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HEALTHCARE GOVERNANCE FOR UNIVERSAL HEALTH COVERAGE: THE ROLE OF THE KENYA MEDICAL ASSOCIATION

Dr. Simon Kigondu
President, KMA

Understanding Health System Governance

Health system governance refers to the rules and norms that define roles, responsibilities, incentives, and interactions within the health sector. Its primary goal is to provide strategic direction that protects and promotes public health.

Governments play a central role in setting governance structures through legal frameworks, policy development, planning, and monitoring. Health service providers are key actors in the health system, while international organizations also contribute significantly. Strong coordination among these stakeholders is vital for effective health system performance and the realization of Universal Health Coverage (UHC).

Beyond formal mechanisms, governance is also shaped by conventions, cultural norms, economic incentives, and persuasive leadership. These dynamics influence how policies are developed, implemented, and sustained.

KMA's Role in Healthcare Governance

The Kenya Medical Association contributes significantly to shaping Kenya's healthcare governance, promoting efficiency, transparency, and equitable use of health resources. KMA has made important proposals in the following areas:

1. Policy and Regulatory Frameworks

KMA has provided input on strengthening the Social Health Authority (SHA), aiming to ensure all Kenyans have access to essential health services through effective policy enforcement and regulation.

2. Financing and Resource Allocation

The association advocates for increased public investment in healthcare to reduce out-of-pocket costs and ensure sustainable funding for UHC. KMA also actively works to eliminate corruption and mismanagement in healthcare expenditure by being a voice for both practitioners and patients.

3. Human Resource Management

KMA pushes for equitable distribution of healthcare workers to underserved areas and champions better pay and working conditions for health professionals. It conducts continuous medical education to improve service delivery and advocates for the creation of a National Health Service Commission to manage human resources more effectively.

4. Strengthening Primary Healthcare Systems

KMA urges investment in preventive and primary care to ease pressure on referral hospitals. This includes upgrading infrastructure and staffing in primary care facilities. Members are encouraged to lead primary care initiatives and establish care networks. Community health workers should be linked to formal health systems and traditional medicine practitioners, supporting holistic and culturally responsive care.

5. Public-Private Partnerships (PPPs)

KMA encourages ethical collaborations between the government and private sector to leverage investment, innovation, and quality benchmarks in healthcare. Members are urged to form strategic PPPs with counties to help achieve UHC.

6. Data-Driven Decision Making

Improving health information systems (HIS) enhances service delivery and transparency. Real-time data supports better planning and accountability. In Murang'a County, for example, KMA members have observed tangible benefits from effective HIS use, leading to improved efficiency across the health system.

7. Decentralization and County-Level Governance

KMA promotes stronger coordination between national and county governments. It calls for the elimination of duplicate licensing and unfair taxation, such as the burden of multiple business permits. KMA supports performance-based financing and urges counties to be innovative in generating revenue while delivering quality care.

8. Health Equity and Social Inclusion

KMA champions inclusive health policies that prioritize marginalized groups, including rural populations and informal settlements. The association also promotes gender-sensitive programs and inclusive leadership to improve maternal and reproductive health outcomes. Public participation in health decision-making is a key principle in ensuring policy responsiveness.

Political Appointments and Healthcare Leadership

KMA strongly believes that top health policy positions should be held by professionals with medical and management expertise. For example, the Cabinet Secretary for Health should ideally be a doctor who understands the healthcare system intimately. Such leadership ensures policy decisions are grounded in evidence, ethics, and lived experience, ultimately improving health outcomes.

Conclusion

By strengthening governance in these critical areas, Kenya can build a resilient and inclusive healthcare system that accelerates progress toward UHC and better health outcomes for all. The Kenya Medical Association remains committed to guiding this transformation through policy leadership and strategic advocacy.

We call upon policymakers, healthcare professionals, and community leaders to collaborate with KMA in advancing evidence-based policies and ethical practices. Together, we can secure a future where accessible, equitable healthcare is a reality for every Kenyan.

Dr. Simon Kigondu, MBChB, MMED, is an experienced obstetrician-gynaecologist with decades of experience and a solid background in governance and policy. He is a long-serving member of the Kenya Medical Association (KMA), where he currently serves as its President and has previously held other significant roles, playing his part in elevating the association and ensuring it continues to play a key National and Regional roles in Health Governance and policy.

HEALTHCARE GOVERNANCE FOR UNIVERSAL HEALTH COVERAGE: FROM POLICY TO PRACTICE

Dr. Diana Marion
Secretary General , KMA

Bridging the gap between policy and practice in health in Kenya is essential for achieving a functional, efficient, and equitable healthcare system. While Kenya has developed strong health policies and strategic frameworks, their implementation remains a challenge, leading to persistent health system inefficiencies, inequities, and poor health outcomes.

Targeting improving health outcomes, policies such as Universal Health Coverage (UHC) and the Kenya Health Policy (2014–2030) set ambitious targets for equitable healthcare access, but without effective implementation, preventable diseases, maternal deaths, and poor service delivery persist. Bridging the gap ensures that policies translate into real, life-saving interventions for citizens.

There is often a disconnect between policymakers, healthcare providers, and communities. Strengthening collaboration ensures that frontline workers have the resources, training, and support needed to deliver quality care while holding policymakers accountable for resource allocation and service delivery. Strengthening Health System Governance Kenya has experienced inefficiencies and wastage of health resources due to misaligned priorities, corruption, and lack of implementation oversight. Policies should be evidence-based and informed by real-world healthcare challenges to ensure efficient use of funds, infrastructure, and personnel.

