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KMA COMMITTEES

Young Doctors Network Committee

Young Doctors Network is a committee under the Kenya Medical Association, launched at the KMA@50 AGM in April 2018. The committee was formed to increase participation of the younger professionals in the association and mentor & un-tap the potential of these professionals. Its Mission is to connect, develop and support Young Doctors by providing opportunities to explore and develop personal and professional growth.

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The Reproductive Health Committee (RHC) envisions a Kenya with all women fully enjoying and accessing sexual and reproductive health rights (SRHR) possible. The committee seeks to advocate for and ensure that policies, services, information, and research on SRHR are people friendly and equitable to all irrespective of gender, age, social, cultural, religious and or economic class diversity

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Managed Healthcare Committee

The committee is responsible for ensuring Health policies being implemented are of standards.

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The committee is responsible in ensuring the association actively participates all public health related awareness and activities.
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HEALTH REFORMS NEED A CHANGE MANAGEMENT PLAN

Dr. Simon Kigondu
President, KMA

Health reforms – shock-and-awe strategy

The new administration has promised Universal Health Coverage (UHC) to Kenyans. To achieve this, it has adopted a shock-and-awe strategy for managing health reforms. It is premised changing the health laws first, then aligning everyone to fit into these laws. As expected, sudden change comes with some opposition in the absence of a change management plan.

Healthcare Financing Reforms - SHA

The most dramatic of the health reforms was the passage of three healthcare finance acts that replaces National Health Insurance Fund (NHIF) with a Social Health Authority (SHA). The effect of this was to impose a higher contributory mandate on salaried workers, abolish health schemes that had been previously developed over many years, and a proposal to register all Kenyans afresh into SHA, and a requirement to register all health facilities anew for purposes of reimbursement, doing away with the work NHIF has done over the years. These are dramatic changes.

National Health Insurance Fund (NHIF)

NHIF started 60 years ago as a health scheme for civil servants. It had evolved slowly

to provide various medical insurance schemes for various groups of the population. The previous administration chose NHIF as the vehicle to on-board regular citizenry into some form of insurance cover, in an effort by government to provide UHC. Whereas NHIF had its challenges, it had gradually grown and was largely responsible for the increase in medical insurance coverage over time. Proposals to reform and improve NHIF to gradually address the challenges of healthcare financing had previously been made.

Primary Healthcare Fund (PHF) Emergency & Chronic and Critical Illness Fund (ECCF)

Then new health laws introduced two tax-financed health funds, PHF and ECCF. Previously there were tax-funded health schemes like Linda Mama. Linda Mama stopped paying its providers a year ago. Linda Mama brought out the human resources for health deficit very clearly. Despite the benefit at the consumer level (many mothers did deliver at heath facilities with Linda Mama cards) the management of the challenges that emerged was wanting i.e. reimbursement of providers and improvement of human resources for health components and equipping of hospitals. These schemes also had been introduced suddenly and the lessons from their introduction and executions should have formed some basis of learning for the two new funds.

Facility Improvement Fund (FIF)

The reintroduction of the FIF through law was also sudden, but FIF is not new. The disappearance of FIF with onset of devolution, was as sudden as its reemergence. Pre-devolution FIF was the driver of the gradual growth of health facilities. FIFs sudden disappearance was as a because governors identified health facilities as cash centres. They closed previously devolved individual hospital accounts and centralized county collections including FIF to county bank accounts. This effectively undevolved health facility autonomy. The result of this was that money trickled back to the facilities, if at all, in an inefficient manner, leading to service delivery problems.

DIGITAL HEALTH ACT.

Digitization of heath has been fast tracked again with the passage of the digital health act. Digitization of health has its advantages as well as its challenges. Digitization allows for easier analysis of the data collected allowing data-driven decision making. This is easy for the part of health that deals with commodities such as pharmaceuticals and non-pharmaceuticals.

Digitization and doctor-patient interaction

Digitization though is a hindrance to the traditional doctor-patient interaction. It shifts patient care away from touching the patient to touching the computer. Because at the end of a doctor-patient interaction something must be keyed in,

slowly by slowly health workers are treating the computer more than the patient. When the system 'goes down' the doctor-patient interaction is affected, resulting in increased waiting times and increased turn-around times. Data may also be incomplete or inaccurate because health providers tend to minimize the amount of data they key in to avoid very prolonged contact times necessitated by the system. This can be improved by employment of more health workforce, but the usual excuse of wage bill means that the problem will persist.

Digitization and data protection

A major drawback of digitization is the issue of confidentiality and data protection. Any health data in a system is visible to many people who may access the system, and breaches of health data can lead to serious legal implications and a reduction of trust in health systems. Many people want their health data private and the current data privacy rules provide very harsh punishments to providers for data breaches. Moreover, the Hippocratic oath is based on confidentiality and some level of secrecy. Digitization must thus have a delicate balance of utility and data protection.

HUMAN RESOURCES FOR HEALTH (HRH)

Human resources for health is key to executing health reforms. Without people health reforms cannot work. Yet traditionally HRH is the area that is least taken care of. In the new dispensation the Kenya Health Human Resources Advisory Committee (KHHRAC) was launched with much aplomb.

The highlight of its work was the October 20th 2023 Kericho declaration where KHHRAC promised many good things in the HRH space. The output of this is yet to be seen. KHHRAC again face the problem it faced as soon as it was enacted in the Health Act 2017, its advisory nature. The Health Service Commission as proposed during the time of constitution making, and during the Building Bridges Initiative, complete with a HSC Bill, would probably be a good solution to the HRH problems bedeviling the sector. Resistance to the HSC continues especially at the Council of Governors level because to the perception that it will take away the funds that come with healthcare. This is in fact not true as the HSC will free the quarter of 35% of recurrent budget that the county is disallowed by law to go above since this budget will be a HSC budget. The counties will then be able to employ more personel to cover their gaps.

HEALTH SYSTEMS CHANGES – LESSONS FROM THE PAST

Poor health system in the 90s

Throughout the health journey both in Kenya and around the world there are lessons to be learnt from a change management direction that health systems choose to take. In the 1990s the public health sector had collapsed and there was l

iterally no health service delivery. The services were poor, the human resources for health demotivated, the health leadership structure was upside down, and there were no health commodities. Patients only came to hospital to get a diagnosis from the health professionals but footed the bill of care. A mother in labor for instance was given a prescription of the items she needed to purchase for the purposes of delivery, including the anaesthetic drugs in case she ended up with a cesarean section. Poor health service delivery was probably a major factor that determined the 2002 Kenyan elections.

A new government and a plan in 2000s

The new government in 2002, Identifying what needed to be done, set about making incremental changes in each of the health service delivery pillars through a well thought out policy paper dubbed 'reversing the trends' health policy. This was the National Health Sector Strategic Plan 2 (NHSSP2). Health had previously been on a downward trend. This policy sort to reverse this gradually, and it did.

Health governance

Health governance and leadership was rectified by appointing the highest qualified personnel as heads of the health institutions. In a hospital where there was a consultant, (s)he was made the medical superintendent. Because healthcare provision hierarchical, governance of health institutions improved. It is important that the caliber of personnel given leadership positions in health institutions is appropriate. It is difficult not to show respect to a leader whose qualifications are higher than yours. In the health sector at the policy level, provision of technical guidance for the health sector was domiciled in the office of the Director of Medical Services (DMS).

Human resources for health pay

Human Resources for Health was improved via a Kenya Medical Association (KMA) proposal that sort to increase health workers take-home pay via the introduction of allowances that were unique to health. An example of this was risk allowance. Health workers are exposed to various health risks in their line of duty like tuberculosis and needle prick injuries that could lead to HIV. The death of health workers during COVID-19 Pandemic was evidence of the risks faced by this group of professionals. The introduction of these allowances to the pay of health workers led to a better take-home pay and led to the retention of more health workforce. In fact, health workers migrated from the private health sector to the public health sector. The numbers of health workers employed increased. Morale became better.

Support supervision and the performance contract

A performance contract (PC) was developed to measure the incremental improvements resulting from the new health policy. The PC captured the needs of

the health facilities. It was marked quarterly via well executed support supervision plan carried out by the Ministry of Health, Provincial Director of Medical Services (PDMS) teams and DMSO zonal teams. Support supervision resulted in an improvement in all aspects of the health system. It generated data that lead to data-driven decision making. From the PC and the supervision identified the health gaps in health infrastructure, human resource and health finances, deficiencies in health commodity supplies. These gaps were incrementally sorted out and health service delivery improved slowly but surely and more health services became available to the populace. More medical internship centres opened. Healthcare financing improved and the health sector indeed moved from a net expenditure sector to a financier of Treasury. These changes were gradual and incremental and well thought out prior to roll out, and they produced good results.

Change management plan

The speed at which current changes in healthcare are being made, and the magnitude at which they are being made, may in my view have monumental challenges that may delay successful actualization. There is need for change management plan in place, with very specific realistic timeline, very clear transitions, with inclusion of all stakeholders in the healthcare space is a basic minimum. Baring this then teething problems of the proposed health reforms will go on for ten years in a similar manner with the sudden devolution of health.

But as they say, time will tell!

Dr Simon Kigondu is the President of Kenya Medical Association.
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27th March 2024

ADVANCING UNIVERSAL HEALTHCARE: KENYA'S LEGISLATIVE MILESTONES AND FUTURE DIRECTIONS (REFERENCE HEALTHCARE REFORMS 2023).

Dr. Diana Marion
Secretary General , KMA

On October 19, 2023, Kenya marked a significant milestone in its healthcare journey as the president signed into law four pivotal Acts aimed at bolstering public healthcare, extending coverage to all Kenyan citizens and long-term residents, and ushering in sweeping changes in healthcare financing and administration. These landmark legislative Acts, which came into effect in November 2023, signify Kenya's steadfast commitment to achieving universal health coverage (UHC) and revolutionizing its healthcare sector.

