



REPUBLIC OF KENYA

THE NATIONAL ASSEMBLY

13TH PARLIAMENT- SECOND SESSION- 2023

THE DIASPORA AFFAIRS AND MIGRANT WORKERS COMMITTEE AND THE
DEPARTMENTAL COMMITTEE ON DEFENCE, INTELLIGENCE, AND FOREIGN
RELATIONS

REPORT ON AN INSPECTION VISIT TO THE KENYAN EMBASSY IN OTTAWA, CANADA
CONDUCTED FROM 18TH TO 23RD SEPTEMBER, 2023

 THE NATIONAL ASSEMBLY PAPERS LAID	
DATE:	05 DEC 2023 Tuesday
TABLED BY:	Hon. Lydia Hatika (Chairperson, Diaspora Affairs & Migrant Workers Committee)
CLERK-AT-THE-TABLE:	Inzofu Mwale

Approved DSMT
6/12/2023

The Directorate of Audit, Appropriations and
Other Select Committees
Clerk's Chambers
Parliament Buildings
NAIROBI

December, 2023

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LIST OF ABBREVIATIONS AND ACRONYMS

APEC	-	Asia-Pacific Economic Cooperation
NATO	-	North Atlantic Treaty Organization
DC	-	District of Columbia
EAC	-	East African Community
FIPA	-	Foreign Investment Protection and Promotion Agreements
FTA	-	Free Trade Agreement
ICAO	-	International Civil Aviation Organization
IPSTC	-	International Peace Support Training Centre
KRA	-	Kenya Revenue Authority
MDA	-	Ministries, Departments and Agencies
MOU	-	Memorandum of Understanding
NIS	-	National Intelligence Service
NTSA	-	The National Transport and Safety Authority
SMEs	-	Small and Medium Enterprises

LIST OF ANNEXURES

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LEADER OF DELEGATION'S FOREWORD

This report documents a foreign oversight inspection visit conducted by a delegation comprising Members of the of the Departmental Committee on Defence, Intelligence, and Foreign Relations and the Diaspora Affairs and Migrant Workers Committee to Kenyan High Commission in Ottawa, Canada from 18th to 23rd September, 2023

The delegation visited Kenya's Kenyan High Commission in Ottawa, Canada to assess the progress made, the challenges faced and the opportunities available in the Mission. The visit provided not only an opportunity for carrying out the Committees' oversight mandate but also a learning environment for Members of the Committees on the thematic areas the Committees oversight.

Having held meeting with the staff at the High Commission in Ottawa, Canada and Representatives of the Diaspora Community inspected both the Chancery building and the Residence, the delegation recommends as follows:

- 1) The Ministry of Foreign and Diaspora Affairs in conjunction with the High Commission in Ottawa should work on budgetary requirements and ensure allocation of funds in the Financial Year 2024/25 to cater for maintenance of the Chancery and the Residence Building to avoid the need for major renovations in future.
- 2) Canada is the second-largest country in the world yet has only one High Commission in Ottawa and two Honorary Consuls. Further, there is only one Immigration Officer serving there. In order to adequately serve the diaspora community, the Ministry of Foreign and Diaspora Affairs should:
 - a) Establish additional Honorary Consuls in order to cater for Kenyans who are spread across Canada, beginning with Alberta where the population of Kenyans is high;
 - b) Work with the Directorate of Immigration Services to post at least two additional Immigration Officers to ease the work load.
- 3) The Ministry of Foreign and Diaspora Affairs should collaborate with the Directorate of Immigration Services to establish modalities of capturing the data of Kenyans leaving the country destined for the diaspora and share it with the relevant diplomatic missions. Further, the High Commission in Ottawa should collaborate with Kenyan Community Associations in Canada to establish a central database for the approximately 40,000 Kenyans living in Canada.
- 4) The Ministry of Foreign and Diaspora Affairs in conjunction with the National Transport and Safety Authority (NTSA) should work to ensure the NTSA starts issuing driving licenses that

indicate the initial year of issuance of a driving license in order to enable Kenyans in the diaspora to benefit from their years of experience as drivers, an important aspect in the diaspora.

- 5) The State Department for Diaspora Affairs should operationalize a welfare kitty for Kenyans in the diaspora. This would help in catering for emergencies like deaths, deportation, and tickets back home for distress cases.
- 6) In order to improve the Mobile Consular Services Exercise, the State Department for Diaspora Affairs should ensure timely disbursement of required funds diplomatic missions where the exercise is scheduled to be undertaken. This will ensure that adequate administrative and logistical arrangements are made prior to the exercise to ensure its success.
- 7) The Ministry of Foreign and Diaspora Affairs in conjunction with the Independent Electoral and Boundaries Commission should device mechanisms to ensure the general elections are conducted in a manner and time that allows Kenyans in the Diaspora to participate in the elections.
- 8) The State Department for Diaspora Affairs should work closely with the State Department of Culture and Heritage and the State Department for Tourism in marketing the Country abroad.
- 9) The Ministry of Foreign and Diaspora Affairs should work closely with the Kenya Investment Authority to establish mechanisms and develop safe investment vehicles in Kenya for the diaspora community.
- 10) The Kenya Revenue Authority should conduct regular public education forums for the diaspora Community to educate them on their rights and obligations as tax payers as well as provide information on how they can access their services with ease.

Pursuant to Standing Orders 199(6), it is my pleasant duty to present to the House a joint Report by the Departmental Committee on Defence, Intelligence, and Foreign Relations and the Diaspora Affairs and Migrant Workers Committee on a foreign oversight inspection visit conducted by a delegation comprising Members of the two Committees to Kenya's High Commission in Ottawa, Canada from 18th to 23rd September, 2023.

Hon. Simon Nganga Kingara, M.P

Vice Chairperson, the Diaspora Affairs and Migrant Workers Committee/Leader of Delegation

1.0 PREFACE

1.1 Introduction

1. This report documents a foreign oversight inspection visit conducted by a delegation comprising Members of the of the Departmental Committee on Defence, Intelligence, and Foreign Relations and the Diaspora Affairs and Migrant Workers Committee to Kenyan High Commission in Ottawa, Canada from 18th to 23rd September, 2023
2. The delegation visited Kenya's Kenyan High Commission in Ottawa, Canada to assess the progress made, the challenges faced and the opportunities available in the Mission. The visit provided not only an opportunity for carrying out the Committees' oversight mandate but also a learning environment for Members of the Committees on the thematic areas the Committees oversight.

1.2 Mandate of the Committees

1.2.1 The Departmental Committee on Defence, Intelligence, and Foreign Relations

3. The Departmental Committee on Defence, Intelligence, and Foreign Relations is established under the National Assembly Standing Order No. 216. The functions and mandate of the Committee include, among others, to:
 - a) investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned ministries and departments;
 - b) study the programme and policy objectives of Ministries and departments and the effectiveness of the implementation.
 - c) study, assess and analyze the relative success of the Ministries and departments as measured by the results obtained as compared with their stated objectives;
 - d) investigate and inquire into all matters relating to the assigned Ministries and departments as they may deem necessary, and as may be referred to them by the House;
4. The Committee's subject matters are stated in the Second Schedule of the National Assembly Standing Orders and are as follows: Defence, intelligence, foreign relations, diplomatic and consular services, international boundaries including territorial waters, international relations, and veteran affairs.
5. In executing its mandate, the Committee oversees the following MDAs: The Ministry of Defence, the Ministry of Foreign and Diaspora Affairs, the State Department for East African Community (EAC) Affairs, the National Intelligence Service (NIS).

1.2.2 The Diaspora Affairs and Migrant Workers Committee

6. The Diaspora Affairs and Migrant Workers Committee is established under Standing Order 208B and is responsible for:
- considering all matters directly relating to policies and programmes for the protection of the rights and welfare of Kenyans in the diaspora, including: Kenyan nationals with dual citizenship; Kenyan migrant workers and their families abroad; and Kenyans undertaking studies overseas.
 - examining policies and programmes of the national government for: efficiently harnessing, mobilizing and steering of Kenyan resources in the diaspora for economic and socio-cultural development; engaging and facilitating Kenyans in the diaspora, including persons eligible for dual citizenship; and suffrage of Kenyan nationals in the diaspora.

1.4 Committees' Membership

7. The Departmental Committee on Defence, Intelligence and Foreign Relations was constituted by the House on 27th October, 2022 and comprises the following Members:

- | | |
|--|---------------------------|
| 1) The Hon. Koech Nelson, M.P. | (Chairperson) |
| 2) The Hon. Maj. (Rtd.) Sheikh Abdullahi Bashir, M.P. | (Vice Chairperson) |
| 3) The Hon. Hassan Abdi Yusuf, M.P | |
| 4) The Hon. Wanjira Martha Wangari, M.P | |
| 5) The Hon. Odhiambo Millie Grace Akoth, MP | |
| 6) The Hon. Kanchory Elijah Memusi, MP | |
| 7) The Hon. (Dr.) Kasalu Irene Muthoni, M.P | |
| 8) The Hon. Kirima Moses Nguchine, M.P | |
| 9) The Hon. Kandie Joshua Chepyegon, M.P | |
| 10) The Hon. Kwenya Thuku Zachary, M.P | |
| 11) The Hon. Luyai Caleb Amisi, M.P | |
| 12) The Hon. Teresia Wanjiru Mwangi, M.P | |
| 13) The Hon. Logova Sloya Clement, M.P | |
| 14) The Hon. Ikana Fredrick Lusuli, M.P | |
| 15) The Hon. Mohamed Abdikadir Hussein, M.P | |

8. The Diaspora Affairs and Migrant Workers Committee comprises the following Members:

- | | |
|--|---------------------------|
| 1) Hon. Mizighi Lydia Haika, MP | (Chairperson) |
| 2) Hon. Kingara, Simon Nganga, MP | (Vice Chairperson) |
| 3) Hon. Chesebe Fred Kapondi, MP | |
| 4) Hon. Obo Ruweida Mohamed, MP | |
| 5) Hon. Chepkwony Charity Kathambi, MP | |
| 6) Hon. Saney Ibrahim Adbi, MP | |
| 7) Hon. Kemei Justice Kipsang, MP | |
| 8) Hon. Babu Owino Paul Ongili, MP | |
| 9) Hon. Bedzimba Rashid Juma, MP | |
| 10) Hon. Aburi Donya Dorice, MP | |
| 11) Hon. Sankaire Leah Sopiato, MP | |
| 12) Hon. Njeru Pamela Njoki, MP | |
| 13) Hon. Lotee Titus, MP | |
| 14) Hon. Khodhe Phelix Odiwuor, MP | |
| 15) Hon. Mohammed Zamzam Chimba, MP | |

1.5 Delegation

9. The delegation comprised of:

- | | |
|--|------------------------------|
| 1) Hon. Kingara, Simon Nganga, MP | -Leader of Delegation |
| 2) Hon. Lotee Titus, MP | -Member |
| 3) Hon. Ikana Fredrick Lusuli, MP | -Member |
| 4) Mr. Dennis Mogare Ogechi | -Delegation Secretary |

2.0 BACKGROUND INFORMATION

2.1 Canadian Government

10. Formally, Canada is a constitutional monarchy with a Federal, Parliamentary system of Government. The titular head is the reigning monarch of the United Kingdom, who is represented locally by a Governor-General. King Charles III, is personally represented by a Governor General (currently Mary Simon) and is head of state. The Governor General is appointed by the monarchy on the advice of the Prime Minister for a five-year term. However, in practice, Canada is an independent federal state established in 1867 by the British North America Act.
11. The Governor-General formally summons, prorogues, and dissolves Parliament, assents to bills, and exercises other executive functions. After a general election, the governor-general calls on the leader of the party winning the most seats in the House of Commons to become Prime Minister and to form a government.
12. Executive power is vested in the Prime Minister and the Cabinet. The Prime Minister is the leader of the party with the largest number of seats or the leader of the majority coalition in the House of Commons. The current Prime Minister is the Right Honorable Justin Trudeau. He is the twenty third Prime Minister of Canada.
13. Federal legislative authority is vested in the Parliament of Canada, which consists of the sovereign (Governor-General), the House of Commons, and the Senate. Both the House of Commons, which has 338 directly elected members, and the Senate, which normally consists of 105 appointed members, must pass all legislative bills before they can receive royal assent and become law. Both bodies may originate legislation, but only the House of Commons may introduce bills for the expenditure of public funds or the imposition of any tax. The House of Commons is more powerful than the Senate, whose chief functions include investigation, reviewing government legislation, and debating key national and regional issues.

2.2 Canadian Economy

14. The economy of Canada is a highly developed mixed economy, with the world's tenth-largest economy as of 2023, and a nominal GDP of approximately US\$2.117 trillion. Canada is one of the world's largest trading nations, with a highly globalized economy. In 2021, Canadian trade in goods and services reached \$2.016 trillion. Canada's exports totalled over \$637 billion, while its imported goods were worth over \$631 billion, of which approximately \$391 billion originated from the United States. In 2018, Canada had a trade deficit in goods of \$22 billion and a trade deficit in services of

\$25 billion. The Toronto Stock Exchange is the tenth-largest stock exchange in the world by market capitalization, listing over 1,500 companies with a combined market capitalization of over US\$3 trillion.