Many policies advocate for universal access, yet inequalities persist, especially in

rural and underserved areas. Aligning policy with practical implementation ensures that vulnerable populations truly benefit from healthcare reforms, rather than just being mentioned in policy documents.

Without a strong implementation framework, many health policies risk being short-lived due to political transitions or funding inconsistencies. Bridging the policy-practice gap ensures that reforms are institutionalized, community-driven, and adaptable, making them more resilient to political and economic shifts.

Policies made without input from frontline workers and communities often fail because they do not reflect on-the-ground realities. Strengthening this connection ensures that healthcare workers are empowered to implement policy-driven best practices and that communities understand and engage with health initiatives.

To close the policy and practice gap, we must build a stronger, more responsive health system that delivers real impact to its people through:
1.Strengthening stakeholder engagement between government, healthcare professionals, and communities.
2.Improving accountability mechanisms to ensure policies translate into action.
3.Investing in data-driven decision-making to align health policies with real-time needs.
4.Enhancing capacity-building for healthcare workers to implement policy effectively.
5.Promoting political will to sustain reforms beyond election cycles.

Kenya's UHC success hinges on governance that prioritizes execution as much as ideation. By closing the policy-practice gap, we can transform health systems from paper promises into lifelines for every citizen.

Universal Health Coverage

HEALTHCARE GOVERNANCE FOR UNIVERSAL HEALTH COVERAGE IN KENYA : BRIDGING CONSTITUTIONAL STANDARDS AND SYSTEMIC CHALLENGES

By Dr. Wairimu Mbogo

Kenya's Constitution guarantees every citizen the right to the highest attainable standard of healthcare. This promise underpins the country's commitment to Universal Health Coverage (UHC), aiming to ensure that every Kenyan, regardless of their financial status, can access quality healthcare. Yet, as the country pushes forward with this vision, systemic gaps in governance, professional service delivery, regulation, and affordability of healthcare inputs continue to challenge its realization.

One of the most pressing concerns is the human resource crisis in healthcare. While thousands of trained doctors, dentists, and pharmacists remain unemployed, the government has increasingly relied on task-shifting, allowing non-specialist cadres to perform high-risk medical procedures. Though often justified as a solution to personnel shortages, this approach puts patients at risk. Procedures that require specialized expertise, such as surgeries, anesthesia, and complex pharmaceutical interventions, cannot be safely delegated to underqualified personnel without compromising patient safety. Instead of task-shifting, the government should focus on proper deployment, fair remuneration, and structured career paths for healthcare professionals. Investing in the available skilled workforce will not only enhance healthcare delivery but also reduce medical errors and preventable deaths. In the long term, a recent trend regarding the export of Kenya's healthcare workforce, without reaching the recommended WHO patient-provider ratios—may further result in detrimental effects on the achievement of UHC.

Beyond the workforce challenges, the state of public healthcare facilities remains a concern. Many government hospitals lack essential medicines and functional equipment, forcing patients to seek treatment in private facilities, which are often unaffordable. Despite heavy investment in constructing and upgrading hospitals, maintenance remains a weak link, with equipment lying idle or broken due to a lack of trained technicians or spare parts. County governments, tasked with managing healthcare at the grassroots level, often face financial mismanagement issues, resulting in frequent stockouts of drugs and supplies. Public-private partnerships could play a key role in addressing these gaps, but these collaborations must be well-structured to ensure they serve the public interest rather than purely profit-

driven motives.

Another critical factor in the realization of UHC is Kenya's regulatory framework for medicines and healthcare products. The country is actively working toward achieving Maturity Level 3 (ML3) under the World Health Organization's Global Benchmarking Tool, which would strengthen regulatory oversight of pharmaceuticals and medical devices. Enhancing the capacity of the Pharmacy and Poisons Board (PPB) to conduct thorough pre-market evaluations and post-market surveillance is essential. A robust regulatory system would not only ensure that only high-quality, safe medicines are available but also promote local pharmaceutical manufacturing, reducing dependence on costly imports.

The cost of healthcare remains one of the biggest obstacles to UHC. Over 80 percent of medicines in Kenya are imported, leaving the country vulnerable to fluctuations in global prices and currency exchange rates. High taxation, tariffs, and inefficient procurement systems further drive up costs. Many Kenyans still have to pay out-of-pocket for essential treatments, making healthcare inaccessible for those without financial means. Encouraging local pharmaceutical production through tax incentives and compliance with Good Manufacturing Practices could significantly lower costs and improve availability.

The Social Health Authority (SHA), the body now overseeing health insurance under UHC, was introduced to streamline payments and ensure the financial sustainability of healthcare services. However, its implementation has faced numerous challenges, including delays in claim reimbursements, gaps in coverage, and a lack of clarity on how funds are allocated. Many private and public healthcare facilities have raised concerns over delayed payments, making it difficult to sustain operations. For SHA to succeed, transparency in fund allocation, prompt reimbursements, and stakeholder engagement are crucial. The authority must also work toward expanding coverage to include vulnerable populations and improving public trust in the system.

Universal Health Coverage is not just a policy ambition but a fundamental right for all Kenyans. However, achieving it requires more than political promises—it demands practical solutions. Properly deploying and utilizing healthcare professionals, equipping and maintaining hospitals, strengthening regulation, and ensuring affordable healthcare inputs are all essential components of a functioning UHC system. If these governance gaps are addressed, Kenya can move closer to fulfilling its constitutional obligation of providing accessible, high-quality healthcare for all.

