

Kenya: Decentralization and Immunization Financing

KEY POINTS

- * Many countries are implementing decentralization—the shifting of functions from higher to lower levels of government—in health and other sectors. Decentralization can improve responsiveness to population needs, but it can also hinder the delivery of health services if roles and responsibilities are not clearly defined and the levels of government taking on new functions are not supported during the transition.
- * Decentralization can make subnational decision-makers such as local mayors good targets for immunization financing advocacy.
- * In some country contexts, it may be possible to pilot-test decentralization and related capacity-building efforts and then roll them out gradually.
- * Kenya experienced challenges with shifting fund management to subnational levels. For immunization, this resulted in some gaps in funding for vaccine and injection supplies and delivery, operational costs, and cold chain maintenance, resulting in a drop in immunization coverage.
- * A compelling argument can be made for keeping certain health functions, especially vaccine financing and procurement, at the national level.

DECENTRALIZATION—shifting responsibilities in health and other sectors from national to local authorities—has been a growing trend among countries around the world, particularly since the 1990s. Decentralization can involve varying degrees of fiscal, administrative, operational, and political power shifts. Examples include *devolution*, in which both decision-making and financial control shift, or *deconcentration*, in which only decision-making control is shifted to lower levels.

In many countries, decentralization is part of a broader political shift for purposes that might include increasing autonomy and control at lower administrative levels, pursuing political and economic liberalization, improving service delivery, bringing resources and resource allocation closer to the population, and improving health and development outcomes. This brief explores issues related to decentralization and immunization and draws insights and lessons from recent experiences in Kenya.

FEDERAL AND SUBNATIONAL FINANCING RESPONSIBILITIES FOR IMMUNIZATION

In highly decentralized countries, the national government's role in the immunization program usually involves policymaking, procurement, financing of vaccines and injection supplies, national storage, stock management (and some distribution), developing overall delivery strategies and multi-year plans, coordinating any external and donor financing, aggregating and reporting on nationalized coverage data and surveillance, setting skills standards, and coordinating training. Financing for salaries, supply chain, and operating costs associated with the immunization program might be a subnational responsibility, using funds raised and allocated to health through local taxation. Procurement almost always remains national—because of the specialized knowledge required, the need for pooled resources, and economies of scale generated.

In countries where both national and subnational governments raise revenues, decentralization reforms can affect the domestic sources of funding that flow to immunization and the health system generally. In some countries, facility operating costs and salaries can be funded through block transfers from the central government to augment local government contributions. Some countries give states, provinces, departments, and/or municipalities and districts primary or sole responsibility for funding immunization services.

Unless health, including immunization, is a priority within a decentralized system and the new structure includes performance agreements and clear guidelines developed with subnational authorities, immunization financing and service delivery can be weakened.

DECENTRALIZATION IN KENYA

Kenya's 2010 constitution recognized the population's right to health and affordable health services. In 2013, in line with these constitutional rights, the central government devolved authority for a number of fiscal and administrative functions—including health, agriculture, and water—to 47 counties. This involved a large number of administrative changes to the health sector and immunization, but the Ministry of Health retained responsibility for standards, policy, regulation, and national hospitals.

Under the new arrangement, counties receive central government resources through three main channels:

- "Equitable-share" block grants, which are based on a formula set by a dedicated central commission for revenue allocation across all sectors
- Conditional grants that are linked to specific priorities such as free maternity care or elimination of user fees
- An equalization fund that was designed to provide support to marginalized counties

The decentralization process in Kenya has affected immunization financing and immunization programs in both negative and positive ways.

Funding gaps and capacity issues have led to procurement delays and shortages of vaccines and supplies.