15. Canada's economic integration with the United States has increased significantly since World War II. As an affluent, high-tech industrial society in the trillion-dollar class, Canada resembles the US in its market-oriented economic system, pattern of production, and affluent living standards. The 1989 the US-Canada Free Trade Agreement (FTA) and the 1994 North American Free Trade Agreement (NAFTA) (which includes Mexico) touched off a dramatic increase in trade and economic integration with the US, its principal trading partner. Canada enjoys a substantial trade surplus with the US, which absorbs nearly 80% of Canadian exports each year.
16. Canada is the United States largest foreign supplier of energy, including: Oil, gas, uranium, and electric power. Given its great natural resources, skilled labour force, and modern capital plant, Canada has enjoyed solid economic growth, and prudent fiscal management.

2.3 Canadian Foreign Policy

17. Although Prime Minister Trudeau renamed Canada's Ministry of Foreign Affairs, Trade and International Development to 'Global Affairs Canada; it is instructive that the portfolio remains the Same, with a dedicated minister each for Foreign Affairs, International Trade and La Francophonie. Former Prime Minister Stephen Harper's Government took a decision to reintegrate the Foreign Affairs, International Trade and Development departments, which he argued would ensure a coherent approach to foreign, international aid and trade policy in the international context.
18. Global Affairs Canada lists its priorities as to: Advance Canada's values and interests through leadership and constructive engagement on key global issues with strategic partners, including at the UN and other multilateral institutions such as La Francophonie; Contribute to inclusive Canadian and global prosperity with an emphasis on expanding and deepening trade and investment relationships with large, fast-growing markets, such as China and India, and traditional partners; Reinforce Canada's relations with the United States and key bilateral partners to advance Canadian interests and; Strengthen Canada's contribution to reducing poverty and inequality, supporting fragile states, building resilience and responding to humanitarian needs.
19. Canada's highest priority is its bilateral relationship (political, cultural and commercial) with the United States. The US is by far its largest trading partner accounting for about 75% of exports and 66% of imports. With more than C\$175 billion in goods and more than 133,000 people moving across the Canada - USA border each day.

20. In multilateral forums, Canada has participated actively in issues ranging from security human rights to cooperation on the environment. It is a member of the G8, G20, NATO, Asia-Pacific Economic Cooperation (APEC), the Commonwealth of Nations, the Francophony and the United Nations.

2.4 Canada-Africa Relations

21. Canada shares many characteristics with Africa, ranging from shared colonial and legal heritage; members of the Commonwealth, multicultural diversity; resource endowment and shared languages (i.e., English and French). During the colonial period, Canada and Africa were both part of a global trading system, linked by European trading companies. However, as both Canada and African were raw-material exporting areas, they mostly traded with manufacturers in Europe, and not with each other. Canadians first became involved with African politics because of British imperial wars in Africa. A group of 386 Canadian voyageurs participated in the 1884-1885 Nile Expedition during the Mahdist War in Sudan. A larger Canadian contingent took part in the Second Boer War (1899–1902), helping to keep South Africa within the British Empire.
22. Following the era of Decolonization in Africa, Canada was one of the few major industrialized Western countries that had good initial relations with most independent countries. This was because of several important Canadian characteristics shared with African countries. Canada's two official languages, English and French are two of the most widely spoken in Africa. Canada's official multiculturalism (after 1971) and growing African-Canadian community have also helped relations.
23. Canada uses both the English common law system and French civil code (Province of Quebec only) that are used in much of Africa. Canada is the only G8 country that never possessed any overseas colonies; thus, Canadians do not carry any imperial baggage in Africa. Canada shares many geographic similarities to many African countries in that the latter are large, sparsely-populated wild areas with few major cities and face major challenges with the delivery of government services, much like Canada at the beginning of the 20th century. Both Canada and most African countries rely on natural resource development and international trade for economic growth. Canadian companies also play a major part in the mining and resource development sector in Africa, with over \$3.5 billion in capital invested on the continent. This makes it the single largest foreign investor in resource development. Canada is also a member of both the Commonwealth and La Francophonie, which together include most countries in Africa.
24. During the 1990s, Canadian involvement in African dropped as the result of government cutbacks to the aid and foreign affairs budgets. This was largely reversed during the short government of Paul Martin, whose government announced several new commitments to Africa. During this period, Canada grew to become the 3rd largest foreign donor in Africa, with numerous humanitarian

development projects spanning many countries. The majority of these projects were administered by the Canadian International Development Agency, with funding provided by the Department of Foreign Affairs and International Trade. However, relations deteriorated under the government of Stephen Harper, which was cited as one of the reasons Canada failed to win a seat on the UN Security Council in 2010. That same year the Canadian government also suspended all aid to Africa, a sharp shift from its position as a key humanitarian donor and development partner in Africa.

25. Canadian Council on Africa (CCAfrica) was launched in May, 2002 with aim of bringing together Canada's large corporations, small and medium enterprises (SMEs), educational institutions and business associations that are active or interested in Africa.
26. Canada's priorities for Sub-Saharan Africa are: **Development Assistance** - Canada focuses its international development efforts in Sub-Saharan Africa in ten countries: Benin, Burkina Faso, Democratic Republic of Congo, Ethiopia, Ghana, Mali, Mozambique, Senegal, South Sudan, and Tanzania; **Promoting Democracy** - Canada supports political and economic reforms in Africa that are based on democracy, strong public sector institutions, the rule of law and human rights; **Peace and Security** - Canada promotes an integrated approach to security, development and regional cooperation. Canada helps strengthen the peace and security capacity of African countries through support for training military and police forces in many African countries. It also helps African countries improve their ability to combat terrorism; **Economic and Trade Relations** - Canada is expanding its trade and investment in sub-Saharan Africa. It has concluded Foreign Investment Protection and Promotion Agreements (FIPAs) with Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Tanzania, Mali, Madagascar, Senegal and Zambia. Canada's trade and investment goals for Africa include: opening new markets to increase opportunities for Canadian exports; focusing on specific sectors, such as extractives and energy; and enhancing Canada's reputation as a world-class corporate citizen committed to sharing knowledge and expertise.

2.5 Kenya-Canada Relations

27. Canada established diplomatic relations with Kenya at the time of its independence in 1963. Canada's High Commission in Nairobi is its largest mission in Africa, accredited to Kenya as well as Burundi, Rwanda, Somalia, and Uganda, and the United Nations Environment Programme and UN-Habitat.
28. Canada and Kenya have had good relations founded on a range of shared interests including poverty reduction, sustainable economic growth, trade diversification, the empowerment of women and girls, supporting refugees, and regional security and stability. Reflecting these common goals, President Kenyatta attended the G7 Summit in Charlevoix (QC) in 2018, as well as the Women Deliver Conference in Vancouver (BC) in 2019. In November 2018, Canada co-hosted with Kenya and

Japan a Sustainable Blue Economy Conference in Nairobi that addressed challenges such as growing the maritime economies of developing countries, the role of women in the Blue Economy, marine security, and the impact of climate change.

29. Canada's Directorate of Military Training and Cooperation offers military training at the International Peace Support Training Centre (IPSTC), which is hosted by Kenya, in Nairobi. Kenya has been a member of Canada's Military Training and Cooperation Programme since 1970, with approximately 500 Kenyan officers trained to date.
30. Canada and Kenya established a Binational Commission in September 2018 through the signing of a Memorandum of Understanding (MOU) between Foreign Ministers. The MOU provides a framework of cooperation for regular dialogue to discuss political and economic issues. The first meeting of the Canada-Kenya Binational Commission took place in March 2019 (hosted by Canada), followed by a second meeting in April 2021 (hosted by Kenya).
31. Trade Relations - Canada has a well-established trade relationship with Kenya. In 2021, two-way merchandise trade reached \$138.3 million. This consisted of \$93.4 million in Canadian exports to Kenya and \$44.9 million in Kenyan exports to Canada. Imports from Canada mainly include wheat, recyclable materials, dried peas and beans, and aerospace products and parts. Exports from Kenya to Canada are primarily vegetable products and textile products.
32. **International Assistance** - In 2020-21, Canada provided \$99.4 million in international assistance to Kenya. Canada's international assistance is well aligned with Kenya's overarching Vision 2030 strategy. The support is geared towards: increasing employment and economic opportunities, especially for women; empowering women and girls; and providing a safe, quality learning environment, skills building, and technical and vocational training. Canada's support to Kenya also includes humanitarian assistance, regional programming, and civil society initiatives. The humanitarian assistance is directed to refugees from neighboring countries as well as Kenyan communities impacted by cyclical drought and flooding. Through the Counter-Terrorism Capacity Building Program, Canada has allocated approximately \$6 million to reduce threats from terrorism in Kenya through provision of training, equipment, technical and legal assistance, as well as through support to community level resilience.

3.0 VISIT TO THE KENYAN HIGH COMMISSION IN OTTAWA, CANADA

3.1 Introduction

33. The Kenya High Commission in Ottawa was established in 1978. The Mission is also accredited to the International Civil Aviation Organization (ICAO) in Montreal, Canada since 2012. ICAO is a United Nations agency, established to help countries share their skies to their mutual benefit. ICAO assists the 193 Contracting States to the Chicago Convention as they cooperate to adopt standards, practices, and policies for international civilian flight.
34. The delegation visited Kenya's Embassy in Ottawa, Canada from 18th to 23rd September, 2023. The delegation held meetings with Mission staff led by Her Excellency Amb. Immaculate N. Wambua, the High Commissioner. It also inspected both the Chancery and the High Commissioner's residence. The proceedings of the visit are recorded hereunder:

3.2 Meeting with the High Commission Staff

35. The delegation held meetings with the High Commission staff on various dates and it was briefed on various aspects of the High Commission as follows:

3.2.1 Mandate of the High Commission

36. The Kenya High Commission's mandate is to implement Kenya's Foreign Policy in Canada, and ICAO as derived from the Ministry of Foreign and Diaspora Affairs of the Republic of Kenya. The Mission guiding the High Commission's operations is "To build new and robust partnerships while enhancing existing bilateral relationships between Kenya and the countries of accreditation, as well as strengthen co-operation with multilateral organizations based in Canada especially the International Civil Aviation Organization."

3.2.2 Core Functions of the High Commission

37. The High Commission lists its core functions as being:
- a) Projecting Kenya's Foreign Policy and defending her interests through Diplomatic Representation,
 - b) Ensuring maintenance of cordial relations with countries of accreditation and ICAO,
 - c) Projecting and protecting the image of Kenya,
 - d) Promoting Kenyan goods and services and showcasing existing investments and trade opportunities in Kenya.

- e) Facilitating varied consultative seminars and meetings with Kenyan investors and foreign entrepreneurs.
- f) Negotiating and coordinating implementation of Bilateral Cooperation Agreements.
- g) Liaising closely with ICAO on matters relating to the Aviation industry.
- h) Offering Immigration and Consular Services and protecting the interests of Kenyan living, travelling or doing business in countries of accreditation

3.2.3 Staff Establishment

38. The staff establishment at the Embassy was as follows:

- | | |
|---|------------------------------|
| 1) Her Excellency Amb. Immaculate N. Wambua | -High Commissioner |
| 2) Abdishakur Hussein | -Minister – Head of Chancery |
| 3) Stanley Cheruiyot | -Minister Counsellor |
| 4) Christal Njoka | -Minister Counsellor |
| 5) Abel Njuguna | -First Counsellor |
| 6) Josephine Saleri | -Second Secretary |
| 7) Stella Musembi | -Foreign Relations Officer |
| 8) Monica Kiruja | -Immigration Attaché |
| 9) John Musembi | -Finance Attaché |
| 10) Grace Mbabu | -Administrative Attaché |

39. The 10 homebased officers above represent two (2) from agencies and 8 being Foreign Service Officers. There are also eight (8) local staff comprising of drivers, cleaner and those assisting the Immigration Officer.

3.2.4 Honorary Consuls

40. Kenya is represented by Honorary Consuls in Toronto and Vancouver. The mandate of the Honorary Consuls is to oversee and safeguard the welfare of Kenyans in Canada as well as Kenya's economic, trade, tourism, commercial interests and relations. They are:

- 1) Mr. Sunir Chandaria - Honorary Consul in the Kenyan Honorary Consulate in Toronto, Canada.
- 2) Mr. George Imbenzi - Honorary Consul in the Kenyan Honorary Consulate in Vancouver, Canada.