The enactment of the Primary Health Care Act, Digital Health Act, Facility Improvement Financing Act, and Social Health Insurance Act underscores Kenya's dedication to advancing UHC. These Acts lay the groundwork for transformative reforms, setting the stage for enhanced healthcare accessibility, affordability, and quality across the nation.

The Kenya Medical Association (KMA) played a pivotal role in shaping these legislative Acts by actively engaging in the policymaking process. Through the submission of written memoranda and active participation in public consultations, KMA leveraged its expertise as a leading voice in health policy advocacy to champion reforms aimed at ensuring quality, affordable, and accessible healthcare for all Kenyans.

In line with its commitment to driving healthcare reforms, KMA has embarked on various initiatives to educate, inform, and empower stakeholders. Collaborative webinars with strategic partners have served as platforms for knowledge sharing and capacity building, while the annual KMA Scientific Conference has provided a forum for in-depth discussions on healthcare reform strategies.

Moving forward, the transformation of health service delivery in Kenya must prioritize efficiency and innovation to meet the diverse healthcare needs of the population within resource constraints. This entails embracing new care models and leveraging technology to enhance service delivery.

Effective stakeholder engagement, from policymakers to healthcare providers and communities, is paramount in driving successful healthcare transformation. A balance between top-down leadership and bottom-up initiatives is essential, with policymakers playing a crucial role in articulating a clear vision, securing resources, and fostering commitment to reform.

Furthermore, governance mechanisms must evolve to support change, clarifying roles, regulations, and payment structures to facilitate seamless implementation of healthcare reforms. Strategic coalition building and alignment of local resources with transformation objectives are vital to garnering stakeholder buy-in and ensuring sustainable progress.

Ultimately, healthcare transformation is an ongoing journey that demands patience, adaptability, and context-specific approaches. By embracing innovation, collaboration, and a shared commitment to advancing universal health coverage, Kenya is poised to realize its vision of a healthier and more equitable society for all.

THE DOCTOR'S STRIKE

THE CURRENT DOCTOR'S STRIKE

By Dr. Joseph A. Aluoch, FRCP

The current Doctors strike in Kenya reminds me of 5th November 1971 when we had the first post-independence doctors strike. I was among the doctors arrested and put in cells for three days. Are Doctors strike morally justified? Though doctors strike provides an opportunity to generate more knowledge about the process in which legitimacy of an organization can be restored, it always meets with a great deal of resistance not only from the public but within the medical professions. It is a worrying trend in Africa where doctor strikes are rampant implying a failure of everyone in the organization including the doctor's themselves and not only the responsible Government, because when a strike occurs there are several questions to be answered.

Traditionally, all medical fraternity the world over are committed to acting comfortably to external demands guaranteeing patient's health. It has often been mistaken that it is against the Hippocratic Oath for doctors to go on strike, but this is strictly not correct as the Hippocratic Oath was constructed during a period when doctors were not in formal employment, they were rendering a service to mankind. With formal employment of doctors under the labor regulations the doctor's strike cannot be guided by Hippocratic Oath.

It is worth noting at this juncture that all doctors strike action take place within an institution which has a structure and a set of factual decision making. While some may blame the doctors, others praise them making strike action a contested terrain. The intractable nature of physicians strike action makes it at root ethical and in part economic. It is in part economic because it deals with professionals who offer their services for a price. And it is a root ethical in so far as it concerned itself with human behavior and conduct and the difference between right and wrong, good and bad. This has consequently made the doctors strike become a common game for almost everybody moralists, economists, academicians, national governments and the public. It is probably the most contentious issue in the medical fraternity.

Although strikes are often used as a bargaining tactic for workers all over the world the concept is deeply controversial for moral and practical reasons especially when dealt with in relation with doctors in general. The question on whether doctors should go on strike or not has so far received different interpretations. It is indeed a contested terrain since the late 19th Century most countries legalized striking, many people support the idea doctors go on strike as long as they feel they are being unjustly treated by their employer. Therefore, the views given so far against and in favor of doctor's strike cannot be resolved.

Any system that favor the idea that doctors have ethical obligation that transcend self-interest exigency or even political and economic forces is evaluated as capricious and unjust in so far as it fails to determine how social burdens and benefits sought to be allocated.

It must be admitted that in general strike are rare events in the history of medicine. The occurrences have been mainly initiated by junior doctors. The root cause appears to be long overdue salary increases with specific attention focused on Collective Bargaining Agreement. It is obvious that the result of doctor's strike would result in avoidable harm including death of patients, although it is quite difficult to separate facts and exaggeration due to media hype and variety of players involved. Clearly strike action breach implicit social contact between doctors and patients as they are to work under special commitment due to the nature of doctor's patient contact.

We can only hope that the doctor's strike will provide some insight on doctor patient and the doctor employer relationship as a result of the strike action. A strike action is a failure on the part of the employer to act in accordance with it stated recognition of importance of health care, failure on the part of the institutions to support the doctors, hospitals to reach the optimal potential and finally a failure on the part of doctors to consider seriously their duties and obligations to self, patients and the profession.

> It has often been mistaken that it is against the Hippocratic Oath for doctors to go on strike, but this is strictly not correct as the Hippocratic Oath was constructed during a period when doctors were not in formal employment, they were rendering a service to mankind

DR JOSEPH ALUOCH.

A Doctors strike veteran

2023 HEALTHCARE REFORMS EXPLAINED

BREAKING DOWN KENYA'S 2023 HEALTH REFORMS

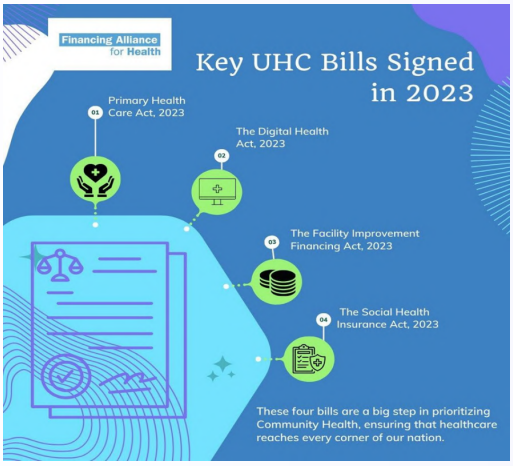
By Esther Anyona

In 2023, Kenya embarked on a journey of significant healthcare reform aimed at improving access, quality, and efficiency within its healthcare system. These reforms, spearheaded by the government, have been met with both anticipation and scrutiny from citizen's eager to see tangible improvements in their healthcare experiences.

Health reforms are not merely bureaucratic maneuvers; they are strategic interventions designed to address systemic challenges and enhance the overall well-being of the population. For the average citizen, understanding these reforms and their implications is essential for making informed decisions about their healthcare needs.

Setting The Stage for Change

One of the central pillars of Kenya's healthcare reform agenda is the pursuit of Universal Health Coverage (UHC) by 2030. UHC promises to ensure that every individual can access essential healthcare services without suffering financial hardship. With the clock ticking towards the 2030 deadline, the Kenyan government wasted no time in setting the wheels in motion.



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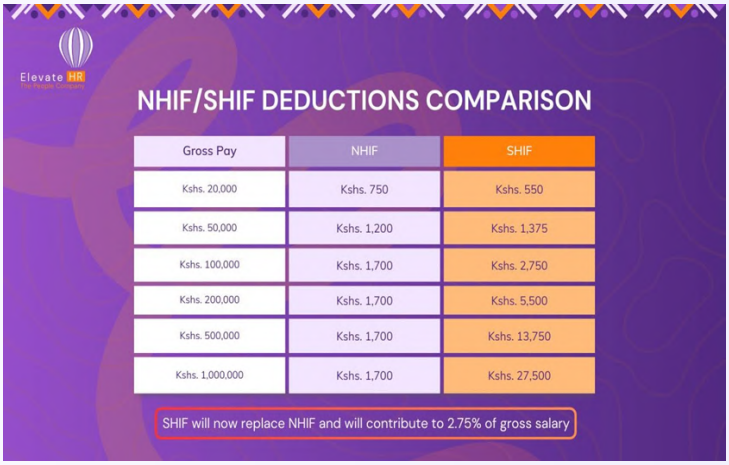

Photo by ElevateHR via LinkedIn

In October 2023, the government took a decisive step forward by enacting four crucial pieces of legislation:

1. The Primary Health Care Act:

This act is designed to strengthen Kenya's primary healthcare system, which serves as the cornerstone of UHC. It aims to promote UHC, define the roles and responsibilities of stakeholders, and ensure the sustainable provision of healthcare services at the community level. By establishing Primary Health Care Networks, Community Health Units, and other engagement forums, the act seeks to ensure

that every Kenyan has access to quality healthcare close to home.

2. The Digital Health Act

In an increasingly digital world, the management of health information is paramount. The Digital Health Act addresses this by regulating health information banks, ensuring the security and interoperability of health data, and facilitating the delivery of healthcare services through digital platforms. It establishes provisions for maintaining business continuity, emergency preparedness, and effective disaster management within the healthcare system, while also promoting initiatives related to health tourism.

3. The Facility Improvement Financing Act:

Public health facilities form the backbone of Kenya's healthcare infrastructure. This act provides a framework for financing the improvement of these facilities, ensuring that they are well-equipped to meet the needs of the population. It establishes guidelines for revenue collection and utilization, promoting equitable financing and a unified system for financial management in public health facilities.

4. The Social Health Insurance Act:

Social health insurance is a key mechanism for providing financial protection to citizens and ensuring equitable access to healthcare services. This act lays down the groundwork for managing social health insurance in Kenya, promoting solidarity, equity, and efficiency in resource allocation and healthcare delivery. It aims to restructure healthcare systems, processes, and programs to ensure they are responsive, reliable, and sustainable within the context of healthcare delivery in Kenya.