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HEALTHCARE GOVERNANCE FOR ALL: BRIDGING EMERGENCY AND HOSPITAL CARE TO ACHIEVE UNIVERSAL HEALTH COVERAGE IN KENYA

By George Amolo

Introduction

Universal Health Coverage (UHC) aims to ensure that all individuals and communities receive the health services they need without suffering financial hardship. Achieving UHC in Kenya requires a strong governance framework that spans both prehospital emergency care and hospital settings. By recognizing the interconnectedness of these two domains, policymakers and healthcare leaders can create a more effective healthcare system that prioritizes patient outcomes, equity, and accessibility. This integrated approach will be key to realizing the vision of UHC for all Kenyans.

Understanding Prehospital Emergency Care

Prehospital emergency care is the critical first line of response for patients experiencing medical, trauma, and gynecologic/obstetric emergencies. This includes the provision of timely and effective care by highly trained undergraduate paramedics before patients arrive at hospitals. Key components of effective prehospital care include:

- **Timeliness:** Rapid response is crucial, especially in life-threatening situations. Delays in prehospital care can lead to worse outcomes.
- **Coordination with Hospitals:** Effective communication and coordination between prehospital teams and hospitals ensure seamless transitions for patients needing urgent care.
- **Training and Resources:** Well-trained paramedics, equipped with adequate resources, are essential for delivering quality emergency care.

The Role of Hospital Settings

Once patients reach the hospital, the governance structure must facilitate optimal care delivery. Hospitals play a vital role in managing patient care and ensuring that individuals receive comprehensive services. Key aspects of hospital governance include:

- **Quality Assurance:** Implementing protocols and standards to maintain high-quality care across departments.
- **Access to Services:** Ensuring equitable access to healthcare services, regardless of a patient's background.
- **Patient-Centered Care:** Focusing on the needs and preferences of patients to

provide holistic and responsive healthcare.

Interconnections between Prehospital and Hospital Care

Effective healthcare governance must recognize the interdependence of prehospital emergency care and hospital settings. Patients typically do not move in isolation; they require a continuum of care that begins outside the hospital. This connection highlights several governance considerations:

- **Integrated Care Models:** Developing integrated care pathways that link prehospital and hospital services can enhance patient outcomes. For example, standardized protocols for patient handoff from prehospital healthcare professionals to hospital staff minimize information loss and improve care continuity.
- **Data Sharing:** Establishing systems for sharing patient data between prehospital services and hospitals facilitates better clinical decision-making and resource allocation.
- **Public Awareness and Education:** Educating the public about the importance of prehospital care and its interaction with hospital services can foster a culture of seeking timely medical help.

Challenges to Effective Governance

While the integration of prehospital and hospital care is essential, several challenges remain:

- **Resource Constraints:** Limited funding and resources for the prehospital sector hinder its ability to provide timely and effective care.
- **Training Gaps:** Variability in the training and skills of prehospital providers can lead to inconsistencies in care quality.
- **Policy Frameworks:** A lack of comprehensive policies bridging prehospital and hospital care may result in fragmented services.

Recommendations for Strengthening Governance

To enhance healthcare governance for UHC in Kenya, the following strategies could be implemented:

1. **Establishing Clear Policies:** Develop national policies that integrate prehospital and hospital care, ensuring accountability and coordination among stakeholders.
2. **Investing in Training:** Focus on improving the training of prehospital personnel and hospital staff to ensure they are equipped to handle the complexities of patient transfers and emergency care.
3. **Enhancing Infrastructure:** Invest in infrastructure that supports efficient emergency response systems and facilitates smooth patient transitions to hospitals.
4. **Encouraging Community Engagement:** Involve communities in designing and implementing healthcare initiatives that reflect their needs and priorities, promoting

a sense of ownership over health services.

Conclusion

The integration of prehospital emergency care and hospital services is a fundamental aspect of achieving Universal Health Coverage in Kenya. Although challenges remain, addressing them through effective policy, training, and infrastructure improvements will strengthen the healthcare system. By fostering collaborative governance, Kenya can move closer to realizing the vision of accessible, equitable, and affordable healthcare for all its citizens.

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HEALTHCARE DEVOLUTION: A STEP TOWARDS UHC OR A GOVERNANCE NIGHTMARE?

By Seliza Opanga

Introduction: The Devolution Dilemma

Healthcare is a fundamental right for every Kenyan, as guaranteed by Articles 43, 53, and 56 of the Constitution. The 2010 Constitution's healthcare devolution aimed to bring services closer to the people, allowing county governments to design localized interventions and improve citizen participation. This shift aligned with global commitments to Universal Health Coverage (UHC), as outlined in SDG 3.8, which seeks to provide essential health services to all without financial hardship.

Devolution promised quicker decision-making, better resource distribution, and a more responsive health system. However, over a decade later, challenges such as strained human resources, infrastructure gaps, financial mismanagement, and conflicts between county and national governments threaten UHC progress. Doctors' strikes, regional disparities, and chronic underfunding have hindered healthcare gains.

Reality on the Ground: How Devolution is Affecting UHC

The transition to devolved healthcare has been marred by inconsistency, poor management, and lack of coordination. These issues are evident in several areas:

1. Salary Delays and Doctors' Strikes

County mismanagement has led to salary delays, causing nationwide strikes. In counties like Vihiga and Nairobi, healthcare workers protested unpaid salaries and lack of essential supplies, disrupting public hospitals.

2. Unequal Healthcare Quality Across Counties

Healthcare access varies widely. While the WHO recommends that health facilities be within 5 km, in Turkana, residents must travel over 50 km, while Nairobi residents have access within 2 km. The doctor-to-patient ratio in Kenya, at 19 per 100,000 people, is far below the WHO's 1:1,000 ratio. Rural areas suffer more, with some counties having just 1 doctor per 30,000 people.