3.2.5 Kenya Associations and Communities in Canada

41. Kenya Associations and communities in Canada are communities of Kenyans living in Canada who have the common and collective accord of working together in support of socio-economic development as well as to promote the harnessing of the Diaspora in Canada for Kenya's national development. They include:

- 1) Kenya Canadian Association
- 2) Kenya Community in Ontario
- 3) Kenya Community in the Capital Region
- 4) Kenya Association of Manitoba
- 5) Kenya Community Association in Calgary
- 6) Kenya Community in Nova Scotia
- 7) Association of Kenya in Edmonton, Alberta
- 8) Kenya Community Association in Vancouver
- 9) Kenya Diaspora Association in Montreal, Quebec

3.2.6 Mobile Consular Services Exercise

42. The Mobile Consular Services involve diplomats providing assistance, such as visa processing beyond the embassy premises. It is a diplomatic practice that aims to bring consulate services closer to citizens, ensuring increased accessibility and convenience. The exercise had been carried out twice in the recent past in Canada. The first was carried out in January, 2022 and the second one in May, 2023.

43. The exercise, carried out between 15th and 29th May 2023, aimed at helping the Kenyan diaspora in processing of E-passports, National Identity Cards and birth certificates. The target cities were Ottawa, Edmonton, Toronto, Vancouver and Manitoba.

44. A total of 446 Kenyans in the diaspora sought various services during the exercise as indicated below:

- | | |
|-----------------------------|--------------|
| 1) Passports | -255 persons |
| 2) Identification Cards | -36 persons |
| 3) Citizenship Applications | -43 persons |
| 4) Birth Certificates | -12 persons |

45. All applicants for passports were served and the passports delivered. The rest of the documents sought were at various stages of conclusion.

46. The feedback from the diaspora was positive. Kenyans in Canada were excited since the exercise helped in cutting the cost normally associated with seeking the services. This includes air travel costs and accommodation costs.
47. Those that reside in areas that weren't covered requested in be considered for inclusion in any such future exercises. Further, many who intended to access the services were left out, even in cities that were covered, due to the limited time (which was one day in most locations). There was therefore a need to increase the number of both cities and days for the exercise.
48. There were a lot of members of the diaspora that walked in without pre-application and weren't served as expected. There was a need to have both a laptop and a printer in all locations in order to facilitate the walk-ins.
49. The challenges the Mobile Consular Services Exercise faced included:
 - a) Delay in disbursement of required funds from the State Department for Diaspora Affairs to the High Commission in Ottawa.
 - b) Inadequate notice to the potential beneficiaries of the exercise.
 - c) Short timelines – one day in most instances – which wasn't adequate to cover all interested members of the diaspora in various stations leading to many missing the chance.
 - d) Inadequate planning leading to the exercise running from 8 am to 5pm without breaks for refreshments. This was fatiguing to the officers offering the services.
 - e) Presence of dignitaries and holding meetings with staff offering the services leading to an overlap between service provisions and attending to the meetings.
 - f) Inadequate stations to offer the services – there was one station for Identity card applicants and one for passport applicants – leading to long ques and delays. There was need to increase the stations for efficiency.
 - g) The high commission in Ottawa had one immigration officer serving the second largest country in the world. This was untenable and there was need for posting of more immigration officers to ease the work load.

3.3 Meeting with Representatives of the Kenya Community in National Capital Region, Ottawa

50. The delegation met with the following Representatives of the Kenya Community in the National Capital Region, Ottawa:

- 1) Ms. Jane Wangari Odongo
- 2) Ms. Dannielle Odongo
- 3) Mr. Thomas Odumo
- 4) Ms. Wambui Muya
- 5) Ms. Mary Nduati

51. The Representatives briefed the delegation that:

- 1) Their community was involved in supporting one another especially in matters of bereavement, training on matters of concern to the diaspora members (especially on access to the resources they can benefit from), welcoming of newcomers to Canada especially lately when a lot of visas were being issued to Kenyans, identifying investment opportunities back home, and youth involvement with Kenya (especially those born or raised in the diaspora) especially with regard to issuance of IDs and investing back home.
- 2) They appreciated the Mobile Consular Services Exercise which enabled them to easily access the documents being processed. Many in the diaspora didn't have them and previously had to cross over to the USA (Washington DC) for the services. Some got the documents posthumously. They appealed for scaling up of the range and duration of the services on offer. They particularly appealed for ease of the process of acquiring a KRA PIN.
- 3) They lauded establishment of the State Department for Diaspora Affairs and the Diaspora Affairs and Migrant Workers Committee as it places the diaspora community at the centre of national conversation.
- 4) They appreciated efforts to involve the diaspora in the voting process during general elections. However, it would be prudent to have the diaspora elections on a weekend (non-working day) in order to capture as many in the diaspora as possible.
- 5) There was need for close collaboration or merging of the State Department of Culture and Heritage and the State Department for Diaspora Affairs to make it easier to market the country abroad since Canada appreciates diversity and encourages retention of authenticity.
- 6) There was need to give the diaspora community adequate notice when planning matters involving them like general elections and mobile consular services.
- 7) The government should consider establishing mechanisms to have safe investment vehicles in Kenya for the diaspora community. This will help them avoid swindlers who pose as investment advisors. For instance, the affordable housing government plan needs a rope in the diaspora that is highly interested in matters real estate.
- 8) There was need for a bilateral agreement to cushion members of the Kenyan diaspora in Canada who wish to relocate back to Kenya. The agreement would address, among others: healthcare challenges, personal security concerns especially since back home such retirees are considered affluent hence posing security challenges to them

3.3 Inspection of the Chancery

52. The Chancery building of the Republic of Kenya in Ottawa is located at 415 Laurier Avenue East in Ottawa, the Canadian capital. It is owned by the Government of Kenya.
53. The delegation conducted an inspection tour of the Chancery and observed that it was a well-maintained building and served the needs of the staff establishment adequately. However, there was need for minor, routine maintenance of a flat side of the roof that tended to accumulate snow during winter and which, if not addressed, may require major renovation in future.

3.4 Inspection of the High Commissioner's Residence

54. The Republic of Kenya Residence building in Ottawa is owned by the Government of Kenya. The delegation conducted an inspection tour of the Residence and observed that it was generally well maintained and of adequate size to house the High Commissioner. However, it requires funding for renovation. There matters to address include: minor renovations of the gazebo at the back of the building, landscaping to eliminate a deep gulley at the backyard of the residence, and routine removal of ice from the flat side of the roof of the residence.

4.0 COMMITTEES' OBSERVATIONS

55. Having held meeting with the staff at the High Commission and Representatives of the Diaspora Community, inspected both the Chancery building and the Residence, the delegation observed as follows:

- 1) The Chancery building of the Republic of Kenya in Ottawa was well-maintained and served the needs of the staff establishment adequately. However, there was need for minor, routine maintenance of the building which, if not addressed, may require major renovations in future.
- 2) The Republic of Kenya Residence building in Ottawa was generally well maintained and of adequate size to house the High Commissioner. However, it requires funding for renovations.
- 3) Canada is the second-largest country in the world and it's approximated that there were 40,000 Kenyans living and working there. There was need to have additional Honorary Consuls in order to cater for Kenyans who are spread across the country. The urgent need for an honorary consul is in Alberta province. This will cater for the needs of Kenyans in the northern and western regions of Canada.
- 4) It is estimated that there are 40,000 Kenyans living in Canada. Although there is no central database of the Kenyans, the Kenyan Community Associations in Canada were helpful in identifying them. However, privacy laws, that were stringent in Canada, hinder access to full information on Kenyans living in Canada.
- 5) The National Transport and Safety Authority issues driving licenses that indicates the year of issue of the latest document but not the year of initial issue of a person with a driving license. This disadvantaged Kenyans in the diaspora since they were considered as experienced as indicated in the driving license. There was need to have the NTSA indicate the initial year of issuance of a driving license in order to enable Kenyans in the diaspora to benefit from their cumulative years of experience as drivers, an important aspect in the diaspora.
- 6) There is need to establish a welfare kitty, domiciled in the State Department for Diaspora Affairs, for Kenyans in the diaspora. This will help in catering for emergencies like deaths, deportation, and tickets back home for distress cases.
- 7) There is no central database of all Kenyans in the diaspora. This makes it difficult to plan for them adequately and assist them in cases of emergencies. There is need to establish modalities of

capturing the data, as Kenyans leave the country destined for the diaspora, and share it with the relevant diplomatic missions.

- 8) The Mobile Consular Services Exercise faced a myriad of challenges including: delays in disbursement of required funds from the State Department for Diaspora Affairs to the High Commission in Ottawa; inadequate notice to the potential beneficiaries of the exercise; short timelines – one day in most instances – which was not adequate to cover all interested members of the diaspora in various stations leading to many missing the chance; inadequate planning leading to the exercise running from 8am to 5pm without breaks for refreshments hence fatiguing to the officers offering the services; and inadequate stations to offer the services in each location leading to long queues and delays.
- 9) The High Commission in Ottawa has one immigration officer serving the second largest country in the world. This was untenable and there is need for posting of more immigration officers to ease the work load.
- 10) Some Kenyans in Canada are holding leadership positions and goodwill exists for collaboration with the government to support Kenyans. Currently, Canada is attracting immigrants with an open visa system until 2025. There is therefore need for the government to take advantage of this visa window and explore opportunities for Kenyans, through regular engagements with the Canadian leadership.
- 11) There are delays in release of funds for Embassy operations. Timely release of funds will ensure efficiency in operations.
- 12) Canada is a growing economy and with an expansion to the regions, there are employment opportunities in property development and health care sectors. However, Kenya does not have a Bilateral Labour Agreement with Canada. The government should negotiate for BLAs with Governments of the Provinces as labour issues are devolved in Canada.
- 13) The diaspora in Canada appreciated efforts to involve them in the voting process during general elections. However, it would be prudent to have the diaspora elections conducted in a manner that allows more Kenyans in the diaspora to participate in the exercise.
- 14) There is need for close collaboration between of the State Department of Culture and Heritage and the State Department for Diaspora Affairs to make it easier to market the Country abroad.

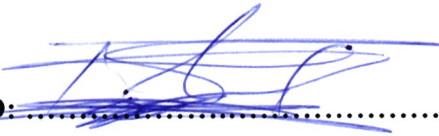
- 15) The government should consider establishing mechanisms to have safe investment vehicles in Kenya for the diaspora community. This will help them avoid swindlers who pose as investment advisors.
- 16) There are challenges experienced in the process of acquiring a KRA pin for the Kenyans in Canada. The Kenya Revenue Authority should consider ways of facilitating Kenyans in the diaspora to acquire essential documents for instance by allowing the use Kenyan passports instead of their Kenyan ID to obtain the PIN certificates.

5.0 COMMITTEES' RECOMMENDATIONS

56. The Committees recommends as follows:

- 1) The Ministry of Foreign and Diaspora Affairs in conjunction with the High Commission in Ottawa should work on budgetary requirements and ensure allocation of funds in the Financial Year 2024/25 to cater for maintenance of the Chancery and the Residence Building to avoid the need for major renovations in future.
- 2) Canada is the second-largest country in the world yet has only one High Commission in Ottawa and two Honorary Consuls. Further, there is only one Immigration Officer serving there. In order to adequately serve the diaspora community, the Ministry of Foreign and Diaspora Affairs should:
 - a) Establish additional Honorary Consuls in order to cater for Kenyans who are spread across Canada, beginning with Alberta where the population of Kenyans is high;
 - b) Work with the Directorate of Immigration Services to post at least two additional Immigration Officers to ease the work load.
- 3) The Ministry of Foreign and Diaspora Affairs should collaborate with the Directorate of Immigration Services to establish modalities of capturing the data of Kenyans leaving the country destined for the diaspora and share it with the relevant diplomatic missions. Further, the High Commission in Ottawa should collaborate with Kenyan Community Associations in Canada to establish a central database for the approximately 40,000 Kenyans living in Canada.
- 4) The Ministry of Foreign and Diaspora Affairs in conjunction with the National Transport and Safety Authority (NTSA) should work to ensure the NTSA starts issuing driving licenses that indicate the initial year of issuance of a driving license in order to enable Kenyans in the diaspora to benefit from their years of experience as drivers, an important aspect in the diaspora.
- 5) The State Department for Diaspora Affairs should operationalize a welfare kitty for Kenyans in the diaspora. This would help in catering for emergencies like deaths, deportation, and tickets back home for distress cases.
- 6) In order to improve the Mobile Consular Services Exercise, the State Department for Diaspora Affairs should ensure timely disbursement of required funds diplomatic missions where the exercise is scheduled to be undertaken. This will ensure that adequate administrative and logistical arrangements are made prior to the exercise to ensure its success.

- 7) The Ministry of Foreign and Diaspora Affairs in conjunction with the Independent Electoral and Boundaries Commission should device mechanisms to ensure the general elections are conducted in a manner and time that allows Kenyans in the Diaspora to participate in the elections.
- 8) The State Department for Diaspora Affairs should work closely with the State Department of Culture and Heritage and the State Department for Tourism in marketing the Country abroad.
- 9) The Ministry of Foreign and Diaspora Affairs should work closely with the Kenya Investment Authority to establish mechanisms and develop safe investment vehicles in Kenya for the diaspora community.
- 10) The Kenya Revenue Authority should conduct regular public education forums for the diaspora Community to educate them on their rights and obligations as tax payers as well as provide information on how they can access their services with ease.