Your Role in Shaping the Future of Healthcare

As a citizen, you are not a mere bystander in this process; you are an active participant whose engagement is vital to the success of these reforms

Here are some ways you can get involved:

- ***Educate Yourself:*** Take the time to understand the reforms and how they impact you and your community.
- ***Engage with Stakeholders:*** Reach out to policymakers, community leaders, and healthcare providers to voice your concerns and contribute to the dialogue surrounding healthcare reform.
- ***Promote Health in Your Community:*** Be an advocate for healthy living in your community. Encourage your family, friends, and neighbors to adopt healthy behaviors and access healthcare services when needed.
- ***Monitor Implementation:*** Stay informed about the implementation of healthcare reforms in your area. Monitor resource allocation, service delivery, and the overall impact of reforms, and speak out against corruption or inefficiency that may hinder progress.
- ***Volunteer Your Time and Resources:*** Support local healthcare facilities, outreach programs, and health education campaigns through volunteering or donations.
- ***Prioritize Your Health:*** Lastly, prioritize your own health and well-being. Seek timely medical care, adhere to treatment plans, and practice preventive measures to safeguard your health.

Kenya's 2023 health reforms hold immense promise for transforming the country's healthcare landscape and improving the lives of its citizens. By actively engaging with these reforms and advocating for positive change, you play a vital role in shaping the future of healthcare in Kenya. Together, we can build a healthier, more resilient nation for generations to come.

ESTHER ANYONA IS A PUBLIC HEALTH PROFESSIONAL WITH THREE YEARS OF EXPERIENCE IN HEALTH PROMOTION AND ADVOCACY. SHE HAS BEEN A DEDICATED ADVOCATE FOR SRHR WITHIN THE FAMILY HEALTH OPTIONS KENYA (FHOK) ORGANIZATION, SERVING IN BOTH THE BONDO AND KAKAMEGA BRANCHES. CURRENTLY, ESTHER SERVES AS THE PROGRAM LEAD FOR THE IMMUNIZATION DEPARTMENT WITHIN THE KENYA MALARIA YOUTH CORPS. HER COMMITMENT TO IMPROVING PUBLIC HEALTH OUTCOMES IS UNDERSCORED BY HER GUIDING PRINCIPLE: "WHY TREAT PEOPLE AND SEND THEM BACK TO THE CONDITIONS THAT MADE THEM SICK?"

KENYA'S HEALTHCARE REVOLUTION: 2023 REFORMS EXPLAINED

By William Kimanzi (First Aid & Health Educator)

Kenyans have long shouldered a heavy financial burden for healthcare, with households spending an average of 40% of their health expenditure out-of-pocket as per data by the World Health Organization. In a bold move to address this challenge and create a healthier future for all, the country embarked on a major healthcare reform plan in 2023. These reforms encompass a range of initiatives, including the expansion of Universal Health Coverage, the strengthening of primary healthcare services, and the integration of mental health into primary care. Let's take a look;

1. Expansion of Universal Health Coverage (UHC)

One of the cornerstone healthcare reforms of the past year was the expansion of Universal Health Coverage to ensure that all citizens have access to essential healthcare services without facing financial hardship. Universal Health Coverage has the potential to lift millions out of poverty by reducing healthcare costs. Under this framework, the government aims to increase coverage of primary healthcare services, including preventive care, maternal and child health services, and treatment for common illnesses. By providing financial protection and reducing out-of-pocket expenses for healthcare, UHC aims to improve health outcomes and promote social equity.

2. Strengthening Primary Healthcare

The Primary Health Care Act No. 13 of 2023 is designed to support primary healthcare services with a focus on a preventive approach rather than a curative one. The Act encompasses investments in local dispensaries and health centers, the recruitment of 100,000 Community Health Practitioners, and the advancement of health education concerning hygiene, nutrition, and disease prevention. The act aims to establish at least one well-equipped health center in every ward across the country, significantly increasing access to primary care services in remote areas. These initiatives are targeted at reaching marginalized communities in distant areas and broadening the scope of community-oriented healthcare services.

3. Digital Health Transformation

The Digital Health Act No. 15 of 2023 promotes the use of technology in enhancing efficient healthcare delivery and administration. Services such as telemedicine and digitization of drug procurement and distribution are being made possible. The roll out of a national Electronic Health Records system to track patient information across facilities is a welcome idea that, if successful, will help to securely manage

patient data for improved service delivery.

4. Improving Healthcare Financing

A major discussion point in the past year has been the switch from the National Health Insurance Fund (NHIF) which has been superseded by the Social Health Insurance. This fund has been created by the Social Health Insurance Act No. 16 of 2023 which aspires to provide more extensive coverage and a more equitable contribution structure. Proposed measures to improve this include strengthening revenue production, increasing the effectiveness of healthcare spending, and obtaining additional resources through innovative financing methods.

A key challenge, however, remains ensuring that the Social Health Insurance program offers contribution rates that are affordable for all Kenyans. The government is exploring various solutions to address this issue, such as implementing income-based contribution plans.

The Facilities Improvement Financing Bill 2023, provides a framework for public health facility improvement financing and management.

The pursuit of Public-Private Partnerships and advancements in health research and innovation are also matters of discussion that are underway to ensure efficient healthcare delivery.

5. Quality Assurance and Regulation

Every patient seeking health services has a right to the highest standards of care and safety. To achieve this, there is need for rigorous assessment of facilities to maintain quality standards, measures to strengthen pharmacovigilance to monitor adverse drug reactions as well as licensing and continuous professional development for different cadres.

6. Integration of Mental Health into Primary Care

There is no health without mental health. Awareness campaigns and integration of mental health services into primary care is a sensible approach in addressing the silent crisis of mental health. Crisis helplines have also been established for virtual support. Understandably, this has faced a few challenges owing to the confidential nature of the counselling process but stakeholders are working around increasing awareness around this.

Conclusion

The success of these ambitious reforms hinges on effective implementation and transforming Kenya's healthcare landscape. To learn more and keep up with the progress, visit the Kenyan Ministry of Health website on *https://www.health.go.ke*

HEALTHCARE REFORMS OF 2023

By George Amolo

Healthcare reforms in Kenya are critical to improving access to quality healthcare services for all residents of the country. Here are some potential healthcare reforms that could be implemented in Kenya in 2023:

1. Universal Healthcare Coverage: Building on the government's efforts to implement universal healthcare coverage through the National Health Insurance Fund (NHIF), further reforms could be made to expand access to healthcare services for all Kenyan residents. This could include reducing out-of-pocket expenses, increasing healthcare facilities in underserved areas, and ensuring that essential healthcare services are available to all.

2. Health Infrastructure Development: Investing in the development of healthcare infrastructure, such as hospitals, pre-hospital, clinics, and medical facilities, is essential to improving access to healthcare services in Kenya. By expanding and upgrading healthcare facilities, the government can ensure that residents have access to high-quality medical care closer to their communities.

3. Healthcare Financing Reforms: Implementing reforms to improve healthcare financing in Kenya can help make healthcare services more affordable and accessible to all residents. This could involve exploring innovative funding mechanisms, increasing investments in healthcare by the government, and strengthening public-private partnerships in the healthcare sector.

4. Healthcare Workforce Development: Investing in training programs and incentives to attract and retain healthcare professionals, such as doctors, nurses, clinical officers, paramedics and other healthcare workers, is essential to addressing workforce shortages in the healthcare sector. By improving the quality and quantity of healthcare workforce in Kenya, the government can ensure that residents receive timely and quality healthcare services.

5. Health Information Systems: Strengthening health information systems in Kenya can help improve healthcare delivery, monitoring, and evaluation. By investing in digital health technologies and data systems, the government can enhance the efficiency and effectiveness of healthcare services, leading to better health outcomes for residents.

6. Health Promotion and Disease Prevention: Prioritizing health promotion and disease prevention initiatives can help reduce the burden of preventable diseases in Kenya. By investing in public health programs, promoting healthy lifestyles, and increasing access to preventive healthcare services, the government can

improve the overall health and wellbeing of the population.

Overall, these healthcare reforms in Kenya aim to improve access to quality healthcare services, reduce healthcare disparities, and enhance the overall health outcomes of the population. By addressing key issues in the healthcare sector, the government can work towards creating a more sustainable and equitable healthcare system that benefits all residents of Kenya.

> Healthcare reforms in Kenya are critical to improving access to quality healthcare services for all residents of the country...
>
> ...these healthcare reforms in Kenya aim to improve access to quality healthcare services, reduce healthcare disparities, and enhance the overall health outcomes of the population.

GEORGE AMOLO
BSC PARAMEDICINE MMUST.
FOUNDER THE PARAMEDIC ASSOCIATION OF KENYA
REGISTERED AND ACCREDITED ADVANCED EMERGENCY MEDICAL TECHNICIAN (AUSTRALASIAN REGISTRY OF EMERGENCY MEDICAL TECHNICIAN).
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SOCIAL HEALTH INSURANCE FUND (SHIF)

KENYA'S SOCIAL HEALTH INSURANCE EXPERIMENT

Dr. Paul Gitonga

Recent conversations around healthcare in Kenya have been awash with the terms Universal Health Coverage (UHC) and Social Health Insurance (SHI). The latter has left a bitter taste in the mouths of those in the formal sector due to the general feeling that this would be one more raid by the state on their already meagre incomes. But what do these two terms mean?

Two Strange Bedfellows.

The World Health Organization defines Universal Health Coverage as "all people having access to the full range of quality health services they need, when and where they need them, *without financial hardship*. The health services may be in the realms of health promotion, disease prevention, treatment, rehabilitation and palliative care. The protection from financial hardship is one crucial nexus between UHC and the myriad means used to finance healthcare. Historically in Kenya, healthcare for the masses has been funded mainly by the exchequer through taxes and other means of raising revenue, including grants. Citizens in formal employment (a paltry 20% of employees in the country) have also been contributing to various insurance schemes such as NHIF and other private insurance schemes. Citizens seeking healthcare without some form of health insurance are at risk of catastrophic out of pocket expenditure.

