



MINISTRY OF HEALTH

A REVIEW OF THE HEALTH SECTOR
INTERGOVERNMENTAL CONSULTATIVE
FORUM

“EFFICIENCY AND EFFECTIVENESS”

VOLUME 1: MAIN REPORT

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Acronyms

CEC	County Executive Committee
CHW	Community Health Worker
CoG	Council of Governors
CS	Cabinet Secretary
CSO	Civil Society Organization
DMS	Director of Medical Services
DPHK	Development Partners in Health Kenya
EAC	East African Community
GIZ	German development agency
HOD	Head of Department
HSCC	Health Sector coordinating committee
HSIGCF	Health Sector Intergovernmental Consultative Forum
ICC	Interagency Coordinating Committee
JASSCOM	Joint Agriculture Sector Steering Committee
JICA	Japan International Cooperation Agency
JICC	Joint Interagency Coordination Committee
MOH	Ministry of Health
OCCADEP	Organizational capacity development project for management of devolved health systems
OGP	Open Government Partnership
SAGA	Semi-Autonomous Government Agencies
TA	Technical Assistance
TCC	Thematic Technical Committees
TOR	Terms of Reference
UK	United Kingdom
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive summary

The Government has a principle role to promote and protect the health of its people. Therefore, health systems and services must be designed and structured to promote and protect citizens' health and the two levels of government should be held accountable for these outcomes. Under the devolved system of Government, the Ministry of Health has the key mandate of health policy, health regulation, capacity building, technical assistance to counties and management of the national referral health facilities, while the county government are responsible for health service delivery.

The Intergovernmental Relations Act 2012 establishes a framework for consultation and co-operation between the national government and county governments and county governments amongst themselves. Pursuant to provisions of this Act, the health sector established a Health Sector intergovernmental consultative forum (HSIGCF) that brings together county health departments represented by the county executive committee members of health (CEC) and the national level represented by the Cabinet Secretary (CS), the Director of Medical Services (DMS) and heads of directorates (HOD) at the Ministry of Health (MOH), Government Agencies; Kenyatta National Hospital (KNH), Moi Teaching and Referral Hospital (MTRH), Kenya Medical Research Institute (KEMRI), Kenya Medical Supplies Authority (KEMSA), Kenya Medical Training College (KMTC), National Aids Control Council (NACC), and National Health Insurance Fund (NHIF) and Development partners under the umbrella of Development Partners in Health Kenya (DPHK) including JICA, USAID, WHO, GIZ, UNFPA, UNICEF and World Bank.

The HSIGCF has been convened ten times during the period 2013-2017. This review has documented the experience of 2013 – 2017 to improve and re-align the HSIGCF so that it can perform its role in the sector more efficiently and effectively. The position of HSIGCF in the proposed health sector coordination and partnership framework has also been reviewed. Information was collected through literature review and interviews conducted one on one, through FGD's and by telephone, from existing literature, previous county executive committee members of health (CEC), Ministry of health staff from different departments, Government agencies and Development partners.

Findings show that although there is a legal framework that supports establishment and conduct of business for the HSIGCF, this framework should be reviewed to remove the conflict observed between the provisions on the consultative forum in the health Act 2017 Vis-à-vis those in the constitution of Kenya 2010 and the intergovernmental relations Act 2012. The HSIGCF has made good progress in defining roles and responsibilities and

creating a platform that brings various actors on board. There is goodwill from the main Actors, but lack of proper alignment with other intergovernmental relations structures in the health sector and competing priorities threatens the ability of the forum to positively influence the health sector. There is need to standardise the HSIGCF process for it to effectively perform its role within the proposed health sector coordination and partnership framework.

It is possible to build on the existing process to create a more inclusive structure for the HSIGCF to be responsive to the diversity of actors.

In order to re-align the HSIGCF for its role going forward, certain measures have to be taken that include;

1. The HSIGCF should establish a ministerial structure for formalized decision making and high level advice to the CoG and MOH, and a technical advisory structure for tackling technical issues in the sector and advising the ministerial level. The technical structure would also be the link point for the various technical committees and Development Partners would engage as needed with the technical arm of the HSIGCF and its constituent committees.
2. There is a need for MOH and CoG to galvanize synergy between political and health management leadership and explore opportunities for alignment. Leadership must strive to effectively coordinate the HSIGCF process and maintain a high level of enthusiasm by all actors in the process while leading from the front
3. HSIGCF should establish a secretariat to interface the HSIGCF and other structures of intergovernmental relations. The secretariat must have a clear mandate for administration, coordination and general management of the HSIGCF.
4. The Secretariat should develop an annual calendar of HSIGCF activities and rally all actors in adhering to the same
5. The draft operational manual developed through this review exercise should be finalized by MOH through engagement of all actors in the HSIGCF
6. There are various levels of decision making and implementation at both levels of government. In order for the HSIGCF to influence these levels effectively, a good stakeholder and communication strategy should be developed with clear objectives, outlining target audience, information needs and expected feedback, communication methodology and a mechanism to evaluate success and failure.
7. An outcome document of meetings in form of a communique co-signed by MOH and CoG should be developed at the end of each meeting identifying key issues discussed, resolutions made, issues with pending matters and issues to be escalated to other structures within the intergovernmental relations process.

8. The induction process for the HSiGCF 2017 – 2022 should include a session on how donors work and how the HSiGCF can be used as an avenue to support issues of common interest.
9. The second term HSiGCF should conduct a capacity needs scan for the Thematic Technical Committees and redefine conduct of business, representation and required technical skills. A technical assistance program should be developed that aims to strengthen these functionality of committees.
10. The HSiGCF structure proposed by this review is to facilitate its proper functioning. Once functional, it should fit in the Partnership Framework by establishing the necessary links with other health sector intergovernmental structures.
11. Government Agencies in the health sector – their structures and roles are evolving (e.g. resulting from implementation of the Health Act, and other possible reforms to streamline the health sector). These entities are ‘centres of expertise’ on specific health functions. Hence there is need for them to play an active role in the HSiGCF technical committees, based on their legal mandates.
12. There is need to review the HSiGCF provisions in the Health Act, to capture the political and decision-making authority of the CS and CECs; and to align with other recommendations of this review. Once the HSiGCF structure is agreed, the key structures therein should be established through a legal instrument by the CS.

1.0 Introduction

The Government has a principle role to promote and protect the health of its people. Therefore, health systems and services must be designed and structured to promote and protect citizens' health and the 2 levels of government should be held accountable for these outcomes. Under the devolved system of Government, the Ministry of Health has the key mandate of health policy, health regulation, capacity building, technical assistance to counties and management of the national referral health facilities, while the county government are responsible for health service delivery. The Intergovernmental Relations Act 2012 establishes a framework for consultation and co-operation between the national government and county governments and county governments amongst themselves.

Pursuant to provisions of the intergovernmental relations Act 2012, the health sector established an Intergovernmental consultative forum that brings together county health departments represented by the county executive committee members of health (CEC) and the national level represented by the Cabinet Secretary (CS), the Director of Medical Services (DMS) and heads of directorates (HOD) at the Ministry of Health (MOH), Government Agencies; Kenyatta National Hospital (KNH), Moi Teaching and Referral Hospital (MTRH), Kenya Medical Research Institute (KEMRI), Kenya Medical Supplies Authority (KEMSA), Kenya Medical Training College (KMTC), National Aids Control Council (NACC), and National Health Insurance Fund (NHIF) and Development Partners (DP).

The HSI GCF has been convened ten (10) times during the 5 year term of 2013-2017. As this was the transition period to devolution, there are a lot of lessons learnt, both in the implementation of devolution in the health sector and also mechanisms to address articulation and coordination of emerging issues in both levels of government. Among the thorny issues included ways and means of addressing the human resource transition, frequent shortages of drugs in health facilities, deteriorating service quality and disruptions in reporting and accountability mechanisms.

This review report documents critical lessons learned from the review period. Focus has also been put to the multiple structures established to promote intergovernmental relations and for proposals to improve the weak intergovernmental relations between national and county governments.

Scope of the Assignment

To review the experience of 2013 – 2017 and use the findings to improve and re-align the HSIGCF to perform its role in the sector more efficiently and effectively. Review the position of HSIGCF in the proposed health sector coordination and partnership framework to strengthen its capacity to guide sector partnership, coordination, planning, and implementation and review processes.

Specific Tasks

- Map the instruments of intergovernmental relations
- Outline achievements, challenges and lessons learned
- Recommend improvements
- Recommend relevant structure, tools, guidelines and processes
- Develop a Draft HSIGCF operations manual 2017 – 2022 for finalization by MOH

Methodology

The consultant led the review process supported by MOH, WHO and JICA. A technical team with expanded representation from Council of Governors (COG), KEMSA, NHIF and DPHK secretariat was set up to provide technical guidance and review the outputs of the assignment. Four (4) meetings were held during the assignment period including a kick-off meeting by MOH, JICA and WHO, an inception meeting, a progress review meeting by MOH, WHO, JICA and the consultant, and a technical meeting to discuss the preliminary report. Minutes of these meetings are attached in Annex 6 to 9 for reference.

The Consultant conducted an extensive desk review to collect information relevant to the assignment. Among the documents reviewed were legislative instruments governing intergovernmental relations (Constitution of Kenya, Intergovernmental Relations Act 2017, Gazette Notices, Kenya Health Act, 2017), Terms of Reference (TOR) of the HSIGCF, reports on proceedings from the previous HSIGCF meetings, selected cases of international best practice among others. Regarding the sample survey, MOH drafted the survey tools in consultation with technical partners and finalized the same with support from the Consultant. Respondents were purposively selected from county health departments represented by the previous county executive committee members of health (CEC) and the national level represented by the Ministry of Health staff, Key Semi-Autonomous Government Agencies (*Government agencies*) and Development partners.

Information to determine efficiency and effectiveness of the HSI GCF was collected in line with the review objectives outlined in the TOR based on Desk/Document review, Key in-depth interviews (Face to Face and Phone), Questionnaires and focus group discussions. The findings contained in this report are therefore derived from information gathered through extensive desk review of relevant documents as well as respondents in the survey. Inputs by the technical team have been adopted in finalizing the report and proposed operations guideline.

1.2 Legal Framework of Intergovernmental Forums

The primary source of legislation and the provisions outlining the relationship between national and county governments is the constitution of Kenya 2010. Chapter four Article 43 of the constitution of Kenya provides every person living in Kenya with the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Kenya is a state party to the UN charter and to the WHO constitution which defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The WHO constitution further outlines that the health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. This places a responsibility on the HSI GCF to ensure that agenda setting prioritises health of the people over any other business.

Article 43 sub-Articles b-f of the constitution of Kenya 2010 provide other health-related rights, i.e. housing, reasonable standards of sanitation, food, clean water, social security and education. The HSI GCF would bear significant responsibility for the realization of these rights. Article 132(5) assigns to the President and the Cabinet Secretary (CS) the duty for the attainment of the international obligations for the republic which include the right to health. The constitution further requires the state to take legislative and policy measures including setting standards to achieve progressive realization of this right. Schedule four of the constitution outlines distribution of functions between National and the County governments, and assigns county governments the responsibility to deliver essential health services and management of human resource for health. The Ministry of Health has responsibility for stewardship for health policy, development of norms and standards, Capacity building, technical assistance to counties and oversight of national referral health facilities.

Intergovernmental relations Act 2012 outlines establishment of intergovernmental relations structures. Section 13 of the Act on sectoral working groups or committees gives power to the Cabinet Secretary to convene consultative fora on sectoral issues of common interest to

the national and county governments. This provides the CS health power to determine sector-specific issues and to design a HSI GCF of the form and context that best aligns to such issues and that borrows from international best practice. This forum should enable consultation on health matters of mutual interest by the two levels of government.

In 2013 the transitional Authority facilitated the analysis and phased transfer of health functions to the national and county governments. A number of legal instruments were relied on to facilitate this process including section 15 of the Sixth Schedule to the Constitution on phased transfer of functions and sections 23 and 24 of the Transition to Devolved Governments Act, 2012. Subsidiary legislation issued through legal notice No.16 of 2013, and legal notices 137 to 183 of 2013 outlined the actual transfer of the functions to all 47 counties.

Although the HSI GCF was established in 2013 based on the authority delegated to the cabinet secretary by the intergovernmental relations Act 2012, the health Act 2017 part five provides the required legal framework to its establishment. The health Act 2017 outlines membership to the HSI GCF as Director-General for health or a designated representative; and each County Director of health or a designated representative. Stakeholders in the health sector have observed that mechanisms for engagement on legislative processes at the national level have been unclear and need to be re-defined. This is so, particularly because there are inconsistencies in law when Article 26 of the health act 2017 is read together with article 132 (5) of the constitution and Article 13 (2) of the intergovernmental relations Act 2012. Based on the constitution and the intergovernmental relations Act, the power to convene the HSI GCF would be vested in the heads of the health ministry at both levels of government i.e the CS and CEC's appointed by the president and the Governor at both levels of government respectively. Based on the power delegated to the forum through section 29 of the health Act to regulate the conduct and regulation of its business and affairs, and in the spirit of aligning institutionally, other organs including technical teams may exist to support the actual HSI GCF.

Based on Article 191 of the constitution, national legislation prevails over county legislation in respect of matters falling within the concurrent jurisdiction of both levels of government. For health, national laws are a critical determinant of county legislation hence, a key function of the HSI GCF should be to scrutinize national legislation, to propose issues requiring national legislation, and to advise the CoG on the health-related issues to be considered therein. This scrutiny should include laws in other sectors that have significant implications on health.

2.0 Key Findings from the Previous Term of HSI GCF

The Health Sector Intergovernmental Consultative Forum (HSIGCF) was established in 2013 and has been convened ten (10) times with the last meeting held in May 2017. The preparatory phase entailed several discussions between the MOH and CoG on how to manage delivery of health services under the devolved health system. Some of these meetings happened in 2013 before formal transfer of functions. This being a transition phase, the need for a consultative forum was urgent, perhaps the reason why the launch was done without a clear definition of roles and responsibilities for actors. The TORs for the HSI GCF were developed by MOH and adopted and are attached as Annex 3 for reference. Although there were proposals on how to finance the HSI GCF, the first meeting was externally funded, a situation most members interviewed think created an impression that partners would always support the process.

Those who attended the initial meetings observed a form of mistrust between the two levels of government and discussions became acrimonious at times potentially undermining the consultation process. It can be remembered by some members interviewed that the Cabinet Secretary at some point encouraged members to improve the engagement process to a business meeting and not a talk show.

2.1 Structures and Composition of the HSI GCF

The HSI GCF has two tiers namely the HSI GCF and thematic technical committees. The HSI GCF brings together the Cabinet Secretary (CS) for Health and the 47 County Executive Committee (CEC) members for health with participation of Senior Officers from the Ministry of Health (MOH), Chief Executive Officers of Government agencies and representatives of Development Partners. The HSI GCF has established five thematic technical committees whose membership through expression of interest comprises members of the HSI GCF. Stakeholders propose to have these committees established based on a joint sector issue-setting based on mutual interest.

1. Healthcare Financing
2. Human Resource for Health
3. Health Products and Health Technologies
4. Health Service Delivery and PPP
5. Joint Monitoring and Evaluation of Health Services and Quality Management.

These committees were proposed in the first HSI GCF meeting but only became functional during the sixth meeting. The TORs for the committees are contained in Annex 4. These

TORs need to be reviewed to outline specific tasks. The previous CEC's for health interviewed described an imbalanced mix in the committees where MOH participants were technical staff with experience in the respective thematic areas, while many CEC's did not necessarily have technical experience in health matters. The committees convened a day before the HSI GCF meeting to discuss operational and technical issues and present reports to the HSI GCF meeting.

The HSI GCF process is not well aligned to the multiple structures in the sector, for instance; CoG has a health committee tasked with coordination of intra and inter agency and governmental consultations on health sector issues. The advisory role of this committee together with those established under HSI GCF is not crystallised to be more detailed and technical and with expertise beyond its membership as constituted. Learning from the Australian model shows that the COAG Health Council (CHC) is a 'ministerial body' established as an 'Advisory Body' of the 'Governors Council (CoG).

MOH has the Health Sector Coordination and Intergovernmental Affairs department that currently plays the role of secretariat for the HSI GCF, CEC's have a forum through a Council and the National and County Government Co-ordinating Summit has an intergovernmental relations technical committee. The link between the HSI GCF with these structures is not clear.

Reports indicate that the HSI GCF has formally packaged issues for referral to the summit once. There are no clear arrangements on how to keep the Council of Governors informed and respondents recommend a coordination framework that is responsive to the diversity of actors that creates synergies and leverages strengths. There is an opportunity for MOH to maintain the sector event calendar through MOH department for Policy, planning and healthcare financing. Priority issues from one level (technical/operational) can be filtered for consumption by another level with decision making authority.

All the respondents mentioned that communication internally within the HSI GCF and externally with stakeholders was weak and is an area that needs strengthening. Experience from the counties indicates that when CEC, Chief Officers for health and directors attend meetings together, information is easily disseminated within the department and recommends a mechanism that will involve all the three officers.

2.2 Coordination of the HSIGCF Process

2.2.1 Agenda setting for specific meetings and convening of the meetings

Agenda setting for specific meetings was mainly done by the MOH department for Health Sector Coordination and Intergovernmental Affairs initially in consultation with the CS but later, it is reported that the chairman of the CEC's forum was involved. Specific meeting's agenda was also done by the technical committees during their meetings. These two levels are believed to have based their specific meeting's agenda to health issues of interest to both levels of government.

During the first meetings, the agenda focused on briefings and updates around devolved health system but later changed to accommodate presentations from thematic technical committees, plenary discussions and recommendations for way forward. Some members think the initial approach worked well at that time to bring all members to the same level, while others say the approach made meetings exhausting and seemed to lack focus.

An example is given of an agenda that seemingly worked well because it was focused on one issue, the nurses' strike, and different committees worked on mitigation measures aligned to their thematic area. The CoG secretariat remarked that they should be more involved in the agenda setting process to ensure discussions are responsive to county priorities. Some members observed that the agenda was at times agreed during the meeting specifically on matters considered urgent such as flow of funds to counties, human resource management issues and agreements with counties on the Managed Equipment Services (MES).

Meetings were convened by the co-chairs of the forum and formal letters sent to the invitees. It is reported by HSCIGA department of MOH that a memo containing a plan for HSIGCF meeting scheduled for second week of the second month in every quarter was prepared and approved by the CS, but it seems none of the participants from CoG knows about this memo. From reports availed to the consultant, this schedule was not strictly followed and various reasons have been cited and are contained in this report.

2.2.2 Selection of Venue for Meetings

All HSIGCF meetings were held in Nairobi in different venues including hotels and the Kenya School of Government. Although Nairobi seems central to everyone, there are those of the opinion that other sites would present less interruptions than those encountered during the first term HSIGCF, and suggest consideration for venues outside Nairobi. Experience shared by a member of the CEC council shows that when the council tried to rotate venue, attendance was affected. The CEC's from the lake basin region learned that hosting

meetings in Kisumu attracted more participation than when hosted in other counties in the region.