SIGNED:  DATE: 5/12/2023

THE HON. SIMON NGANGA KINGARA, M.P.
**LEADER OF DELEGATION / VICE CHAIRPERSON, DIASPORA AFFAIRS AND MIGRANT
WORKERS COMMITTEE**

THE NATIONAL ASSEMBLY

THIRTEENTH PARLIAMENT- SECOND SESSION (2023)

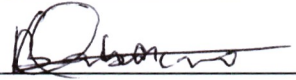
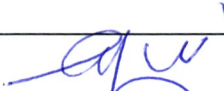
DIASPORA AFFAIRS AND MIGRANT WORKERS COMMITTEE

ADOPTION LIST

Report of the Joint delegation from Defence Intelligence and Foreign Relations and Diaspora Affairs and Migrant Workers, Committee on the oversight inspection visit to the Kenyan Diplomatic Mission in Ottawa, Canada from 18th to 23rd September, 2023.

We, the undersigned members of the Diaspora Affairs and Migrant Workers Committee do hereby append our signatures to this Report to affirm our approval:

DATE: _____

	HON. MEMBER	SIGNATURE
1.	Hon. Haika Mizighi, MP (Chairperson)	
2.	Hon. Simon Nganga Kingara, MP (Vice Chairperson)	
3.	Hon. Fred C. Kapondi, MP	
4.	Hon. Capt. Ruweida Mohamed Obo, MP	
5.	Hon. Charity Kathambi Chepkwony, MP	
6.	Hon. Kemei Justice Kipsang, MP	
7.	Hon. Ibrahim Abdi Saney, MP	
8.	Hon. Paul Ongili Babu Owino, MP	
9.	Hon. Rashid Juma Bedzimba, MP	
10.	Hon. Donya Dorice Aburi, MP	
11.	Hon. Leah Sopiato Sankaire, MP	
12.	Hon. Pamela Njoki Njeru Double N, MP	
13.	Hon. Titus Lotee, MP	
14.	Hon. Phelix Odiwuor Khodhe, MP	
15.	Hon. Zamzam Chimba Mohamed, MP	

MINUTES OF THE 47TH SITTING OF THE DIASPORA AFFAIRS AND MIGRANT WORKERS HELD ON SATURDAY 18TH NOVEMBER 2023 AT 2.30PM IN THE GARDEN SUITE 3, 6TH FLOOR, HILTON GARDEN INN HOTEL, MACHAKOS COUNTY

PRESENT

- | | | |
|--|---|-------------------------|
| 1. The Hon. Haika Mizighi, MP. | - | Chairperson |
| 2. The Hon. Simon Nganga Kingara, MP. | - | Vice Chairperson |
| 3. The Hon. Capt. Ruweida Mohamed Obo, MP. | | |
| 4. The Hon. Charity Kathambi Chepkwony, MP. | | |
| 5. The Hon. Kemei Justice Kipsang, MP. | | |
| 6. The Hon. Ibrahim Abdi Saney, MP. | | |
| 7. The Hon. Rashid Juma Bedzimba, MP. | | |
| 8. The Hon. Donya Dorice Aburi, MP. | | |
| 9. The Hon. Pamela Njoki Njeru Double N, MP. | | |
| 10. The Hon. Titus Lotee, MP. | | |
| 11. The Hon. Phelix Odiwuor Khodhe, MP. | | |
| 12. The Hon. Zamzam Chimba Mohamed, MP. | | |

ABSENT WITH APOLOGY

1. The Hon. Fred C. Kapondi, MP.

ABSENT

1. The Hon. Paul Ongili Babu Owino, MP.
2. The Hon. Leah Sopiato Sankaire, MP.

IN-ATTENDANCE

National Assembly Secretariat

- | | |
|----------------------------|------------------------------------|
| 1. Ms. Lucy Kimathi | - Principal Clerk Assistant I/ HOD |
| 2. Ms. Ruth Mwihi Gakuya | - First Clerk Assistant |
| 3. Ms. Fidlizah S. Mwagogo | - Third Clerk Assistant |
| 4. Ms. Viola K. Saiya | - Researcher III |
| 5. Mr. Collins Mahamba | - Audio Officer III |
| 6. Mr. Meshack Mutali | - Serjeant At Arms |
| 7. Ms. Juliet Minayo | - Office Assistant |

MIN.NO.NA/DA&MWC/2023/194: PRELIMINARIES

The Chairperson called the meeting to order at 2.56pm with a prayer.

**CONSIDERATION OF THE REPORT OF THE
JOINT DELEGATION FROM DEFENCE
INTELLIGENCE AND FOREIGN
RELATIONS, DIASPORA AFFAIRS AND
MIGRANT WORKERS COMMITTEE ON THE
OVERSIGHT INSPECTION VISIT TO THE
KENYAN DIPLOMATIC MISSION IN
OTTAWA CANADA**

The Committee was taken through the report. Members deliberated on the content of the report and noted that:

1. The oversight inspection visit was conducted by a delegation comprising Members of the of the Departmental Committee on Defence, Intelligence, and Foreign Relations and the Diaspora Affairs and Migrant Workers Committee to Kenyan High Commission in Ottawa, Canada from 18th to 23rd September, 2023.
2. The delegation visited Kenya's Kenyan High Commission in Ottawa, Canada to assess the progress made, the challenges faced and the opportunities available in the Mission. The visit provided an opportunity for carrying out the Committees' oversight mandate and a learning environment for Members of the Committees on the thematic areas the Committees oversight.
3. The delegation held meetings with Mission staff led by Her Excellency Amb. Immaculate N. Wambua, the High Commissioner. It also inspected both the Chancery and the High Commissioner's residence.
4. Kenya High Commission in Ottawa was established in 1978. The Mission is also accredited to the International Civil Aviation Organization (ICAO) in Montreal, Canada since 2012. ICAO is a United Nations agency, established to help countries share their skies to their mutual benefit. ICAO assists the 193 Contracting States to the Chicago Convention as they cooperate to adopt standards, practices, and policies for international civilian flight.
5. The Kenya High Commission's mandate is to implement Kenya's Foreign Policy in Canada, and ICAO as derived from the Ministry of Foreign and Diaspora Affairs of the Republic of Kenya.
6. Canada established diplomatic relations with Kenya at the time of its independence in 1963. Canada's High Commission in Nairobi is its largest mission in Africa, accredited to Kenya as well as Burundi, Rwanda, Somalia, and Uganda, and the United Nations Environment Programme and UN-Habitat. Canada and Kenya have had good relations founded on a range of shared interests including poverty reduction, sustainable economic growth, trade diversification, the empowerment of women and girls, supporting refugees, and regional security and stability.
7. Canada has a well-established trade relationship with Kenya. In 2021, two-way merchandise trade reached \$138.3 million. This consisted of \$93.4 million in Canadian exports to Kenya and \$44.9 million in Kenyan exports to Canada. Imports from Canada mainly include wheat,

recyclable materials, dried peas and beans, and aerospace products and parts. Exports from Kenya to Canada are primarily vegetable products and textile products

8. The delegation had made the following observations from the visit:
 1. The Chancery building of the Republic of Kenya in Ottawa was well-maintained and served the needs of the staff establishment adequately. However, there was need for minor, routine maintenance of the building.
 2. The Republic of Kenya Residence building in Ottawa was generally well maintained and of adequate size to house the High Commissioner. However, it requires funding for renovations.
 3. It is approximated that there were 40,000 Kenyans living in Canada hence the need to have additional Honorary Consuls in order to cater for Kenyans who are spread across the country. The urgent need for an honorary consul is in Alberta province. This would cater for the needs of Kenyans in the northern and western regions of Canada.
 4. The National Transport and Safety Authority issues driving licenses that indicates the year of issue of the latest document but not the year of initial issue of a person with a driving license. This disadvantages Kenyans in the diaspora since their driving experience is considered based on the year indicated in the Kenyan driving license. There was need to have the NTSA indicate the initial year of issuance of a driving license in order to enable Kenyans in the diaspora to benefit from their years of experience as drivers, an important aspect in the diaspora.
 5. There was need to establish a welfare kitty, domiciled in the State Department for Diaspora Affairs, for Kenyans in the diaspora. This would help in catering for emergencies like deaths, deportation, and tickets back home for distress cases.
 6. There was no central database of all Kenyans in the diaspora. This made it difficult to plan for them adequately and assist them in cases of emergencies. There was need to establish modalities of capturing the data, as Kenyans leave the country destined for the diaspora, and share it with the relevant diplomatic missions.
 7. The Mobile Consular Services Exercise carried out between 15th and 29th May 2023 faced a myriad of challenges including: delay in disbursement of required funds from the State Department for Diaspora Affairs to the High Commission in Ottawa; inadequate notice to the potential beneficiaries of the exercise; short timelines – one day in most instances – which wasn't adequate to cover all interested members of the diaspora in various stations leading to many missing the chance; inadequate planning leading to the exercise running from 8 am to 5pm without breaks for refreshments hence fatiguing to the officers offering the services; and inadequate stations to offer the services in each location leading to long queues and delays.
 8. The High Commission in Ottawa has one immigration officer serving the second largest country in the world. There is need for posting of more immigration officers to ease the work load.
 9. The diaspora in Canada appreciated efforts to involve them in the voting process during general elections. However, they proposed that diaspora elections be held on a weekend (non-working day) in order to capture as many in the diaspora as possible.

10. There was need for close collaboration or merging of the State Department of Culture and Heritage and the State Department for Diaspora Affairs to make it easier to market the country abroad.
11. The Committee further observed that:
- a) Some Kenyans in Canada are holding senior government leadership positions and goodwill exists for collaboration with the government to support Kenyans. Currently, Canada is attracting immigrants with an open visa system until 2025. There is therefore need for the government to take advantage of this visa window and explore opportunities for Kenyans, through regular engagements with the Canadian leadership.
 - b) There are delays release of funds for Embassy operations. Timely release of funds will ensure efficiency in Embassy operations.
 - c) Canada is a growing economy for instance with an expansion to the regions, there are employment opportunities in property development and for health care professionals. However, Kenya does not have Bilateral Labour Agreement with Canada. The government should negotiate for BLAs with Governments of the Provinces as labour issues are devolved in Canada.
 - d) There are challenges experienced in the process of acquiring a KRA pin for the Kenyans in Canada. The KRA should consider ways of facilitating Kenyans in the diaspora to acquire essential documents for instance by allowing the use Kenyan passports instead of their Kenyan ID to obtain the KRA pins.

12. The Committee recommended that:

- a) The Ministry of Foreign and Diaspora Affairs in conjunction with the High Commission in Ottawa should work on budgetary requirements and ensure allocation of funds in the 2024/25 financial year to cater for maintenance of the Embassy and the Residence to avoid the need for major renovations in future.
- b) Canada is the second-largest country in the world yet had only one High Commission in Ottawa and two Honorary Consuls. Majority of Kenyans live in Toronto and Ottawa. Further, there was only one Immigration Officer attached to the Embassy. In order to adequately serve the diaspora community, there, Ministry of Foreign and Diaspora Affairs should:
 - i. Establish additional Honorary Consuls in order to cater for Kenyans who are spread across Canada, beginning with Alberta where the population of Kenyans is high.
 - ii. Work with the Directorate of Immigration Services to post at least two additional Immigration Officers to ease the work load.
- c) The Ministry of Foreign and Diaspora Affairs should collaborate with the Directorate of Immigration Services to establish modalities of capturing the data of Kenyans leaving the country destined for the diaspora and share it with the relevant diplomatic missions. Further, the High Commission in Ottawa should collaborate with Kenyan Community Associations in Canada to establish a central database for the approximately 40,000 Kenyans living in Canada.
- d) The Ministry of Foreign and Diaspora Affairs in conjunction with the National Transport and Safety Authority (NTSA) should work to ensure the NTSA starts issuing driving

licenses that indicate the initial year of issuance of a driving license in order to enable Kenyans in the diaspora to benefit from their years of experience as drivers, an important aspect in the diaspora.

- e) The State Department for Diaspora Affairs should operationalize a welfare kitty for Kenyans in the diaspora. This would help in catering for emergencies like deaths, deportation, and tickets back home for distress cases.
- f) In order to improve the Mobile Consular Services Exercise, the State Department for Diaspora Affairs should ensure: timely disbursement of required funds to the relevant diplomatic missions and that adequate administrative and logistical arrangements are made prior to the exercise to ensure its success.
- g) The Ministry of Foreign and Diaspora Affairs in conjunction with the Independent Electoral and Boundaries Commission should device mechanisms to ensure the general elections are conducted in a manner and time that allows Kenyans in the Diaspora to participate in the elections.
- h) The State Department for Diaspora Affairs should work closely with the State Department of Culture and Heritage and the State Department for Tourism in marketing the country abroad.
- i) The Ministry of Foreign and Diaspora Affairs should work closely with the Kenya Investment Authority to establishing mechanisms and develop safe investment vehicles in Kenya for the diaspora community.
- j) The Kenya Revenue Authority should educate Kenyans in the Diaspora on their rights and obligations as tax payers as well as provide information on how they can access their services with ease.