Social Health Insurance unpacked.

Like any other insurance, SHI seeks to optimize revenue collection, pool risks and purchase healthcare sustainably. The definition of SHI may be inferred from the characteristics that set it apart from other forms of health insurance. These characteristics are that: it is compulsory (usually for all citizens in a jurisdiction, who must regularly contribute and cannot opt out); only those registered under the scheme enjoy its benefits; that it is backed by legislation spelling out the benefits to those enrolled and lastly, premiums are based on ability to pay.

Germany is arguably the first country to dabble in SHI way back in the 1880s when other countries were scrambling for Africa. Other developed and developing nations have since rolled out SHI in various permutations to varying degrees of success. These include France, Netherlands, China, Philippines, Nigeria and certain states in India.

Kenya and the SHI Experiment.

Kenya recently joined the fray with the introduction of the Social Health Insurance Act no 16 of 2023. The act introduced the Social Health Authority which would be

responsible for rolling out and managing SHI in Kenya. In keeping with the tenets of SHI above: all Kenyan households and some categories of foreigners must contribute to the fund; only with up to date contributions shall one be able to access healthcare and every beneficiary shall enjoy an essential healthcare package.

What considerations promote successful roll out of SHI?

With other countries having gone before Kenya, there's numerous reference points for best practice and pitfalls to avoid. Common considerations that influence performance of SHI include incomes of citizens, distribution of labour between formal and informal sectors, geographical distribution of citizens and the mix of the groups targeted such as the elderly, unemployed or the indigent. The level of supervision, whereby the funding bodies are monitored and any behaviour deviating from the regulations and best practice is censured and corrected, is also paramount in regulating Social Health Insurance.

Potential pitfalls

Kenya has a convergence of various factors that could adversely affect SHI rollout. Healthcare delivery is a shared function between Ministry of Health (operating approximately 47% of health facilities), Faith Based Organizations (8%) and Private for profit facilities (46%) that own most level IV and Level V health facilities in Kenya (Kenya Health Facility Census Report, 2023). Additionally, healthcare delivery in Kenya is skewed in favour of urban centres where healthcare providers prefer to practice and where private hospitals prefer to set up. Unsurprisingly, compared to healthcare offered in public, the healthcare offered in Kenyan private facilities has consistently been rated better on most of the building blocks of health systems. Consequently, with the World Bank in 2022 estimating that 71% of Kenyans live in rural areas, access to quality healthcare for the majority of Kenyans may be a challenge.

Another challenge that SHI may face in Kenya is the ability to enforce the regular compulsory payments. The SHI Act of 2023 envisions regular individual contributions being monthly for salaried individuals or annualized for those with income not from salaries. The government shall pay for 2 groups of people; those needing financial assistance after subjecting them to an esoteric means testing instrument and people under lawful custody. As per their website, the Kenya Prisons Service has nearly 54000 prisoners, a cluster of individuals who by virtue of prison conditions are more likely to fall ill and need healthcare compared to the general population. On the other hand, approximately 40% of Kenyans live in overall poverty with nearly 6% being considered hard-core poor while 30% of Kenyans are considered food poor. It is from this pool of the have-nots that the government must select those whose contributions it'll meet. The possibility of SHI alone not being able to accommodate all these people cannot be ruled out.

The inefficiencies and excesses that bedevilled NHIF are likely to follow the Social Health Authority (SHA). The SHA has a very ambitious target of capping administrative expenditure at 5% of annual expenditure of the fund. NHIF barely managed 15%. In a departure from NHIF modus operandi, The SHI Regulations consider contracting private claims settling agents and medical insurance providers to process claims. How this will affect administrative costs will be revealed in due course.

Grand corruption has been a stubborn stain on the operational fabric of NHIF. There is no evidence that an antidote to that ill has been procured for the new authority. Finally, NHIF was beset with retention rates as low as 22% for those in the informal sector. Typically, there was adverse selection with members paying their dues around the time they were sick and thereafter ceasing payments once treatment was done. How will the new authority prevent this?

Way Forward.

Previous research on SHI modelling in Kenya suggested that contributory SHI had limited sustainability beyond the first 5 years with non-contributory (e.g. through taxes) having better sustainability outcomes within the initial years and later on. After all, simply increasing the pool of contributors wouldn't necessarily translate into more revenues as the government may reduce allocations to health or divert some of the funds to other needs. Therefore, funding for health would still need to be bumped up. There never was a better time to work towards the Abuja Declaration than during this time when the winds of change are blowing through the health sector.

In other countries, having tax agencies collect contributions, educating the masses through outreaches on benefit packages and establishing relatively easy registration systems have all contributed to improving uptake and roll out of SHI. Lastly, and perhaps paradoxically, involving labour movements and unions has been instrumental in the success of social health insurances elsewhere. That is food for thought, what with the government currently locking horns with human resources for health who are agitating for dignified terms of employment in the ongoing industrial action.

“The inefficiencies and excesses that bedevilled NHIF are likely to follow the Social Health Authority (SHA)

DR. PAUL GITONGA

GOVERNANCE BY SHEGE: CONSTRAINTS IN SHIFT FROM NHIF TO SHIF

"Tie your camel first, and then put your trust in Allah." Prophet Muhammad (Peace and blessings be upon him).
"My house is boring." "Mine too." "But at least you have food and a 4 Billion budget on hospitality!"

By Ismail Lutta

Introduction

Kenya has decided to undertake a very ambitious change in its healthcare system following the introduction of Social Health Insurance Fund (SHIF) to replace the National Health Insurance Fund (NHIF). The Ministry of Health has gazetted a ten-member transition committee on the Social Health Authority and is mandated to ensure a seamless transition from the National Health Insurance Fund (NHIF) to the Social Health Authority (SHA).

Social Health Insurance Act, No. 16 of 2023 (SHIA) was assented to on 19th October 2023 and it establishes the Social Health Authority and a framework for managing social health insurance fund. The Social Health Insurance Regulations, 2024 were gazetted on the 8th March 2024 via Legal Notice No.49. The board members of the Social Health Authority have been appointed. The object of the said Regulations is to give effect to the provisions of the SHIA by facilitating a mandatory registration of every person resident in Kenya and the access to the highest attainable standards of health.

The regulations to govern SHIF are supposed to address the limitations observed in the National Hospital Insurance Fund (NHIF) by prioritizing equitable access to quality, affordable and comprehensive health care for all in an effort to achieve Universal Health Coverage (UHC).

The Regulations shall apply in respect to the implementation of the following funds: The Primary Health Fund (PHF) whose object is to purchase primary healthcare services from level 2 and 3 health facilities that is made universally accessible to individuals and families at the community level; The Social Health Insurance Fund (SHIF) which purchases healthcare services from empanelled and contracted healthcare providers and level 4, 5 and 6 health facilities on referral from primary health facilities with a mandatory registration requirement for all Kenyans; and Emergency, Chronic, and Critical Illness Fund (ECCIF) whose object is to defray the cost of chronic illness after completion of social insurance cover and to cover the costs of emergency treatment.

Constraints in the Implementation of the Shift

1. Lack of clear communication. Kenyans were supposed to start contributing to the new kitty in the beginning of the year in January as per the presidency pronouncement last year. It was shifted to March by the pronouncement of the Cabinet Secretary of Health and then to July as per the pronouncement of the acting corporation secretary at the Social Health Authority before being returned to March thereby creating confusion among the public.

2. Lack of data on needy Kenyans. In the Regulations every household whose income is derived from salaried employment shall pay a monthly statutory deduction contribution to the Social Health Insurance Fund at a rate of 2.75 percent of the gross salary or wage of the household by the ninth day of each month with unemployed citizens paying or being paid for an annual contribution to the Social Health Insurance Fund at a rate of 2.75% of the proportion of household income as determined by the means testing instrument prescribed in the regulations. The amount payable every month shall not, in any case be less than Kshs. 300 per month payable within 14 days before the lapse of the annual contribution of the beneficiary.

The national and county governments will pay contributions for needy Kenyans. How many needy Kenyans have been identified? and as collections begin in March when will the governments' allocation for needy Kenyans be disbursed at SHA? Keeping in mind that the 57-year-old NHIF had a total of 15.4 million members and only 6.7 million were active members.

3. Lack of adequate time for the transition. All Kenyans are supposed to register with the Social Health Authority (SHA) with biometrics for those 7 years and above at Huduma Centres across the country, at NHIF offices that are now under SHA and at medical centres before 1 st July. There is time constraint as from Kenya's experience with voters' registration, it will require a longer time to capture the data of all citizens. And in case the SHA goes ahead and roll it before data is captured it may pose challenges in planning and smooth execution of SHIF.

4. Lack of Human resource at SHA. At the time of writing this article no staff has been recruited for SHA except a few who have been seconded from NHIF such as chief executive officer of NHIF who is acting chief executive officer for SHA. There is no system to manage the funds that are eager to be collected.

5. Paying insurance but benefits are delayed. Deductions towards SHA had been planned to start in January but halted by court orders as there were no regulations. It has now been moved to the end of March. It seems there will be a lacuna if

deductions are done from March to June and access to services starts in July. Kenyans will be wondering what happens when they fall sick in between since NHIF has been revoked and SHIF has not yet started. The Public need clear communication from the transitioning committee on this issue lest they appear keen to collect the monies without readiness of offering services.

6. A constrained health budget. Counties are expected to enhance the capacity of their human resource, medical supplies and technologies to guarantee access to quality healthcare services by all Kenyans. The Primary Health Care Act, 2023 provides for the construction of community health units across the country to facilitate delivery and access to primary health care services at the grassroots. With the current allocation of 59B for health which is a paltry 4.4% of the total budget compare to the Abuja declaration of 15% of budgets to be allocated to health it makes UHC to be a wild dream.