2.2.3 Attendance and Frequency of Meetings

HSIGCF meetings were characterised by inconsistencies in attendance by both levels of government. It is reported that there was a tendency of the forum officials and CEOs of the Government agencies to send representatives. Some CEC's could attend one meeting and not show up for the next. A number of factors believed to have affected attendance include;

- a) Parallel sector meetings planned at the same time in different locations or at times in the same hotel.
- b) Late communication sent within a busy schedule
- c) Those traveling from counties took advantage of being in Nairobi to attend to other issues of their own interest.
- d) Meeting in the same venue became monotonous and at times failed to inspire participants to attend.
- e) Lack of ownership for the process among the actors

Some CEC's indicated having received invitations for the HSIGCF meetings on short notice and could not manage to make the necessary arrangements to attend. The 6th HSIGCF meeting for instance was attended by only 10 out of 47 CEC's and both the CS and PS were not present. Partners also cited instances when they had to bear cancellation costs for re-scheduled meetings or for participants who did not show up.

Some members were enthusiastic and attended most meetings. Among them are those who believed the HSIGCF is the best forum to learn new developments in the sector, and those who view the forum to provide opportunities to interact with other actors.

A review of reports shows that between 2013 and 2015, only 5 out of the targeted 20 meetings were organised. The frequency increased from 2016, when JICA started supporting MOH to secure venue and pay day conference package for participants as well as the costs for the rapporteur. A number of factors are reported to have affected the frequency and timing of meetings among them the following;

- a) The transition period presented a lot of competing priorities in the sector.
- b) Lack of a dedicated budget from MOH and Counties for HSIGCF activities
- c) Lack a definite calendar for the HSIGCF meetings to facilitate advance planning

- d) A bureaucratic communication process during inception made the communication path long sometimes delaying the process.

2.2.4 Deliberations and Decision Making Process

All actors are of the opinion that quality of discussions improved over time alongside growing awareness on roles and responsibilities among actors. Some members describe the first meetings to as acrimonious and talk shows in nature. Discussions were plenary and not well organised and technical issues dominated sessions. A respondent remarked that the plenary sessions provided a learning opportunity for CEC's that originated from other sectors outside health. Most CEC's in the first term HSI GCF did not have technical knowledge and experience in the health sector and whenever MOH proposed technical issues to be handled by technical team, they felt that they were being undermined. On several occasions, CEC's did not get enough time to be briefed by their technical teams, a situation that made the learning curve long and often discussions were faced with hostility. However, interpersonal relations improved and mid-way the process, participation in discussions became collegial.

Participants interviewed share the frustration that a mechanism to ensure resolutions and recommendations were implemented was absent. Despite these frustrations, a few examples were mentioned where action was taken on recommendations made at the HSI GCF. Some of them include representation of counties on the KEMSA board of management, post graduate training for doctors and health financing and communication to CEC's through the CoG secretariat. CEC's from border counties like Mandera and Lamu were unhappy that cross border disease surveillance dominated the agenda of the forum but never got resolved. A secretariat has been proposed to keep track of proceedings and create an interface between the HSI GCF and other mechanisms in the sector.

The TOR for the HSI GCF identifies consensus as one of the methods for decision making, but a number of respondents question whether the HSI GCF as constituted is a decision making forum. Suggestions have been made to inspire all actors including the political class to understand the value of the HSI GCF and support the process. Both MOH staff and CEC's interviewed would like to see a lot of issues filter to the council of governors and the National and County Government Co-ordinating Summit. Some government agencies prefer sponsoring meetings for CEC's at the governor's council to increase chances of decision making and implementation.

The HSI GCF provides a platform for the two levels of government to discuss and resolve any conflict over matters of mutual interest. It is reported by both levels of government that

during inception, participants took positions over issues based on their affiliation. Because of this, a lot of issues pertinent to both levels of government had to be resolved outside the forum. Although relations improved over time, issues around the industrial action by health workers, the Managed Equipment Service project (MES) and drawing rights of funds remained thorny and required intervention by parties outside the forum. It is not clear how the forum played a mediation role to resolve matters but media was packed with debates as the political class seemed to have a strong influence.

2.2.5 Tracking Implementation of Resolutions and Recommendations of Previous HSI GCF

Thematic technical committees were involved in reporting progress on resolutions of the previous HSI GCF meeting at successive HSI GCF meetings. Committees such as the one on HRH explained that sometimes they had to make calls to the relevant offices during the forum for updates. The committees did not have resources and time to manage this process. An example is given by HSCIGA department of MOH that extracts of resolutions made at the previous meeting were received with a request to provide status update for the next meeting. This is a measure the HSCIGA department would like to see embedded in the HSI GCF process to make sharing of information with other intergovernmental structures clear. It is believed a well-structured and functional secretariat will improve the tracking of implementation of resolutions and recommendations.

2.2.6 Leadership of TTCs and Continuity of TTCs /Membership/Discussions

All committees had officials selected by way of appointment but the number of positions and their distribution were not standardised across all committees. It is good to note that the concept of Co-chair and Co-secretary was adopted to enable meetings proceed with either of the two. However, some CEC's are of the opinion that it was unfair for the CS to send a representative to discuss policy matters with them. Table 2 below shows the type of officials put in place for each committee.

Table 2: Established Officials of Thematic Technical Committees

Thematic Technical Committee	Officials	Level of Government
Healthcare Financing Committee	Chair Co-Chair Secretary Co- secretary	National Government County Government National Government County Government
Human Resource for Health Committee	Chair Secretary	County Government County Government

Health Products and Health Technologies Committee	Chair Co-Chair Secretary Co-Secretary	County Government GOVERNMENT AGENCIES DP National Government
Health Service Delivery and PPP Committee	Chair Co-Chair Secretary Co- secretary	County Government GOVERNMENT AGENCIES County Government County Government
Joint Monitoring and Evaluation of Health Services and Quality Management Committee	Chair Secretary	County Government National Government

While some committees had four officials, others had two with varying distribution across all committees. Membership to the committees comprised MOH, CEC's, Government agencies and Development Partners linking to thematic areas relevant to their area of expertise and / or interest.

Issues discussed by the committees were mainly technical/operational and related to the respective thematic area. Committees organised discussions around issues of common interest, resolutions of previous meetings, progress on the resolutions and recommendations with action points. Recommendations by these committees were technical and operational and some respondents believe more focus should have been put on matters to influence policy and legislation.

The committees recommend the need for structured technical assistance to ensure capacity is strengthened. Some committees like finance and HRH had an opportunity to be supported by partners to conduct meetings away from the HSI GCF. Examples were given of meetings on results based financing supported by World Bank that yielded a learning trip to Zimbabwe. Another group visited Japan together with NHIF to learn about Japan's experience in attaining universal health coverage. Some committee members believe officials of committees had an advantage over other members to be selected for such visits, but learnings were not shared with members upon return. The consultant learned from CoG that the Joint Agriculture Sector Steering Committee (JASSCOM) has a TA arrangement in place that could provide lessons to HSI GCF.

Committee members indicated that there was no formal handover process among officials during change of guard. It is not clear if handover of HSI GCF matters was formally done with

the change in Cabinet Secretary, but the HSCIGA department prepared a report to inform the new Cabinet Secretary. A number of CEC's have been dropped by the County Governments following the general elections in August 2017, and this may negatively impact continuity within committees if proper measures are not taken to systematically induct incoming CECs and hand over of committee reports. Most committee officials indicated that it took long to create cohesion within the teams and they cautioned that a change in members will require time before the committees operate to the optimum, with the learning curve being longer for those with no health background knowledge.

2.2.7 Documentation of TTCs and HSIGCF Meetings and Archiving

A report was prepared for every HSIGCF meeting and signed off by the Chair and co-chair during the subsequent meeting. The first five reports were prepared by the HSCIGA department of MOH, but later on the JICA project for Organizational Capacity Development for Management of Devolved Health System (OCCADEP) hired the services a rapporteur to capture proceedings and prepare the meeting reports. Committees summarised their discussions and presented to the plenary session of the HSIGCF although not following a standard format of reporting. There wasn't sufficient time available for participants to fully interrogate the committee reports during the plenary sessions.

A record of every committee meeting is available in the HSIGCF reports stored by the HSCIGA department of MOH. The department has more documents on operation of the TTCs and HSIGCF including terms of reference, talking points, a description of functions and TTC resolutions. Strong records management has been recognised in the Kenya Open Government Partnership process as the backbone of transparency and accountability, and HSIGCF should put in place a structured and robust information sharing system to strengthen these values.

2.2.8 Funding of HSIGCF/TTCs Meetings and Proposals on Sustainability of HSIGCF

The HSIGCF was launched with no concrete plan and budget to finance its operations. The first meeting was externally funded creating an impression that partners would always financially support the process. The funding arrangement was later agreed to be done jointly, with counties meeting the cost of travel and accommodation for the CEC's and MOH taking responsibility for the venue and meeting package. It is important to note that development partners have supported the process at different stages. JICA for example has been supporting MOH on its part through the OCCADEP project to plan, pay for the day conference and rapporteur costs and drafting of the HSIGCF SOP.

Development partners observed that requests for support for HSI GCF came in last minute when they had already made their projections either for the quarter or the year. A budget was developed and included in the concept note of 2015/16, but there is no evidence that it got funded. The preferred approach is for MOH and CoG to make an annual plan/calendar of HSI GCF with a budget which can be used to discuss pool funding. The draft budget presents an opportunity for the sector leadership to discuss funding arrangements between national and county governments.

3.0 Partnership

A Health Sector Partnership Framework has been proposed to establish structures and mechanisms that bring together key health Actors; State Actors - National Government and county Governments (represented by MOH with its related units/programs and County Health ministries and related social sector ministries respectively), Non state actors (Public benefit organizations: CSOs, NGOs, FBOs, private commercial providers and Professional Associations), External actors (Donors and their implementing agents and Technical Partners).

These partners either individually or through their coordination structures can link with the HSI GCF at different levels to work in collaboration to support the country's health agenda using the principles of Sector Wide Approach¹. The HSI GCF can establish these partnerships with actors at the technical level for technical advice, and at decision making level as observers. Partnerships can also be established with other intergovernmental relations structures for coordinated decision making. The partnership framework identifies the HSI GCF as the core forum for guiding and enabling sector partnership and joint health sector coordination, planning, implementation and review processes (See annex 5).

To perform on this task, the HSI GCF will bear the responsibility to steer consultation and cooperation between the various actors. The HSI GCF needs to strengthen its leadership as a prerequisite for effective guidance and coordination.

4.0 Discussion

Health and health rights are social matters and high level guidance is required to minimise variations in how these matters are administered. In this regard, the IGF should be an accountability point for promoting and protecting health. Its work should demonstrate (to citizens, Parliament, and internationally) that the health sector is advancing peoples' health rights. In order to strengthen the HSI GCF as an accountability point, the existing legal

¹ Kenya Health Partnership Framework

framework needs alignment and a policy framework specific to implementation of the HSI GCF process should be developed, borrowing best practice. Though the UN Charter and WHO Constitution which Kenya is a state party to are not legally binding, they serve to guide Governments on what works to advance the right to health. Therefore, in organizing its health system and governance structures, Kenya should be guided by the Global norms and standards as set by WHO; and also the precedents and best practices that are known to produce good health outcomes. This responsibility should be taken by the CS and the CEC's in the context of the HSI GCF to steer the process towards better health outcomes.

It is the general view of respondents in this review exercise that there has been remarkable improvement in the conduct of business by the HSI GCF, but would like to see the consultation process institutionalised across the health system with components of technical and operational discussions while the top level focuses on influencing policy, legislation and conflict resolution geared towards better service delivery and improved health outcomes. The lack of trust observed by participants during the first meetings could continue if the HSI GCF process is not institutionalised with deliberate effort to enhance mutual trust and accountability. A change in attitude, mind-set and commitment by both officials and members is needed to avoid undermining the gains made.

Quick gains may be achieved if the actors in the HSI GCF realise that they have a shared vision. In Sierra Leon, through the Open Government Partnership (OGP) process, relations between government and civil society were characterized by distrust and a culture of "we against you." This needed to change if open government initiatives were to succeed. A key decision was made to establish, by executive order, a national OGP Steering Committee. This process has been successful in creating a balanced and functional partnership framework. An important aspect to the process was the willingness of government to forego its tendency to micromanage the consultation process without eroding its leadership².

The HSI GCF presents an opportunity for both levels of Government to influence issues from a collective bargaining point. Several examples have been given that demonstrate opportunities the HSI GCF would use to positively influence the sector performance. Some counties approach NHIF to make service level agreements directly with the county, while others prefer NHIF to contract health providers instead. NHIF views service contracting as a policy gap and believes the HSI GCF can play a role to develop a guiding framework. KEMSA needs to create a sustainable business model engaging with both levels of

² Samba et-al (2015) "Open-Government Partnership Process in Sierra Leone: Engaging in mutually respectful manner and Finding a common ground to actualise the reforms we need"

government. It is reported that timely payments for commodities supplied to counties and health facilities has been a persistent challenge. KEMSA has also continued to support O&M of regional depots shared with National Vaccines & Immunization Program (NVIP) of MOH, but these costs remain outstanding, yet the HSIGCF could facilitate a process to get negotiated agreements between KEMSA and NVIP. Donors who have signed bilateral agreements with the national government have continued to receive individual requests from counties for technical and financial support although this can be facilitated through intergovernmental relations. The HSIGCF provides the best platform to arrange block funding or oversight services that are still managed at the national level like NHIF, research through KEMRI, national programs like HIV, TB, Malaria, Reproductive Health etc.

Structure of the HSIGCF

Aligning the HSIGCF structure to the numerous instruments under intergovernmental relations across the two levels of government with a clear schedule of how they interact is vital in order to run an all-inclusive process that is acceptable to both technical and political class. Some sectors, have designed structures that aim to create synergies across the system, reduce duplication and provide an enforcement mechanism for decisions made at the forum. The functionality of these models can be reviewed to learn lessons but the intention is important in making considerations to strengthen the HSIGCF structure. Existing sector partnership frameworks should be explored since HSIGCF is anchored in law.

Lessons can be learned from how the World Health Assembly conducts its annual process with two types of meetings, each with its purpose. Two committees A and B meet to debate technical and health matters, financial and management issues respectively. These committees approve texts of resolutions, which are submitted to the plenary meeting. The plenary meeting comprises all delegates to the World Health Assembly and meets several times in order to listen to reports and adopt the resolutions transmitted by the committees. Technical briefings are organised separately on specific public health topics to present new developments in the area, provide a forum for debate and to allow for information sharing³.

HSIGCF can also borrow lessons from the Council of Australian Governments (COAG) which is chaired by the Prime Minister and comprises state and territory First Ministers and the President of the Australian Local Government Association. COAG has eight councils including a health council that support it enabling COAG to focus on key national priorities. The COAG Health Council (CHC) has an advisory body, the Australian Health Ministers'

³ http://www.who.int/mediacentre/events/governance/wha/how_wha_works/en/

Advisory Council (AHMAC) and provides a mechanism for the state and territory governments to discuss matters of mutual interest concerning health policy, services and programs. AHMAC has six principal committees, which manage the business of AHMAC and provide advice. These committees are established around health priority issues and they include;

1. National Health Information and Performance Principal Committee (NHIPPC)
2. Health Workforce Principal Committee (HWPC)
3. Mental Health and Drug and Alcohol Principal Committee (MHDAPC)
4. Hospitals Principal Committee (HPC)
5. Community Care and Population Health Principal Committee (CCPHPC) and,
6. Australian Health Protection Principal Committee (AHPCC)

The health council produces a COAG health council meeting communique containing approvals and agreements which is posted on the council's website⁴.

Most respondents prefer quarterly meetings for technical teams to package policy and legislative issues that filter to the main HSI GCF, with the two levels playing an oversight role for each other. The issues should be articulated in form of policy briefs and circulated in advance to ensure they get the right attention. Development partners can also make submissions for consideration during the forum meetings. It is important to develop a strong link with all stakeholders relevant to intergovernmental relations to facilitate ownership of decisions made across the ecosystem.

It is important to note that though health is a social matter with inherent rights that are not always visible or quantifiable in political engagements, lessons can also be learned from other sectors specifically how they have structured their engagement processes to facilitate the right interactions for a shared vision.

Example: The Agricultural sector model (Kenya)

The Agricultural sector has developed a three tier consultation and cooperation mechanism that brings together technical/operational and policy related actors in the agriculture, livestock and fisheries sector for consultation and cooperation and make recommendations on policy matters. The structure is as outlined below;

⁴ COAG health council Communique 3 November 2017

a) Intergovernmental Forum on Agriculture

This forum comprises all levels of the agriculture; livestock and fisheries sector with a mandate for stakeholder consultation and cooperation, and make recommendations on policy matters in the agriculture sector. Membership comprises;

- 1. Cabinet Secretary and Chair of Council of Governors as co-chairs*
- 2. All governors*
- 3. The chairpersons of standing committees in the senate and the national assembly*
- 4. Principal secretaries & Directors*
- 5. County executive committee*
- 6. County chief officers*
- 7. Representatives of the county assemblies' forum.*

b) Joint Agriculture Sector Steering Committee (JASSCOM)

Forum focuses on policy and strategic direction, review and adoption of sector reports, approval of work plans and budgets, resolution implementation oversight, provide direction on critical emerging sectoral and cross-sectoral issues, link with IGR technical committee. This forum has a leaner team responsible for agriculture, livestock & fisheries and comprises;

- 1. Cabinet Secretary and chair Council of Governors as co-chairs*
- 2. Principal Secretaries*
- 3. Three Governors representing the Council of Governors*
- 4. Coordinator of Joint Agriculture Secretariat (Secretary)*

c) Joint Agriculture sectoral working groups

Four groups have been established to deliberate on technical thematic issues and report to the Joint Agriculture Sector Steering Committee. Each committee comprise;

- 1. Five representatives of county governments*
- 2. Five members from the MoH*
- 3. Joint Agriculture Secretariat to provide secretariat services.*

Secretariat

This is a support function established to serve the three tiers by following up on the decisions made, plan and convene meetings, develop and circulate approved

agriculture sector reports, provide secretariat support and facilitate the agriculture sector monitoring and evaluation

The success of this model is attributed to strong and willing leadership that accepted to work with the structure the way it is and is committed to achieve sector results. The support provided by the secretariat can not be underestimated given the need to keep all actors well informed and interested in the process.

Example 2: East African community (EAC)

EAC has a structure that is designed to enable different teams to identify and discuss requirements for a specific issue given their area of responsibility. The process includes a level that makes binding decisions.

a) The summit

The EAC is structured in such a way that the summit which comprised heads of governments for the EA member states meet to give strategic direction towards realization of the goals and objectives of member states.

b) The council of ministers

The council whose membership constitutes Ministers or Cabinet Secretaries from the Partner States meets twice a year with one meeting held immediately preceding a meeting of the Summit as a way to maintain a link between the political decisions taken at the Summits and the day-to-day functioning of the Community. Decisions taken by the council are binding to all member states.

c) The coordinating committee

The coordinating committee has a role for regional co-operation and co-ordinates the activities of the Sectoral Committees. Subject to any directions given by the Council, the Coordinating Committee meets twice a year preceding the meetings of the Council but the chair may convene other meetings if need arises.

d) Sectoral committees

Sectoral Committees conceptualise programmes and monitor their implementation. They meet as often as necessary for the proper discharge of their functions.