The report was adopted having been proposed by the Hon. Donya Doris Aburi and Seconded by the Hon. Charity Kathambi Chepkwony, M.P.

MIN.NO.NA/DA&MWC/2023/196

ADJOURNMENT AND DATE OF NEXT MEETING

The meeting was adjourned at 4.05 p.m. The next meeting will be held on notice.

SIGNED..... DATE04/12/23.....

CHAIRPERSON

 THE NATIONAL ASSEMBLY PAPERS Laid	
DATE: 05 DEC 2023	
Day: Tuesday	
TABLED BY:	Hon. Lydia Haeika (Chairperson, Diaspora Affairs & Migrant Workers Committee)
CLERK-AT-THE-TABLE:	Inzafu Mwale



Approved
Boss
D/SNA
5/12/23.

REPUBLIC OF KENYA
THE NATIONAL ASSEMBLY
THIRTEENTH PARLIAMENT – SECOND SESSION – 2023
DIRECTORATE OF DEPARTMENTAL COMMITTEES
DEPARTMENTAL COMMITTEE ON HEALTH

REPORT ON THE ON HEALTH SYSTEM MANAGEMENT TRAINING IN GALILEE
INTERNATIONAL MANAGEMENT TRAINING INSTITUTE IN ISRAEL FROM 30TH
MAY TO 7TH JUNE, 2023

THE NATIONAL ASSEMBLY PAPERS Laid	
DATE: 05 DEC 2023	DAY: Tuesday
TABLED BY:	Hon. Dr. Robert Pukose (Chairperson, Health Committee)
CLERK AT THE TABLE:	Inzafu Mwale

DIRECTORATE OF DEPARTMENTAL COMMITTEES,
CLERK'S CHAMBERS,
PARLIAMENT BUILDINGS,
NAIROBI.

DECEMBER, 2023

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3.1 GALILEE INTERNATIONAL MANAGEMENT TRAINING INSTITUTE	10
PRIMARY CARE VISIT, SPECIALISTS AND ALLIED MEDICAL PROFESSIONAL CONSULTATIONS AND IMAGING DIAGNOSTIC EXAMS	13
<i>How is the delivery system organized and how are providers paid?</i>	13
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LIST OF ANNEXURES

Annex 1- Minutes on the proceedings of the Committee

Annex 2- Report adoption list

CHAIRMAN'S FOREWORD

The National Assembly Departmental Committee on health was invited to undertake a training in health systems management in Galilee international training management Institute in Israel from 30th May to 7th June, 2023.

The aim of the training was to equip Members as law makers with the relevant knowledge to make informed healthcare policy decisions to enhance the quality of life for the people of Kenya in line with the government's agenda of enhancing Universal Health Coverage (UHC) and assist Members in understanding the legislative, policy and funding frameworks in health systems management in Israel and in general. This will enhance policy formulation and for priority health systems areas in health sector in the Country.

May I take this opportunity to commend the Committee members for their devotion and commitment to duty which made the benchmarking visit successful, express gratitude to the offices of Speaker and Clerk of the National Assembly for always providing leadership and guidance and appreciate the Committee secretariat for exemplary performance in providing technical and logistical support. Indeed, their roles were critical to the Committee in the conduct of this training.

On behalf of the Departmental Committee on Health, it is my pleasant privilege and duty to present to the House a report on the training in Galilee International management training institute on health system management in Israel from 30th May to 7th June, 2023.

THE HON. DR. ROBERT PUKOSE, M.P.
CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

CHAPTER ONE

1. PREFACE

1.1 Establishment of the Committee

The Departmental Committee on Health is established pursuant to the provisions of Standing Order 216 of the National Assembly Standing Orders and in line with Article 124 of the Constitution which provides for the establishment of the Committees by Parliament.

The mandate and functions of the Committee includes:

- a) *To investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned ministries and departments;*
- b) *To study the programme and policy objectives of ministries and departments and the effectiveness of the implementation;*
 - ba) *on a quarterly basis, monitor and report on the implementation of the national budget in respect of its mandate;*
- c) *To study and review all legislation referred to it;*
- d) *To study, assess and analyse the relative success of the ministries and departments as measured by the results obtained as compared with their stated objectives;*
- e) *To investigate and inquire into all matters relating to the assigned ministries and departments as they may deem necessary, and as may be referred to them by the House;*
- f) *Vet and report on all appointments where the constitution or any other law requires the national Assembly to approve, except those understanding Order 204 (Committee on appointments);*
- g) *To examine treaties, agreements and conventions;*
- h) *To make reports and recommendations to the House as often as possible, including recommendation of proposed legislation;*
- i) *To consider reports of Commissions and Independent Offices submitted to the House pursuant to the provisions of Article 254 of the Constitution; and*
- j) *To examine any questions raised by Members on a matter within its mandate.*

1.2 Mandate of the Committee

In accordance with the Second Schedule of the Standing Orders, the Committee is mandated to consider all matters relating to the health sector. The Committee oversees the Ministry of Health with its two State Departments i.e., State Department for Medical Services and State Department for Public Health and Professional Standards.

These Semi-Autonomous Government Agencies (SAGAs); Kenya National Hospital (KNH); Moi Teaching and Referral Hospital (MTRH); Kenyatta University Teaching, Research and Referral Hospital (KUTRRH); Kenya Medical Training College (KMTC); Kenya Medical Supplies Agency (KEMSA); Kenya Medical Research Institute (KEMRI); National Aids Control Council (NACC); National Hospital Insurance Fund (NHIF) fall under the Ministry of Health.

1.3 Committee Membership

1. The Committee was constituted by the House on 27th October 2022 and comprises the following Members;

Chairperson

Hon. (Dr.) Robert Pukose, MP
Endebes Constituency
UDA Party

Vice-Chairperson

Hon. Ntwiga, Patrick Munene MP
Chuka/Igambang'ombe Constituency
UDA Party

Members

Hon. Owino Martin Peters, MP
Ndthiwa Constituency
ODM Party

Hon. Muge Cynthia Jepkosgei, MP
Nandi (CWR)
UDA Party
Hon. Wanyonyi Martin Pepela, MP
Webuye East Constituency
Ford Kenya Party

Hon. Kipngok Reuben Kiborek, MP
Mogotio Constituency
UDA Party

Hon. Dr. Nyikal James Wambura, MP
Seme Constituency
ODM Party

Hon. Kibagendi Antoney, MP
Kitutu Chache South Constituency
ODM Party

Hon. Julius Ole Sunkuli Lekakeny, MP
Kilgoris Constituency
KANU

Hon. Maingi Mary, MP
Mwea Constituency
UDA Party

Hon. Mathenge Duncan Maina, MP
Nyeri Town Constituency
UDA Party

Hon. Lenguris Pauline, MP
Samburu (CWR)
UDA Party

Hon. Oron Joshua Odongo, MP
Kisumu Central Constituency
ODM Party

Hon. (Prof.) Jaldesa Guyo Waqo, MP
Moyale Constituency
UPIA Party

Hon. Mukhwana Titus Khamala, MP
Lurambi Constituency
ANC Party

1.4 Committee Secretariat

5. The committee is serviced by the following secretariat staff:

Mr. Hassan Abdullahi Arale
Clerk Assistant I/Head of Secretariat

Ms. Gladys Jepkoech Kiprotich
Clerk Assistant III

Mr. Salat Abdi Ali
Senior Serjeant-At-Arms

Ms. Faith Chepkemai
Legal Counsel II

Ms. Rahab Chepkilim
Audio Recording Officer II

Mr. Hiram Kimuhu
Fiscal Analyst III

Ms. Angela Cheror
Public Communication Officer III

Mr. Yakub Ahmed
Media Relations Officer II

Ms. Abigel Muendi
Research Officer III

Mr. Benson Kimanzi
Serjeant-At-Arms III

CHAPTER TWO

2. INTRODUCTION

1. The National Assembly Departmental Committee on health was invited to undertake a training in health systems management in Galilee International Training Institute in Israel from 30th May to 7th June, 2023.

2.1 Objective of the Training

2. The aim of the training was to equip Members as law makers with the tools to make informed healthcare policy decisions to enhance the quality of life for the people of Kenya in line with the government's agenda of enhancing Universal Health Coverage (UHC) and assist Members in understanding the legislative, policy and funding frameworks in health research from health research institutions in South Africa such as the South Africa Medical Research Council. This will enhance policy formulation and exchequer funding for priority health research areas in the country especially in light of the declining donor funding for the health sector in the Country.

1.2 The Delegation

2. The following undertook the benchmarking visit and represented the Departmental Committee on Health.
 - a) The Hon. Pauline Lenguris, MP. - **Leader of delegation**
 - b) The Hon. Antony Kibagendi, MP.
 - c) The Hon. Reuben Kiborek, MP
 - d) Mr. Hassan A. Arale, Clerk Assistant I- **Delegation Secretary.**

CHAPTER THREE

3. TOPICS COVERED IN THE TRAINING

3.1 GALILEE INTERNATIONAL MANAGEMENT TRAINING INSTITUTE

3. The Kenyan delegation met the Galilee training institute team headed by their president Dr. Joseph Shavel at the training institute in Afula. During the training, the delegation visited Galilee Medical Centre in Naharya, The Israel National Emergency Medical Services in Mada, Afula, Rakati HMO Clinic Tiberias and Bet Loewenstein Rehabilitation Hospital Raanana.

THE ISRAEL HEALTHCARE SYSTEM

4. Israel provides universal coverage to citizens and permanent residents as part of its national health insurance law. Residents choose from four competing nonprofit health plans that provide a mandated benefit package, including hospital, primary, specialty, mental health, and maternity care, as well as prescription drugs and other services. There are no deductibles, but some cost-sharing is required for specialist visits and prescription drugs. The compulsory insurance system is funded primarily through a national income tax and an income-related health tax. Most citizens also purchase voluntary health insurance for medications not covered by the benefit package and for faster access and greater provider choice. Almost all governmental health functions are organized by the Ministry of Health, which has regional and district health offices.

SECTIONS

5. The Section Includes; Universal Coverage, Care Delivery and Payment, Ensuring Quality of Care, Reducing Disparities, Integration and Coordination, Electronic Health Records, Cost Containment and Innovations.

How does universal health coverage work?

6. Since 1995, Israel's National Health Insurance (NHI) law has ensured universal coverage for citizens and permanent residents. As the law states, "Health insurance...shall be based on principles of justice, equality and mutual assistance." Under this commitment, every resident is entitled to health care services.
7. Residents are free to choose one of four competing nonprofit health plans that must cover anyone who applies. Every resident has a right to receive all services included in the benefit basket that is mandated by the government, subject to medical discretion. While residents also have the right to receive services at a reasonable quality level, within a reasonable period of time, and at a reasonable distance from their home, no formal definition of "reasonable" exists, and there is no penalty for health plans that fail to comply.
8. **Some populations are excluded:** Soldiers, who receive health care directly from the army; inmates, who receive care from the Israel Prison Service; documented and undocumented foreign workers, whom employers are required to enrol in private insurance programs; and undocumented migrants, temporary residents, and tourists.
9. **Role of government:** The national government, through the Ministry of Health, is responsible for population health and the overall functioning of the health care system. It

- supervises and works with the NHI health plans and owns and operates a large network of maternal and child health centers, about half of the nation's acute care bed capacity, and about 80 percent of its psychiatric bed capacity.³ In addition to financing insurance, the national government funds public-health services and is directly responsible for the provision and funding of certain other health services, including prenatal and preventive care, infant developmental tests, communicable disease surveillance, screenings, and institutional long-term care.
10. Local governments have limited involvement in health care provision. Accordingly, nearly all governmental health functions are organized by the national Ministry of Health, which comprises a network of regional and district health offices.
 11. Various advisory bodies counsel the Ministry of Health and handle specific responsibilities:
 - a) The National Health Council, a public advisory council, advises on prominent health policy issues.
 - b) The Benefits Package Committee provides guidance on the prioritization of new technologies for inclusion in the NHI benefit package and carries out health technology assessments for new medications.
 - c) Various national councils provide external professional input in specific areas, such as trauma care, mental health, and women's health.
 - d) The Ministry of Finance's Insurance and Capital Markets Division regulates commercial voluntary health insurance.
 - e) An ombudsman's office helps citizens realize their rights under the NHI law. In addition, there are various nongovernmental patient advocacy organizations, many of which focus on particular diseases.
 - f) The Scientific Council of the Israel Medical Association is responsible for specialty provider certification programs and examinations, in coordination with the Ministry of Health.
 - g) The Council for Higher Education is responsible for the authorization, certification, and funding of all university degree programs, including the training of health care professionals.
 - h) A joint Ministry of Health – Ministry of Finance committee sets the fees for hospitals, other providers, and services. These ministries are also engaged in cost-control efforts, but responsibility for cost containment is distributed over a number of different departments.
 12. The Ministry of Health also has units that monitor quality and patient safety in hospitals and additional settings, provide national leadership in health information technology, promote health equity, and address issues of competition within health care.
 13. In 2017, National health expenditures accounted for 7.4 percent of GDP, a figure that has remained stable during the last two decades. In 2017, 63 percent of health expenditures were publicly financed, a share that is one of the lowest among Organisation for Economic Co-operation and Development (OECD) countries.
 14. Israel's NHI system is funded primarily through an earmarked, income-related health tax (5% of income for individuals age 22 and older) in combination with general government revenues, which are funded primarily through progressive income taxation paid by individuals. Married women, children, and all those who are excluded from the NHI (such as soldiers) are exempt from the health tax.