3. Poor Resource Allocation and Corruption

Despite healthcare being a priority, budget allocations remain inadequate. In the 2018/19 fiscal year, 81% of counties allocated at least 15% of their budgets to health, yet the national government allocated only 4% to healthcare. Corruption exacerbates the problem, leaving county hospitals underfunded.

4.Parallel Programs and Conflicts Between National and County Governments

The lack of coordination between the two levels of government has led to

inefficiencies. Some counties reject national health policies, impeding the implementation of UHC programs.

National vs. County Government: Who is Responsible?

A major challenge in Kenya's devolved healthcare system is the unclear division of responsibilities between the national and county governments. Counties handle service delivery, personnel, and infrastructure, while the national government is responsible for policy, training, and specialized services. However, blame-shifting is common, with counties blaming the national government for inadequate funding, while the national government accuses counties of mismanagement.

A clear governance framework is needed to harmonize financing, policy execution, and human resource management.

Global Case Studies and Lessons for Kenya

Other countries have successfully used decentralization to improve UHC. In Brazil, the Unified Health System (SUS), decentralized since 1988, allows municipalities to manage resources efficiently. Through the Family Health Strategy (FHS), local governments expanded primary healthcare, improving health outcomes. Kenya can learn from Brazil's balance of financial autonomy and national oversight.

In Kenya, a domestic comparison between Makueni and Lamu counties shows the importance of effective governance. Makueni has implemented a successful county-led UHC model, improving community-based health insurance and healthcare facilities. In contrast, Lamu struggles with inadequate medical facilities, poor staffing, and resource mismanagement, leading to low healthcare delivery. This highlights that effective governance, not just devolution, determines success.

The Way Forward: Finding the Right Governance Balance for UHC

For devolution to support UHC, Kenya must balance county autonomy with national oversight. The current system needs reform through better coordination, accountability, and strategic resource allocation.

1. Strengthening Intergovernmental Coordination

Kenya's Intergovernmental Relations Act (2012) should be amended to establish a binding arbitration mechanism for disputes over funding, personnel, and service provision. A centralized national health service commission should oversee human resource issues, preventing salary delays and strikes.

2.Equitable Resource Allocation

Counties should implement needs-based budgeting, ensuring rural areas receive resources based on healthcare demand. Conditional grants should be tied to performance, and independent audits should curb corruption.

3. Implementing a Monitoring and Accountability Framework

Kenya needs a national healthcare governance scorecard tracking key metrics like doctor-to-patient ratios, facility coverage, and financial accountability. This should be publicly accessible, updated annually, and help citizens and policymakers

assess county performance.

4.Leveraging Technology and Health Innovation

Digital health solutions, such as electronic medical records, should be scaled up to improve healthcare access. Counties with large rural populations, like Turkana, should adopt mobile health units and community health worker programs.

Conclusion: Can Kenya Fix the Healthcare Governance Crisis?

Kenya faces a critical crossroads in its UHC journey. While devolution was meant to bring healthcare closer to the people, governance failures have widened inequalities, strained healthcare workers, and stalled progress.

Change is possible. By clarifying governance roles, enforcing financial accountability, improving coordination, and investing in infrastructure, devolution can drive UHC forward. Brazil and Spain show that strong governance can make decentralization work.

Fixing Kenya's healthcare governance is not just possible—it's urgent. The future of UHC and the health of millions depend on it.

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MOST ANSWERS WE SEEK LIE WITHIN THE QUESTIONS WE ASK

By Dr. Aloyce Rieko

There was a time when a beautiful dream was conceived in our beloved country. The dream? That every Kenyan citizen—from the remotest villages in Baringo and Turkana to the city dwellers of Nairobi and Nakuru—would one day walk into a health center close to them, receive the highest quality of healthcare, and walk out without relatives having to sell a parcel of land to cover the cost.

For our dream to become a reality, we all knew what we needed: proper governance in the health sector. On paper, one would be forgiven for prematurely concluding that we already had this in the bag. After all, in an ideal setup, what more would you need to bring such a beautiful dream to life? The answer seemed clear. Yet, this is Kenya and matters of governance here tend to be more erratic than your regular boda-boda rider in Nairobi traffic—unpredictable, fast-moving, and, most times, even on the wrong side of the road. We are a very impatient nation, often to our detriment.

We got this wrong from the onset when 'professional' policymakers landed on our dream and declared that all health records would be digitized immediately. A noble proposal by all accounts, but did we think through what it would take to implement that idea? I don't need an answer to that. The whole concept of our dream was to leave no one behind. Yet here we were, cheering on as though Kenya were suddenly a first-world country where the 'small' matter of computer literacy in the population could just be swept under the carpet, and life would go on. Somewhere in Turkana, a resident wondered whether they were in the same country. Our policymakers followed the mantra that if it could work in Nairobi, it would work everywhere else. Makosa kubwa! Without proper, well-calculated, and executed systems, we all knew our policies were bound to fail. Yet, we kept looking and hoping.

Hot on the heels of the policymakers were the county health officials, who went on a launching spree, cutting ribbons even at the doors of buildings whose construction was still incomplete. With their reflective jackets and polished speeches, they sure felt like the saviors our healthcare system yearned for. But when you visited the clinics a few days later, you'd be lucky to find one clinical officer doubling as a nurse, two or three stray cats yawning on the floor, and multiple unused rooms. We knew from the launch that health centers would need staff, equipment, and drugs, but we were too excited to question such things, lest we anger our politicians. It always feels like these services are a favor and not a right from our governments, but today, I'm not on politicians, so I'll spare them a little.