This structure may provide insights on how to break down responsibilities and focus deliberations to a groups mandate. Similar insights may be gathered from the example provided by committees on how they handled the agenda on industrial action by nurses, by each committee focusing on mitigation measures within their respective thematic area.

Coordination of the HSIGCF process

The first term HSIGCF operated in a transition period with a number of administrative challenges. Findings show that meetings were convened on convenience, agenda setting evolved through an intergovernmental relations phase that was full of suspicion and little trust among actors, reporting needed strengthening, and progress monitoring had not been developed as an integral component of the process. Actors in the HIGCF have their normal jobs and may not have the time to commit to administrative functions of the forum. A secretariat has been proposed to comprise staff appointed by MOH and CoG. Recommendations have been made to host the secretariat away from MOH and CoG but some parties are of the opinion that this will weaken the momentum. Secretariats have been established by several multi stakeholder forums to create efficiencies and operational excellence through proper coordination of forum activities.

Examples;

The open government multi-stakeholder forum in Georgia has a secretariat in charge of convening meetings, defining the agenda, preparing the meetings minutes, and preparing reports of the activities twice a year⁵.

The secretariat for the east African community ensures general administration and financial management of the Community, proposing draft agenda for the meetings, organisation and keeping of records of meetings, promotion and dissemination of information, planning, management and monitoring of programmes. The secretariat also ensures that regulations and directives adopted by the Council are properly implemented and provides the Council of Ministers with strategic recommendations including submission of reports on the activities of the EAC⁶.

The Summit has an intergovernmental relations technical committee that is responsible for the day to day administration of the Summit, convenes meetings and makes reports among others⁷.

Some of these secretariats are funded through pooled funding by donors or respective governments, while others make cost sharing arrangements like what was agreed for the HSIGCF. It is however recommended that MOH and counties secure adequate budget provisions to finance administrative and operational costs of the forum

⁵ Open Government Partnership Action Plan, Georgia 2014 - 2015

⁶ The Treaty for the Establishment of the East African Community 1999

⁷ Intergovernmental relations Act 2012

Deliberations and Decision Making

The HSI GCF is believed to provide a good platform for discussing health issues that are of mutual interest to both levels of government at a strategic level. These discussions should focus on policy matters, impact of legislation, co-ordination of development planning and the co-ordination and alignment of intergovernmental strategic and performance plans. Depending on the matter at hand, some issues will be decided upon and referred to relevant levels for implementation. Other issues will be escalated to higher levels for decision making while others will be referred back to technical committees for more information. It is important to have an outcome document published at the end of each meeting and outlining formal agreements reached. This has worked well in established intergovernmental relations systems such as the Council of Australian Governments (COAG)

The frustration experienced by participants due to recurring topics and the alleged lack of information on implementation of recommendations needs to be addressed by learning from mechanisms that have managed to keep participants enthusiastic. Intergovernmental relations have matured in cases like the UK to a level where consultations are mainly informal, underpinned by good communication, goodwill and mutual trust⁸. Good practice demands that once consultations have taken place, keep stakeholders informed about which of their suggestions have been taken on board, what risk or impact mitigation measures will be put in place to address their concerns, and how, for example, project impacts are being monitored⁹

The experience of the Health Sector Coordination structures may provide critical lessons for strengthening the flow of events in the HSI GCF process. In this process, issues related to specific investments in the sector are discussed by the Interagency Coordinating Committee (ICC) headed by the head of department for the respective area of ICC. The ICC forwards priority issues to the Health Sector Coordinating committee HSCC headed by the DMS. The HSCC has a steering committee that coordinates and manages the day to day technical and administrative functions of the HSCC. The HSCC being a mechanism that formally coordinates all operational and strategic actions in the Health Sector then packages strategic policy issues for the JICC' s guidance and endorsement. JICC is chaired by the Cabinet Secretary and is also responsible for resource mobilization and allocation for priority issues. An example of such interventions was the policy directive on the payment of a monthly

⁸ McEwen et.al, 2015, Intergovernmental Relations & Parliamentary Scrutiny, A comparative overview

⁹ Stakeholder Engagement: A Good Practice Handbook for Companies doing business in emerging markets: IFC 2007

stipend to Community Health Volunteers (CHVs). The progress of devolution may require alignment of the coordination structures to the HSI GCF.

5.0 Challenges and Limitations in the Review

- Many CEC's have been dropped from their previous positions or do not know if they will retain their positions in the County governments and have thus been reluctant to participate in the review process
- Due to limitation of resources the Consultant was not able to travel to the counties to collect broader views from the technical teams at the county level
- Political events around electioneering period coupled with uncertainty on the security situation made it difficult for those CEC's who planned to travel to Nairobi to participate in the review to avail themselves during the review period
- This review was conducted within the scope of the TOR hence focus was on the functionality of the HSI GCF process. The findings can be used as a basis to look at the influence of the IGF on health outcomes.

6.0 Conclusions

Although there is a legal framework that supports establishment and conduct of business for the HSI GCF, this framework should be reviewed to remove the conflict observed between the provisions on the consultative forum in the health Act 2017 Vis-à-vis those in the constitution of Kenya 2010 and the intergovernmental relations Act 2012.

The HSI GCF has made good progress in defining roles and responsibilities in form of TORs and creating a platform that brings various actors on board. The TORs for thematic technical committees are however a list of activities and need to be reviewed into proper TORs.

There is goodwill from the main Actors but lack of proper alignment with other intergovernmental relations structures in the health sector and the need for stronger commitment by the leaders threatens the ability of the forum to influence the health sector

The information collected during this review shows the need to standardise the HSI GCF process and to draw on precedence and best practice from other parts of the world, where devolved/federal systems have developed to considerable maturity. Further engagement with relevant stakeholders will be vital to creating a manual for the HSI GCF.

It is possible to build on the existing process to create a more inclusive structure for the HSI GCF to be responsive to the diversity of actors

7.0 Recommendations

1. The HSI GCF should establish a ministerial structure for formalized decision making and high level advice to the CoG and MOH, and a technical advisory structure for tackling technical issues in the sector and advising the ministerial level. The technical structure would also be the link point for the various technical committees and Development Partners would engage as needed with the technical arm of the HSI GCF and its constituent committees.
2. Once established, the HSI GCF should meet at least twice a year while the technical level meets at least quarterly. Both levels may convene other meetings based on need.
3. There is a need for MOH and CoG to galvanize synergy between political and health management leadership and explore opportunities for alignment. Leadership must strive to effectively coordinate the HSI GCF process and maintain a high level of enthusiasm by all actors in the process while leading from the front
4. HSI GCF should establish a secretariat to interface the HSI GCF and other structures of intergovernmental relations. The secretariat must have a clear mandate for administration, coordination and general management of the HSI GCF.
5. The Secretariat should develop an annual calendar of HSI GCF activities and rally all actors in adhering to the same
6. The draft operational manual developed through this review exercise should be finalized by MOH through engagement of all actors in the HSI GCF
7. There are various levels of decision making and implementation at both levels of government. In order for the HSI GCF to influence these levels effectively, a good stakeholder and communication strategy should be developed with clear objectives, outlining target audience, information needs and expected feedback, communication methodology and a mechanism to evaluate success and failure.
8. An outcome document of meetings in form of a communique co-signed by MOH and CoG should be developed at the end of each meeting identifying key issues discussed, resolutions made, issues with pending matters and issues to be escalated to other structures within the intergovernmental relations process.
9. The induction process for the HSI GCF 2017 – 2022 should include a session on how donors work and how the HSI GCF can be used as an avenue to support issues of common interest.
10. HSI GCF should conduct a capacity needs scan for the Thematic Technical Committees and redefine conduct of business, representation and required technical skills. A TA program should be developed that aims to strengthen the functionality of these committees.

11. The HSI GCF structure proposed by this review is to facilitate its proper functioning. Once functional, it should fit in the Partnership Framework by establishing the necessary links with other health sector intergovernmental structures.
12. Government Agencies in the health sector – their structures and roles are evolving (e.g. resulting from implementation of the Health Act, and other possible reforms to streamline the health sector). These entities are ‘centres of expertise’ on specific health functions. Hence there is need for them to play an active role in the HSI GCF technical committees, based on their legal mandates.
13. There is need to review the HSI GCF provisions in the Health Act, to capture the political & decision-making authority of the CS & CECs; and to align with other recommendations of this review. Once the HSI GCF structure is agreed, the key structures therein should be established through a legal instrument (by the CS).

8.0 References:

1. Terms of Reference for reviewing the health sector intergovernmental consultative forum for its efficiency and effectiveness
2. Terms of Reference for the health sector intergovernmental consultative forum
3. Terms of Reference for the Thematic Technical Committees
4. Reports of the health sector intergovernmental relations consultative forum meetings
5. Draft SOP for HSI GCF and Thematic Technical Committees
6. Minutes of the kick off meeting, Inception, progress review and Technical Meeting on Preliminary Report
7. Kenya Health Partnership and Coordination Framework (Draft)
8. Kenya (2012) Intergovernmental Relations Act 2012
9. Legal Notice No. 16 of February 2013
10. Kenya gazette supplement No. 116
11. Health Act 2017
12. Samba et-al (2015) Open-Government Partnership Process in Sierra Leone: Engaging in mutually respectful manner and Finding a common ground to actualise the reforms we need
13. Georgia (2014 – 2015) Open Government Partnership: Action Plan
14. EAC (1999): The Treaty for the Establishment of the East African Community
15. McEwen et.al (2015) Intergovernmental Relations & Parliamentary Scrutiny, A comparative overview
16. COAG health council Communique 3 November 2017
17. Constitution of the World Health Organization

9.0 ANNEX:

1. Work Plan for the Review
2. List of Respondents
3. Terms of Reference for the HSI GCF
4. Terms of Reference for the Thematic Technical Committees
5. Draft Health Sector Partnership and Coordination Framework
6. Minutes of Kick off Meeting
7. Minutes of Inception Meeting
8. Minutes of Progress Review Meeting
9. Minutes of Technical Meeting on Preliminary Report
10. Terms of Reference for the Review



MINISTRY OF HEALTH

A REVIEW OF THE HEALTH SECTOR
INTERGOVERNMENTAL CONSULTATIVE
FORUM
“EFFICIENCY AND EFFECTIVENESS”

VOLUME 2: DRAFT OPERATION MANUAL

December 2017

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Acknowledgement

Foreword

1.0 Background

The Intergovernmental Relations Act 2012 establishes a framework for consultation and co-operation between the national government and county governments and county governments amongst themselves. Pursuant to provisions of this Act, the health sector established a Health Sector Intergovernmental Consultative Forum (HSIGCF) that brings together county health departments represented by the county executive committee members of health (CEC) and the national level represented by the Cabinet Secretary (CS), the Director of Medical Services (DMS) and Heads of Directorates (HOD) at the Ministry of Health (MOH), Government Agencies; Kenyatta National Hospital (KNH), Moi Teaching and Referral Hospital (MTRH), Kenya Medical Research Institute (KEMRI), Kenya Medical Supplies Authority (KEMSA), Kenya Medical Training College (KMTC), National Aids Control Council (NACC), National Health Insurance Fund (NHIF) and Development partners under the umbrella of Development Partners in Health Kenya (DPHK) including JICA, USAID, WHO, GIZ, UNFPA, UNICEF and World Bank.

The Health Sector Intergovernmental Consultative Forum (HSIGCF) plays a crucial role for structured dialogue on health matters through cooperation, collaboration, consultation, concurrence, consensus, communication and commitment. The HSIGCF is also expected to be a platform for addressing key priority health sector issues of concern between the two levels of governments.

This operational guideline describes the process and procedures to be followed in active engagement, consultation, cooperation and mutual accountability between the ministry of health and the county departments of health. The guidelines outline structures and key functions, conduct of business, communication mechanism, monitoring and evaluation for sustainability of the HSIGCF.

1.1 Authority

This guideline draws its mandate from section 13 sub section 2 of the Intergovernmental Relations Act, 2012 that gives cabinet secretaries powers to convene consultative fora on sectoral issues of common interest to the national and county governments.

1.2 Application and scope

This guideline applies to health managers and health sector technical staff working at both levels of government. Specifically, this guideline defines roles and responsibilities of various teams within the scope of work defined by section 5 (27) of the health Act 2017. The guidelines seek to standardise ways for the health sector consultative forum to ensure uninterrupted service delivery under devolved system of government through continued determination of matters requiring intergovernmental consultation; developing inter-governmental agreements for joint implementation of activities for health service delivery and mutual consultation, coordination and collaboration between the national and county governments on all matters related to health.

1.3 Mandate of the HSIGCF

The HSIGCF provides the National Government and the 47 County Governments an opportunity to share achievements, successes, experiences, opportunities and challenges in implementation of devolution with a view to providing quality, equitable, affordable, accessible and acceptable services to all Kenyan.

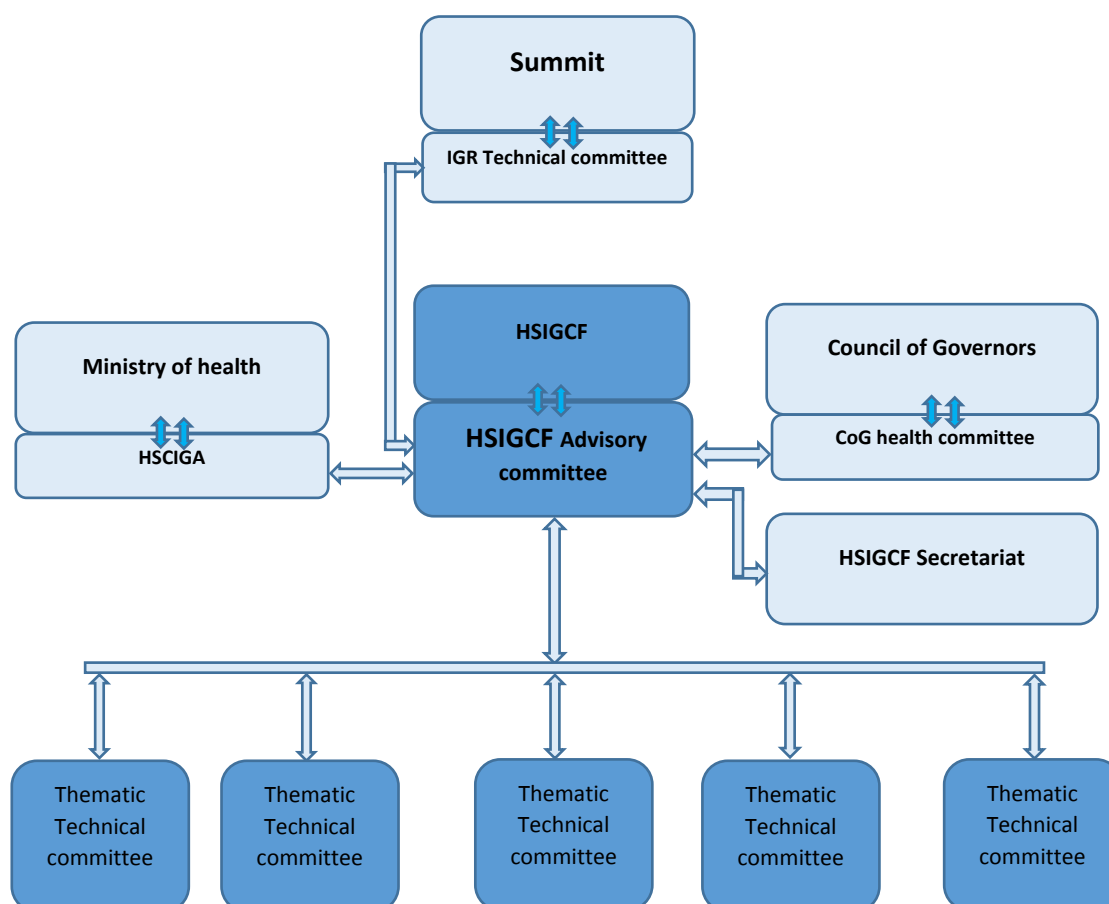
1.4 Guiding Principles

The HSIGCF plays a crucial role in providing opportunity for structured dialogue and is guided by the following principles;

- Cooperation:
- Collaboration:
- Consultation:
- Concurrence
- Consensus:
- Communication:
- Commitment:

1.5 Structure of the HSIGCF

The HSIGCF consultative forum will mainly comprise three levels namely, thematic technical committees (TTCs), HSIGCF Advisory committee and HSIGCF. These levels will relate to each other and to other intergovernmental relations structures as shown below;



2.0 The HSIGCF

The HSIGCF is a health forum for consultation and co-operation between the national government and county governments and county governments amongst themselves on health matters of mutual interest. HSIGCF has been convened ten (10) times during the 5 year term of 2013-2017. The Forum has terms of reference outlining its activities as follows:

- i) Identify issues for discussion during the intergovernmental consultative mechanisms and establish systems to address these issues.
- ii) Facilitating and coordinating the transfer of functions, power or competencies from and to either level of government.
- iii) Coordinating and harmonizing development of health policies and laws
- iv) Evaluate the performance of the national or county governments in realizing health goals, and recommend appropriate action
- v) Monitoring the implementation of national and counties' sectoral plans for health
- vi) Produce annual reports on national health statistics pertaining to the health status of the nation, health services coverage and utilisation
- vii) Promotion of governance and partnership principles across the health system
- viii) Implement and follow up of actions and recommendations from the National and County Government Coordinating Summit
- ix) Consideration of issues on health that may be referred to the forum by member of the public and other stakeholders and recommending measures to be undertaken.

2.1 Composition of the HSIGCF

The HSIGCF is an intergovernmental mechanism, and membership is only derived from the two levels of government. Other stakeholders may be invited to make submissions on a need basis, and in fulfilment of the broader democratic goal of public participation. Some development partners may sit in the HSIGCF as observers.

The HSIGCF is therefore proposed to comprise:

- i) The Cabinet Secretary of Health
- ii) Chair of the County Executive Committee for health council
- iii) Council of governors health committee
- iv) Chair of the thematic technical committees
- v) The 47 County Executive Committee Members for Health
- vi) The PS, DMS and MOH heads of departments
- vii) Members of constitutional commissions and offices with mandates concerning devolution will be co-opted as ex-officio members
- viii) Representatives of Partners (as observers)

The members identified above may delegate participation to a senior member of their office or department to attend on their behalf, but the authority to participate in decision making processes will need approval from the other members in attendance.

2.2 Charing arrangements

The chair of the HSI GCF is the Cabinet Secretary assisted by the Chair of the CEC's council as co-chair. The term of both the chair and co-chair expires as soon as their mandate as cabinet Secretary and chair of the CEC council expires. The chair convenes the HSI GCF meetings and together with the co-chair represent the interests of the national government and county governments respectively.

2.3 Scheduling of HSI GCF meetings

An annual schedule of meetings for the HSI GCF aligned to the health sector calendar is prepared by the secretariat and circulated to all stakeholders. The HSI GCF meets at least twice a year, but additional meetings may be convened by the Chair as required to deal with emerging issues of common interest in the sector.