15. The government distributes the NHI budget among the four health plans primarily through a capitation that accounts for sex, age, geographic distribution of their members and five chronic, expensive-to-treat diseases.
16. Private, voluntary health insurance financed 14 percent of national health expenditures in 2016. Residents can obtain voluntary health insurance from the four NHI nonprofit plans as well as from for-profit commercial plans. The NHI plans cannot reject applicants, and premiums are based on age only. Commercial private plans tend to be more comprehensive, more individually tailored, and more expensive, and can be purchased by individuals or groups, such as employers, unions, or kibbutzim.
17. Nearly all individuals purchase private insurance from either the NHI plans or commercial insurers, or both. In 2016, 84 percent of Israel's adult population was enrolled in an NHI private insurance plan, and 57 percent were enrolled in a commercial private insurance plan.
18. Voluntary health insurance plays a complementary role, covering benefits excluded from the NHI scheme (dental care for adults, certain medications, alternative medicines), as well as a supplementary role, expanding access to NHI-covered benefits, offering access to private providers, and providing improved amenities and faster access to care. The high number of those with voluntary health insurance coverage reflects a general lack of confidence in the NHI system's capacity to fully fund and deliver all services needed in cases of severe illness.
19. The mandated NHI benefit package includes the following: Hospital care, Primary and specialty care, Prescription drugs, Certain preventive services, Mental health care, Dental care for children and the elderly aged 75 and above, Diagnostic exams, Maternity care, Allied medical care (physiotherapy, Occupational therapy, Nutrition, Speech therapy), Some durable medical equipment (wheelchairs, orthopaedic aids), Limited coverage of palliative and hospice services, Dental care for adults, optometry and hearing aids are excluded.
20. Means-tested institutional long-term care, infant developmental screenings and vaccinations, and postpartum care like breastfeeding guidance are covered by the Ministry of Health, but separately from NHI.
21. In 2016, out-of-pocket spending accounted for 22 percent of national health expenditures. Most of this was for voluntary health insurance (38%), adult dental care (22.5%), and pharmaceuticals (15%). The remainder was for other services not included in the NHI benefit package, including vision care and medical equipment, as well as cost-sharing for NHI-covered services.
22. NHI health plans are allowed to impose user charges for certain services. These include a flat quarterly copayment rate for visits to specialists and allied medical professionals and for imaging diagnostic exams; a user charge for after-hours emergency care in the community; and coinsurance for pharmaceuticals (see table below). User charges, which are regulated by the Ministry of Health, constituted about 6.5 percent of health plan income in 2016. There are no copayments for primary care visits, preventive care, cancer screenings, or hospital admissions. There are also no quarterly or annual deductibles with NHI coverage.

23. Safety nets: Safety nets include an annual cap on the health tax at NIS 43,370 (USD 11,565). In addition, individuals with low incomes (60% of average income or less) pay a reduced health tax rate of 3 percent, compared to 5 percent paid by individuals with higher incomes. The unemployed and others without income pay a minimum flat health tax of approximately NIS 100 (USD 27) per month.
24. Israel also has caps on user charges and discounts for older adults, the chronically ill, and other vulnerable populations, as shown in the table below.

PRIMARY CARE VISIT, SPECIALISTS AND ALLIED MEDICAL PROFESSIONAL CONSULTATIONS AND IMAGING DIAGNOSTIC EXAMS

How is the delivery system organized and how are providers paid?

25. Israel has six medical schools, which are all part of public, non-profit universities. The number of medical schools and students is regulated by the higher education council. As of 2015, more than half (58%) of Israeli physicians under age 65 had completed their medical studies abroad. Annual tuition, heavily subsidized by the government, is approximately NIS 11,100 (USD 3,000) for the first three years and NIS 14,800 (USD 4,000) for the next three years.
26. To address physician shortages in the entire country and in remote areas in particular, the government introduced two measures in 2011: it increased the number of physician positions in all hospitals throughout the country and introduced financial incentives (onetime bonuses and salary differentials) to encourage physician graduates to pursue their residencies in remote regions. The combination of these two programs has increased the number of residencies completed, especially in remote settings. Similar financial incentives encourage physicians to choose in-demand specialties, such as anaesthesiology, geriatrics, and paediatric neurology.
27. In 2018, 5,052 of the 38,523 licensed physicians (13%) were employed as general practitioners (GPs). The average number of GPs per capita in Israel is 0.6 GPs per 1,000 people (or 1 GP per 1,653 insured). However, this rate varies across regions and health plans (ranging from 0.57 to 0.73). Most GPs contract with one of the four competing nonprofit NHI health plans. Only 5 percent have contracts with more than one health plan.
28. The four NHI health plans (**Clalit**, **Maccabi**, **Meuhedet**, and **Leumit**) have different approaches to organizing care. **Clalit**, the largest health plan, provides most primary care in clinics that it owns and operates, and GPs are salaried employees. The typical clinic is multidisciplinary, with three-to-six GPs and several nurses, pharmacists, and other professionals. **Clalit** also contracts with independent physicians who tend to work in solo practices, with some access to administrative and nonphysician services at **Clalit** district clinics.
29. The other three health plans also use a mix of multidisciplinary clinics and independent primary care practices. In **Maccabi** (the second-largest plan) and **Meuhedet**, almost all of the primary care is provided by independent physicians, while in **Leumit** the clinic model predominates. Members of all plans can generally choose their GP from among those on the plan's list and can switch freely. In practice, nearly all patients remain with the same GP for extended periods.

30. In Clalit, each patient is registered with a GP who has responsibility for coordinating care. Clalit is also the only plan that requires gatekeeping; referrals are required for secondary care, except for five common specialties (dermatology, otorhinolaryngology, ophthalmology, orthopaedics, and gynaecology). In Leumit, patients are registered with a clinic rather than with a GP, and in the other two plans there is no registration. Approximately one-third of Israel's nurses work in community settings, primarily as salaried employees of the four NHI health plans. Their roles have been expanding beyond traditional routine nursing care "What innovations and reforms have recently been introduced?"
31. In a 2015-2016 national survey, 38 percent of frontline nurses employed by health plans identified "caring for chronically ill patients" as their main area of activity in addition to routine care, and 30 percent noted "health promotion." Doctors are paid entirely by the health plans; they cannot collect additional fees from their patients.
32. Salaries of Clalit clinic-based physicians are set via a collective bargaining agreement with the Israel Medical Association. Capitation rates for independent physicians in all health plans are set by the plans in consultation with physicians' associations.
33. Clalit and Leumit use predominantly "passive capitation," a quarterly, per-member payment made irrespective of whether the member visited the GP in the relevant quarter. Maccabi and Meuhedet use "active capitation," whereby payment is made only for members who visited their GP at least once during the quarter. Independent physicians also receive limited fee-for-service payments for certain procedures. Quality-related financial incentives are generally not used.
34. Outpatient specialty care is provided predominantly in community settings, either in health plan clinics or in physicians' offices. The former tends to be integrated multispecialty clinics, while the latter tend to be single-specialty.
35. Patients can choose freely among community-based specialists who are contracted with their health plan. Services provided by out-of-network specialists are paid for out-of-pocket or covered by voluntary health insurance.
36. Most outpatient specialists are paid on an active capitation basis, plus fee-for-service for certain procedures, up to a quarterly ceiling. Rates are set by the health plans. Specialists may not "balance bill" for NHI-covered services. Nevertheless, specialists can receive patients from NHI health plans along with patients who have private voluntary health insurance, but not the same patient in both settings. For privately insured patients, specialists can set their payment rates at their discretion.
37. When copayments and coinsurance are owed, such as for specialist visits and pharmaceuticals, patients never pay providers directly. Instead, they use their health plan membership cards to make copayments. The provider then receives the full fee from the health plans, which collect copayments electronically from enrollees' bank accounts each month.
38. After-hours care is available via hospital emergency departments (EDs), freestanding walk-in urgent care centers (both non-profit and for-profit), and physician home visits provided by for-profit companies. The Ministry of Health has overall responsibility for after-hours care, and it has promoted the establishment of urgent care in several localities that are far from hospital EDs.

39. Primary care physicians are not required to provide after-hours care. They receive reports on their patients from the after-hours providers and, increasingly, this information is conveyed electronically.
40. All health plans operate national telephone advice lines for their members, staffed by nurses with physician backup. All of Israel's hospital EDs are connected to the national health information exchange; efforts are underway to link them with community-based urgent care centers as well.
41. Of the 45 acute care hospitals, 18 are government-owned, either by the Ministry of Health or by municipalities. These account for 57 percent of the national capacity. Another 40 percent of acute care beds are operated by 16 private nonprofit hospitals that are owned by health plans or nonprofit organizations. Eleven for-profit hospitals account for the remaining 3 percent of bed capacity. These tend to be smaller hospitals that specialize in elective procedures. Reimbursement of hospital care varies:
- a) Hospital emergency care is reimbursed on a fee-for-service basis.
 - b) Inpatient medical care is reimbursed on a per-diem basis.
 - c) Inpatient procedures are paid either per diem or through activity-based, procedure-related group (PRG) arrangements.
 - d) Outpatient care is reimbursed on either a fee-for-service or a procedure-related group basis.
42. Maximum payment rates are set by the government, but health plans negotiate discounts. The government also sets revenue parameters (minimum and maximum), which limit the extent to which each hospital's total revenues can decrease or grow from year to year. Hospital payments cover all costs, including the cost of the physicians. Procedure-related group payments include all costs of a hospitalization episode, excluding rehabilitation. There are no extra payments for severity, outliers, expensive treatments, or the adoption of new technologies.
43. Government and nonprofit hospitals follow a national hospital fee schedule, but for-profit hospitals' prices are unregulated. Fee-for-service is the predominant payment mode for private for-profit hospitals.
44. In government and nonprofit hospitals, physicians are predominantly salaried employees, with limited arrangements for supplemental fee-for-service payments for procedures performed outside regular hospital hours.
45. Until 2018, there was largely no choice of specialist in nonprofit hospitals. Patients wishing to choose a specialist or surgeon had to go to a for-profit hospital and pay out of pocket or use voluntary health insurance. Since 2018, some large public hospitals have started offering free choice of surgeon.
46. In 2015, responsibility for the provision of mental health care was transferred from the Ministry of Health to the NHI health plans, which provide care through a mix of salaried professionals, contracted independent professionals, and purchased services. The Ministry of Health continues to own and operate community-based mental health clinics, which are now under contract with the health plans.
47. NHI-mandated mental health coverage is broad and includes psychotherapy, medications, and inpatient and outpatient care. Integration of mental health and medical services is

currently limited but is expected to improve because of the transfer of responsibility to the health plans. Psychologists are the main source of professional mental health care for half of patients, and psychiatrists and primary care physicians serve a quarter of patients.

48. Since the health plans took over mental health care, the availability of community-based services has increased substantially. However, there are still significant waiting times, particularly for psychotherapy and child psychiatry. These delays are due in part to shortages of some types of mental health professionals and to the health plans' difficulties in attracting and contracting with professionals, who can earn much more in the private sector.
49. Long-term care is not covered by NHI, but is covered separately. The government publicly funds long-term care services through general taxes.
50. In 2014, 86 percent of adults age 65 and older with disabilities received community-based long-term care, while the remaining 14 percent received institutional long-term care. Community-based services account for 52 percent of total long-term care expenditures, of which 67 percent was publicly funded. Approximately half of the adult population purchases private long-term care insurance.
51. Institutional long-term care financing is subsidized by the Ministry of Health and is awarded based on needs and means tests. These subsidies are generally paid directly to providers, although families can receive cash subsidies to pay providers.
52. Community-based long-term care is funded by the National Insurance Institute, and eligibility is based on needs and means tests. It includes personal care and housekeeping services for community-dwelling seniors with disabilities. In addition, the National Insurance Institute covers an extensive network of daycare centers and a growing network of supportive neighbourhoods. An emergency call service, physician home visits, and social activities are also covered. Additionally, in every community, a facilitator coordinates social supports and apartment repairs.
53. Until 2018, there was no financial support for informal or family caregivers; there are means-tested government subsidies for home aids.
54. NHI health plans are responsible for providing medical care, such as home nursing care, for the disabled elderly living in the community. In recent years, they have increased access to clinicians (particularly for the homebound elderly) via home care teams and telemedicine. About two-thirds of nursing home care and nearly all home aids are provided by private, for-profit companies, with the remainder being public.
55. Hospice care is a mandated NHI benefit. In practice, however, while some hospice care is available, particularly home hospice, there is considerable unmet need.
56. Israel has a well-established system for monitoring the quality of primary care. Comparative quality data for individual health plans has been made public since 2014. While the published data relate to the health plans at the national level, the plans also maintain internal data on regions, clinics, and individual physicians. Plans monitor the care provided by their GPs and work closely with them to improve quality.
57. The Ministry of Health publishes comparative, hospital-specific quality data. The number of quality indicators and of the types of services covered has been growing rapidly.