7. Shortage of health care workforce

It's a great irony that in the financial year that Social Health Authority is to be launched as a vehicle for Universal Health Care no one planned for two essential building blocks of health system namely the health workforce and financing. It baffles one to think that it had to take doctors to go to the streets to remind the administration to post medical interns who form 27% of their workforce and fight for preservation of their remuneration as had been agreed in 2017 CBA. Health workers are supposed to midwife UHC and without them UHC will be stillborn, dead on arrival. The ongoing doctors' strike and the unfulfilled promise of employing 20,000 health care workers is the major constraint in the attempt to roll out UHC under SHA.

Other changes

With the elimination of ***Linda mama*** which just needed a pregnant lady to have a birth certificate or national identity card to enroll with no payment one wonders whether we are taking backward steps and undermining the gains we had made under the previous administration. Unless the above constraints are addressed, Social Health Authority may just be a change of name and a promise rather than a vehicle for rolling out Universal Health Care in the Country.

KMA MEMBER. PUBLIC HEALTH COMMITTEE MEMBER. MASTERS OF PUBLIC HEALTH STUDENT IN MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY

SOCIAL HEALTH INSURANCE FUND Vs THE SOCIAL DETERMINANTS OF HEALTH, PUTTING THE CART BEFORE THE HORSE ?

Dr. Joseph A. Aluoch, FRCP

The Case for Universal Health Coverage

At the half-way point to the 2030 Sustainable Development Goal of Universal Health Coverage (UHC), more than half of the world's population are still not fully covered by essential health services. Progress towards Sustainable Development Goal #3 ("Ensure healthy lives and promote well-being for all at all ages") has stalled alarmingly in many countries and financial protection has been progressively worsening for two decades. This was starkly remarked on at the United Nations General Assembly's high-level meeting on Universal Health Coverage on 21 September 2023, with the subsequent adoption on 5 October 2023 by the General Assembly at its seventy-eighth session of a new political declaration on universal health coverage: "expanding our ambition for health and well-being in a post-COVID world". By that account, world leaders committed themselves to redoubling efforts to achieve UHC by reorienting health systems and investments through a primary health care approach. At the same time, WHO's Global Monitoring Report for 2023 on tracking Universal Health Coverage, launched on 18 September 2023 by WHO and the World Bank, shows that the world is off-track in making significant progress towards achieving UHC by 2030 (Sustainable Development Goal target 3.8). In total, 4.5 billion people were not fully covered by essential health services in 2021, and billions of people experienced catastrophic health spending or impoverishing health spending.

The Social Determinants of Health: Time to Consider the Underlying Causes of Disease and ill-health

The pursuit of UHC has become a top global health priority and an increasing number of Low- and Middle-Income Countries (LMICs) are explicitly aiming for it. In most of them, however, progress must happen against the backdrop of a severely resource constrained healthcare system, the inefficient and inequitable use of available resources, and a heavy burden of out-of-pocket payments (OOP). In their quest to move towards UHC, many countries have opted to collect contributions from the population, believing this to be an additional, untapped source of revenue. However, compared with high-income countries, many LMICs operate in a very constrained fiscal space. This may also be coupled with large sectors of society operating in the informal economy, where it can be challenging to rely on contributions as a reliable source of revenue. According to the ILO, informal employment without taxable income can account for up to three-quarters of all employment in parts of Africa and Asia, making the collection of revenues

particularly challenging. Moreover, in the case of social health insurance, it is possible that contribution collection from formal employment in LMICs may hinder the formalization of the labour market, questioning the economic sustainability of social health insurance schemes.

Research indicates that the Social Determinants of Health (SDH)—defined by the World Health Organization as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" can be more important than healthcare or lifestyle choices in influencing health. Numerous studies suggest that SDH accounts for between 30-55% of health outcomes. SDH have been shown to have a greater influence on health than either genetic factors or access to healthcare services. For example, poverty is highly correlated with poorer health outcomes and higher risk of premature births. Indeed, the impact of social inequality is pervasive and deeply embedded in our society, creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These inequities put people at higher risk of poor health and premature death.

The dramatic increase in life expectancy since the 19th century is due primarily to improved living conditions, including nutrition, sanitation, and clean water. Decades before the availability of modern medical-care modalities such as antibiotics and intensive care units, the mortality from many diseases were already falling quickly and steadily. While advances in medical care also may have contributed, most believe that non-medical factors, including conditions within the purview of traditional public health, were probably more important.

Another example of the limits of medical care is the widening of mortality disparities between social classes in the United Kingdom in the decades following the creation of the National Health Service in 1948, which made medical care universally accessible. Using more recent data, researchers found that although health overall was better in the United Kingdom than in the United States, which lacks universal coverage, disparities in health by income were similar in the two countries. Large inequalities in health according to social class have been documented repeatedly across different European countries, again despite more universal access to medical care.

Isn't it Time to Address the Cause before the Cure?

With the foregoing evidence, which is widely and freely available, one would have expected the Kenya Government to put its money where its mouth is by bolstering spending on health coverage. Among the key challenges that Kenya faces in achieving UHC include human resources constraints, patchy accreditation of health facilities, dilapidated health infrastructure, limited coverage by the NHIF, lack of a

proper health information management system, improper governance, fraud and overall insufficiency.

It follows that improved sanitation and nutrition will have a greater impact on the health of Kibera or Mathare slum residents than accessing SHIF. As an old colonial medical officer once put it, "the best way to improve the health of the Natives is to stop them from eating their feaces." Crude as that may sound, it expresses a sound observation: social determinants of health have a higher effect on health.
The elimination of health inequities occurs through well-designed economic and social policies. Every aspect of social determinants influences the health aspects of people; hence, some areas to focus on include employment, education, socioeconomic status, social support networks, health policies, and healthcare access. A large and compelling body of evidence has accumulated that reveals a powerful role for social factors—apart from medical care—in shaping health across a wide range of health indicators, settings, and populations. This evidence does not deny that medical care influences health; rather, it indicates that medical care is not the only influence on health and suggests that the effects of medical care may be more limited than commonly thought, particularly in determining who becomes sick or injured in the first place.

The French proverb grasps the irony of the situation: *"The communal donkey gets the heaviest burden". Which is to say, a Kenyan slum resident having access to an improved healthcare facility will go back to the slums and come back to the healthcare facility with the same recurrent ailment, unless water and sanitation health in the slums are improved!*

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PRIMARY HEALTH CARE

EMPOWERING KENYA'S COMMUNITY HEALTH PROMOTERS FOR ENHANCED PRIMARY HEALTHCARE

Dr. Wairimu Mwaniki

As the world continues to support global health initiatives advocating for healthcare equity and community empowerment, we cannot fail to recognize the invaluable role that Community Health Promoters (CHPs) play in bridging the gap between underserved communities and access to primary healthcare services. Rooted in the principles of the 1978 Alma-Ata Declaration, which highlighted the role of community health workers in providing essential health services, CHP programs across the globe have effectively addressed health disparities and improved health outcomes, particularly in marginalized populations.

Stock takes from successful CHP programs like those in India and the Philippines have shown the transformative impact of CHPs in the healthcare system. These frontline workers have played a critical role in bridging the gap between communities and formal healthcare facilities by providing basic health education, offering primary care services, and facilitating referrals. Their efforts have translated into better community health outcomes, especially in remote and underserved communities across these countries.

The Kenya Primary Healthcare Act of 2023 recognizes the invaluable role that CHPs have to play in supporting primary healthcare networks. In Kenya, each CHP oversees 100 households, with 10 CHPs serving 1,000 households. These 1000 households collectively form a Community Health Unit. In support of their services, the Kenyan government launched 100,000 CHP kits in September 2023. Each kit contains a backpack, first aid box, jacket, weighing scale, infrared clinical thermometer, and mid-upper arm circumference (MUAC) tapes. The purpose of these kits is to empower and equip CHPs with essential tools to offer basic healthcare services at the community level. While we applaud these supportive efforts, CHPs still encounter various challenges that impede their ability to play their roles effectively.

One of the foremost challenges faced by CHPs in Kenya is the lack of formal recognition and structured training. While they undertake diverse responsibilities ranging from maternal and child health to infectious disease prevention, there exists no standardized national training curriculum for CHPs. This gap not only hinders the quality of care provided but also perpetuates them navigating complex healthcare landscapes with limited guidance. To address this issue, the Kenyan government must develop a comprehensive training curriculum tailored

to the needs of CHPs, ensuring standardization of care and enhancing their professional development. This will ultimately empower CHPs to deliver consistent and high-quality care to the communities that they serve.

Furthermore, the fragmented nature of CHP programs poses a significant obstacle to their effectiveness. Without a clear delineation of their roles and responsibilities, CHPs encounter challenges in coordination, supervision, and resource allocation. To mitigate these challenges, there is a need to integrate CHPs more effectively within the healthcare system, aligning their roles and responsibilities with existing health policies. This not only enhances the efficiency of service delivery but also fosters a supportive environment for CHPs to thrive in their roles.

Moreover, the issue of remuneration and working conditions remains a pressing concern for CHPs. Many CHPs operate voluntarily or receive inadequate compensation for their services, exacerbating concerns of financial insecurity and low morale. Recognizing the critical role played by CHPs, the Kenyan government recently initiated a stipend payment program, signaling a step in the right direction. However, sustainable measures should be established to ensure equitable compensation and support for CHPs, thereby incentivizing their continued dedication to community health.