2.4 Convening of the HSI GCF meetings

The Chair will convene meetings based on the annual schedule. Participants should be invited two weeks in advance through a letter signed by both the Chair and co-Chair. The invitation should contain the date, venue and agenda for the meeting, and should be sent together with the report of deliberations from the previous meeting. The invitation should be sent to all members through an agreed communication process.

2.5 Agenda setting for meetings and venue selection

The agenda for meetings should be identified based on the priority issues in the sector and distributed in advance in order for the participants to provide input. The following process should be followed at the bare minimum.

- The HSI GCF secretariat consults the advisory council and HSI GCF chair and co-chair on priority issues and drafts an agenda for the proposed HSI GCF meeting
- The draft agenda is presented by the secretariat to the chair and co-chair of HSI GCF for approval
- The final agenda circulated to all participants together with material containing the necessary information to be discussed during the meeting two weeks in advance
- The meeting venue is selected based on convenience in terms of participants, alignment to other activities and cost

The meeting agenda may vary based on emerging priority issues within the health sector, but should contain the following at bare minimum.

1. Confirmation of last meetings report
2. Matters referred for more details from the previous meeting
3. Report on matters referred to other coordination structures either for implementation or decision making
4. Update on ongoing matters being deliberated upon by the HSI GCF e.g, legislation or policy formulation process
5. Matters that require decision making by the HSI GCF
6. Emerging issues in the health sector

2.6 Decision making

The HSIGCF has determined that decisions are made by consensus but depending on the nature of the issue, other decision making rules may be applied.

i) Consensus

Decisions made by way of consensus require all parties to unanimously agree with the decision. To reach consensus, the decision making process requires dialogue and inclusion of every person's opinion to acceptable levels. A lot of time is required for consensus building hence selection of this method must be based on the sensitivity of the issue at hand and availability of time

ii) Majority rule:

This may take the form of making decisions based on the vote of 50 percent-plus-one of the participants attending the HSIGCF forum. It may raise legitimacy issues of difficulties in implementation especially by those who opposed it.

iii) Qualified majority rule:

This approach is based on majority thresholds such as two-thirds of the participant votes at the meeting of two thirds of the total number of members to the HSIGCF. This method assumes an approach similar to consensus and majority rules.

iv) Mixed rule

Consensus building is favoured ahead of casting of votes which can be used as a last resort.

2.7 Procedure for conducting meetings

The date of next meeting should be announced by the chair at the end of each meeting. The secretariat prepares the agenda based on the procedure described under 2.5 – Agenda setting for meetings and circulates it two weeks before the meeting day.

2.7.1 Establish quorum

The chair should establish whether the number of members with decision making rights available represents the minimum number required in order to conduct business by the forum. This is important to ensure that decisions/resolutions passed will be binding. Robert's Rules of order lays out options that can be considered when a meeting is deficient of the required quorum. Based on these options, the chair might decide on one of the following;

1. Fix a time to adjourn the meeting by allowing some time to wait for late comers
2. Adjourn immediately and wait for the next regular meeting
3. Take measures to assemble a quorum by making calls to round up enough members for the meeting to continue. In the meantime, the meeting can proceed with matters that will not require decision making

2.7.2 Opening formalities

Once quorum is established, the opening formalities such as recognition of guest participants, opening remarks etc. can be administered.

2.7.3 Confirmation of last meeting report

The chair of the session should seek confirmation from members present at the previous meeting that the report represents what was deliberated. In case amendments have been proposed that seek to significantly change the report, those members who were present at the last meeting are asked to consider the changes and to agree on the specifics of any amendments to be made. In case of dispute among members at the last meeting in regards to the proposed amendment, those who were present at the last meeting vote on whether to adopt the amendment or not.

The report should then be confirmed, either in its original form or with agreed amendments. Any amendments are recorded in the minutes of the current meeting. The Chair and co-chair sign the report after they have been amended as approved.

2.7.4 Status report on matters referred

This will be presented by the secretariat as a status update but may not require discussion. Issues arising can be noted and assigned to pending matter on the agenda for the meeting.

2.7.4 Presentation of issues requiring decision making

In line with the agenda for the meeting, thematic technical committee chairs or designates should present issues requiring decision making. Depending on the nature of the issue, participants can decide through the chair to discuss issues individually or combined. Other matters to be listed for presentation should include submissions like policy briefs or research findings prepared by relevant stakeholders but vetted by the advisory committee.

2.8 HSI GCF Secretariat

This will comprise a minimum of four staff nominated by MOH and COG and approved by the HSI GCF. The Secretariat will be responsible to the HSI GCF for the day to day administration of the affairs of the HSI GCF and organizing the larger group. Specific tasks will include

- Proposing draft agenda for the meetings after consultation with relevant stakeholders
- Selection of meeting venue
- Facilitate the process to convene meetings for the HSI GCF and subsidiary committees
- Administration of the meeting process and support to the Chair and members
- Organisation and keeping of records of the meetings with specific focus on decisions and resolutions of made.
- Promotion and dissemination of information internally and externally
- Tracking implementation of decisions made by the HSI GCF

- Preparing reports of the activities quarterly

3.0 The HSI GCF Advisory Committee

The Advisory committee provides advisory and support to the HSI GCF. This committee consolidates issues from thematic technical committees and prepares a draft of resolutions for decision making by the HSI GCF. Implements action points from HSI GCF in collaboration with TTC's and sector partners.

3.1 Composition of the advisory committee

Membership of the advisory committee comprises representatives from the national Ministry of health and county government departments of health as follows;

- i) Director General/DMS
- ii) Heads of directorates aligned to the respective thematic areas of the TTCs
- iii) Chair of the COG / Health Committee
- iv) 4 representatives of county director of health

This membership should be endorsed by the HSI GCF before the committee commences work.

3.2 Terms of Reference for the HSI GCF advisory committee

This committee is proposed to support and advice the HSI GCF. The terms of reference will be developed to contain the following at the bare minimum;

1. Advising on strategic issues relating to the coordination of health services across the country
2. Review the recommendations of thematic technical committees and draft resolutions for approval by the HSI GCF
3. Coordinate with MOH, COG and IGR technical committee to align health matters of in mutual interest to both levels of government
4. Coordinate with other sector fora whose work impacts the health sector
5. Review the HSI GCF communique before it is approved by the chair and co-chair

3.3 Chairing of meetings

The Director of Medical Services and a nominated county director of health will chair and co-chair the meetings respectively. The rest of the process follows what is done by the HSI GCF

3.4 Scheduling of HSI GCF advisory committee meetings

An annual schedule of meetings for the HSI GCF Advisory committee aligned to the meetings of thematic technical committees and HSI GCF meetings is prepared by the secretariat and circulated to all stakeholders. The HSI GCF advisory committee meets at least quarterly, but additional meetings may be convened by the Chair as required to deal with emerging issues of common interest in the sector. Two of the meetings must be scheduled to take place before the HSI GCF meetings as a measure to filter issues to the HSI GCF meeting

3.5 Convening of the HSIGCF meetings

The Chair will convene meetings based on the annual schedule. Members should be invited two weeks in advance through a letter signed by both the Chair and co-Chair. The invitation should contain the date, venue and agenda for the meeting. The invitation should be sent to all members through an agreed communication process.

3.6 Agenda setting for meetings and venue selection

The agenda for meetings should be identified based on the priority issues discussed by thematic technical committees and issues referred by the HSIGCF. The advisory committee might flag out issues that need deliberations by TTCs and referred such issues appropriately. The following process should be followed at the bare minimum.

- The HSIGCF secretariat consults the advisory council chair and co-chair on priority issues and drafts an agenda for the proposed HSIGCF meeting
- The draft agenda is presented by the secretariat to the chair and co-chair of Advisory committee for approval
- The final agenda circulated to all committee members with material containing the necessary information to be discussed during the meeting two weeks in advance
- The meeting venue is selected based on convenience in terms of participants, alignment to other activities and cost

The meeting agenda may vary based on emerging priority issues within the health sector, but should contain the following at bare minimum.

7. Matters referred for more details from the HSIGCF
8. Report on matters referred to TTCs for more information of for implementation
9. Matters that require preparation of draft resolutions
10. Emerging issues in the health sector

3.7 Decision making

The HSIGCF has determined that decisions are made by consensus and the Advisory committee will follow the same. In case consensus doesn't work, other methods identified under 2.6 may apply.

3.8 Procedure for conducting meetings

The same procedure identified under 2.7 will apply where appropriate.

4.0 Thematic Technical Committees (TTCs)

How successful committees become can be directly linked to the effectiveness of the chair, who is ultimately responsible for the conduct of business including scheduling and convening of meetings, Agenda setting, venue selection, conducting meetings, maintaining records and ensuring decisions and recommendations made are implemented or action taken respectively.

TTCs are subsidiary bodies of the HSIGCF and membership is primarily given to county department of health and MOH officials. However, TTCs may require technical input from third parties hence involve such parties by way of invitation. This invitation is on temporal

basis, and does not mean permanent membership have been granted to the persons or organizations. If the TTC finds that continuous participation of the person/organization is necessary, an invitation should be issued at each time of the concerned meeting. The size of each committee will depend on the thematic group but a committee of 10 to 15 members represents a good size that is able to split into smaller groups if need arises.

4.1 Composition of TTCs

- ii) MOH head of department for the respective thematic area
- iii) Selected County Directors for Health
- iv) Government agencies
- v) Development Partners
- vi) Private sector

Specific tasks include; (Terms of reference)

- i) Discuss the technical and operational matters of mutual interest
- ii) Review of the achievements regarding the way forward/resolutions and recommendations made at the previous HSI GCF
- iii) Selection of priority issues to be discussed
- iv) Preparation of the 1st draft of resolutions and recommendations.
- v) Review of the resolutions and recommendations by top management of CECs and MOH

4.2 Charing arrangements for TTCs

The chair of the TTCs is the MOH head of department for the respective thematic area assisted by a County Director for health nominated by the committee as co-chair. The term of chair and co-chair will be renewed on an annual basis with rotation for the county Directors of health. However, the position expires as soon as their mandate as Director of medical services or County Director for Health expires. The chair convenes the HSI GCF meetings and together with the co-chair represent the interests of the national government and county governments respectively.

4.3 Scheduling of TTC meetings

An annual schedule of meetings for the HSI GCF aligned to the health sector calendar is prepared by the secretariat and circulated to all stakeholders. TTCs meets at least quarterly, but additional meetings may be convened by the Chair as required to deal with emerging issues of common interest in the sector.

4.4 Convening of TTC meetings

The Chair will convene meetings based on the annual schedule. Members should be invited two weeks in advance through a letter signed by both the Chair and co-Chair. The invitation should contain the date, venue and agenda for the meeting. The invitation should be sent to all members through an agreed communication process.

4.5 Agenda setting for TTC meetings and venue selection

The agenda for meetings should be identified based on the priority issues in the sector and issues referred by the HSIGCF through the advisory committee. The chair and co-chair should consult with counties and national government including government agencies to identify priority issues that shape the agenda. Venue will be selected based on convenience and cost.

4.6 Decision making

The HSIGCF has determined that decisions are made by consensus and the same will apply at the level of TTCs, but depending on the nature of the issue, other decision making rules identified in 2.6 may apply. Some decisions of technical/operational nature can be made at this level, but matters that require policy or legislation will be referred to the HSIGCF through the advisory committee.

4.7 Procedure for conducting meetings

The date of next meeting should be announced by the chair at the end of each meeting. The secretariat prepares the agenda based on the procedure described under 2.5 (Agenda setting for meetings) and circulates it two weeks before the meeting day.

5.0 Communication and reporting

5.1 High level briefs

A communique on resolutions passed, matters referred back to the committees and those escalated to other levels should be prepared, signed by the chair and co-chair and circulated to relevant stakeholders within (proposal - two weeks) after the meeting

5.2 Meeting reports

HSIGCF meeting reports should be written by the secretariat soon after the meeting and circulated to officials of respective committees for input within two weeks. The final draft should be circulated to participants within four weeks to stimulation those tasked with action and update those who missed the meeting.

Quarterly reports will be submitted to the technical committee of the National and County Government Coordinating Summit, the Ministry of Devolution and Planning, the Council of Governors health committee, commission on Revenue Allocation and Salary Review Commission.

5.3 Minutes

All committees should take and share minutes of discussions with relevant stakeholders. The minutes should clearly outline agreements reached and matters referred to other levels within the HSIGCF process

6.0 Positioning HSIGCF in the health sector partnership coordination framework

Several Actors in the health sector will either individually or through their coordination structures link to the HSIGCF at different levels to work in collaboration to support the country's health agenda using the principles of Sector Wide Approach. The HSIGCF can establish these partnerships at the technical level (Thematic technical committees) and such

Actors will participate in discussions to provide technical advice. They may also participate by submitting research findings, mission reports, position papers etc. Such partners include Government Agencies; Kenyatta National Hospital (KNH), Moi Teaching and Referral Hospital (MTRH), Kenya Medical Research Institute (KEMRI), Kenya Medical Supplies Authority (KEMSA), Kenya Medical Training College (KMTC), National Aids Control Council (NACC), and National Health Insurance Fund (NHIF), Development partners under the umbrella of Development Partners in Health Kenya (DPHK) including JICA, USAID, WHO, GIZ, UNFPA, UNICEF and World Bank, NGOs, and the private sector among others.

At the policy level, MOH and CoG are at liberty to decide the level of participation for a select group of partners depending on the type of arrangements such partners have with the government. For most partners, the level of engagement at this level will be as observers. Partnerships will also be established with other intergovernmental relations structures such as the summit through intergovernmental relations committee, Kenya health forum, CECs council, council of governors, development partners consultative group, GOK consultative group and HENNET among others for coordinated decision making.

7.0 Sustaining engagement enthusiasm

It is important to keep members interested in the HSI GCF process to ensure stakeholders remain enthusiastic. If subjects of discussion become monotonous, topics include content that is too technical for participants, decisions are not made in good time or when they are made, they are not implemented, members may feel wasted and think their contribution is not impactful hence loose interest in the process. Some of the measures to sustain enthusiasm include;

- i) Create a relaxed environment and time that enables participants to interact at individual level and increase trust for each other.
- ii) Plan to achieve short-term results. Participants' interest in the process is partly based on attribution of their effort to results achieved. Obtaining short-term results is crucial to gaining credibility.
- iii) Create capacity-building opportunities matched with the needs of the Forum members.

8.0 Budget arrangements

Joint budget arrangements for HSI GCF were made during the period 2013-2017. This and other options are proposed for

Option 1

Counties meet the cost of travel and accommodation for the CEC's and County Directors for Health and MOH takes responsibility for the venue, meeting package and costs for staff from MOH. This arrangement applies to the HSI GCF with its subsidiary committees.

Option 2

An annual budget based on the copy obtained during this review (Annex 3) is prepared and submitted to both levels of government for discussion and funding through the normal government procedures

Option 3

An annual budget based on the copy obtained during this review (Annex 3) is prepared and used to discuss with partners for pool funding with participation of MOH and COG.

Option 4

HSIGCF breaks the budget into components that can be adopted by different parties with MOH and CoG supporting the main components and reaching out for support for other components through projects that are aligned to the HSIGCF process.

9.0 Monitoring and accountability

Monitoring and accountability provide decision makers with regular information on progress relative to targets to enable them strengthen management and decision making for effectiveness in realization of results.

In order to hold the different levels within the HSIGCF structure accountable, an oversight mechanism is required over the fulfilment of responsibilities. Various dimensions should be built in the work process of the HSIGCF to enable accountability. To do this, each level should;

- Be obligated to inform, explain and justify their decisions and actions, and should involve formal monitoring mechanisms for action on recommendations and decisions made.
- Clear de-limitation of responsibility with clearly defined duties and performance standards, which would enable their performance to be assessed objectively and transparently.

The HSIGCF secretariat should play the role of accountability coordinator and ensure that;

1. sharing of information internally within the HSIGCF structures and with external stakeholders is done on a regular basis
2. Agreeing on a procedure on how complaints will be raised and handled against each other in a safe and accessible way
3. Regularly monitoring and evaluating the quality of consultation, and each other's agreed performance.

10.0 References

Standard of Operation for the Health Sector Intergovernmental Consultative Forum and the Thematic Technical Committee

Terms of Reference for reviewing the health sector intergovernmental consultative forum for its efficiency and effectiveness

Terms of Reference for the health sector intergovernmental consultative forum and the thematic technical committees

Reports of the health sector intergovernmental relations consultative forum meetings

Kenya health sector partnership coordination framework

COAG Health Council Operating Guidelines 2014

Robert's Rules of Order, 11th edition 2011

Ernesto velasco-sánchez, designing and managing an open government partnership multistakeholder forum, a practical handbook with guidance and ideas

The Sacco societies regulatory authority; guidelines on good governance of deposit taking Sacco societies 2015

Programme accountability guidance pack: a save the children resource 2013

Working Together for Development Understanding Intergovernmental Relations; governance, accountability, communication, consulting, planning, implementing

Health Sector intergovernmental consultative forums 2015/2016 financial year concept note

11.0 Annexes

Annex 1: Proposed functions and members (Kenya Health partnership framework)

<p>Health Sector Intergovernmental Forum (HSIGCF)</p> <p>Policy, decision-making, refers issues to IGRTC, National Summit.</p> <p>Meets twice yearly</p> <ul style="list-style-type: none"> • Co-lead: MOH CS-Health (1) • Co-lead: CECs-Health Execs (3) • MOH Heads of Departments (6) • COG Health Committee (2+) • COG HC Secretariat (1+) • CECs-Health (47) • Development Partners - DPHK officers (4+) • Private Sector – HENNET, FBOs, KHF (3) • Other technical partners (5) • Other reps invited ad hoc • <i>Health-related sectors: Education, Agriculture, Water</i> <p>HSIGCF Steering Committee</p> <p>Sets agenda for HSIGCF. Formulates issues from ICCs/TWGs, prepares recommendations to take to HSIGCF for decision-making. Implements action points from HSIGCF in collaboration with HSIGCF-TCs/ICCs and sector partners.</p> <p>Meets monthly or quarterly?</p> <ul style="list-style-type: none"> • Co-leads: MOH-DMS, CEC-H Execs (4) • Dept HSC-IGA, COG (4) • MOH key Depts, divisions, programs (4+) • Partners: DPs (4), HENNET (2), FBOs (1), KHF (1) 	<p>HSIGCF Secretariat</p> <p>Organizes meetings of HSIGCF-SC, HSIGCF. Monitors operations of HSIGCF-TCs/ICCs(?). Facilitates communication between all sector partners.</p> <ul style="list-style-type: none"> • Lead: MOH-DMS, Dept HSC-IGA(?) • Links to COG, CECs-H Sec, DPHK Sec, private sector <p>HSIGCF Technical Committees / ICCs</p> <p>Discuss technical issues and priorities, coordinate and harmonize inputs from GOK and partners, jointly monitor progress against KHSSP technical targets, make recommendations for actions to HSIGCF-SC for onward decision-making by HSIGCF.</p> <ul style="list-style-type: none"> • Co-leads: MOH technical officer; CEC-H • CECs-Health • MOH technical officers • DP technical officers • NGOs, FBOs, private sector technical partners
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Annex 2: Checklist for Committee Meeting Management
(http://www.ashe.org/chapters/pdfs/handbook/06_committees.pdf)

A new committee chair will find the following checklist invaluable as they set out in their new role.