It took almost three years for Kenya to fully implement devolution, which affected the procurement of vaccines and injection supplies because funds for these purposes were transferred to lower levels. The Ministry of Health and other stakeholders worked with the parliamentary committee on health to address the resulting vaccine and supply shortages. Through this channel, they lobbied the Ministry of Finance to shift all vaccine procurement back to the national level because some county governments did not recognize the funding requirements, did not have forecasting expertise, or did not understand the procurement and distribution rules and processes. By July 2014, protected national funds were secured to meet some vaccine procurement needs; the bulk of funding for injection supplies remained at lower levels of the system. The Kenyan Medical Supplies Authority (KEMSA) also led reforms that moved medical supplies into a pooled procurement system through which counties could place orders directly with KEMSA using local budgets. While there is broad recognition at the national and county levels that vaccine procurement functions should be centralized, there are challenges to doing so: Kenya's constitution does not allow for reducing funds allocated to counties or shifting funds from the county to the national level, so the central government has had to raise additional funding for vaccine procurement. These challenges are likely to persist. Kenya defaulted on its co-financing commitment to Gavi in 2013 and 2014—an outgrowth of the complexities of decentralization as well as misalignment of the government fiscal year and Gavi's fiscal year. In 2015, Gavi aligned the co-financing obligation with the Kenyan government's fiscal year and Kenya fulfilled its Gavi co-financing obligations on time. This shows that the government and partners are moving toward rectifying funding flow issues.

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Commitment to immunization may not be equally strong in all counties. Under Kenya's new system, counties receive block grants and allocate funds as they see fit across sectors, including health. Health management teams in counties further allocate funds across the health sector. If county administrators do not see immunization or other health matters as a priority, such programs might not get funded and immunization advocates have to present their case to new decision-makers in the system. In some parts of Kenya, advocates have made significant efforts to reach local decision-makers (such as mayors and district health management teams); this has resulted in some counties allocating sufficient funds for immunization programs. In other counties, some aspects of immunization programs, such as outreach, are no longer properly funded. This is because facilities have less control over their own funding. Previously, some operational costs for immunization and certain other activities were financed using income generated, retained, and allocated by the facility; these funds are now consolidated in county bank accounts for use across sectors.

Capacity to manage services and financing varies by county. As counties move to control health under district health management teams, retaining the right level of competencies at the county level can also be a challenge. In Kenya, counties have varied capacity to procure quality vaccines at reasonable prices and from approved manufacturers, to operate and maintain the cold chain and logistics, and generally to manage the system. In early 2013, this translated to significant issues around the country with procurement of both injection supplies and cold chain components. For instance, injection supplies for the BCG vaccine became a challenge because supplies had previously been procured by the central health ministry and counties were not able to procure them locally. This led to some local health staff trying to substitute other supplies that did not permit accurate measurement of the smaller dosage for BCG and could have resulted in dangerous misadministration of the vaccine and compromised

the entire immunization program. BCG coverage began to decline. World Health Organization / UNICEF estimates showed a drop in BCG coverage in Kenya from 97% in 2012 to 92% in 2013. In 2014, KEMSA reverted to stocking BCG syringes to address this issue.

Accountability has likely improved in some counties. Alongside the many initial challenges as a result of decentralization, there were also some benefits. Decentralization gave some local decision-makers more autonomy to manage money and identify personnel issues such as salary payments to nonexistent people, or "ghost workers." Some Kenyan counties are reportedly spending more money on health, pharmaceuticals, and expanded primary health care networks.

Local champions for immunization had a positive impact in some counties. Decentralization may have led to increased community participation in planning. Despite initial challenges with building support for immunization funding, many counties now have immunization champions who can mobilize local political and community support.

LESSONS AND CONCLUSIONS

Decentralization can be part of a country's political evolution. But if roles and responsibilities are not carefully considered and clarified at the outset, the decentralization process can have a negative effect on health service delivery. The success of decentralization will likely depend in part on how far responsibilities devolve, and how quickly. A reform that shifts responsibilities without considering the full range of consequences at the lowest political level is likely to face significant challenges and result in potentially harmful consequences.

In some country contexts, it may be possible for decentralization and related capacity-building efforts to be pilot-tested first and then rolled out over time, using an incremental approach. In others, ongoing policy decisions can be supported through consensus building and targeted support. For instance, in South

Africa all nine provinces have significant power over financial decisions. Additions to the vaccine schedule are discussed in cross-governmental forums and then released as national policy with guidelines and related training. In Brazil, institutional and management reforms led by decentralized authorities have led to positive outcomes when the central government has provided the right level of incentives, guidance, and support.

These lessons aside, questions remain about what aspects of immunization financing and delivery should or should not be decentralized. The documents listed in the box below give a high-level overview of functions that should ideally be maintained at the central level during decentralization reforms and functions that can be distributed effectively to lower levels.

SOURCES AND FURTHER READING

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