The silver lining so far is that governance in our healthcare system hasn't been all doom and gloom. Where it works, it has really worked. Look at Makueni County, for instance. You get the feeling from multiple audited reports that in Makueni, the leaders treat the health budget with the seriousness it deserves. Cases of healthcare budgetary allocations mysteriously vanishing only to reappear in some individuals' bank accounts are unheard of. It points us toward something that we already know, but somehow, we conveniently lose our voices when it's time to speak up. Matters of transparency, accountability, integrity, and community involvement must be the driving forces of Universal Health Coverage. When decisions are made with the most vulnerable members of our societies in mind—rather than just in boardrooms with reclined seats and bottled water—we end up with a system that will fully deliver and thrive because everyone understands their obligations.

Bottom line? Good governance is the least we can demand if this dream of Universal Health Coverage is to live on. We must fight for what we're convinced will benefit the majority, and we must demand accountability and transparency at every level. Most importantly, we must strive to get people of integrity into critical decision-making and governance organs. I promised not to touch on the politicians, but unfortunately, our political decisions and the goodwill of those we entrust with leadership cannot be overlooked in this journey. Good governance is what we need to keep the dreams and aspirations of a better and more efficient healthcare system running; otherwise, Universal Health Coverage will forever remain a campaign slogan, shouted by politicians during the perennial election campaigns to make them appear like they actually care. But we know them already—or do we?

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REIMAGINING HEALTH GOVERNANCE: WHY PUBLIC PARTICIPATION MATTERS FOR UHC

By Dr. Paul Gitonga

Centrality of PHC to UHC

In 1978, under the auspices of WHO and UNICEF, the world met in modern-day Kazakhstan for the International Conference on Primary Health Care and made the famous Alma-Ata Declaration. This defined primary health care as "essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in their spirit of self-reliance and self-determination." Forty years later, the world returned to Kazakhstan for the Astana Declaration, which reaffirmed PHC as the most viable and sustainable approach to achieving UHC. It emphasized the need for an empowered populace with knowledge, skills, and resources to maintain their health. It also urged governments to promote health literacy and meet citizens' expectations for access to health information.

The People: A Forgotten Dimension of UHC

The Astana Declaration further stated that people have the right and duty to participate, individually and collectively, in planning and implementing their healthcare. It highlighted education as a tool to enhance this participation and called on governments to provide relevant information, improve literacy, and create supportive policies and institutions.

Kenya has shown commitment to ensuring that citizens access quality health services without financial hardship, as articulated in the Constitution, Vision 2030, Kenya Health Policy 2014-2030, and Health Act 2017. WHO outlines three dimensions of UHC: financial protection, services offered, and population coverage—with a focus on the underserved, marginalized, and vulnerable.

Globally, progress towards UHC has been off track since 2015 on all three dimensions, a trend worsened by COVID-19. In LMICs, disparities are evident: urban, educated populations have better access to reproductive, maternal, child, and adolescent health services, while catastrophic health spending is more common among the poor, the elderly, and rural households. These groups, though they vote every five years, rarely influence health decisions made in distant urban offices. This detachment highlights the need for public participation in the health sector.

Public Participation

Public participation is a constitutional requirement and a core principle of governance in Kenya. Yet, the Kenya Policy on Public Participation (2023) acknowledges significant barriers: lack of standards, poor coordination, insufficient inclusivity, and widespread citizen apathy. Many Kenyans are unaware of their rights and responsibilities due to inadequate civic education and a tendency to delegate their power to elected leaders. The policy aims to ensure citizens receive timely, understandable information and have opportunities to provide feedback on governance.

Social Accountability Through Participation

Effective public participation must include mechanisms that enable citizens to hold public officers and institutions accountable. Social accountability theory offers a framework for empowering communities to demand accountability. Local participation shortens the accountability chain between citizens and service providers, including the government.

Key accountability elements include:

· **Voice:** channels for citizens to express preferences and views.
· **Enforceability:** systems to uphold commitments through sanctions or incentives.
· **Answerability**: feedback loops showing how input influenced decisions.

To succeed, public voices must reach decision-makers who can influence service provider behavior. Tools like citizen report cards, community scorecards, citizen charters, and town hall meetings can serve this purpose. These tools are widely used in the private sector for customer service; similar responsiveness should apply to public services funded by taxpayers.

Thailand exemplifies this model. Healthcare laws require the government to publish service quality data, and underperforming facilities can face censure, demonstrating enforceability.

Organizing Community Feedback

The IFRC uses the Ground Truth Solutions Constituent Voice methodology in its programs, including community feedback systems. This method involves regularly asking key questions, analyzing responses, and sharing insights with affected communities for dialogue and program improvement. Topics may include relationships with health staff, service delivery, problem-solving capacity, and health outcomes.

Kenya's devolved health system presents an opportunity to integrate such social accountability tools. Past successes in health promotion (e.g., vaccination, HIV/TB programs) have relied on community health volunteers (CHVs), civil society groups,

and non-state actors. However, these programs have been largely paternalistic—prescribing actions rather than engaging communities in identifying their own needs. Moving forward, collaboration through public participation is essential.

Bottom-Up-Bottom Feedback Strategy

A bottom-top-bottom approach involves collecting community feedback, transmitting it to decision-makers, and then communicating back to the community about how their input was considered. This promotes self-determination, community ownership, and reduced apathy, ensuring program sustainability.

Through CHVs and facility-based education, communities can be informed about their rights, policies like the Social Health Insurance Act, and health promotion initiatives. They can then provide feedback via tools like community scorecards. This input can be aggregated at the facility, subcounty, and county levels, analyzed using existing digital infrastructure, and addressed at appropriate levels. Once decisions are made, feedback should flow back through the same channels —CHVs, civil society, town halls, and other community engagement mechanisms.