- Start on time.
- Make sure everyone is introduced by name and role.
- List the objectives of the meeting.
- Review the background material.
- Encourage participation by all, which includes talking judiciously and succinctly and listening carefully.
- Assign tasks prior to the start of the meeting, such as note takers and timekeepers.
- Remember that members of a committee are well informed in some areas and not in others.
- Keep the meeting moving and on task.
- Summarize major points during the session.
- Pay attention to interpersonal dynamics that may affect the meeting outcome.
- Talk to the group as a whole. Avoid speaking only to one person for any length of time.
- If energy flags or interest wanes, take a break.
- Solicit opinions and experiences, especially in areas of disagreement.
- If you are losing the group's attention, ask a question or shift the meeting pace.
- Try to draw out silent members. Direct questions to them or solicit their opinions.
- If someone dominates a meeting, direct thought-provoking questions to them, ask for their cooperation, or give them a special assignment.
- Adjourn on time. If you must run over, ask the group's permission to do so or solicit their input in how to change the agenda to end on time.

Annex 3: Budget proposed in the HSI GCF 2015/2016 financial year concept note

Budget Item	Unit	Qty	Unit Rate in Kshs.	Days	Est Budget in KES	Est Budget in USD	DP Support Commitments
1. Accommodation							
1.1 CECs	Pax	47	15,000.00	2	1,410,000.00	14,842.11	
1.2 Drivers	Pax	22	6,000.00	2	264,000.00	2,778.95	
Sub Total Accommodation					1,674,000.00	17,621.05	
2. Return Air Ticket							
2.1 CECs	Pax	25	20,000.00	2	1,000,000.00	10,526.32	
Sub Total Air Ticket					1,000,000.00	10,526.32	
3. Fuel Refund KES 45/Km							
3.1 CECs	Pax	22	45.00	450	445,500.00	4,689.47	
Sub Total Fuel Refund					445,500.00	4,689.47	
4. Taxi Expenses							
4.1 CECs	Pax	25	5,000.00	2	250,000.00	2,631.58	
Sub Total Taxi Expenses					250,000.00	2,631.58	
5. Incidentals							
5.1 CECs	Pax	47	7,000.00	2	658,000.00	6,926.32	
5.4 Drivers	Pax	22	4,000.00	2	176,000.00	1,852.63	
Sub Total Incidentals					834,000.00	8,778.95	
6. Venue Expenses							
6.1 Conference Package	Pax	100	5,000.00	1	500,000.00	5,263.16	JICA
6.2 PAS	No	1	15,000.00	1	15,000.00	157.89	
6.3 Casual Hires	Pax	4	7,000.00	3	84,000.00	884.21	
6.4 Banners	PCs	2	7,000.00	2	28,000.00	294.74	
6.5 Use of Business Center	Pax	1	15,000.00	1	15,000.00	157.89	
6.6 Rapporteurs	Pax	2	30,000.00	5	300,000.00	3,157.89	JICA
Sub Total Venue Expenses					942,000.00	9,915.79	
Total All Budget Items					5,145,500.00	54,163.16	
Miscellaneous @ 10% of Total Budget					514,550.00	5,416.32	
Total One HSI GCF Meeting					5,660,050.00	59,579.47 USD	

Explanatory Notes

1. Drivers: 22 for CECs
2. CECs travelling by air are 25 who include;
 - i) Coast: Mombasa, Kwale, Kilifi, Taita Taveta, Lamu and Tana River (6)
 - ii) North Eastern: Mandera and Wajiri (2)
 - iii) Rift Valley: Turkana, WPokot, Trans Nzoia, Uasin Gishu, Elgeyo Markwet, Nandi, Kericho (7)
 - iv) Western: Vihiga, Kakamega, Bungoma, Busia (4)
 - v) Nyanza - Siaya, Kisumu, Homabay, Migori, Kisii, Nyamira (6)
3. Expected Forum Participants are 100 who include;
 - i) 47 CECs
 - ii) MoH Top Leadership - 3 (CS, PS, DMS)
 - iii) MoH HoDs, 6
 - iv) Forum Secretariat & Planning Committee Members - 15
 - v) Partners and other stakeholders - 10
 - vi) Commissions and Regulatory bodies - 11
 - vii) Rapporteurs and support staff -6



Japan International Cooperation Agency, (JICA) Kenya Office
The Rahimtulla Tower, 10th & 11th Floor, Upper Hill Road
P.O. Box 50572-00200 Nairobi, KENYA
Tel: +254-20-2775000
E-mail: ky_oso_rep@jica.go.jp
www.jica.go.jp/kenya/english/index.html
Facebook: https://www.facebook.com/jicakenya

Date: 20th December 2017

Ref: TC – 29 – 293(EK)

Mr. Julius Korir
Principal Secretary
Ministry of Health, NAIROBI

**RE: Final Report on Review of the Health Sector Intergovernmental
Consultative Forum for its Efficiency and Effectiveness**

Dear Sir,

Kindly refer to your letter MOH/ADM/CONF/AID/5/A VOL.XVI/30 of 21st September 2017.

JICA contracted a local consultant to undertake the review of the Health Sector IGF performance during 2013 – 2017, and to make recommendations and proposals for enhancing the IGF efficiency and effectiveness in the future.

The Consultant received guidance and technical support from officers at the Ministry of Health and Development Partners including WHO, JICA and DPHK Secretariat. There were also valuable inputs from the Secretariat of the Council of Governors.

Attached please find the Final Report comprising;
Volume 1: Main Report
Volume 2: Draft Operation Manual for the IGF

We hope that the Report will be useful for the intended purpose of strengthening the Health Sector IGF.

Sincerely yours,

Shinjiro AMAMEISHI
Senior Representative
JICA Kenya Office

Annex 1: Work Plan for the Review

Activity/Task	Responsibility	Time frame
Kick off meeting between MOH, JICA and Stakeholders	MOH / JICA	3 rd November 2017
Desk Review of relevant documents and reports from the HSI GCF	Consultant	Week 1
Inception Meeting with MOH, JICA and Other Stakeholders	MOH	November 8 th 2017
Dispatch of Questionnaires to Selected Respondents	Consultant	November 9 th 2017
Key Informant Interviews with MOH, COG, Government agencies	Consultant	November 13 th – 16 th 2017
FGDs with MOH and DPHK	Consultant	November 16 th – 17 th 2017
Collection and Collation of Responses to Questionnaires	Consultant	November 22 nd 2017
Progress Review meeting with Technical Team	MOH	November 23 rd 2017
Preparation and Submission of the Preliminary Report	Consultant	December 1 st 2017
Technical Meeting to Review Preliminary Report	MOH	December 6 th 2017
Submission of Final Report	Consultant	December 8 th 2017

Annex 2: List of Respondents

Organization	Name	Designation
DPHK	- Sandra Erickson	DPHK Secretariat
JICA	- Elijah Kinyangi	Senior Program Officer
NHIF	- Gibson Muhuhu	Deputy director, Benefits and Compliance
MOH	- Dr. Jackson Omondi	Health Sector Coordination and Intergovernmental Affairs
MOH	- Dr. Mary Wangai	Head, Division of Health legislation
MOH	- Kumiko Yoshida	JICA UHC Advisor to MOH
MOH	- Dr. David Kariuki	Head, Policy, Planning and Healthcare Financing
MOH	- Hellen Kiarie	Head, Unit of M&E, Health Research & Development and Health Informatics
CoG Secretariat	- Jackline Mogeni	CEO, CoG
CoG Secretariat	- Meshack Ndolo	Health advisor, CoG
WHO	- Dr. Rudolf Eggers	WHO Representative
WHO	- Dr. Regina Mbindyo	National Professional Officer
WHO	- Dr. Martin Chabi	WHO
WHO	- Joyce onsongo	WHO
CEC's	- Dr. Andrew Mulwa	CEC Makueni County
CEC's	- Mr. Thomas Rutto	Former CEC Elgeyo Marakwet County
CEC's	Ahmed Sheikh	CEC Mandera County
CEC's	- Dr. Mohamed Kombo	Former CEC Lamu County
CEC's	- Dr. Charles Githua	Former CEC Nyeri County
CEC's	- Ms. Sarah Omache	CEC Kisii County
MOH	- Dr. John Kihama	Health Sector Coordination and Intergovernmental Affairs Department

MOH	- Dr. Charles Kandie	Division of Health Standards and Quality Assurance
JASSCOM	- David Wanjohi	Agriculture, Livestock and Fisheries
MOH	- Mr. Stephen Cheruiyot	Health Sector Coordination and Intergovernmental Affairs Department
KEMSA	- Dr. George Walukana	KEMSA
CEC's	- Dr. Maurice Siminyu	Former Chair CEC's Forum and CEC Busia County
CEC's	- Dr. Elizabeth Ogaja	Former Vice Chair CEC's Forum and CEC Kisumu County

**REVISED TERMS OF REFERENCE FOR THE HEALTH SECTOR
INTERGOVERNMENTAL CONSULTATIVE FORUM**

1. Background

Pursuant to Article 6(2) of the Constitution 2010, on devolution and access to services and Article 13(2) of Intergovernmental Relations Act, 2012, on intergovernmental sectoral working groups and committees, a consultative framework should be established to facilitate active engagement, consultation, cooperation and mutual accountability between the ministry of health and the county departments of health. This consultative mechanism is expected to provide a platform for dialogue on health system issues of County and National interest in particular. The major focus of the forum will include transfer and delegation of powers between the two levels of governments, shared services, policy gaps and the required statutory amendments, addressing the capacity building and technical assistance needs, consultations within the sector identification of sector specific issues requiring intervention by both levels of the government. The key deliverables of this entity will be among others development of options and agreements for service delivery as provided for in the Article 118 (1) of County Government Act, 2012, to ensure uninterrupted service delivery under devolved system of government. The consultation process between the national and county governments both levels will observe the principles of of intergovernmental relations in line with Article 189 of the Constitution and Article 4 of the Intergovernmental Relations Act, 2012. This will include; recognition of the sovereignty of the people as provided for under article 1 of the Constitution; inclusive and participatory and respect for the function and constitutional integrity of the two levels of the government. In deliberating over these agenda, the two levels of governments will strive to minimize intergovernmental disputes while cooperating in exercising their functions.

Cognizant that both National and County governments have Specific roles and obligations as defined in the Fourth Schedule of the Constitution in realizing the Right to Health, the two levels must closely work together to assure effective delivery of health services under the devolved system. The health sector intergovernmental consultative forum will provide a platform within the health sector to guide the discussions on the implementation of health functions under devolved system of government, to deepen engagement between the two levels of government and relevant stakeholders on health sector issues of common interest, as well as address issues of concern raised between the two levels of government.

Establishment and Management of the Health Sector Intergovernmental Consultative Forum

The framework for establishment and management health sector intergovernmental consultative forum will include the following:

a) Purpose

- i. Facilitating consultation and cooperation between the two levels of the governments
- ii. Providing forum for coordinating health policies, legislation and functions
- iii. Providing a forum for sharing and disclosing of necessary data and information to enable the two levels of governments to undertake their respective functions effectively
- iv. Providing for mechanisms for the transfer of power, functions and competencies to either level of government.
- v. Promoting accountability between the two levels of governments.

b) Membership

The forum is an intergovernmental mechanism, and membership is only derived from the two levels of government. Other stakeholders may be invited to make presentations on a need basis, and in fulfilment of the broader democratic goal of public participation.

The Health Sector Intergovernmental consultative forum is therefore proposed to comprise:

- i. The Cabinet Secretary of Health who will be the Chairperson
- ii. A vice-chairperson will be elected from amongst the 47 CEC members for health for a one year term.
- iii. The 47 County Executive Committee Members for Health
- iv. Members of constitutional commissions and offices with mandates concerning devolution will be co-opted as ex-officio members

c) Functions

The functions of the Health Sector Intergovernmental consultative forum shall include:

- i. Identify issues for discussion during the intergovernmental consultative mechanisms and establish systems to address these issues.
- ii. Facilitating and coordinating the transfer of functions, power or competencies from and to either level of government.
- iii. Coordinating and harmonizing development of health policies and laws
- iv. Evaluate the performance of the national or county governments in realizing health goals, and recommend appropriate action
- v. Monitoring the implementation of national and counties' sectoral plans for health
- vi. Produce annual reports on national health statistics pertaining to the health status of the nation, health services coverage and utilisation
- vii. Promotion of governance and partnership principles across the health system

- viii. Implement and follow up of actions and recommendations from the National and County Government Coordinating Summit
- ix. Consideration of issues on health that may be referred to the forum by member of the public and other stakeholders and recommending measures to be undertaken.

d) Conduct of Meetings

- i. The Health Sector Intergovernmental Consultative Forum shall meet quarterly
- ii. The Chairperson will convene and chair meetings of the Health Sector Intergovernmental Consultative Forum
- iii. Decisions during meetings will be arrived at by consensus.
- iv. The quorum for the conduct of the business of a meeting of forum shall be a majority of the total membership.
- v. Other stakeholders may be invited to make presentations at the request of the Forum
- vi. Rules of procedure governing conduct of business during the forum will include:
 - a. Chairing of meetings
 - i. In the absence of the chairperson at a meeting, the meeting shall be chaired by the vice-chairperson
 - ii. In the absence of both the chairperson and the vice-chairperson at a meeting of the Health Sector Intergovernmental Consultative Forum, the members present shall elect a member to chair the meeting
 - b. Convening of special meetings
 - i. Additional meetings may be may be convened by the Chairperson as required to deal with emerging issues of common interest in the sector
 - ii. The Chairperson may convene special meetings upon written requisition of one-third of the members of the Forum
 - c. Agenda date, time and venue for the meetings will be determined by the chairperson and vice-chairperson in consultation with the Secretariat
 - i. Written notice of a meeting shall be issued to each member at least fourteen days before the date of the meeting for normal meetings, and at least seven days' notice for special meetings

e) Reporting

The Health Sector Intergovernmental Consultative Forum shall submit quarterly reports on the health sector to the Technical Committee of the National and County Government Coordinating Summit, the Ministry of Devolution and Planning, the Council of Governors, Commission for Implementation of the Constitution, commission on Revenue Allocation, Transition Authority and Salary Review Commission.

f) Establishment of operational committees

The forum may establish operational committees at technical levels as need arises to provide technical inputs or follow-up of decisions of the Forum

g) Secretariat

a) There will be a Secretariat that will be responsible for the day-to-day administration of the affairs of the Forum, as well as follow-up of decisions made during meetings and any other duties assigned by the summit, National and County Coordinating Summit, the Technical Committee or any other intergovernmental consultative mechanism.

b) The secretariat shall comprise of officials from the national government appointed by the Ministry of Health and a member elected amongst the 47 CEC members for health. h)

h) Schedule of Meetings

An annual schedule of meetings will be generated by the Secretariat based on the health sector calendar and the schedule of the National and County Government Coordinating Summit.

i) Review of Terms of Reference

The Term of Reference shall be reviewed annually by the secretariat in consultation with the members and endorsed by the forum

j) Costs

The operation costs for the forum will be shared between the Ministry of Health (secretariat services and meeting costs- venue meals and stationery) and county Departments of Health (travel, accommodation and per diems)

Annex 4: TOR for the Thematic Technical Committees

Sixth Intergovernmental Forum

02 March 2016

Thematic Committees

Group 1: Health Care Financing Committee

Appointed Committee Officials:

1. Dr Peter Kimuu - Head of Policy, Planning and Health Financing (Chair)
2. Mr Thomas Rutto – CEC Health, Elgeyo Marakwet (Co-Chair)
3. Dr Omar Ahmed Omar - Head of Health Financing Division, MoH (Secretary)
4. Dr. Kabii Mungai - CEC Health, Nakuru County (Co-secretary)

Committee members:

1. Dr David Njoroge - CEC Health, Laikipia County
2. Mr Nzoya Munguti - Health Financing Adviser, USAID
3. Mr. Elkana Onguti - Head of Policy and Planning Division, MoH
4. Mr John O. Olima – Senior Finance Officer, MoH
5. Ms Rhodah Njuguna - Council of Governors Secretariat
6. Ms Hubbie Hussein - CEC Health, Garissa County
7. Ms Sheila Yieke - Legal Director, Commission on Revenue Allocation
8. Mr Gifton Mkaya - CEC Health, Taita Taveta County
9. Ms Asha Abdi - CEC Health, Isiolo County
10. Ms Sandra Erickson - DPHK Secretariat
11. Mr Ahmed S. Mohamed - CEC Health, Mandera County

Terms of Reference:

The committee will focus on the following issues;

- a. Capacity building for budget development
- b. Conditional Grants , their disbursements, budgets and expenditures reviews
- c. Managed Equipment Services budget
- d. Resource envelope both at national and county levels
- e. Health Financing and Universal Health Coverage
- f. Resource mapping and tracking g. Budget monitoring and development (capacity needs)
- h. Identify key issues to be tabled to IGF and/or Summit
- i. NHIF issues
- j. Costing of health services
- k. Facility improvement fund

Quorum for meetings:

- 2 MoH officials
- 4 CECs
- 1 CoG representative
- 1 CRA representative

Frequency of meetings: At least twice per quarter

Meeting facilitation:

- Venue/hosting will alternate between CoG and MoH
- CECs to cater for own transport and accommodation
- Resources can be mobilized from GoK/Development partners
- Explore working with the Ministry of Devolution

Group 2: Human Resource for Health Committee

Appointed Committee Officials:

1. Dr. Athman Chiguzo - CEC Health, Kwale County (Chair)
2. Ms Pauline Njegi - CEC Health, Embu County (Secretary)

Committee members:

1. Mr. David Njoroge - Head of HRM & D Division, MoH
2. Sarah Omache - CEC Health, Kisii County
3. Dr Pacifica Onyancha - Head of Health Standards, Quality Assurance and Regulation, MoH
4. Ms Racheal Musyoki - CEC Health, Kilifi County
5. Ms Gladys Marima - CEC Health, Kajiado County
6. Mr Joel K. Ngolekong- Ag CEC Health, West Pokot County
7. Ms Anne Mutie - Human Resources, MoH

Key issue of focus: Training and capacity building;

- Procedures and guidelines were already in place and members agreed that MoH should send copies to all CECs in the 47 counties.
- Communication on availability of both local and foreign scholarships should be made by MoH to CECs to cover the current information void.
- On local scholarships, national government should pay tuition while county governments cater for personal emoluments. But in a rejoinder, the committee suggested that national government should develop budgets to take up personal emoluments since counties paid salaries then personnel were transferred to other counties.
- On promotional courses, county governments were advised that it was a county function and therefore they needed to budget for training.

- On developing KMTCS in every county, counties were advised to partner with KMTC and national government in apportioning land and funds.