Drawing insights from successful global models of primary health care, Kenya can adopt several strategies to strengthen its CHP program. Firstly, the designation of specific roles and responsibilities for CHPs, aligned with national health priorities, can help streamline their activities and prevent overburdening them. Additionally, prioritizing training in vital areas such as maternal and child health, nutrition, and infectious disease prevention can enhance the capacity of CHPs to address community health needs effectively. Investing in robust support systems for CHPs, including supervision, mentoring, and ongoing professional development, would also support the CHP program. By providing CHPs with the necessary tools and resources, the Ministry of Health can empower them to deliver high-quality, comprehensive care to communities countrywide.

Empowering Community Health Promoters can play a pivotal role in strengthening Primary Health Care networks in Kenya. By addressing the challenges facing CHPs and implementing evidence-based strategies to support their work, Kenya can harness their full potential in advancing Universal Health Coverage and achieving the health targets of the Sustainable Development Goals. Through collaborative efforts between the government, healthcare stakeholders, and communities, we can elevate the role of CHPs from not only being health providers but also to being catalysts for social change and equity, paving the way for a healthier future for all Kenyans.

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Health Articles

RE-IMAGINING HEALTH SYSTEMS IN THE 21ST CENTURY

By Dr Ndirangu Wanjuki

In 2024, 16 years post the WHO Health System framework's (WHO, 2007) introduction and with six years to SDG 2030 conclusion, the framework's impact on health system resilience and population health outcomes calls for open discussion. The Summit of the Future in September 2024 and other gatherings like the World Health Assembly, United Nations General Assembly, Africa Health Agenda Internal conference, and the International Conference on Public Health in Africa, provides platforms for global health leaders to review the health system framework and expedite progress towards SDG 3.

Why Re-imagine Health Systems?

The Service Coverage Index tracked as SDG indicator 3.8.1 is a good measure of the effectiveness of primary health care and health systems strengthening initiatives by a country. Variable performance on the index in different regions, such as Africa where it averages 48 on a range of 1 to 100, reveals huge gaps in healthcare access affecting hundreds of millions of people. Amidst commendable progress, such as halving child mortality in Africa between 2000 to 2019, (UN IGME 2021; The Lancet Global Health, 2022), maternal health outcomes remain troubling, with maternal mortality off track to SDG targets (WHO, 2023) while the raging epidemiologic trajectory of non-communicable diseases threatens to erode gains made by the continent. This mixed situation signals the need for a paradigm shift towards a health system build for people, and capable of delivering impact amidst contemporary global challenges like climate change and pandemics (Githinji G. Ndirangu W, 2023). It is time to redefine the current health system framework to its next iteration —Health Systems 2.0—towards health systems resilience and impact.

Theoretical Foundations for Health Systems 2.0

To build Health Systems 2.0, I recommend using a design methodology that integrates three theories namely systems thinking, human-centered design, and adaptive leadership.

(a) Systems Thinking

Originating from Ludwig von Bertalanffy's (1969), Systems Theory emphasizes the interdependence of system components (including problems) and the importance of holistic solutions that meet the needs of stakeholders. Paina and Peters (2012) and Braithwaite, J. et al, 2018) argue that viewing health system changes through the complex adaptive systems framework is crucial for scaling up interventions by

paying attention to local nuances and social practices, interconnectedness nature of health care, and transparent, adaptive problem-solving. When a system comprises people, high complexity arises due to unpredictable human emotions and needs, often resulting in unexpected events like health worker strikes that disrupt the system's functioning.

In this paper, Health Systems 2.0 is defined by a framework that includes inputs, processes, outputs/outcomes, feedback loops, control mechanisms, and the operating environment. The framework incorporates the six building blocks of the 2007 WHO health systems framework, placing them within the context of systems thinking.

Inputs in Health Systems 2.0 are adaptive leadership for vision and direction in terms of health laws and policies; and funding in terms of total expenditure on health from a blended financing perspective. When health systems fail to deliver population health despite immense efforts to improve processes, it's often due to flaws in inputs - lack of adaptive leadership and/or grossly inadequate allocation of funds.

Processes within eight domains each of which is a subsystem, operate interactively towards the goal of producing health. These are finance management, human resources, supply chains for medicines, deployment of technologies, community engagement, multi-sectoral collaboration (with sectors like education, gender, environment, agriculture, water and sanitation), data and digitization of processes including visualization of performance, and delivery of both preventive and curative services across various settings and contexts.

Outputs/outcomes measure system performance, including service coverage index, equity, access, financial protection, and population health indicators namely incidence and prevalence such as malaria, HIV, and TB incidences as well as maternal mortality ratios and child death rates, broken down by demographics. Managers at sub-national levels such as districts and counties need to focus their efforts on organizing the eight processes to optimize system performance and population health outcomes in their specific settings and contexts.

Feedback loops for self-regulation involve analyzing digitized data to understand why interventions succeed or fail, foresee possibilities through scenario projections, and provide surveillance for public health security.

Control mechanisms informed by feedback loops include laws and policies that affect health by solidifying and institutionalizing key aspects of direction. In addition, regulations, quality assurance programs, service protocols, financial checks,

performance metrics translated into dashboards or visualizations that leaders and managers easily understand, and accreditation standards all constitute control mechanisms.

Health Systems 2.0 must be open and adaptive to environmental factors and trends like climate change, pandemics, technological advancements (such as digitalization and artificial intelligence), limited financial resources, demographic and epidemiological shifts, geopolitical changes, international conflicts, as well as the effects of migration and trade impacts on health systems.

As urgued by Straub (2013), managers often underestimate system complexity in efforts to simplify work, hindering their control. Applying Health Systems 2.0 (ie systems theory along with human-centered design and adaptive leadership) can help managers in the health sector deploy effort at suitable leverage points in one or more of the eight processes, to affordably improve health outcomes in their unique contexts, even with limited resources such as Africa and other developing country setting provides. For example, Rwanda (Binagwaho et al., 2014) and Ethiopia (Medhanyie et al., 2012) improved health outcomes by strengthening community health worker programs, while in Malawi, task-shifting to clinical officers led to better surgical outcomes (Gajewski et al., 2019).

While systems theory has its successes, it is not a cure-all. Health systems often find themselves in an "inefficient equilibrium," where processes appear stable across one or more of the eight domains but ultimately fall short of improving population health outcomes as expected given the levels of effort. By combining systems theory with adaptive leadership (to notice inefficiency and offer leadership for change) and human-centered design (to prioritize the needs of people across the eight process domains), it is possible to create efficient systems that are optimized to deliver population health outcomes.

(b) Adaptive Leadership

Adaptive leadership is a key input in Health Systems 2.0. Nations' Presidents and Prime Ministers should prioritize appointing practitioners of adaptive leadership to roles such as Minister of Health, Permanent Secretary, and Director of Medical Services or similar positions. Adaptive leadership fundamentally involves distinguishing between adaptive challenges, which require leadership, and technical problems, which do not (Heifetz R et al, 2009). Heifetz et al emphasizes that technical problems, like a surgeon performing an operation, can be resolved with existing knowledge. Conversely, adaptive challenges, like a persistently high maternal mortality ratio or teenage pregnancy rate, exist within a complex ecosystem of individuals with various interests, values, and motivations. Health Systems 2.0 encourages the recognition of adaptive challenges as distinct from technical

problems, as mistaking the two is a common cause of leadership failures.

Effective leadership through adaptive challenges requires empathetically helping people to learn and adjust to change, including managing loss, fostering a culture of observation, experimentation and learning, creating the right amount of discomfort to stimulate learning while maintaining a supportive holding environment, and aiding the development of adaptive solutions within a diverse ecosystem of stakeholders. To tackle adaptive challenges, adaptive leadership practitioners engage in a diagnostic process to understand the problem's ecosystem by identifying stakeholders, appreciating their perspectives, clarifying their desired outcomes, noticing instances of positive deviance where parts of the system works (Pascale R et al, 2010) and coaching them to enhance their adaptive leadership capacities to drive change while preserving what works as a foundation. The practice of adaptive leadership demands self-awareness, presence, deep listening, genuine engagement with others, and self-care to avert exhaustion and burnout.

(*c) Human Centered Design*

Human-Centered Design tailors solutions to specific community needs and contexts, rather than designer preferences (IDEO, 2015). It involves empathizing with communities to understand their needs, defining problems clearly, ideating and prototyping solutions, testing with communities, and iterating based on feedback. This approach ensures that health solutions are customized to meet real community needs in terms of access, quality, and affordability. Successful examples in health systems include the Better Immunization Data initiative in Tanzania and Zambia and Sayana® Press self-injectable contraception method in over 40 countries (Huffman, 2019), the Aravind Eye Care System in India (S. Lewallen & R.D. Thulasiraj, 2010), the Kimormor one-stop-shop outreach model in Kenya (Amref, 2021) and Solar-powered health trucks delivering COVID-19 vaccines to remote areas (Amref, 2022).

Re-imagining Health Systems is a Game of Stakeholders

Everyone has a part to play in shaping the future of health systems. UN bodies like the World Health Organization, along with regional entities, should maintain their roles in facilitating and mediating, and provide technically sound guidance for countries to customize their health systems. The World Health Assembly, the UN General Assembly, and the Summit of the Future offer prime platforms to discuss the evolution from the WHO Health Systems Framework of 2017 to contemporary iterations, Health Systems 2.0 being an illustrationof such. The WHO should consider convening a high-level dialogue on 'The Health System of the Future.'

Governments are well placed to adopt adaptive leadership and allocate funds, as foundational inputs for robust health systems, central to Health Systems 2.0 philosophy. Bilateral, non-UN multilateral development organizations, global health partnerships, and philanthropic foundations would do great to re-imagine their

support to reinforce adaptive leadership and data-driven performance improvent in health systems. Perfomance improvement includes focusing on short term results such as service coverage and long-term population health measures, such as disease incidence and prevalence.