Currently, explicit financial incentives for hospitals to improve quality exist only for timely care of hip fractures or stroke.

58. The Ministry of Health also has a well-developed system for monitoring the quality of care in nursing homes and mother-and-child clinics, and is sharing this performance information with the public. There is no parallel system for home care services.
59. Practice guidelines exist for some clinical areas. These have been developed by professional medical associations, often in collaboration with the Ministry of Health.
60. All Israeli general hospitals are required to have received, or to be working toward, accreditation by Joint Commission International. As of June 2018, almost all of the general hospitals were accredited.
61. An independent research institute carries out biannual surveys of the general population regarding the service level provided by NHI health plans and the level of satisfaction with the health system. The Ministry of Health recently launched an annual survey of hospitalized patients, publishing results for individual hospitals.
62. National registries are maintained by the Ministry of Health for certain expensive medical devices and for a broad range of diseases and conditions, including cancer, low birth weight, trauma, and occupational diseases.
63. The Ministry of Health is leading a major national effort to reduce disparities, in cooperation with the NHI health plans and hospitals. Key initiatives include:
 - a) Reducing financial barriers to care, particularly for those with low incomes and other vulnerable populations. Most prominently, mental health and dental care for children and the elderly have been added to the NHI benefit package.
 - b) Enhancing the availability of services and professionals in remote regions by increasing the supply of beds and technologically advanced equipment in those regions.
 - c) Addressing the unique needs of minorities through the adoption of cultural responsiveness requirements for all providers, the establishment of a national translation call center, and targeted interventions for the Bedouin and other high-risk groups.
 - d) Implementing intersectoral efforts to address the social determinants of health and promote healthy lifestyles.
64. The four NHI health plans are essentially the main source of primary, specialty, and mental health care. This structural integration provides a foundation for providing relatively seamless care, including care for complex and chronically ill patients. The plans' health information systems link primary and specialty care providers, and a new national health information exchange is adding hospital data to this system. These systems are increasingly providing access to electronic patient information at the point of care.
65. In addition, the health plans have established several targeted care management programs that aim to provide comprehensive integrated care for complex patients with chronic conditions. These make extensive use of the plans' sophisticated information systems, videoconferencing, and other innovative techniques.

66. All health plans have electronic health record (EHR) systems that link all community-based providers: primary care physicians, specialists, laboratories, and pharmacies. All GPs work with EHRs. Hospitals are also computerized but are not fully integrated with health plan EHRs. The Ministry of Health is leading a major national health information exchange project to create a system for sharing relevant information across all hospitals and health plans.
67. Each citizen has a unique patient ID. Patients have the right to get copies of their medical records from hospitals and health plans, and patients can book appointments and access many components of their EHR online (such as lab test results), but full records are not generally available. Efforts are underway to set up secure messaging systems linking patients and their GPs.
68. Among high-income countries, Israel is one of the most successful at containing costs. Strategies include:
- a) Instituting tight control of resources and expenditures. About half of national health expenditures are channelled through the Ministry of Finance. There are rigorous controls on key supply factors, such as hospital beds and expensive medical equipment, as well as physician and nurse positions in hospitals. In addition, the government sets maximum reimbursement rates and global revenue caps for hospitals.
 - b) Using various managed care approaches. The NHI health plans essentially work as managed care organizations, providing care within budgets that are largely determined prospectively by capitation. The plans employ a variety of mechanisms for controlling utilization and costs, such as purchasing pharmaceuticals in bulk and incentivizing the use of generics. Health plans also maintain a well-developed system of prevention and community-based services to reduce reliance on high-cost hospital care.
 - c) Explicitly prioritizing public funding for new technologies included in the NHI benefit package.
 - d) Deploying risk-sharing agreements for certain high-cost drugs. The pharmaceutical companies fund patients' drugs after a predetermined supply have been depleted.
 - e) Implementing demand-side levers, including cost-sharing for specialist visits and coinsurance for pharmaceuticals, with higher rates for patented medications.
 - f) Aligning organizational and financial incentives between clinicians and the hospitals or health plans for which they work. For example, health plans have various internal processes for discouraging the delivery of care that provides poor value.
69. A number of innovations have been launched in recent years, including the following:
- a) Creating an environment to encourage healthy diets. The Ministry of Health has imposed measures such as mandatory food labelling and restrictions on advertising unhealthy food for children. It has been incentivizing food manufacturers to produce healthier products, and has been improving economic access to healthy food through the taxation of unhealthy food. In addition, the Ministry of Health is improving the nutritional value of food served in public institutions, and is including education on healthy diets in the school curriculum for young children.

- b) Expanding the role of nurses in the community. In 2018, the Ministry of Health extended the responsibilities and scope of practice for specialist nurses in the community, to relieve some of the pressure on primary care physicians. Specialist nurses can now treat mild cases of acute diseases and cases that are urgent but simple to treat; treat and monitor patients with chronic diseases; provide preventive care and handle health promotion; and prescribe medications and contraceptives. Specialist nurses can also provide palliative care and refer patients for diagnostic tests, to specialists, and to EDs.
- c) Improving continuity of care. Urgent care centers are required to report patient data (diagnosis, treatment, recommendations for future care) to the patient's health plan and to the hospital if the patient is referred for acute care, bridging the information gap between community and inpatient care. Centers must also report cases of communicable or rare diseases and domestic violence to relevant authorities.
- d) Further expanding dental care coverage. The 2018–2019 Ministry of Health budget funds the expansion of the health basket to include dental care for people aged 75 years and above during 2018, and for children up to 18 years old during 2019. This step concludes the “reform of dental care for children,” which started in 2010 with the inclusion of dental care for children up to 8 years of age to the health basket.
- e) Increasing the scope, breadth, and depth of services for older people. To better meet the needs of Israel's aging society, the Ministry of Health is broadening eligibility for long-term care.

- 70. A team is a group of people with complementary capabilities, consolidated or joint objectives and consider themselves responsible for the mutual achiever. Interdependent people working to achieve a common task in the most efficient way in cooperation and coordination.
- 71. For effective working relationship the team must possess the following characteristic, shared goals and objectives, Interdependence, Personal responsibility and accountability, Skills of cooperation, Direct and open communication, Group processing: learning teamwork skills and Maintenance staff: Testing, Evaluation and feedback to team members.
- 72. For effective communication among the team players there must be Basic trust, Direct and open, Targeted messages, “I message”, Empathy, Timing, direction, Conflict resolution and Creativity.
- 73. From time to time there will arise conflicts on different issues and therefore any organization must be Striving to find solutions, striving for fair treatment, Mind the needs of the other, Seek Mediation, avoiding defeating your opponent and seek long-term solution.
- 74. For effective execution of tasks and achieve its vision and mission as planned any organization the personnel must be able to Understanding the task, Brainstorming, Joint decision-making, Planning the work process, division of roles, Mission and appreciative Inquiry.
- 75. Appreciative inquiry is very necessary in an organization to achieve its goals through Performance analysis, Persistence even when successful, avoiding accusations, taking

personal responsibility, Personal goal setting to improve, setting group goals to improve and Practice Redo. In improving organization work, strength, weaknesses, opportunities and strength.

76. The developing world has the potential of digital health to improve healthcare. Digital health refers to the use of information and communication technologies (ICTs) to deliver healthcare services.
77. Information Communication Technology (ICTs) can be used to improve healthcare in developing countries in a number of ways, including: Providing access to healthcare services in remote areas, Improving the quality of healthcare services, Reducing the cost of healthcare services and the use of digital health in developing countries is still in its early stages, but there is a growing body of evidence to suggest that it has the potential to make a significant impact on healthcare delivery.
78. Mobile health (mHealth) is the use of mobile devices, such as smartphones and tablets, to deliver health-related services. Through,
- a) Wearable devices: Small, portable devices that can be worn on the body to collect health data.
 - b) Telemedicine: The use of telecommunications technologies to provide medical care remotely.
 - c) Electronic health records (EHRs): Electronic systems store and manage health information.
 - d) Artificial intelligence (AI): The use of computer algorithms to analyze data and make predictions.
79. **Telehealth:** Telehealth allows patients to receive care from a doctor or other healthcare provider remotely, using video chat or phone calls. This can save money by reducing the need for in-person visits, which can be costly for both patients and providers. For example, a study by the American Telemedicine Association found that Telehealth can save patients an average of \$160 per visit.
80. **Remote patient monitoring:** Remote patient monitoring uses technology to track patients' health data remotely, without the need for in-person visits. This can help to identify and manage chronic conditions early, which can prevent costly complications. For example, a study by the Centres for Disease Control and Prevention found that remote patient monitoring can save Medicare an average of \$1,500 per patient per year.
81. **Prescription drug management:** Prescription drug management tools can help patients to better manage their medications, which can reduce the risk of adverse drug events and improve patient outcomes. This can save money by reducing the need for emergency room visits and hospitalizations. For example, a study by the National Institute of Mental Health found that a prescription drug management program can save patients an average of \$1,000 per year.
82. **Health information exchange:** Health information exchange (HIE) allows healthcare providers to share patient data electronically. This can help to improve coordination of care and reduce duplication of tests and procedures, which can save money. For example, a study by the Office of the National Coordinator for Health Information Technology found that HIE can save hospitals an average of \$200,000 per year.

83. **M-Pesa** is a mobile money service that was launched in Kenya in 2007. It has been used to pay for healthcare services, including doctor's visits, hospital stays, and medication. A study by the World Bank found that M-Pesa users were more likely to seek healthcare than non-users, and that they spent less on healthcare overall.
84. **MamaYe** is a mobile app that provides health information and support to pregnant women in Ghana. The app has been shown to reduce the number of unnecessary hospital visits and to improve the health outcomes of babies.
85. **DHIS2** is a health information system that is used by over 40 countries in Africa. It helps to track and manage health data, which can be used to improve the efficiency and effectiveness of healthcare delivery. A study by the World Health Organization found that DHIS2 can save up to \$10 per person per year in healthcare costs.
86. The trends that are expected to shape the future of healthcare includes; The rise of mobile health (mHealth) - iKNOW-IT, MTieBreak, U-Report, the growth of telemedicine, the development of personalized medicine and precision health - H3Africa, Project 10K and the increasing use of artificial intelligence (AI) and machine learning in healthcare.
87. Challenges that digital health implementation is facing includes; Infrastructure (Reliable electricity, Reliable Internet connection), Cost of infrastructure and internet connectivity, Lack of awareness, Regulation and Human resources with technical know-how.
88. Opportunities for healthcare stakeholders includes; Improved patient care and outcomes (ARC), Reduced costs, Increased efficiency and Enhanced patient engagement (Uniper).
89. Digital health has the potential to improve access to care, improve the quality of care, and reduce the cost of care in Africa. There are a number of challenges to the adoption of digital health in Africa, including the lack of infrastructure, the lack of skilled workers, and the high cost of technology. There are a number of programs that exist to reduce the cost of digital health implementation in Africa, such as the WHO Digital Health Initiative, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNICEF, and the Bill & Melinda Gates Foundation.
90. By taking steps to reduce the cost of digital health implementation in Africa, we can help to make digital health more affordable and accessible to people in Africa. This will help to improve the health of people in Africa and contribute to economic growth.
91. Digital transformation is the adoption of digital technology by an organization to digitize non-digital products, services or operations. The goal for its implementation is to increase value through innovation, invention, customer experience or efficiency on how products, processes and organizations can be changed through the use of new, digital technologies.
92. A process that aims to improve an entity by triggering significant changes to its properties through combinations of information, computing, communication, and connectivity technologies.