Group 3: Health Products and Health Technologies Committee

Appointed Committee Officials:

1. Dr William Muraah - CEC Health, Meru County (Chair)
2. Dr John Munyu - CEO, KEMSA (Co-Chair)
3. Dr Rose Rao - Chairperson, EMAK (Secretary)
4. Dr. Josephat Mbuva – Senior Deputy Chief Pharmacist, MoH (Co-Secretary)

Committee members:

1. Mr. Tai Mathew - CEC Health, Nandi County
2. Mr. Eliud Muriithi - Commercial Director, KEMSA
3. Dr Mary Wangai - Head of Department Standards QA & Regulation, MOH
4. Dr. Izaq Odongo -Head of Curative and Rehabilitation, MOH
5. Jackline Mainye -Sales & Marketing Manager, KEMSA
6. Dr George Walukara -Ag Customer Service Manager, KEMSA
7. Stephen Muchiri - HPP/USAID Program
8. Dr Elizabeth Ominde-Ogaja - CEC Health, Kisumu County

Terms of Reference:

Feedback mechanism for addressing key issues such as policy direction will be discussed and developed at a later date.

Committee's agenda:

Committee drew its agenda as follows;

- a. Need to combine private and public supplies and commodities under one umbrella.
- b. Need to follow up on legislation of supplies and commodities for the country
- c. Need to develop a more comprehensive National Formulary to be called Kenya National Formulary or 'KNF'
- d. It was noted that the current formulary is divided into two groups one of which is Essential Medical Supplies (EMS) comprising of the Essential Drug List (EDL). The EDL is limited and restrictive and thus urgent need to develop an expanded list that reflects the current needs and requirements of the counties.
- e. Develop list 2 to address other necessary drugs and commodities often used by the counties on a regular basis that are not in the essential drug list and or commodities list.
- f. List 2 is expected to be useful for level 4,5 and 6 Hospitals, and would greatly assist KEMSA with making stocks available for the often urgent requests by these higher tier facilities
- g. Review of National Formulary to be done on agreed regular intervals dictated by need.

- h. Need for a National/Central Information Data Base of supplies and commodities usage/need.
- i. The Data base should include all commodities including items such as implants
- j. Commodities/supplies Data Base should be linked to Clinical Data
- k. Paperless data was more useful as paper data proved to have insurmountable problems, particularly with donor supplies, stocking and projection.
- l. The committee took cognizance that county needs would be variable depending on matters such as bacterial sensitivities and geographical disease variation, among other factors.
- m. Counties should be encouraged to develop activities that determined their specific needs, both immediate and projected. This would greatly assist KEMSA with stocking and sourcing.
- n. KEMSA was of the experience that more often not much thought was placed by counties in their ordering processes.

Action Points

Committee identified the following action points;

- Essential for projection by KEMSA for sourcing purposes towards accurate stocking.
- CEC's to be sensitized and informed to perform surveys, such as on drug sensitivities, adverse effects, allergies, e.t.c.
- KEMSA should develop accurate consumption data
- Need for demand forecasting and quantification training at the counties
- Quality Assurance of commodities, supplies and technologies
- Linkages/representation of other committees in this committee necessary so as to incorporate matters of PPP
- Develop post sales and post marketing surveillance.
- Committee members noted that sometimes what KEMSA supplies is not what the patient buys or gets due to tampering with supplies

Payment

Committee members concluded that;

- MOU's need to be honored by counties
- The current agreement was 30 days yet certain counties were known to KEMSA to be repeat defaulters.
- Payment compliance strategies such as payment transparency through public publication of account statements should be used as tools to assist in compliance.

KEMSA Bill

Members agreed that the Act of 2013 was available in the public domain and that the Amendment Bill still at the Senate should be made available to committee members.

Next Committee meeting:

Program on how and when the committee will be meeting was to be finalized by members after the main forum.

Group 4: Health Service Delivery and PPP Committee

Appointed Committee Officials:

1. Mr. Wambu Miano - CEC Health, Kirinyaga County (Chair)
2. Dr. Wilson K. Aruasa - CEO, MTRH (Co-Chair)
3. Mr Leonard Mutai - CEC Health, Bomet County (Secretary)
4. Ms Rukiya M. Kahiya - CEC Health, Wajir County (Co-Secretary)

Committee members:

1. Ms Lily Koros Tare - CEO, Kenyatta National Hospital
2. Ms Gladys Momanyi - CEC Health, Nyamira County
3. Dr. Andrew Mulwa - CEC Health, Makueni County
4. Dr Jackson Kioko – Head, DPPHS, MoH 5. Dr Simon Kibias – Head, DDPM, MoH

Terms of Reference:

Committee lacked terms of reference though it envisaged the need for development to define way of progress. Main issues of focus for the committee included; On services-

- a. Implementation of Referral Strategy and strengthening health systems;
 - Interrogate strategy to buy in at all levels
 - There should be streamlined and improved services in facilities which are overstretched.
 - Should be anchored in law
 - Related policy should be reviewed together with implementation framework
- b. Capacity building in counties;
 - To reduce number of referrals to be handled at the lower levels
 - For quality service delivery
- c. Customer oriented service delivery;
 - To achieve quality and right attitudes
 - Ensure availability of infrastructure, equipment, commodities and personnel
 - Certification to quality standards and accreditation (Level II and III)

On Public-Private Partnership (PPP)-

- a. Identifying areas of engagement under PPP;
 - Leasing vis-à-vis purchasing
 - Areas of partnership i.e. laboratories, equipment and funeral services
- b. Interrogating the legal framework;
 - PPPs should have a social component supported by both national and county governments since not all are profitable.
 - Set structure of engagement.

Group 5: Joint M&E of Health Services and Quality Management Committee

Appointed Committee Officials:

1. Dr Susan Magada - CEC Health, Murang'a County (Chair)
2. Dr David Soti–Head, M&E, Health, Development and Health Informatics Division
Ministry of Health (Secretary)

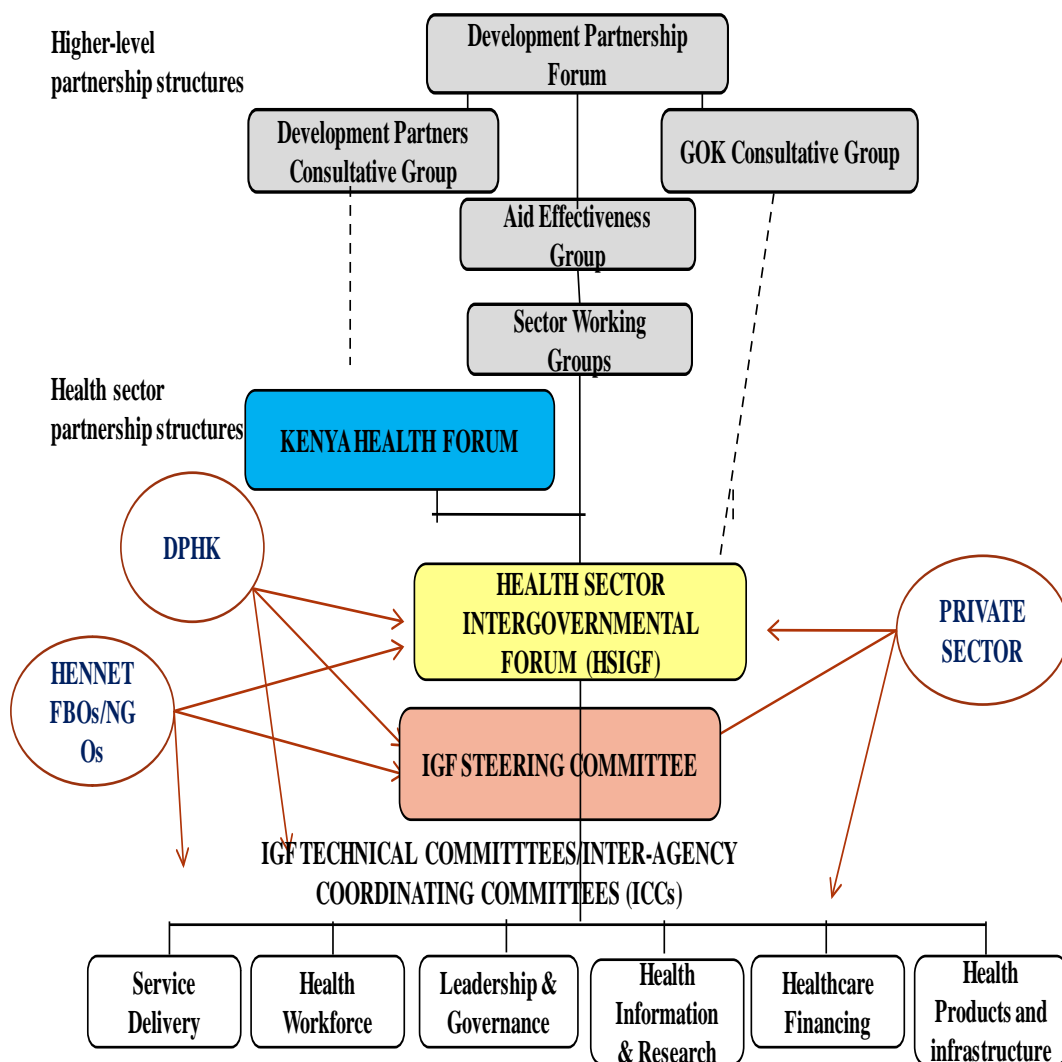
Committee members:

1. Ms Isabella Maina - Head of Monitoring and Evaluation, MoH
2. Dr Andrew Kwonyike - CEC Health, Baringo County
3. Ms Magdalene Njeru - CEC Health, Tharaka Nithi County
4. Ms Hellen Ngeno - CEC Health, Kericho County
5. Dr Mohamed Kombo - CEC Health, Lamu County
6. Ms Margaret Chepkwony – CEC Health, UasinGishu County
7. Mr. Peter Kung'u Mbugua - CEC Health, Nyandarua County
8. Mr. David Onchonga – Monitoring and Evaluation, MoH Samburu
9. Ms Mary Ekai – CEC Health, Samburu County
10. Dr Ruth Kitetu – Head, HSP&P Unit

A uniform Monitoring and Evaluation (M&E) framework already existed and members agreed on Program of Work as follows;

- Need clear Terms of Reference to guide committee
- Need situation analysis of existing M&E and quality assurance
- Need to develop consensus on indicators of interest based on the Constitution and other deeds.
- Suggest who should be in the M&E team to ensure quality assurance in the counties
- Ensure participation in the development of policy documents in order to harmonize M&E tools and quality management
- Disseminate all the M&E and quality assurance quality documents
- Joint M&E should be aligned to the county structures.
- Ensure reporting to IGA

Aid Effectiveness and Health Sector Partnership Coordination Framework, KHSSP 2014-18



**Review of Performance of Health Sector Intergovernmental Consultative Forum
(HSIGCF)**

2013 - 2017

Date: 3rd November 2017

Introduction

Based on a request by the Ministry of Health (MOH), JICA contracted services of a local consultant to carry out a review of the performance of the health sector HSIGCF over the period 2013 – 2017 to extract experiences and lessons learnt towards its future effectiveness and efficiency. The kick off meeting convened by MOH provided an opportunity for the ministry and other partners (JICA and WHO) to map out the strategy and activities towards successful implementation of the review exercise.

Participants

The following were in attendance;

1. Mr. Stephen Cheruiyot, Principal Economist, MOH
2. Dr. John Kihama, Head, IGA Unit, MOH
3. Mr. Elijah Kinyangi, Senior Program Officer, JICA
4. Dr. Martin Chabi, WHO

Agenda

The following were the items on the agenda;

- Contractual arrangements (JICA)
- Plan for Inception Meeting
- Division of labour among the stakeholders steering the process
- Logistical support for the consultant work
- Plan for the stakeholders' meeting
- Utilization of the final product
- AOB

Contractual Arrangements

JICA informed the meeting of signing of agreement with Mr. Kasmil Masheti, a local consultant, to undertake the assignment. The contract period ends on 8th December 2017 with submission of the final product. JICA shared a copy of the letter to Principal Secretary, MOH, notifying Masheti's contract and requesting for support and cooperation for the exercise.

Plan for Inception Meeting

- Date: Wednesday, 8th November 2017
- Time: 0900hr EAT
- Venue: MOH (specific room to be informed)
- Participants: MOH, COG, JICA, WHO, DPHK Secretariat
- Invitation: To be sent out by MOH (on 3rd November 2017)
- Inception Note: To cover Consultant's understanding of the TOR, proposed approach and methodology, detailed work plan and activities, any special considerations and deliverables
- Output: Consensus on technical approach, methodology, work plan and deliverables

Division of Labour**Ministry of Health:**

- Arrange courtesy calls to MOH top management and COG as may be necessary
- Organization of the Inception Meeting and Stakeholders' Workshop
- Provide all necessary documents to the Consultant for reference
- Prepare the survey tool (s) by sharing the draft with core group (JICA, WHO, DPHK Secretariat) for input and finalize together with Consultant ahead of the inception meeting
- Provide stewardship and technical guidance to the Consultant
- Endorsement and ratification of the final product by MOH and HSI GCF

JICA:

- Management of contract with the Consultant
- Technical input to the review exercise
- Support for day conference package for stakeholders' workshop
- Submit final product (Report) to MOH

WHO:

- Provide technical support to review exercise through Country office (Dr. Hillary Kipruto) and the regional office (to be confirmed). This may include joining interviews with key informants, analysis of responses and development of the HSI GCF operation manual, SOPs and tools in the context of the health sector partnership and coordination framework
- Financial support for the stakeholders' workshop
- Support for utilization of the review report in operation of the HSI GCF

CONSULTANT:

- Prepare and present the Inception Note to the steering team on 8th November 2017
- Conduct desk review of relevant documents and materials
- Dispatch the survey tool (s), conduct key informant interviews, telephone calls, collect and collate responses
- Prepare the draft report for stakeholders' workshop

- Provide technical input during the stakeholders' workshop and collect feedback to finalize the report
- Prepare and submit final report to JICA as per the contract arrangements
- Undertake such other tasks that may be necessary for proper execution of the assignment within the TOR

Logistical Support

The MOH and Partners will:

- Provide the necessary documentation required for the exercise
- Support necessary linkages with top management at MOH and COG
- Provide Consultant with an introductory letter to various agencies identified for the exercise
- Communicate with all the target former County Executive Members for Health and inform them of the exercise and their expected contribution
- Accompany the Consultant to key informant interviews as necessary
- Provide supplementary support that is required to have in-depth discussions with the former leadership of the CECs forum (Dr. Siminyu, Dr. Mulwa, Dr. Kombo, Dr. Ogaja) either in Nairobi or specific locations where available for value addition to the review exercise

Plan for Stakeholders' Workshop

- Date: Between 27th November and 1st December 2017 **(2.5 days)**
- Venue: To be arranged by JICA (based on day conference package)
- Participants: To be confirmed by MOH (30 – 40 pax)
- Invitation: To be sent out by MOH
- Transportation: WHO (for external participants from outside Nairobi)
- Accommodation: WHO (for external participants from outside Nairobi)

Utilization of the Product (Report)

- To be undertaken in line with proposals made in the TOR
- WHO AFRO may provide technical support in this phase.

AOB

The Consultant to make immediate contact with MOH focal point to further discuss the way forward

END

Annex 7: Minutes of Inception Meeting on Review of the Health Sector IGF

VENUE: GTZ BOARD ROOM

DATE: 8th NOVEMBER 2017

TIME: 9:30AM-11:15AM

IN ATTENDANCE

	Name	Organization
1	Dr. O.A Omar	MOH (Chair)
2	Joseph Gichimu	MOH
3	Dr. Regina Mbindyo	WHO
4	Joy Njeri	MOH
5	Esther Kamau	COG
6	Elijah Kinyangi	JICA
7	Dr. Consolata Ogot	MOH
8	Kasmil Masheti	Consultant

The meeting was called into order at 9:30am by the chairperson and the agenda was:

1. Introductory remarks
2. Consultant scope of review
3. Input session
4. Way forward
5. AOB

Minute 1:08/11/2017- Introductory remarks

The chair welcomed members and they were given a chance to introduce themselves.

Minute 2:08/11/2017- Adoption of the agenda

Members were taken through the agenda for the meeting which was then adopted.

Minute 3:08/11/2017: Minutes confirmation

The members were taken through the notes of the kick off meeting of Health Sector IGF performance review. The members agreed to pick up any outstanding issues as part of the inception meeting

Minute 4:08/11/2017: Consultant scope of review

The consultant took the members through the scope of review of the health sector intergovernmental consultative forum for efficiency and effectiveness that he had prepared in readiness to kick off the exercise.

Minute 5:08/11/2017: Inputs from the members

- The consultant was urged to incorporate best practices both from local and international sectors.
- Involvement of legal mechanisms/instruments is paramount to an effective IGF which conforms to our Kenyan constitution.
- The members agreed to scale down the number of stakeholders during the workshop meant to review the draft report prepared by the consultant.
- FGD with development partners who have been involved in IGF process like WHO, JICA, USAID is prudent in exploring their expertise and incorporating their inputs.
- Synthesizing the past IGF proceedings in one document should be done as a separate assignment since it will be very much labor-intensive.
- The IGF manual would be reviewed by stakeholders before finalization.

Way forward

1. Time constrain was foreseen as factor to hinder efficient review. In regard to this, the consultant will give feedback on the progress made, on 23rd November 2017 in a stakeholders' meeting.
2. Questionnaire will be shared with the stakeholders for review and inputs but this should not hinder progress of the review due to limited time.

AOB

The members ascertained to accord the consultant support and urged him to reach out if need be.

**Reviewing the health sector intergovernmental consultative forum
for efficiency and effectiveness**



Afya house GIZ Conference Room
8th November, 2017
0900h

Scope of the review

Broadly

- Review the experience of 2013 – 2017 to improve and re-align the IGF so that it can perform its role in the sector more efficiently and effectively.
- Review the position of IGF in the proposed health sector coordination and partnership framework to strengthen its capacity to guide sector partnership, coordination, planning, implementation and review processes.

Specifically

- Map the instruments of intergovernmental relations
 - Provide a synthesis of proceedings from the IGF and its thematic committees
 - Outline achievements, challenges and lessons learned
 - Recommend improvements
- 
- Review past and present
- Recommend relevant structure, tools, guidelines and processes
 - Develop an IGF operations manual 2017 - 2022
- 
- Propose future

Specific subject matters

- Purpose and process for conducting IGF
- TOR
- Roles of members
- Preparation of the forum
- Agenda and schedule setting
- Communication mechanism
- Activities of each thematic group

- Follow mechanisms for agreed actions
- Financial arrangement / cost sharing
- Participation and continuity
- Expected outcome
- Achievement and deliverables
- Constraints/obstacles that prevent achievement of objectives of the forum

Approach and Methodology

- The consultant will lead the review process supported by MOH and development partners
- Respondents will be purposively selected from MOH, National Institutions (KEMSA, KNH, NHIF) CoG, CECs and development partners based on their involvement in the IGF processes
- Information to determine efficiency and effectiveness of the IGF will be collected in line with review objectives outlined in the TOR and based on the following approaches;
 1. Desk/Document review
 2. Key in-depth interviews (Face to Face and Phone)
 3. Questionnaires
 4. FGD

1. Desk/Document review

Legislative framework (Establishes the structures)

i) The Kenya constitution 2010 (Schedule 4)

- Distribution of functions between National and the County governments

ii) Intergovernmental relations Act 2012

- Establishment of intergovernmental relations structures (Part II)
 - National and County Government Co-ordinating Summit
 - Intergovernmental Relations Technical Committee with sectoral working groups
 - Council of County Governors
- Transfer and Delegation of powers, functions and competencies (Part III)
- Dispute resolution mechanisms (Part IV)

1. Desk/Document review

Legislative framework continued

iii) Transition to devolved government ACT 2012 (Part III)

- Outlines phased transfer of functions

iv) Kenya subsidiary legislation (Legal notice No. 16 and 137)

- Transferred functions

v) The Health Act 2017 (Part IV)

- **Kenya Health Sector Intergovernmental Consultative Forum**

Establishment, purpose, meetings and conduct of business.