Civil society, representing various communities, should better organize themselves to push for the early implementation of evidence-based and effective health system models, including the iterations such as Health Systems 2.0. Facilitating strategic discussions with government ministers, WHO, and philanthropic foundations during key global health events is a strategic move. Academics specializing in health should contribute to these discussions by presenting evidence on the efficacy of current health systems framework and potential Health Systems 2.0 adaptations, particularly in lower-income countries.

Health workers need to continue to exemplify excellence in implementation at the frontline, employing adaptive leadership to address persistent health challenges. Persistence of a health challenge at population level is possibly the easiest proxy marker of adaptive challenges (as opposed to technical challenges) in the health sector.

By re-envisioning health systems through the lens of system theory, human-centered design, and adaptive leadership, we can enhance system resilience and sustainably improve health outcomes in the face of economic realities and threats such as climate change and pandemics.

In closing, I thank you for reading this opinion piece and encourage you to identify adaptive challenges in your work and practice proactive leadership, regardless of your position of authority.

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DR. NDIRANGU WANJUKI SERVES AS THE COUNTRY DIRECTOR OF AMREF HEALTH AFRICA IN KENYA. HE LEADS A DYNAMIC AND DIVERSE TEAM OF 500+ PROFESSIONALS AND MANAGES AN ANNUAL BUDGET EXCEEDING ~USD 70 MILLION. WITH MORE THAN TWO DECADES OF EXPERIENCE IN PUBLIC HEALTH AND A DECADE IN EXECUTIVE LEADERSHIP, DR. NDIRANGU IS RENOWNED FOR HIS STRATEGIC ACUMEN AND IMPACT-DRIVEN INTERVENTIONS.

INTERGENERATIONAL COHESION IN LEADERSHIP

Dr Liz Wangari Irungu

It was during my master's degree in public health studies that I decided to vie for a position within Medecins Sans Frontiers as an elected board member and to be honest I think I really did not know what I was doing at the time.

You see dear avid reader of Medicus magazine, global health is amazing and exciting to read about, but the reality of being a woman in leadership in the humanitarian sector is not for the faint hearted. I am however fortunate that I have over the years met colleagues who became friends and others now are even family. In my uncertainty I reached out to a former country director who was and remains a mentor; I sought the advice of Bjørn Nissen as I was truly anxious, and Imposter Syndrome was creeping in. He is a former president of MSF Norway had alot of insights to share and during the consultation I literally wrote down every word. Next, I worked on my application and of course consulted everyone I had as a referee because of due diligence and reference checks. Later I had to pitch myself verbally and you can be sure catecholamines were over the roof, my heart was beating like African drums 'du du du du du du'

Dr Simon Kigondu, KMA President , I think is extremely patient because for all potential 'gigs' I often ask for his input and kindly request for a good word, thank the heavens he has always urged me to go for the stars. Thank you Doc.
Global health and leadership are indeed a matrix of complexity, often with no obvious answers. One thing I have found helpful over the course of the past sixty-five months of service is to read avidly and seek to understand related fields to an in-depth level and I believe this is the only reason my lenses have been useful. I was quite intimidated in the beginning being a typical type A personality and being very self-driven. I like to push beyond my limits and do any task I accept with all my energy so naturally I felt very small in the first year of my mandate and barely spoke!!

For those who think they know me perhaps a silent Liz Irungu is difficult to picture.

I am grateful that I not only have given my best, but I have made lifetime friends that I cannot fully list here but one that I must mention is a lady called Anneli Erikson. Having a nursing background and being very good with soft skills, I believe she noticed my uncertainty and always was reassuring in the sense that if I needed any assistance or historical background contextual briefing, she was willing to assist. Being me, I buried my nose in books because I felt I needed to get it right.
Dear Reader, do you know the best part

of my nine-year journey in the humanitarian field? I made friends that I could enjoy a drink with and let loose and dance with to let off steam. Deep belly laughter and pain in my ribs is the secret to winging it in this very complex arena. To quote Leonardo Da Vinci 'Simplicity is the ultimate sophistication'.

In summary to all my colleagues in leadership, particularly in global health please be the person that pulls others up and be the mentor that is willing to pass on the baton when time is ripe and you have groomed the next generation to lead with integrity, patience, diligence and trust with of course a background that is firmly rooted in best evidence based or evidence informed practice. Plus, the acknowledgement that we are all human and we err, apologising when one has offended colleagues and the genuine desire to self-improve continuously, in keeping with theories of incrementalism.

(Two great books are Thinking fast and slow by Daniel Kahneman and Outlive by Peter Attia MD)

As we are in the current embargo of a looming doctors strike it is my sincere hope that the leaders find an amicable way of resolving the stalemate and that the dignity of the medical profession will be restored. A wise man once said 'A chain as strong as its weakest link'

TEAM = Together Everyone Achieves More

My deepest gratitude to all colleagues, friends and family who have walked the talk in this enchanted path that I decided to meander upon. Bedankt, Asante sana, Āmeseginalehu :)

God bless you all abundantly.

...to all my colleagues in leadership, particularly in global health please be the person that pulls others up and be the mentor that is willing to pass on the baton when time is ripe and you have groomed the next generation...

DR LIZ WANGARI IRUNGU

PUBLIC HEALTH DIPLOMAT

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ASPIRING IMPLEMENTATION SCIENCE GURU

#TEAM KENYA TO THE WORLD#

WOOP WOOP!

EARLY DIAGNOSIS: ROUTINE MENTAL HEALTH SCREENING IN SCHOOLS

By Dr. Halima Ibrahim

Major psychiatric conditions such as schizophrenia, mood disorders, and anxiety disorders often manifest early in life, with symptoms tracing back to childhood. Subtle indications, like truancy in school, are sometimes dismissed as childish behavior but persist into adulthood, often accompanied by substance abuse and alcoholism. Unfortunately, inadequate identification and acknowledgment of these conditions are common. Individuals with childhood psychiatric illnesses face heightened vulnerability to social exclusion, discrimination, stigma, educational challenges, risky behaviors, physical health issues, and human rights violations.

According to key facts from the World Health Organization (WHO)[1] globally, one in seven 10-19-year-olds experiences a mental disorder, constituting 13% of the global burden of disease in this age group. Depression, anxiety, and behavioral disorders rank among the leading causes of illness and disability among adolescents. Suicide stands as the fourth leading cause of death among 15-29 year-olds. The Kenya National mental health survey of 2022 showed that mental health problems and mental disorders were common among adolescents in Kenya. Over two-fifths of adolescents (44.3%) had a mental health problem in the past 12 months of the study, with one in eight adolescents (12.2%) meeting criteria for a mental disorder. A further 2.4% had more than one mental disorder in the past 12 months. Adolescents reporting suicidal behaviors and self-harm were more likely to be those with a mental health problem. [2] Despite this, data on the prevalence of mental health issues specifically among Adolescent and Young People in Kenya is limited [3].The repercussions of neglecting adolescent mental health extend into adulthood, compromising both physical and mental well-being and restricting opportunities for a fulfilled life.

Early diagnosis of psychiatric illnesses involves considering family history and changes in behavior, often affecting academic performance. I have encountered numerous patients who excelled academically during primary school but experienced declining performance in high school or university due to issues like substance abuse, hallucinations, and thought disorders. A significant portion of the population encounters mental health challenges for the first time during college years[4]. Academic pressure, separation from family, and the transition to individual decisions contribute to this phenomenon. It is not uncommon to encounter bright students from secondary schools who struggle academically in university, some resorting to alcohol abuse, while others are overwhelmed by numerous

commitments or neglect their responsibilities. Early identification of students facing mental health challenges is crucial[5]. Warning signs such as absenteeism should not be disregarded or met with threats of suspension. Instead, a collaborative effort involving guidance counselors and parents to address the root causes of such issues is essential. Regular performance evaluations and mental health assessments, with parental involvement, are imperative to ensure better outcomes that lead to graduation.

Teenage suicide is a prevalent issue, often stemming from an inability to effectively manage emotions. It ranks as the fourth leading cause of death among older adolescents (15–19 years) [6], with depression, anxiety, and personality disorders being common underlying factors. However, children's struggles with mental health are frequently misunderstood, and societal expectations exacerbate the situation. Contributing factors include physical, emotional, and social changes during adolescence, often compounded by poverty, exposure to violence, and abuse at home, leading to isolation and withdrawal. The pervasive use of social media has exacerbated mental health challenges among youth [7], fostering addiction to content consumption, diminishing attention spans, straining social connections, and affecting academic performance. Unrealistic comparisons to curated online personas breed dissatisfaction with one's present circumstances.

Addressing these challenges requires comprehensive policies and programs to strengthen mental health systems. With push towards implementation of Primary health care act, the Digital health act and Social Heath Insurance Act 2023, its vital to take a multifaceted approach involving parents, schools, and digital health platforms not limited to mainstream media but also including social media [7]. Increasing awareness of common symptoms and behavioral changes among children is crucial, alongside providing self-analysis toolkits and access to hotlines for support. The government should implement training programs and self-help manuals for educators and community volunteers to promote mental health awareness, prevention, and intervention among students. Furthermore, the coordination of services through the utilization of electronic medical records (EMRs) holds promise for enhancing care for college students by facilitating communication between providers, streamlining coordination, improving measurement practices, and providing decision support.

In conclusion, early recognition of mental health disorders among adolescents and young adults is important, ranging from control of the disease sequelea to improvement of quality of life of the affected. Management is multidisplinary involving parents, educators and health care workers. A focus on the use of Primary care to identify and manage mental health problem on time. This will enable the vulnerable demographic to be empowered both in their social, personal and

academic life.

