and programs, the available alternatives, and the costs to be incurred (Brinkerhoff, 2010).

All three counties in which interviews were conducted are identifying and experimenting with different methods for selecting health sector priorities. Despite the varied methods, HPP did not find any evidence that the counties sought input from either civil society organizations (CSOs) or citizens, nor that any CSOs or citizens were successful in reaching out to county health management teams (CHMTs)—the teams responsible for coordinating the delivery of health services—to voice their concerns.

Box 3: County Budget–setting Process

The program and policy selection processes in the three selected counties were first and foremost affected by their budgets. A county's health budget is determined by the amount of money it receives from the national government, how much its treasury allocates to health, and how much revenue the county is able to raise from local taxes. While budgeting is supposed to be based on strategic plans, experience has shown that it is, in fact, based on historical spending patterns.

Prioritizing health financing

In County A, HPP found that senior health managers had often requested input from technical staff when making decisions or setting strategy. For example, the county developed a strategic plan in 2013, which included input from different departments within the CHMT. In this same county, senior managers recognized that the user fees collected and disbursed by health facilities would, under the devolved system, go into an account managed by the County Treasury. This redirection of funds would reduce the ability of health facilities to purchase supplies or hire auxiliary staff. The CHMT convinced the County Assembly to keep user fees within the health system by establishing a dedicated bank account for user fee revenue. Because the CHMT in County A wanted to maintain control of its own revenues, it identified a way to sustain a steady source of revenue for county health activities.

Political influence as a driver of political will

Processes and decisions related to policy and program selection can also be incentivized by political influence. In County B, the visibility of county spending drives health investment decisions. This results in significant investments in infrastructure, often without investments in other areas that are necessary to support the intended infrastructure improvements. For example, County B purchased 10 ambulances, but did not budget for the drivers or supplies needed for them to operate. By contrast, County C has combined political incentives with technical needs. The county's governor has a background in community health and pledged to increase access to health in the 2013 election. Specifically, he was concerned that too few women were giving birth in health facilities. In 2013, 22.6 percent of births in County C occurred in health facilities, compared to 37.5 percent across all of Kenya (CRA, 2013). To address this gap, the county is building delivery rooms at all health facilities and hiring new health workers to staff them, as a way to encourage women to deliver in facilities.

Stakeholder Mobilization

Stakeholder mobilization (when government actors consult with, engage, and galvanize stakeholders) builds constituencies that support health sector strategic plans and brings legitimacy to the idea that governments should respond to their populations' health needs (Brinkerhoff, 2010). The informant interviews revealed that the three counties recognized the value of stakeholder mobilization to support counties' efforts to

- Retain or increase funding
- Advocate for county objectives
- Gain insights on county health priorities
- Influence spending decisions

Similar to the findings on policy and program selection processes, counties did not necessarily view CSOs or citizens as stakeholders, and HPP did not see evidence of sustained dialog between civil society and government.

Involving health sector stakeholders to restructure county health systems

In County A, HPP saw extensive stakeholder mobilization in support of the county's efforts to restructure the health system. A technical committee comprised of representatives from sub-counties, the former Ministry of Public Health and Sanitation, the former Ministry of Medical Services, and all cadres of health workers (doctors, nurses, clinical officers, public health officers, lab technologists, pharmacists, etc.) oversaw the entire restructuring process. Historically, in Kenya, doctors have been in management and leadership positions, resulting in tension with nurses, clinical officers, and pharmacists who typically are not promoted into these positions. Having all health worker cadres involved in the county's restructuring efforts proved to be particularly helpful in addressing some of this tension and ensuring that advancement opportunities are open to everyone under the devolved system.

Once County A completed its restructuring process, the County Executive Committee Member for Health (CEC-Health) discussed health sector challenges with Members of the County Assembly (MCAs), who are responsible for passing the budget and appropriations bill. During these meetings, the CEC-Health presented the strategic plan to the MCAs to help them understand the priorities for the health sector, and advocated increased health spending.

County A also held public hearings. While not specific to health, the hearings did provide an opportunity for the public to give direct feedback to county officials. While County A demonstrates the usefulness of stakeholder mobilization, this trend has not yet caught on in the health sector or in the other two counties. For example, in County B, the health sector budget was developed by one individual without input from anyone else.