1. Desk/Document review

Operational framework (Brings the structures to life)

- i) TOR's of the Intergovernmental consultative forum and its thematic technical committees
- ii) SOPs (Draft SOP on IGF operation and thematic technical committees)
- iii) Concept notes
- iv) Budgets
- v) Reports of the 10 IGF meetings (2013 – 2017)
- vi) Other documents relevant to the review

2. Key in-depth interviews (Proposal)

Face to Face interviews	Phone interviews
<ol style="list-style-type: none">1. Dr. Jackson Kioko DMS2. Dr. Patrick Amoth H/HSCIGA3. Dr. John Kihama H/IGA4. Dr. Andrew Mulwa CEC Makueni/Chair5. Dr. Bernard Muia CEC Nairobi6. Dr. Omar Ahmed Omar Head/THS UC Project7. Gibson Muhuhu NHIF8. Dr. John Onge'chi KNH9. Eliud Muriithi KEMSA10. COG Health Committee COG11. Mr. Sakwa Buliba Chief Rapporteur/IGF	<ol style="list-style-type: none">1. Former Chair CEC's2. Former vice chair CEC's3. CEC's Elgeyo Marakwet Kisii, Kwale, Mandera, Bungoma, Mombasa, Nyeri, Nakuru and Meru

3. Focus Group Discussions

- Selected MOH officers (HODs)
 - This group could also be interviewed in case it is not possible to get them together
- Selected DPHK members
 - Respondents will be drawn from development partners who have been involved in the IGF processes

4. Questionnaires

Questionnaire survey (By mail)

- Other CEC's not interviewed
 - Agree on names
- Chief officers/Directors
 - Confirm if these have been involved in the process

Work plan

Activity/Task	Responsibility	Time frame
Desk Review of relevant documents and reports from the IGF	Consultant	Ongoing
Inception Meeting with MOH, JICA and Other Stakeholders	MOH	8 th Nov 2017
Dispatch of Questionnaires to Selected Respondents	Consultant	9 th Nov 2017
Key Informant Interviews with MOH, COG, Parastatals	Consultant	13 th – 16 th Nov 2017
FGDs with MOH and DPHK	Consultant	16 th – 17 th 2017
Collection and Collation of Responses to Questionnaires	Consultant	22 nd Nov 2017
Preparation and Submission of the Draft Report	Consultant	24 th Nov 2017
2.5 – Day Retreat to Review Draft Report	MOH	29 th Nov – 1 st Dec
Submission of Final Report	Consultant	8 th Dec 2017

Special considerations

1. For this assignment to be completed within the timeframe allocated;
 - No travel out of Nairobi is planned
 - The face to face interviews will be confined to respondents who will be available in Nairobi
 - In case MOH HODs are not available for FGD, we propose to conduct in-depth interviews with some of them
 - If MOH will be able to coordinate a number of CEC's to be available in Nairobi, we shall consider an FGD with them
2. MOH and JICA will be responsible for the inception meeting and Stakeholders workshop
 - The consultant will be present to provide technical input and receive input on recommendations

Deliverables

1. Detailed 15 – day work plan covering the assignment period.
2. Draft IGF review report
3. IGF operations manual
4. Final IGF review report

Input session

Annex 8: Minutes of the Progress Review Meeting

VENUE: MOH, UPPER GROUND FLOOR ROOM 12B

DATE: 23RD NOVEMBER 2017

TIME: 14:30 - 16:00HR

IN ATTENDANCE

	Name	Organization
1	Mr. Stephen Cheruiyot	MOH / Chair
2	Dr. John Kihama	MOH
3	Dr. Jackson Omondi	MOH
4	Mr. Elijah Kinyangi	JICA
5	Dr. Chabi	WHO
6	Mr. Kasmil Masheti	Consultant

The meeting commenced at 1500hr chaired by MOH and the agenda included:

1. Opening remarks by Chair
2. Consultant Progress
3. Discussion on the Progress
4. Way forward
5. AOB Minute

1:23/11/2017- Introductory remarks

The chair welcomed members to the meeting and highlighted its purpose as reviewing progress of the survey by Consultant.

Minute 2:23/11/2017- Adoption of the agenda

The agenda was adopted as indicated herein.

Minute 4:23/11/2017: Consultant Progress Report

The consultant reported the progress made with interviews and questionnaire surveys with respondents. The following were the key highlights of progress made;

- (1) Consultant had made commendable progress with interviews given the tight timeline and availability of respondents. He shared a matrix with schedule of interviews with various respondents highlighting interviews completed, pending and those cancelled
- (2) Previous term CECs for health had proved to be difficult in responding to the questionnaire sent to them
- (3) A number of key previous CECs had responded to phone interviews with the Consultant
- (4) Priority was to interview DMS/Dr. Amoth, Dr. Wangai, Dr. Omar (MOH), Dr. Mulwa, Dr. Ogaja (leaders of the CEC Forum), KEMSA, Sandra (DPHK), and expand the target respondents to include interviews with the Agriculture Secretariat of the HSIGCF (JASSCOM) and the Intergovernmental relations technical committee (IGRTC)
- (5) The Consultant requested to be given time to complete all the interviews by Wednesday 29th November 2017.

Minute 5:23/11/2017: Discussions

In view of the progress reported by the Consultant and going forward, it was agreed that;

- (1) The steering group agreed to allow the Consultant time to complete the outstanding interviews and reach out to the expanded target organizations in order to consolidate indepth information sufficient for the review
- (2) The Consultant will then submit the preliminary report by COB on Friday 1st December 2017 to the steering group (MOH, JICA, WHO, COG, DPHK Secretariat) for review
- (3) Instead of the stakeholder workshop as earlier planned, the steering group agreed to hold a technical meeting to discuss the preliminary report on Wednesday 6th December 2017 at MOH. Participants would be drawn from MOH, COG, JICA, WHO, DPHK Secretariat, KEMSA and NHIF
- (4) The Consultant will submit Final Report to JICA on 8th December 2017 as per Contract
- (5) MOH will use the Final Report by the Consultant for further engagement with top leadership within the Ministry and further with sector stakeholders at a workshop to be convened later on probably in January 2018. The Consultant agreed to provide technical input to the workshop.
- (6) The Final draft will be used for induction of the incoming CECs for health once the meeting is scheduled in conjunction with COG
- (7) The proposals on strengthening the Health Sector HSIGCF as contained in the Final Report by the Consultant will be presented to the full HSIGCF for review and adoption

Way forward

MOH to schedule the technical meeting on 6th December 2017 at Afya House and send invitation to target participants

AOB

None

Annex 9: Minutes of Technical Meeting on the Preliminary Report

VENUE: BOARDROOM, WHO COUNTRY OFFICE

DATE: 6TH DECEMBER 2017

TIME: 09:50 - 14:00HR

IN ATTENDANCE

	Name	Organization
1	Mr. Stephen Cheruiyot	MOH / Chair
2	Dr. Jackson Omondi	MOH
3	Mr. Joseph Gichimu	MOH
4	Ms. Joan Manji	KEMSA
5	Mr. Elijah Kinyangi	JICA
6	Dr. Regina Mbindyo	WHO
7	Ms. Kumiko Yoshida	MOH / JICA
8	Dr. Meshack Ndolo	CoG
9	Ms. Sandra Erickson	DPHK Secretariat
10	Mr. Kasmil Masheti	Consultant

The meeting was hosted by WHO and chaired by MOH and the agenda included:

1. Introductions
2. Opening remarks by Chair
3. Presentation by Consultant
4. Discussion
5. Way forward

Minute 1:06/12/2017- Preliminaries

The standard meeting preliminaries were completed through guidance from the chair.

Minute 2:06/12/2017: Consultant Preliminary Report (Presentation)

The consultant made a presentation highlighting findings from the review exercise as contained in the preliminary report. The presentation covered the following key areas;

- (1) Challenges in the Survey: There were no responses to the questionnaire sent to previous CECs outside those targeted for interviews. The CECs that had own plans to visit Nairobi to possibly have a face-to-face interview with the Consultant did not make it.
- (2) Legal instruments that govern intergovernmental relations and legislative & policy issues to note
- (3) General notes and features of the HSI GCF at its inception phase
- (4) The structure of HSI GCF and conduct of business
- (5) Resources for the operation of HSI GCF process
- (6) Major considerations including institutionalization of HSI GCF and opportunities to influence sector performance
- (7) Conclusions and recommendations
- (8) Proposed structure and draft outline of the HSI GCF operations guide

Minute 3:06/12/2017: Discussions

In view of the presentation made by the Consultant the following issues were raised for discussion;

- (1) The need for harmonization of approaches across the legislative framework (Constitution of Kenya, Intergovernmental Relations Act 2012, Kenya Health Act 2017) that governs the HSI GCF and other instruments such subsidiary legislations, gazette notices, County legislations and the proposed HSI GCF operations guide
- (2) Appropriate referencing of remarks or comments made by various respondents that are specifically captured in the report is necessary
- (3) Elaboration of the major factors that promoted and / or hindered participation of CECs at the HSI GCF and those that accounted for delegation by higher authorities
- (4) Indication of the major reasons why the HSI GCF meetings were frequently postponed
- (5) Highlighting of the Constitutional provision that provides for mutual respect, consultation and cooperation between the two levels of government
- (6) The applicability of the Agriculture sector model (JASSCOM) to the health sector
- (7) The uniqueness of the health sector HSI GCF particularly in the context of the citizens' right to health and wellbeing as mandated by the Constitution of Kenya
- (8) Technical assistance and facilitation of Thematic Technical Committees (TTCs) to collect and synthesize key sector issues from diverse sources of information such as government agencies, private sector, civil society, academia, research institutions, case studies, best practices locally and internationally and public participation. TTCs should be

able to set up standing committees and ad-hoc working groups composed of persons with the technical knowledge of the subject at hand

(9) Mainstreaming the HSIGCF in National and County Government schedule of functions to enable leadership at the 2 levels recognize its value and support participation and engagement in the process

(10) Strengthening M&E for the HSIGCF

(11) Leadership and secretariat support for the HSIGCF

(12) Identification of key actors for governance, oversight and implementation and appropriate structure for executive decision making in support of HSIGCF resolutions

(13) Agenda setting should be seen in the context of health sector priority issues across time as opposed to issues to be discussed at specific meetings

(14) Addition of a section on key issues that MOH should take into account in finalizing the operations guide for the HSIGCF

Minute 3:04/12/2017: Way forward

The Consultant to incorporate the outputs from the meeting and submit the Final Report to JICA as scheduled

Upon receipt from JICA, MOH shall process the Report within its leadership and management structures with a view to debriefing relevant officers and organizing the stakeholder workshop to collect further views and inputs on the proposals made by the Consultant in the Draft Operation Manual for the IGF

**Reviewing the Health Sector Intergovernmental Consultative Forum
for efficiency and effectiveness**

WHO Office
6th December, 2017

Scope of the review

Broadly

- Review the experience of 2013 – 2017 to improve and re-align the IGF so that it can perform its role in the sector more efficiently and effectively.
- Review the position of IGF in the proposed health sector coordination and partnership framework to strengthen its capacity to guide sector partnership, coordination, planning, implementation and review processes.

What the review set out to do

- Map the instruments of intergovernmental relations
- Outline achievements, challenges and lessons learned
- Recommend improvements
- Recommend relevant structure, tools, guidelines and processes
- Develop an IGF operations manual 2017 - 2022

Approach and Methodology

- Consultant lead the review process supported by MOH & CoG and JICA
- Respondents were purposively selected from MOH, CoG, CECs, SAGAs and development partners based on their involvement in the HSI GCF process, and other sectors
- Information was collected in line with review objectives outlined in the TOR and based on the following approaches;
 1. Desk/Document review (Legislation, Reports, SOP's, TOR's, Minutes, Manuals e.t.c)
 2. Key in-depth interviews (21 respondents)
 3. Questionnaires (S32 R1)
 4. FGD (2)

Findings

Instruments of Intergovernmental relations

Findings show that there is a legal framework that supports establishment and conduct of business for the HSI GCF

The Kenya constitution 2010

- **Schedule 4** outlines distribution of functions between National and the County governments, **Article 189** of the constitution and **article 4** of the intergovernmental Act 2012 outline principles of intergovernmental relations
- **Intergovernmental relations Act 2012**
- Establishes a framework for consultation and co-operation between National government and county governments County governments amongst themselves
 - National and County Government Co-ordinating Summit
 - Intergovernmental Relations Technical Committee with sectoral working groups
 - Council of County Governors
 - Transfer and Delegation of powers, functions and competencies (Part III)
 - Dispute resolution mechanisms (Part IV)
- Section 13 (2) of the Act delegates power to the Cabinet Secretary to convene consultative fora on sectoral issues of common interest to the two levels of governments.

Instruments of Intergovernmental relations

Transition to devolved government ACT 2012 (Part III)

- Outlines the procedure for phased transfer of functions
- Provides a criteria for the transfer of functions

Kenya subsidiary legislation (Legal notice No. 16 and 137-183)

- Transferred functions

The Health Act 2017 (Part IV)

- Establishes the Kenya Health Sector Intergovernmental Consultative Forum

Legislative and policy Issues to note

- The Health Act 2017 defines membership to the HSI GCF as;
 - Director-General for health or a designated representative and
 - Each County Director of health or a designated representative
- The Kenya health policy 2014-2030 outlines mechanisms for intergovernmental relations in health but does not provide a framework for conduct of business.

The inception phase of the Health Sector Intergovernmental Consultative Forum (HSIGCF)

- HSIGCF was established in 2013 and has been convened ten (10) times with the last meeting held in May 2017
- All respondents believe it provides a good platform for consultation and cooperation on health matters between the two levels of government

General notes on the inception phase

- The preparatory phase involved several discussions between the ministry of devolution, Ministry of Health and county governments
- Some of these meetings happened in 2013 before formal **transfer of functions**
- The forum was launch without a clear definition of **roles and responsibilities** for actors
- There was no plan on how to **finance** the HSIGCF processes
- Participants in the initial meetings observed some **mistrust** between the two levels of government
- Discussions became **acrimonious** at times potentially undermining the consultation process.

The Structure

- The Health Sector Intergovernmental Consultative Forum brings together the following actors;
 - CS for Health
 - 47 CECs
 - Senior Officers from the MOH
 - CEOs of Semi Autonomous Government Agencies (SAGAs)
 - Representatives of Development Partners.
- The forum has established five Thematic Technical Committees (TCCs)
 1. Health Care Financing
 2. Human Resource for Health
 3. Health Products and Health Technologies
 4. Health Service Delivery and PPP
 5. Joint Monitoring and Evaluation of Health Services and Quality Management.
- TCCs were proposed in the first HSI GCF meeting but only became functional during the sixth meeting.
- It is reported that TCCs were not balanced in knowledge and skills and convened a day before HSI GCF meeting

Conduct of Business

Attendance and Frequency of meetings

- Attendance and frequency was characterised by inconsistencies by both levels of government
- Officials and CEOs often sent representatives, while some members only attended occasionally
- Meetings were often postponed

Factors affecting attendance include;

1. Parallel sector meetings
2. Late communication within a busy schedule
3. Members engaging in personal issues around Nairobi
4. Monotony of venue
5. Lack of ownership for the process among the actors

Noted Consequences

- Cancellation costs
- Meetings conducted without sufficient quorum at times

Factors affecting frequency and timing of meetings

1. The transition period presented competing priorities
2. Lack of a dedicated budget for HSIGCF activities
3. No schedule for the meeting to facilitate advance planning
4. Bureaucratic communication process

Conduct of Business

Discussions during meetings

- Quality of discussions improved over time with growing awareness on role of the HSI GCF and responsibilities of actors
- Some members describe the first meetings as acrimonious and of **talk show** in nature
- Discussions were **plenary and technical**, but the plenary sessions provided a learning opportunity for those from other sectors outside health.
- CEC's from other sectors outside health lacked technical knowledge and experience in the health sector and did not get enough time to be briefed by their technical teams
- Initially, discussions were faced with hostility but interpersonal relations improved mid-way and the process became friendly

Conduct of Business

Decision Making:

- Consensus is identified as the method for decision making but some members question whether the HSI GCF as constituted is a decision making forum
 - Recommendations have been made to seek **political goodwill**
 - Most respondents desire to see more issues filtering to the CoG and the Summit.

Conflict resolution:

- Initially, participants took positions on issues during meetings but later objectivity improved
- Some issues appeared complex leading to resolutions and interventions away from the forum meetings
 - Industrial action by health workers
 - Managed Equipment Service project (MES)

Conduct of Business (TTCs)

Tracking implementation of resolutions and recommendations

- Frustration have been expressed over lack of a mechanism to ensure resolutions and recommendations made are implemented
- TTCs were involved in taking stock and reporting on issues of common interest, resolutions of previous meetings, progress and action points.
- TTCs lacked dedicated resources, and some had to make calls for updates during the forum

Leadership of TTCs/continuity/membership/discussions

- TTCs had officials but number and distribution were not standardised
- Co-chair and Co-secretary concept adopted to enable meetings to proceed in case of absence

(Reservations expressed by CECs about the CS sending representatives who are not their counterparts to discuss policy matters)

Conduct of Business (TTCs)

- Some respondents believe TTC discussions should focus on identifying policy and legislation gaps and make position papers for discussion by the HSI GCF.
- TTCs advocate for a structured capacity strengthening program

Examples of what should continue

- Finance and HRH were supported by partners to conduct meetings away from the HSI GCF.
- Support by World Bank to the finance committee yielded a learning trip to Zimbabwe
- A group visited Japan together with NHIF to learn about Japan's experience in attaining universal health coverage.
- Joint Agriculture Sector Steering Committee (JASSCOM) has a TA arrangement in place that could provide lessons to HSI GCF.
- Some CECs changed midway and others have been dropped which may negatively impact continuity
- It took long to create cohesion within teams and this may be repeated with the changes in CEC's

Conduct of Business (TTCs)

Documentation of TTCs and HSI GCF meetings and archiving

- HSI GCF meeting reports exist and they include TTC reports
- TTCs did not following a standard format of reporting.
- There wasn't sufficient time available for participants to fully interrogate the TTC reports
- Other documents available include TORs, talking points, a description of functions e.t.c

Comments

- Strong records management has been recognised in the Kenya Open Government Partnership process as the backbone of transparency and accountability,
- HSI GCF should put in place a structured and robust information sharing system to strengthen these values.

Resources

Funding of HSI GCF/TTCs meetings and proposals on sustainability of HSI GCF

- Launched with no concrete plan and budget to finance its operations.
- Funding arrangement later agreed to be done jointly by counties and MOH (DP's have supported MOH)
- Development partners noted that requests for support came in last minute
- A budget was developed and included in the concept note of 2015/16 but not funded

Comments

- Produce an annual schedule with budget for the HSI GCF process
- Sector leadership should discuss funding arrangements between national and county governments.