Conclusion

PHC is the sustainable path to achieving UHC, with community engagement at its core. A bottom-up approach—collecting, analyzing, and responding to community feedback—is key to delivering accessible, socially acceptable healthcare.

Now is the time for governments, civil society, and healthcare leaders to prioritize public participation. Empower communities with the tools to engage, strengthen feedback mechanisms, and ensure all voices shape the future of healthcare. Together, we can build a more inclusive, accountable, and sustainable health system.

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> Public participation is a constitutional requirement and a core principle of governance in Kenya. Yet, the Kenya Policy on Public Participation (2023) acknowledges significant barriers: lack of standards, poor coordination, insufficient inclusivity, and widespread citizen apathy.
>
> -Dr. Paul Gitonga

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HEALTHCARE GOVERNANCE FOR UNIVERSAL HEALTHCARE: A PARADIGM SHIFT LED BY THE GLOBAL SOUTH

By Dr. Michael Ouma

Introduction

The pursuit of Universal Health Coverage (UHC) stands at a critical crossroads. For decades, global health governance has been dominated by Western institutions, creating dependencies and perpetuating colonial power structures that have hindered true health sovereignty in the Global South. Today, a paradigm shift is underway—one where countries in Africa, Latin America, and Asia are increasingly asserting their right to determine their healthcare futures.

The Colonial Legacy in Global Health Governance

Global health governance has historically operated through vertical, donor-driven programs that prioritize Western interests. The World Health Organization (WHO), World Bank, and bilateral donors have maintained control over funding mechanisms, priority-setting, and policy recommendations, often at the expense of local autonomy and contextual solutions.

As Abimbola and Pai (2020) note, "Decolonizing global health is about dismantling the current order in which individuals and institutions in high-income countries dictate the agenda for health equity in low and middle-income countries."

The Case for Health Sovereignty

Health sovereignty emerges as a critical concept—the right of nations to determine their own health policies, develop their own health systems, and leverage their indigenous knowledge and resources. This sovereignty isn't just a matter of national pride; it's a practical approach to developing sustainable healthcare systems that respond to local needs and contexts.

Rwanda's community-based health insurance (Mutuelle de Santé) represents an exemplary case of health sovereignty in action. By developing locally accountable governance structures rather than relying on external aid architectures, Rwanda achieved over 90% coverage, demonstrating that context-specific solutions can outperform imported models.

Global South Leadership: Emerging Models

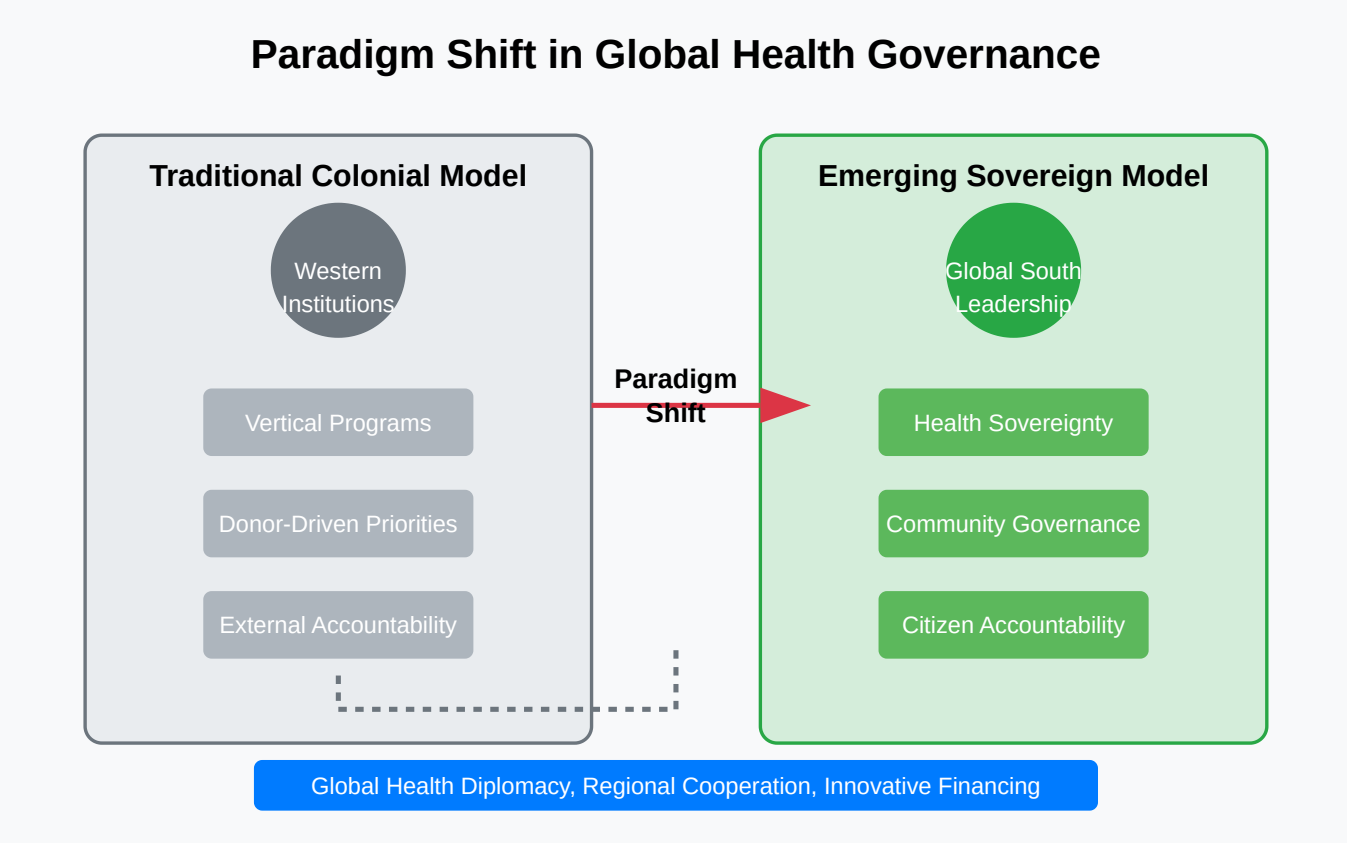
Several innovative governance approaches from the Global South are challenging traditional paradigms:

1. South-South Cooperation: Brazil, Cuba, and China have developed bilateral health cooperation programs that emphasize knowledge exchange rather than aid dependency. Cuba's physician diplomacy program has deployed over 30,000

healthcare workers to over 60 countries, offering an alternative to Western aid models.

2. Regional Health Governance Bodies*:* The African Union's Africa CDC, established in 2017, has demonstrated remarkable leadership during the COVID-19 pandemic, coordinating a continental response that transcended the fragmentation often created by donor-specific initiatives.

3. ***Community Governance Structures****:* Countries like Thailand have integrated village health volunteers into their UHC models, ensuring accountability to communities rather than external funders.



Global Health Diplomacy as a Tool for UHC

Global health diplomacy presents a powerful opportunity for Global South nations to reshape governance for UHC. Through strategic diplomatic engagement, these countries can:

· *Negotiate more equitable pharmaceutical trade agreements*
· *Develop regional procurement mechanisms to increase bargaining power*
· *Advocate for reform of international financial institutions that influence health policy*
· *Build coalitions that amplify their collective voice in global health forums*

During the COVID-19 pandemic, India and South Africa's proposal for a TRIPS waiver at the WTO demonstrated how diplomatic coalitions can challenge intellectual property regimes that impede access to health technologies.

The Financing Nexus

A critical aspect of healthcare governance is addressing the financing nexus. Global South countries are pioneering innovative approaches:

· ***Domestic Resource Mobilization*:** Ghana's National Health Insurance Scheme utilizes a combination of value-added tax and social security contributions, reducing donor dependency.

· ***Public-Public Partnerships*:** Uruguay's integrated healthcare system demonstrates how public institutions can collaborate to expand coverage without privatization.

· ***Progressive Taxation:*** Thailand funded its UHC through tobacco and alcohol taxes, simultaneously addressing funding needs and public health priorities.

A New Framework for Healthcare Governance

As the Global South leads this paradigm shift, a new healthcare governance framework for UHC is emerging—one that prioritizes:

· ***Accountability to Citizens****:* Governance structures that answer to local populations, not distant donors

· ***Contextualized Solutions****:* Health systems designed for specific epidemiological, cultural, and economic realities

· ***Horizontal Integration****:* Cross-sectoral collaboration that addresses social determinants of health

· ***Knowledge Democracy****:* Valuing diverse epistemologies and evidence sources, including traditional healing systems

Conclusion

The path to Universal Health Coverage requires not just technical solutions but a fundamental rethinking of power structures in global health. As countries in the Global South increasingly assert their health sovereignty, they offer valuable lessons for creating sustainable, equitable healthcare systems. The future of UHC lies not in replicating Western models but in nurturing diverse approaches that reflect the rich experiences and innovations emerging from Africa, Asia, and Latin America.

This paradigm shift demands courage—from Global South leaders to challenge established power structures, from Western institutions to relinquish control, and from global health practitioners to embrace new ways of thinking. The result, however, will be healthcare systems that truly serve the needs of all people, regardless of where they live.

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> -Dr. Michael Ouma

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BRIDGING THE GAP TOWARDS UNIVERSAL HEALTH COVERAGE

By Dr. Madeline Iseren

As a pharmacist in a busy private hospital in Kenya, I witness the harsh realities of our fragmented healthcare system every day. Patients don't just grapple with illness—they face the overwhelming challenge of accessing quality care.

To me, Universal Health Coverage (UHC) is not just a policy aspiration; it's the pain in a mother's eyes when she's told her child's treatment isn't covered by insurance. It's the frustration of an elderly patient turned away due to lack of resources, the heartbreak of someone who can't afford their medications, and the constant struggle to ensure equitable access to essential medicines.

The Kenya Harmonized Health Facility Assessment (KHFA 2018) underscored the urgent need to reform health system governance to realize UHC. While the Kenya Universal Health Coverage Policy 2020–2030 offers a promising roadmap, my concern remains: how will these policies translate into real, meaningful change for the people who need it most?

One fine morning, a young man—barely out of his twenties—came to my counter with a prescription for antibiotics from one of the county referral hospitals. He looked pale and frail, clearly suffering from a severe infection. When I told him the cost, his face fell. He pulled out all the notes and coins he had—barely a third of the required amount—and pleaded with me to give him enough for just one or two days.

“I’ll look for money and come back for the rest,” he promised, his voice trembling as he fidgeted with his fingers.

This wasn’t an isolated incident—it’s a daily occurrence. Patients, especially those from low-income backgrounds, are often forced to choose between buying food and buying medicine.

The KHFA 2018 report highlighted the urgent need for better resource allocation, financial inclusion, and protection mechanisms. Until these policies are effectively implemented, stories like this will continue to be the norm.

The same report also emphasized the importance of good governance in ensuring effective and efficient healthcare delivery. As a pharmacist with three years of experience in the industry, I see the impact of governance every day. When clear protocols and guidelines are in place, along with transparent drug procurement and distribution systems, and accountability at every level, things run smoothly. Patients get the medicines they need when they need them.