The limited role of civil society as health sector stakeholders

Across all three counties, evidence shows that mechanisms exist for regular engagement with stakeholders, but that they are not used consistently. The mechanisms that are used do not result in sustained dialog with citizens. In addition, the national government has not prioritized stakeholder mobilization and has not included it in its capacity development training.

Further, the international nongovernmental organizations that operate at the national level and often demand stakeholder mobilization do not yet have a significant presence at the county level. CSOs exist at the county level, but do not have the same capacity as their national counterparts and are not calling for increased engagement. As a result, while County A's health strategic plan calls for quarterly review meetings with stakeholders, HPP's informant interviews revealed that none had been held. According to one key informant, there is a forum in County A for all development partners working in the county that effectively ensures that partner activities are aligned with the county strategic plan. At the facility level, the county's Health Facility Management Committees (HFMCs) include facility managers, staff, and community members, but community representation is limited. Across all three counties, decisions about who serves on the HFMC are politically driven because HFMCs influence employment, facility operations, and health service outreach. Additionally, HFMC members are often community leaders and serve on other sector-specific committees, limiting opportunities for other citizens to engage with health facilities.

Public Commitment and Allocation of Resources

Whether or not decisionmakers fund their public commitments is one way to characterize political will (Brinkerhoff, 2010). Recent budget data show that all three counties increased their per capita budget allocation for health from FY 2014/15 to FY 2015/16 (MOH, 2015). For counties B and C, the health budget allocation as a percentage of the overall county budget also increased (MOH, 2015). This increase could be interpreted as a sign of general political will for the devolved health sector.

Historical spending patterns remain

In analyzing specific allocations within the health sector, some patterns emerge. While county strategic plans are meant to drive budgeting, HPP's interviews revealed that budgeting is still largely based on historical spending patterns (Box 3). As noted above, infrastructure receives the most development funds in all three counties, while funding for capacity building and other activities is low. In fact, budget data reveal that, overall, Kenya's counties spend most of their development resources (over 50%) on construction, without the complementary funding for human resources, supplies, or maintenance needed for completed construction projects to become operational (MOH, 2015). This disproportionate infrastructure spending is possible because the national government sets only one limit on how counties' health resources are allocated: counties must retain all health workers employed before devolution in March 2013 at their former salaries and benefits packages (Republic of Kenya, 2012).

Because the national government has not incentivized certain types of spending in the health sector, county-level spending is at the discretion of county leadership. Because the county in County C has prioritized health, infrastructure investments have been accompanied by the necessary complementary spending on human resources and supplies, and have been aimed at improving health outcomes. As a result, there are a number of infrastructure projects underway under the broad focus of community health. For example, the CHMT is working with the local members of Parliament to build seven new staff houses and four new dispensaries (three of which are already open), and the CHMT is building a new maternity wing at the local hospital.

The need to incentivize capacity development

The national government has committed limited funds to general capacity development. Recently, the MOH facilitated a health systems strengthening training program for more than 100 county leaders and provided funds for postgraduate training in obstetrics and gynecology, pediatrics, and oncology.

There is also evidence of limited funds for capacity development at the county level. In County C, the county strategic plan includes an objective to increase the number of community health workers (CHWs) from 10 to 150. If implemented, this would result in one CHW for every 100 households, improving the system's capacity to provide primary care. Because County C is rural, with citizens in remote areas, the county has also shown its commitment to recruiting CHWs by including a provision that CHWs will receive bicycles to facilitate easy movement within the community. The CHMT, with the governor's support,

developed the community-based model to reach community members with health services. While this is an example of an innovative county-level effort, most capacity development efforts across counties are focused on health workers and are donor-supported.

Structural constraints impede responsive resource allocation

National and county government efforts to commit and effectively allocate resources face a number of structural constraints. These constraints, combined with a lack of civil society engagement, create incentives for health spending that fails to meet the population's needs.