Major considerations

- Institutionalising the HSI GCF process across the health system will create;
 1. An all-inclusive process that is acceptable to as **issues filter** from one stage to the other (Example of JASSCOM, EAC, Health sector coordination structures)
 2. A change in **attitude, mind-set and commitment** by all to avoid undermining the gains made (OGP process in sierra Leone)
 3. Shared vision and enhanced **mutual trust** and **accountability** (OGP process in Sierra Leone)
- Opportunities for the HSI GCF to positively influence the sector performance
 1. NHIF service level agreements (Policy gap on service contracting)
 2. KEMSA support for O&M of regional depots shared with National Vaccines & Immunization Program (NVIP) of MOH (negotiated agreements between KEMSA and NVIP)
 3. Donors bilateral agreements with the national government can facilitated support through intergovernmental relations.
 4. Block funding or oversight services that are still managed at the national level like NHIF, research through KEMRI, national programs like HIV, TB, Malaria, Reproductive Health e.t.c

Major considerations

Aligning HSI GCF structure to the numerous instruments under intergovernmental relations will facilitate;

- Creation of synergies across the system and reduce duplication/redundancies
- Provide an **enforcement mechanism** for decisions made at the forum
- Most respondents prefer quarterly meetings for technical teams to package policy briefs that filter to the main HSI GCF
- Respondents prefer an **outcome document** (Communique), **policy briefs and position** papers to facilitate communication within the structures
- Existing sector partnership frameworks should be explored since HSI GCF is anchored in law
- Establish a secretariat to support administration and coordination of the alignment

Conclusions and recommendations

- Refer to the report

Proposed HSIGCF structure

Composition of the HSIGCF

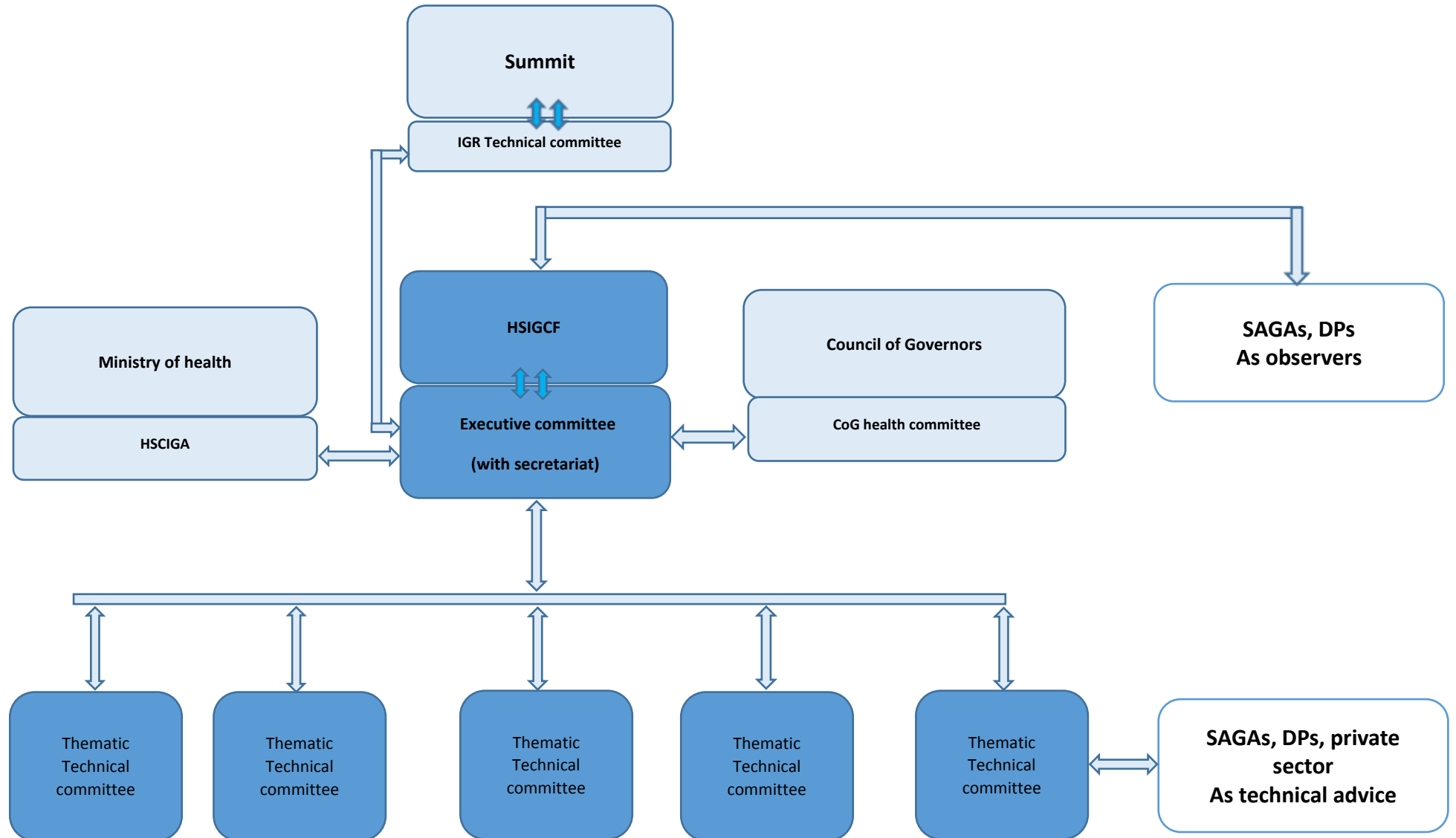
- CS (Chair)
- Chair CEC council (Co-Chair)
- CoG health committee
- 47 CECs
- PS, DMS MOH (HODs)
- SAGAs (Invitation)
- DPs (invitation)

Composition of the executive comm.

- CS/MOH
- DMS
- COG / Health Committee
- Secretariat

Composition of TTC

- MOH
- County Directors for Health
- SAGAs
- DP (Invitation)



Draft copy available

Thank you



MINISTRY OF HEALTH

TOR FOR REVIEWING THE HEALTH SECTOR INTERGOVERNMENTAL CONSULTATIVE FORUM FOR ITS EFFICIENCY AND EFFECTIVENESS

Background

The Constitution of Kenya 2010 provides for the right to the highest attainable standards of health to every Kenyan, and places a fundamental duty on the State to take legislative, policy and other measures, including the setting of standards, to achieve progressive realization of the rights set out under Article 43, which include the right to health. These constitutional provisions determine the roles and obligations of the health sector to facilitate progressive realization by all to the right to health. Schedule 4 of the Constitution assigns to the County Governments the function of delivering essential health services and the management of human resources for health, and to the National Government the functions of stewardship for health policy, development of norms and standards, Capacity building, technical assistance to counties and oversight of national referral health facilities.

The national government is supposed to perform the above functions through modulation in the health sector via promoting public interest, proposing strategic direction, mobilizing resources, protecting consumers evaluating performance; systems development through policy formulation, strategic planning, priority setting and intersectoral advocacy.

The national government should also take the lead in coordination of sector players, financial design, strategic purchasing, budget caps and health regulation.

In order to deliver on the above mandate, the devolution of health service delivery presents opportunities and challenges to the health sector that together determine the effectiveness of service delivery and the character of the overall health system.

HEALTH SECTOR INTERGOVERNMENTAL CONSULTATIVE FORUM

The Intergovernmental Relations Act 2012 establishes a framework for consultation and co-operation between the national and county governments and amongst county governments; to establish mechanisms for the resolution of intergovernmental disputes pursuant to Articles 6 and 189 of the constitution, and for connected purposes. Pursuant to provisions of the Intergovernmental Relations Act, the health sector established an Intergovernmental consultative forum (hereinafter referred to as IGF) between the County Health Departments represented by the County Executive Committee Members of Health and the National level represented by the Cabinet Secretary, the Principal Secretary, the Director of Medical Services and Heads of Departments at the Ministry of Health.

The IGF has been convened ten (10) times during the 5 year term of 2013-2017. As this was the transition period to devolution, there are a lot of lessons learnt, both in the implementation of devolution in the health sector and also mechanisms to address articulation and coordination of emerging issues in both levels of government. Among the thorny issues included ways and means of addressing the human resource transition, frequent shortages of drugs in health facilities, deteriorating service quality and disruptions in reporting and accountability mechanisms. The documentation of these experiences can improve the efficiency and effectiveness of the IGF to ensure that it is strengthened to deliver on its mandate in the new government term of 2017-2022.

The Intergovernmental Forum convened in May 2017 recommended a review and documentation of the critical lessons learned from the previous IGFs in the health sector with their purpose of identifying the main challenges as establishing a balance between the natural evolution of intergovernmental relations and the need for prescription. It also called for a review of the multiple structures established to promote intergovernmental relations and for proposals to improve the weak intergovernmental relations between national and county governments.

Scope of the assignment

The purpose of this assignment is to use the experience of 2013-2017 to improve and re-align the IGF so that it can perform its role in the sector. The now-approved Health Sector Partnership Framework identifies the IGF as the core forum for guiding and

enabling sector partnership and joint health sector coordination, planning, implementation and review processes. This is a new expanded function for the IGF and it would be useful for the TA to identify strengths, challenges, and opportunities for expanding and transforming the IGF into this new role. The specific key areas to review will be the purpose, perception/expectation and process for conducting IGF including roles of members, preparation of the forum, agenda and schedule setting, communication mechanism, activities of each thematic group, following up the agreed actions from the previous IGF, financial arrangement, participation and continuity, expected outcome, achievement and deliverable, constraints/obstacles that prevent achievement of objectives of the forum etc.

Objective of this assignment

The core objectives of this work are as follows:

1. To provide synthesis of the proceedings from the 10 conventions of the IGF and its thematic technical committees
2. To map the numerous instruments of intergovernmental relations, intergovernmental processes, and the current reality of intergovernmental relations across the different levels of government
3. To outline the key achievements, challenges and lessons learnt in addressing issues in the health sector
4. To engage stakeholders so as to develop an IGF operations manual for the 2017 – 2022 term based on the SOP proposed in the previous term
5. Further to findings obtained in (4) recommend relevant structure, tools, guidelines and processes that can improve the efficiency and effectiveness of the IGF Health and its committees.

Specific Tasks to be undertaken by both MOH and Consultant

The specific tasks include the following, among others:

1. Desk review of relevant literature, including the intergovernmental relations act (2012), TORs of the IGF and its thematic technical committees, draft SOP on IGF operation and all the reports of the 10 IGF meetings
2. Conduct an inception meeting with MOH and stakeholders

3. Conduct Key in-depth interviews and focus group discussions with relevant stakeholders drawn from National Government, devolved government (former CEC Members of Health), development partners (DPHK), Council of Governors Secretariat, Parastatals (NHIF KEMSA, KNH), as per attached list with the aim of collecting and collating their views on the subject
4. Send the short questionnaire prepared by MOH to other former CEC Members of Health outside the selected interview pool, DPs and other stakeholders to collect their views on key issues around operations of the IGF. MOH shall provide the list and contact information of target questionnaire respondents
5. Review the position of IGF in the proposed health sector coordination and partnership framework and recommend suitable linkages for effectiveness
6. Develop an IGF operations manual, including (but not limited to) Institutional arrangements, tools, processes and guidelines / SOP
7. Facilitate workshop with key stakeholders to receive input on recommendations in (5) above
8. Finalize the report and proposals for strengthening IGF to be presented to the regular health sector IGF.

Activities, Deliverables and Timeframe

The duration for the work will be 4 weeks with the deliverables outlined in the table below.

No.	Activity / Task	Responsibility	Time Frame
0	Signing of Contract	JICA and LC	Start Date
1	Desk Review of relevant documents and reports from the IGF	MOH and LC	Week 1
2	Inception Meeting with MOH, JICA and Other Stakeholders	MOH / JICA / LC	Week 1
3	Dispatch of Questionnaires to Selected Respondents	LC	Week 1
4	Key Informant Interviews and FGDs	LC and MOH	Week 2

	with MOH, COG, Parastatals (NHIF, KEMSA, KNH), Selected CECs and DPHK		
5	Collection and Collation of Responses to Questionnaires	LC	Week 2
6	Preparation and Submission of the Draft Report	LC	Week 3
7	3 – Day Retreat to Review Draft Report	MOH / JICA / LC	Week 4
8	Submission of Final Report	LC	Week 4

Note: The LC shall prepare and submit a detailed 15 – day work plan covering the assignment period.

Draft contents of the IGF Report

- Introduction
- Background
- Legal framework of intergovernmental forums
- Key findings from the previous Health Sector Intergovernmental forums
- Structures of HSIGCF
- Composition of HSIGCF
- Agenda setting – who sets the agenda
- Committees and their modus operandi
- Attendance of IGF and frequency of meetings
- Tracking the implementation of resolutions and recommendations of previous IGF
- Schedule of activities and programming of HSIGCF meetings
- Leadership of TTCs
- Continuity of TTCs /membership/discussions
- Documentation of TTCs and HSIGCF meetings and archiving
- Funding of HSIGCF/TTCs meetings and proposals on sustainability of HSIGCF

Utilization of IGF Review Report

Outputs of IGF Review	Details	How	Timeframe
Clearly provide proposals on how resolutions /recommendations will be escalated	Define a criteria and framework (e.g. mechanism, communiqué) for decision making with focus on having a technical and political components	<ul style="list-style-type: none"> - Presented and approved at IGF in Nov 2017 - Share with the IGF members, IGRTC, COG by Dec 2017 	Nov – Dec 2017
Provide way forward on the functioning of IGF by proposing a protocol that deals with the basic operational manual	<ul style="list-style-type: none"> - Define the structures, membership and TORs - Propose business conduct for the IGF and its structures 	<ul style="list-style-type: none"> - Present and approve at IGF in Nov 2017 - Distribute to members and make operational by Mar 2018 	Nov 2017 – Mar 2018
Framework for induction of the incoming county officers including the Governors, CECs and Chief officers	Review report as above details	<ul style="list-style-type: none"> - Disseminate at IGF in Nov 2017 - Induction of CECs and Chief Officers by Jan 2018 - Induction of Governors by Jun 2018 	Nov 2017 – Jun 2018
Provide guidance on the setting up of IGF Secretariat	<ul style="list-style-type: none"> - Define the task, membership and host organization of secretariat - Constitute the secretariat 	<ul style="list-style-type: none"> - Share with MOH, COG, DPHK and NSA respectively by Nov 2017 - Request for representation for the secretariat in Nov 2017 	Nov 2017
Advocacy tool and inform the cost sharing arrangements between the National and County governments	<ul style="list-style-type: none"> - Define cost elements - Propose cost sharing arrangement for sustainability 	<ul style="list-style-type: none"> - Share at IGF in Nov 2017 	Nov 2017
Provide proposal on how IGF will fit into the implementation of the health sector partnership and coordination	<ul style="list-style-type: none"> - Recommend how IGF should link with other structures in Partnership Framework 	<ul style="list-style-type: none"> - Share with MOH, COG, DPHK and NSA respectively by Jan 2018 	Jan 2018

structures			
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Consultant Qualifications

The following qualifications and experience will be considered:

1. At least a master's degree in Health related field or other such relevant masters level courses with understanding of health reforms.
2. At least five (5) years relevant experience in public health.
3. Experience in Organizational Development/restructuring will be an added advantage
4. Demonstrate excellent interpersonal skills required for high level engagement with government ministries departments and agencies, Counties, development partners and other stakeholders.
5. Demonstrated experience in the field of policy review, drafting and implementation
6. Excellent understanding of devolution, Constitution of Kenya and devolution related legislations and structures
7. Good writing and presentation skills-ability to communicate effectively to diverse audiences

Implementation Arrangements

The Ministry of Health will be seeking technical and financial support from Partners for implementation of this assignment. The Ministry will therefore work closely with the partner (s) to provide required support for oversight, coordination, technical guidance and quality assurance throughout the period of consulting service.

PROPOSED LIST OF RESPONDENTS: REVIEW OF HEALTH SECTOR CONSULTATIVE FORUM

FACE – TO – FACE INTERVIEWS

	NAME	DESIGNATION	CONTACT	EMAIL ADDRESS
1	Dr Jackson Kioko	DMS	2717707	Jackson.kioko@health.go.ke
2	Dr Patrick Amoth	H/HSCIGA		dhsciga@gmail.com
3	Dr. John Kihama	H/IGA		jmkihama@gmail.com
4	Dr Andrew Mulwa	CEC MAKUENI / CHAIR		andrewmulwa@ymail.com
5	Dr Bernard Muia	CEC NAIROBI		
6	Dr Omar Ahmed Omar	HEAD/THS UC	2717707	humphomar@gmail.com
7	Gibson Muhuhu	NHIF		
8	Dr John Onge'chi	KNH		
9	Eliud Muriithi	KEMSA		
10	COG Health Committee	COG		
11	Mr. Sakwa Buliba	Chief Rapporteur / IGF		

PHONE INTERVIEWS (HIGH / MODERATE / LOW ATTENDEES)*Complemented by Interview Guide

Dr Elizabeth Ogaja (H)	FORMER VICE CHAIR CECs-H	lizogaja@gmail.com	0702 - 283 632 / 0786 - 555 592
Mr. Thomas Ruttoh (H)	CECs-H ELGEYO MARAKWET		
Dr Maurice Siminyu (H)	FORMER CHAIR CECs-H	siminyumaurice@yahoo.com	0722-389373
Ms. Sarah Omache (H)	CEC KISII	pacepbs@yahoo.com ;	0702-560801
Dr Ahmed Chiguzo (H)	CEC, KWALE	athuman.chiguzo@gmail.com ;	0722-756962
Mr Ahmed Sheikh (M)	CEC MANDERA	ahmedsheikhs@yahoo.com ;	0713-192199 0704-387630
Mr. Stephen Kokonya (M)	CEC BUNGOMA	smkokonya@yahoo.com ;	0719-547732
Ms Binty Omar (L)	CEC MOMBASA	health@mombasa.go.ke ; bintya@yahoo.com ;	0702-2115528
Dr Charles Githua Githinji (L)	CEC NYERI	daktgithuah@gmail.com ;	0722-785517
Dr Daniel Mungai Kabii (L)	CEC NAKURU	kabii.mungai@gmail.com ;	0721-570862
Dr William M Muraah (H)	CEC MERU	muraahw@gmail.com	0722-865933

FOCUS GROUP DISCUSSIONS

	NAME	DESIGNATION	CONTACT	EMAIL ADDRESS
1	SELECT MOH OFFICERS	HODs / MOH	Dr. Stephen Cheruiyot 0722 - 784012	stephenkipchirchir@yahoo.com
2	SELECT DPHK MEMBERS (WB, UNFPA, WHO, JICA, DANIDA, USAID, SECRETARIAT)	DPHK MEMBERS	Ms. Sandra Erickson +254 720-717033	dphk.secretariat@gmail.com

QUESTIONNAIRE SURVEY (BY EMAIL)

	NAME	DESIGNATION	CONTACT	EMAIL ADDRESS
1	OTHERS	CECs for Health	TBA	TBA
2	OTHERS	CHIEF OFFICERS	TBA	TBA

*TBA: To be availed by MOH