However, the system breaks down when bureaucratic red tape, corruption, selfishness, or lack of coordination among key stakeholders—including the government—takes the lead. I’ve seen patients suffer due to stock-outs of essential medicines in county hospitals, forcing them to seek treatment in private hospitals or pharmacies where they must pay out of pocket.

I’ve also witnessed patients helplessly moving from one facility to another, searching for resources like diagnostic equipment, laboratory reagents, or, worst of all, a qualified healthcare professional to attend to them.

The Kenya UHC Policy 2020–2030 seeks to address these challenges by strengthening leadership and management, enhancing infection prevention and control, improving information systems, and promoting community participation.

But these are not just words on paper, they require a concerted effort from all stakeholders involved.

I believe that the vision of Universal Health Coverage is achievable in Kenya. However, it takes more than setting policies and drafting plans. It demands a fundamental shift in mindset.

We must transition from a system that focuses solely on treating illness to one that promotes overall health and well-being. This includes empowering individuals to take ownership of their health by encouraging sustainable lifestyle changes, like healthier eating, regular physical activity, and the long-term commitment to maintaining those habits.

The government must step up and ensure that the concept of health is taken seriously—not just in policy, but in practice. We must guarantee that everyone, regardless of income or geography, has access to quality healthcare.
Let's share our stories, our experiences, and our ideas. Together, we can make a difference.

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> concern remains: how will these policies translate into real, meaningful change for the people who need it most?
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Health Articles

EQUITY AND ACCESS IN HEALTHCARE: A CASE FOR TOBACCO CESSATION INTERVENTIONS IN KENYA

By Dr Leon Ogoti

Tobacco use has existed for centuries, deeply embedded in various cultural, religious, and social practices. Beyond tradition, it has remained popular for its stimulating effects, with nicotine enhancing pleasure and relaxation. However, this indulgence carries a heavy price.

Since the 1950s, extensive research has exposed the devastating health effects of tobacco. It is a major contributor to respiratory, cardiac, and systemic illnesses, and alarmingly, cigarettes kill 50% of their users. In Kenya, where 9% of the population smokes, thousands are at risk of premature illness and death.

Tobacco is one of the leading risk factors for non-communicable diseases (NCDs), alongside alcohol consumption, poor diets, and lack of physical activity. NCDs account for 50% of hospital admissions and 40% of deaths in Kenya, straining healthcare resources and pushing uninsured households—who form the majority—toward catastrophic health expenses. The chronic nature of these conditions leads to a higher burden of Disability-Adjusted Life Years (DALYs) and Years of Life Lost (YLLs), while significantly reducing Quality-Adjusted Life Years (QALYs).

The impact of tobacco use is felt most acutely by low-income households. Kenya's tax system allows cheaper, unfiltered cigarettes to be taxed less, making them more affordable for individuals in lower-income brackets. However, when the adverse effects of smoking begin to manifest, these same individuals face significant barriers to accessing quality treatment. They are more likely to rely on out-of-pocket healthcare payments, and when disease complications or death occur, families suffer not just from medical costs but also from the loss of household income.

As a health advocate, I have always been aware of the dangers of tobacco use. Yet, I was often perplexed by patients who, despite suffering from smoking-related conditions and acknowledging the harm, continued to use tobacco. Like many of my colleagues, I would issue a stern health warning and advise them to quit, without truly considering how difficult it is to stop smoking.

A 2022 survey by the Tobacco Control Board, NACADA, and the Kenya National Bureau of Statistics found that 70% of smokers intended to quit within twelve months, but more than half did not know where to seek help. Many were unaware

of the NACADA helpline 1192 or that cessation services were available at rehabilitation centers and public health facilities. Even more concerning, less than half of those who had visited a healthcare facility in the past year had been advised to quit or had any discussion about their tobacco use.

Studies reveal that while 75% of tobacco users attempt to quit, 30% relapse within two days, and only 5–10% succeed without support—often requiring multiple attempts. The reality is that quitting tobacco without assistance is nearly impossible for most users.

So, where should individuals seeking cessation support go?

Tobacco control efforts have traditionally focused on reducing overall use by limiting supply, restricting access, and discouraging new users. However, for those already addicted, there remains a glaring gap in structured cessation support.

A comprehensive cessation framework should include:
1. Identification and Data Collection*:* Routine screening and documentation of tobacco use in Kenya's National Health Information System (KHIS).
2. Education and Awareness*:* Consistent efforts to educate both users and non-users on the risks associated with tobacco consumption and the benefits of quitting.
3. Healthcare Worker Training*:* Empowering healthcare professionals with the knowledge and tools to guide patients through cessation strategies effectively.
4. Accessible Cessation Services*:* Establishing dedicated centers where individuals can seek help and ensuring widespread awareness of these resources.
5. Nicotine Replacement Therapy and Medications*:* Registration and affordability of cessation aids such as nicotine replacement therapies and medications for those with severe dependence.

The saying "prevention is better than cure" has never been more relevant. As Kenya moves toward Universal Health Coverage, prioritizing tobacco cessation is not just a public health necessity—it is an economic imperative. Investing in cessation programs is far more cost-effective than managing the long-term healthcare costs associated with tobacco-related illnesses such as cancer, chronic respiratory diseases, and heart conditions. Additionally, reducing tobacco use translates into improved productivity and reduced loss of human capital due to premature death and disability.

Kenya stands at a crucial crossroads. By making tobacco cessation a national priority, we can prevent needless suffering, save lives, and significantly reduce the strain on our healthcare system. We must act now—through education, policy reforms, and accessible cessation programs—to ensure that those who want to quit

have the support they need.

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