- CHMTs do not have the ability to incur expenditures and funds are controlled by the respective county treasuries. Therefore, funds are not reaching sub-county health structures.
- Because government staff are protected from reductions in pay and benefits and from being demoted or fired, counties—especially those with former Provincial General Hospitals and former city councils—are locked into paying high salaries without any recourse (Republic of Kenya, 2012).
- Poor communication and coordination between and within national and county governments have slowed the transition to devolved governance. For example, the national government has not effectively coordinated trainings for health sector employees, often informing counties on short notice about training opportunities for county staff. As a result, county employees are unable to attend the training, or there is a gap in service delivery if they are required to attend the training on short notice.
- The central government does not provide standardized guidance to operationalize or fund policy and program choices. For example, one county's CHMT was hampered by internal power struggles between its members, and the central government provided no assistance in resolving the conflict.
- In the three counties where HPP conducted interviews, CSOs lack capacity to engage in budget tracking or monitoring. Increased capacity in this area could help CSOs hold county governments accountable for how they allocate and spend health resources and provide valuable data for them to advocate for resources.

RECOMMENDATIONS

A number of legislative, policy, and capacity factors can reduce political will to meet constituents' health needs. To incentivize county leadership to make decisions that will have the greatest positive impact on health, Kenya's national government can take specific steps to improve counties' ability to meet commitments. To address challenges in the policy and program selection process, stakeholder mobilization, and public commitment and allocation of resources, HPP proposes the following actions be taken by the national government:

- *Provide support for evidence-based strategic planning*

  The national government can help counties analyze policies and develop strategies, set priorities, design programs, and cost different policy options. For example, the national government can provide technical support to counties to make data-informed decisions, enabling CHMTs to identify the available data and use them to make decisions by assessing the trade-offs associated with prioritizing investments. Kenyan counties, like every other government structure around the world, face resource constraints, and will always need the ability to objectively assess policy and program options, and effectively allocate resources once priorities are selected. Approaches to guide data-informed decision making could include program-based budgeting, strengthening of policy monitoring and evaluation, and costing exercises (among others). While these activities are often emphasized by donors and governments, technical considerations must be balanced with political feasibility (Brinkerhoff, 2010). To make technically sound policy choices more politically appealing, the Kenyan government can link budget transfers with quarterly, semi-annual, or annual health goals; establish a basic healthcare package that all counties must deliver with financial support from the national government; develop either block or matching grants for specific health priorities; or adjust the formula that determines the amount of money transferred to counties to account for salary and benefit payments (Bossert et al., 2003; Steffensen, 2009). In addition, counties can leverage citizens' voices by providing support in developing and implementing citizen satisfaction surveys for health services, and tracking public service delivery and expenditures.

- *Improve dialog*

  The national government can improve dialog with the counties through existing mechanisms such as the Health Sector Intergovernmental Forum to clarify roles, responsibilities, and authority at the county level, especially in regard to human resources. Dialog can include discussions about incentive structures and how these can be adapted for the devolved government context. County-level public hearings also provide an opportunity to strengthen direct dialog with citizens.

- *Build county-level capacity for resource mobilization*

  The national government can work with donors to develop the capacity of county administrators to map stakeholders and engage in advocacy. In effect, devolution created a cadre of county managers and administrators with new roles and responsibilities, including stakeholder mobilization. However, current capacity development efforts are primarily focused on frontline health workers and training in medical specialties (e.g., OB/GYN, oncology, etc.). Strengthening the ability of county managers and administrators to mobilize stakeholders will allow them to better understand what citizens want from their health system and to be more responsive to those needs.

- *Strengthen county-level civil society organizations*

  The national government can work with donors to encourage and strengthen national and county-level CSOs to engage in quarterly public forums, provide input to CHMTs and MCAs on health budget and policy formulation, and monitor health services. A strengthened civil society could advocate for greater overall health spending, specific health priorities, and improved responsiveness from county governments.

CONCLUSION

While the current process of devolution is not Kenya's first effort to decentralize, it is perhaps the most ambitious attempt. Kenya's devolution has created new incentive structures for politicians, civil servants, and civil society. As a result, political will for health sector devolution exists in varying degrees across the three specific factors examined by HPP's informant interviews: country-led policy and program selection, stakeholder mobilization, and public commitment and allocation of resources.

Overall, HPP found that the desire for improved health outcomes is one of many factors driving political will for devolution in Kenya's health sector. Meeting constituents' and political stakeholders' expectations are also prominent drivers, resulting in investments in tangible activities and projects. Kenya's decision to devolve will not, by default, strengthen political will for improving health in the country. Just as the national government took the lead in developing and implementing devolution, it can take a leadership role to incentivize and encourage counties to make decisions for improving health outcomes.

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