> Teenage suicide is a prevalent issue, often stemming from an inability to effectively manage emotions. It ranks as the fourth leading cause of death among older adolescents (15–19 years)

I AM DR HALIMA IBRAHIM,A MEDICAL OFFICER INTERN IN NAKURU COUNTY LEVEL 5 HOSPITAL.I AM A COMMUNITY AND GLOBAL HEALTH ADVOCATE.I TAKE EXPERIENCES FROM MY ROTATION AND TELL A STORY OF THE GAPS THAT CAUGHT MY EYES AND WHAT CAN BE DONE ABOUT IT.I ASPIRE TO BE A CARDIOLOGIST BUT I ALSO WANT TO BE CONTRIBUTE STRENGTHENING HEALTH SYSTEMS IN LMICS BECAUSE I BELIEVE AS DOCTORS WE ARE CAN CLEARLY IDENTIFY THE WEAKNESSES EXISTING AND FORMULATE SOLUTIONS TO ACHIEVING THE UNIVERSAL HEALTH COVERAGE.

BANISH PASSIVITY, TIME TO ADOPT PERSON CENTRED PRACTICE

The good physician treats the disease; the great physician treats the patient who has the disease. - Sir William Osler.

By Brian Kipkoech

Person-centered care campaigns have gained traction in most parts of the globe, with much emphasis on a shift from disease-focused care to the adaptation of person-centered care. Person-centered care can be precisely defined as a model of care delivery that has much emphasis on the individual's needs and values and involves the active collaboration of the clients, families, and providers to create an inclusive clinical care plan. It is largely made of but not limited to promoting respect, honoring client preference, supporting autonomy, improving quality of life, empowering the recipient of care, and promoting positive well-being.

In many African countries, healthcare systems have consistently been victims to limited resources, larger client-to-physician ratios, and limited funding for healthcare training and facilitation that has limited the extent of adoption of holistic care. Holistic care includes meeting emotional, psychological, and social needs, and in a culturally diverse nation like Kenya, cultural competence is key for the delivery of quality care. On most occasions, the clients feel marginalized, disconnected, and disempowered from the care. The limited person-centeredness undermines the quality of care and leads to poor health outcomes.

Healthcare training holds a critical role in the irrigation of person-centered care culture within our context. In Kenya, there is the privilege of training a number of basic healthcare levels with a number of specialties. Curriculum developers and policymakers ought to make keen interest and efforts to ensure the incorporation of person-centered care within the basic training. Importantly, it is subtle to isolate and dissect these components in our existing curricula critically. Future developments should consider incorporating this aspect not only in training but also in regular assessments, including clinical assessments.

But does it only start with deeds, or will our customers be empowered to be part of the stakeholders in care if we refer to them as clients, not patients? Some healthcare providers opine that the use of the conventional name brings bad attitudes, and the adoption of the word client would change attitudes, behavior, and appropriate mutual interaction. The term client has, however, been widely used in some parts of the multidisciplinary umbrella, including in physical and occupational therapy and psychology, with minimal application in clinical care. Further, private practice has also embraced this name, giving a more personalized outlook, unlike in the public

sector. It is also high time that we heed the call to empower and consider positive names for the people we serve in various units and recipients of care, including in the public sector.

In conclusion, the journey towards the achievement of a person-centered care culture is collective. There is a need for the intentional and active play of the healthcare trainees, healthcare providers, educators, curriculum developers, and policy developers. Quality care, positive client outcome, client satisfaction, healthcare provider satisfaction, and overall healthcare outcome are anchored on the collective input to bring all stakeholders on board, including making the clients the bigger players and reducing the traditional feeling of vulnerability. Borrowing from the South African disability rights movement in the 1990s, there is Nothing about us without us. Meaningful and active participation of all stakeholders is vital.

I AM A REGISTERED NURSE WITH A B.SC. NURSING DEGREE FROM MOI UNIVERSITY, AND CURRENTLY A MASTERCARD SCHOLAR AT THE KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY-KUMASI, GHANA. I HAVE A GREAT INTEREST IN RESEARCH, ESPECIALLY ON QUALITY CARE, HEALTH SYSTEMS MANAGEMENT, SERVICE DELIVERY, ONCOLOGY, AND PALLIATIVE CARE.

Holistic care includes meeting emotional, psychological, and social needs, and in a culturally diverse nation like Kenya, cultural competence is key for the delivery of quality care.

TALES FROM THE FIRESIDE

By Maina Michael Muriithi

CK came to me as an informal referral from a friend 3 years ago. 'She gets some pain during her periods and vomits a lot. She even gets diarrhea and sometimes has to go for pain injections.'
From what I gathered later, she had just broken up with her partner as he considered her a lot of work to bear with. 'She was done for a scan the other day and it showed a cyst in one of her ovaries', he said.

I had just completed my internship. We met at the friends business premise and had a conversation. I thought she could have been having pain from the cyst.

I wrote for her some pain killers and we agreed to monitor and see how things go.

She didn't get better. She kept calling. She was losing it. She felt anxious. Depression could be felt in her voice.

'What did I get myself into', I asked myself. I had committed to phone consultations and I couldn't find a solution here.

I wanted to suggest to her to see a psychologist but I thought she would think I'm judging her or invalidating her symptoms.
I had suggested to her the idea of taking daily contraceptive pills but she was very adamant about it. She was a staunch Christian and could not think of herself taking contraceptives. She would have to disclose to her spiritual dad and mum and they would not be happy- maybe.
I requested her to see a gynecologist after 3 months of trying different pain killers.
She went to the hospital but was booked to see a General Practitioner. The gynecologist there came once a week and had just come the previous day.

The GP gave her some medications to take daily and other painkillers. She called me after a week and sent me the prescription to ask her what the medicine was.

It was Visanne, a progesterone hormone. Immediately I mentioned that, she almost vomited. It was the same medication she didn't imagine taking. She stopped it immediately.

The next 3 months were hell on earth for her. She kept complaining of pain, bloating and vomiting. Sometimes diarrhea. She got some links to a city gynecologist and went to see him.

She had a scan done. Just the same cyst no much change. They had a great conversation about endometriosis. They talked about the condition, the symptoms, the medication and other options including surgery. For once, she felt like someone understood her.

She agreed to try the medication.

It was expensive but she would try and

buy it. Two months into the medication, her periods had disappeared and so had her pain. She felt good. She felt happy. She even applied for and got a job.

She was looking brighter.

She had finally found a solution. I lost contact.

The story above just shows how much endometriosis patients go through before they finally find help. The median duration of symptoms before a patient gets to know her diagnosis of endometriosis is postulated to be around 7-10 years.

There are a myriad of challenges from sociocultural beliefs about period pains and contraceptives, lack of diagnostic services especially in this part of the world and lack of specialists.

The condition also being less clear in terms of pathogenesis and pathophysiology in the African population and being an understudied area is also a challenge posed towards its diagnosis and management.

Over the last 4 weeks in the month of March, I have been doing my preceptorship in fertility and endomemtriosis as part of my residency training. I have seen the whole spectrum from mild to severe disease. I have seen the completely well to the completely unwell from endometriosis. I have seen functional patients doing well and patients disabled from the condition. Not physically, but functionally disabled.

On my last day of the rotation, I spent time with specialists involved in management and research in endometriosis together with endometriosis warriors. I have come to appreciate a few things.

1. We are still much behind as a country and even a continent in terms of diagnosis and care for endometriosis patients. Most times by the time the patients come to us, they have gone through a lot more challenges and this is mostly an urban population. Not to mention those in rural areas.
2. Care for endometriosis is multidisciplinary. As a care provider, on most times you will need a pain specialist, a general surgeon, a psychologist and a social worker to complement the services offered by gynecologists for these patients.
3. Period pain affecting function is not normal. It should be investigated. Let us not normalize it.

I am now wiser. I am now better and I know how to approach this enigma called endometriosis in a better way. My wish would be that more and more clinicians get to learn how to interact, diagnose and manage endometriosis patients comprehensively.
March is endometriosis awareness month and what a way it was to close the month by spending a day together with patients and specialists involved in endometriosis management. From now henceforth, it is onwards and upwards for the Yellow Endo Movement.
Viva.

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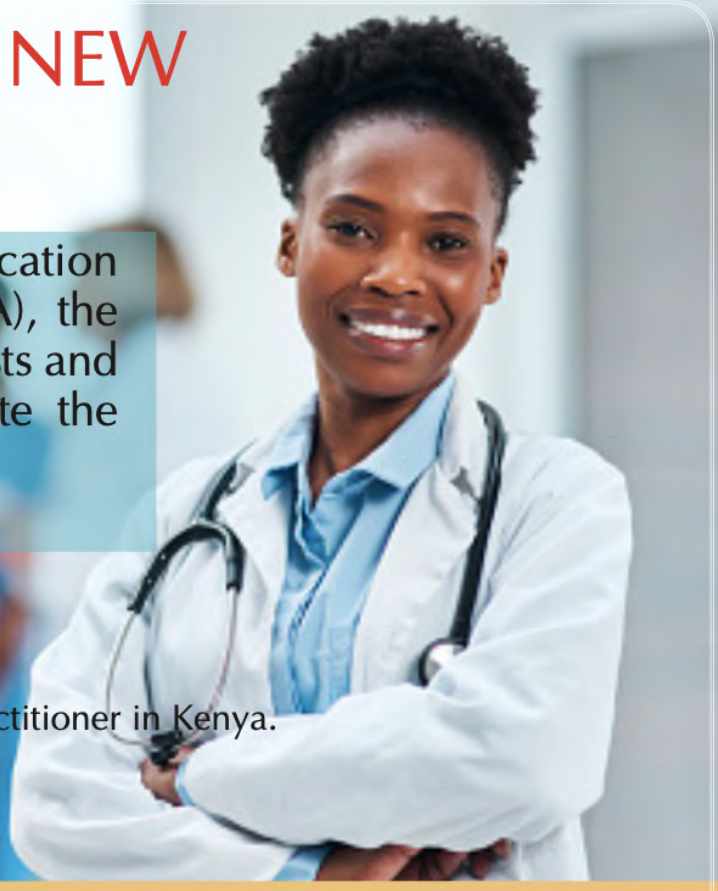

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