93. There are four key areas of digital transformation which includes Empowering employees, Engaging Customers, Optimize operations and Services and products.
94. The application of the following strategies is critical in the transformation of healthcare that is by defining the needs and Goals, Leadership/Management Support, start small but Strategic, start with Business needs and then move to choose technology, choose your partners well, collect feedback and be agile and use momentum to scale digital Transformation.
95. The digital transformation is not about technology but about mindset, instead of replicating, African countries must consider their own realities and finally Coordination and data sharing are key for more efficiency.
96. An information system (IS) is a formal, sociotechnical, organizational system designed to collect, process, store, and distribute information. From a socio-technical perspective, information systems are composed by four components: task, people, structure (or roles), and technology.
97. Information systems can be defined as an integration of components for collection, storage and processing of data of which the data is used to provide information, contribute to knowledge as well as digital products that facilitate decision making.
98. The following are major types of information systems that can be applied in an organization which includes; Transaction processing systems (deposits, withdrawals, orders etc.), Office automation systems (email, voice, word processing), Knowledge work systems (CAD, financial workstation), Management information systems, Decision support systems and Executive support systems and Enterprise Resource Planning (ERP).
99. The following are tips for effective change management in an organization which are Define the goals and Objectives Communicate, Communicate, Communicate, Manage resistance (soft skills), Gradual Implementation and training and Support. The current trends, Artificial Intelligence (AI) and Machine Learning (ML), Edge computing, Cybersecurity, Blockchain, Virtual Reality (VR) and Augmented Reality (AR), ChatGPT number of users Source:
100. **ChatGPT** (Chat Generative Pretrained Transformer) is a complex machine learning model that is able to carry out natural language generation (NLG) tasks with such a high level of accuracy that the model can pass a Turing test.
101. **NHIA ICT (ICT Solution for the National Health Insurance Authority) Phase A-** The scope of the phase A of the project included an Integrated ICT Solution for the National Health Insurance Authority in Ghana which had three components;
 - a) **A Software** on Membership Management, Claims Management, Membership Cards Issuance, HP Accreditation, ERP (Finance, HR, Payroll, Logistics)
 - b) **Hardware** on Data Centre and DR, PCs, printers and LAN @ Scheme Offices (155 Locations), PCs and Card readers @ Service providers (789 Locations)
 - c) **Communications** on VSAT/Radio based WAN with close to 1,000 Locations.

102. The results were, Complete Software Implementation, over 1,500 Staff trained, Increased registration from less than 4 million Registered to over 10 million registered, Complete Hardware Infrastructure and Communications WAN Implementation and membership Cards Printing and Distribution.

103. **NHIA ICT Project - Phase B-** Some of the challenges raised from Phase A included, Poor Data Quality in the Membership module, Claims fraud, the “power” of the NHIA Card Solutions, Biometric registration, Smart Cards and Claims Processing Centres with Claims OCR and Rules Engine.

104. **GCB Bank WAN-** The scope of the project involved to Install WAN (Wide Area Network) for all bank branches across Ghana, Improve Uptime availability, improve service reputation and connected over 100 branches nation-wide.

105. Some of the Documents Management strategies include, document Scanning, workflow Automation, digital Archiving, retention and Information Management Policy and EDMS Training.

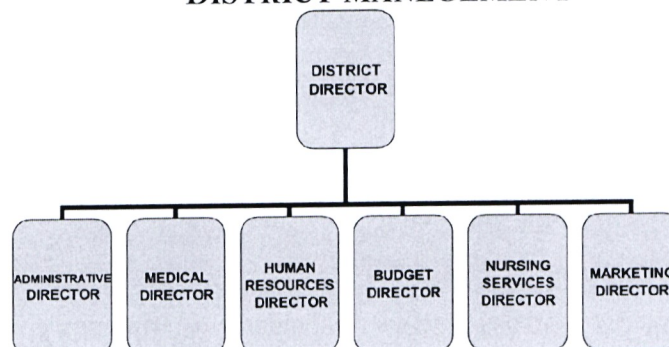
106. **TECHNOLOGY FOR HEALTH APPLICATIONS-** The following are the ideas to explore in the technology for healthcare applications,

- a) **Data Analytics and Artificial Intelligence (AI)** can help policymakers to analyse vast amounts of data quickly and accurately, identify trends, and make predictions about future economic/health conditions. AI can also be used to model the impact of different policy scenarios and help policymakers to make evidence-based decisions.
- b) **Geographic Information Systems (GIS):** GIS technology can help policymakers to visualize data spatially, making it easier to identify areas of need and target interventions effectively. It can also be used to map the impact of policy decisions on different regions, helping policymakers to make more informed decisions.
- c) **Social Media Analytics:** Social media analytics can help policymakers to understand public opinion and sentiment about different policy issues, which can inform policy decisions and help policymakers to communicate more effectively with the public.
- d) **Cloud Computing:** Cloud computing can help policymakers to store and analyse large amounts of data, collaborate with other policymakers and stakeholders, and access data and analytics tools from anywhere with an internet connection.
- e) **Blockchain:** Blockchain technology can be used to create secure and transparent systems for tracking and monitoring policy decisions and their impact. This can help to increase accountability and transparency in policymaking, which can lead to better outcomes for citizens.
- f) **Case Studies-** Using GIS to combat HIV in South Africa by using Social Media Analytics to provide information during the Zika Virus outbreak in Brazil and Blockchain for medical supplies traceability.

107. The general management includes, building the main policy in all areas, directing the field units and inspecting and controlling the field units. The medical activities in the communities includes, Primary Care-Pediatric & family care, secondary care-professional care like-gastro, women, etc., para-medical-physiotherapy, art-therapy etc., geriatric, preventive care, health education, industrial care and recovery care.

108. Most of the above activities are given in the community clinics, and its centers.

DISTRICT MANAGEMENT



DIRECTORS RESPONSIBILITIES

- a) **Medical Director-** all the medical services medical policy controlling and inspecting the doctor's physiotherapy, health therapy, social work communication therapy, diet services health education laboratories, roentgen pharmacies.
 - b) **Nursing Director-** All the nursing services nursing policy directing and managing the Nursing staff
 - c) **Administration Director-** Planning, systems managing, Computers maintenance of Infrastructure Gardens Logistics.
 - d) **Marketing Director-** General marketing of the Organization collection of ideas for services development Coordination of topics for public relations and image.
 - e) **Human Resources Director-** Manpower and salaries human resources develop
 - f) **Budget Director-** Managing the budget payments, money collection supplying information to the district staff preparing the financial reports.
 - g) **The clinic's office-** Professional teaching for the staff and administrative services includes, in the clinic, in the district, outside the Organization. The services in the Clinic are given by the reception office. The administration director is in charge for the above services and the clerks are helping in giving a better and efficient service.
 - h) **Hierarchical Management-** District administrator- County administrator- Clinic's administrator and then the clerks. The clinic professional manager is the doctor.
 - i) **Project Management (Pm)-** Strategic Justification & Scope of project management includes the major objectives and outcomes to understand the Project Management concept, to become familiar with the Project management technique, application & implementation to get the 'know-how' capacity and to be able to run a project independently.
109. The sectors include Private, Public, NGO's, Personal whereby the tangible Production are the mass production, Batch, Project. Research and Development through Technology Development, Hi-Tech, Pharmaceutical Medicine and Vaccine (COVID-19), Patent (intangible). Service is the preparing of a training Program, shortening of the emergency room for patient admission duration rather than Personal which is Preparing your family holiday.

110. No project is ever installed on time, within the budget, or with the same staff and resource allocation as planned and started. It is better to make a project plan rather than not to do at all. The Leading Questions in Strategy includes, who will be our customers in 10 years' time? How they will behave? Who will be our competitors in 10 years' time? Who will be our employees in 10 years' time? Which is the desired competitive position of AA Which is the Value Created and to Whom?
111. Vision is what the business aspires to be, a view of the future position and how the stakeholders (government, private sector, people & community, etc.) want and hope the business/University to be. While the Mission provides stakeholders with clarity about the overall distinctive purpose, reason of the business for being entrepreneurship etc. that guide decision making while values are the principles innovation, integrity and teamwork.
112. Objective is focusing on the things that will make the most progress accomplishing the vision by key Performance areas and CSF. Specific outcomes that are to be achieved.
- a) As you look toward the future, we believe our organization will/should become what will our organization look like 5 years from now?
 - b) We want the Organization to be "Thought of" as what attributes do, we most Want Our Organization to achieve? What Characteristics Should Be Considered as The Essence of Organizational Excellence in Our Field of Endeavor?
 - c) In the future, our employees will have and be seen as what Characteristics reflect significant professional of competence by all relevant stakeholders?
 - d) The realization of this vision will bring to all of us, what fundamental positive changes will occur to us and our stakeholders if we achieve the Vision, we have set for ourselves.
113. Mission Statements target customers and markets, indicates the Principal Services Delivered by The Organization, specify the Geographical Area Within the Organization Intends to Concentrate, identifies the Organization's Philosophy. Mission statements includes confirmation of the Organization's Preferred Self – Image and specify the Organization's Desired Public Image.
114. To develop strategy by identifying opportunities arising from an understanding of the environmental forces, acting upon the State/organization, and adapting resources so as to take advantage of these. Adopting the "Outside – Inside" strategy.
115. The identification and leverage of the resources, capabilities and competence of the university which yield creating new opportunities and provide competitive advantage Adopting the "Inside – Outside" strategy.
116. Components of strategy where the organization must excel to outperform competition & fulfill expectation strategy is implemented on time, expenses as or less to the budget planned, the Customer Operates the strategy implementation result, dilemma/problem is solved by the strategy, the strategy affects positively the stakeholders, the strategy improves existing performance, the strategy results recover the investment, "Time to Market", risk related to the benefit/cost criteria, "Smart" objective model. Specific to the strategic dilemma, measurable through Quantification (M&E & KPI), achievable as to the strategic challenge relevant to the stakeholders and finally to timely under the implementation time frame.

117. Communicating Skills, Problem solving skills, decision making skills, planning skills, staffing skills, organizing skills, group dynamics skills, morale building skills and personal skills.
118. Project completed on time, expenses as or less as to the budget planned, the customer operates the project result, dilemma and problem is solved by the project, the project affects positively the user, the project improves existing performance, the project recovers the investment, time to market and risk and benefit and cost.
118. Set up objectives, project organizational structure, design and planning activity network & Scheduling, resource allocation and budget establishment, tracking the project progress, reports and control decision making, monitoring & evaluation and updating. What is to be done? when will the task be done? Why will the task be done? How much money is available to do the task? and how well has the total project been done.
119. Request for information (Rfi), Request for proposal (Rfp): - Request from Potential contractors to prepare the required information related to the project including technical & Engineering information, time table and costing. This Includes: -
- a) Covering Letter: - General Description of the Product/Service
 - b) Statement of Work (Sow)
 - c) Product Specifications
 - d) Contract Schedule
 - e) Technical Proposal Requirements and Design Approach and cost breakdown.
120. Overall Frame Work of the Project, Specifications of the Product/Service. For Example: - A Car Length, Width, Weight, No. Of Passengers, Fuel Consumption, Transmission System and Color, Upholstery Etc. The Information and know-how Required, Contract Schedules, Milestones, "Dead Line" Etc. Technical Proposal Requirement (Tpr)- Detailed Technical Information, Concept & Design Approach, Drawings, Materials, Cost Framework and Instruction Manual.
121. Generically, a work breakdown structure is a family tree Subdivision of effort required to achieve an end objective (E.G. Program, Project, Service, Contract Etc.). The work breakdown structures are developed by starting with the end objective required and successively subdividing it into manageable components in terms of size and complexity, such as program, project, system, subsystems, components, tasks, subtasks, and work elements. It should be product or task oriented and should include all the necessary effort which must be undertaken to achieve the end objective.
122. Justification of a project are goals and objectives, while the duration is from start to the end, Milestones is the turning points, resource allocation: Budget & Cash Flow, Implementation: Result(S) Based Management, Risk: - Uncertainty & the objective result gap, Project Life Cycle No project is ever installed on time, within the budget, or with the same staff and resource allocation as planned and started. Yours will not be the first but it is better to make a Project plan rather not to do that at all.
123. Specific to the strategic dilemma, measurable to the quantification (M&E & KPI), achievable as to the strategic challenge, relevant to the stakeholders and timely under the implementation time frame.

124. In the request for proposal through the request from Potential contractors to prepare the required information related to the project including technical & Engineering information, Time table, Costing includes, covering letter, general description of the product/service, statement of work, product specifications, contract schedule, technical proposal requirements & design approach and cost break down.
125. Project funding announcement posted by an organization, primarily used by government agencies, for which companies place bids. The RFP outlines the bidding process & contract terms & guides how to bid should be formatted to get the lowest possible bid.
Example, the Federal Railroad Administration issues a request for proposals to finance, design, construct, operate, and maintain a high-speed rail system. Interested parties submit proposals meeting the requirements outlined in the document. Based on the proposals received by the deadline, the Department of Transportation establishes commissions for further review and development of the proposals. The DOT chooses the proposal most encompassing its goals and hires the company to carry out the work.
126. A summary from a potential supplier that shows they are interested in and capable of delivering particular goods or services. Asking for EOIs is usually the first stage of a multi-step tender process. A call to potential providers of goods and/or services to register interest in supplying them. Commonly a document describing requirements or specifications and seeking information from potential providers that demonstrate their ability to meet those requirements. Estimate the activity duration because you are moving to the uncertain future. Time Estimate is based upon Past experience (us and or others), Technical Data on site impression management & Expert personal opinion.
127. Time Estimate, Subcontractors, Duration of Activities, new activities emerge during the Project while uncertainty in cost through the prediction of resources needed by change in wages and salary rate. Technological uncertainty risks can be management through research and development, methods and systems change and use of equipment and finally the uncertainty in the political environment can be cured through regulations and stakeholders' engagement.
128. Project Risk Management is the decision how to approach and to plan project Risk through the establishment of the Possible risk types which may affect the Project Out of Its Objectives. Qualitative Risk Analysis through the assessment of risk by qualitative approach and their Priorities and Quantitative Risk Analysis through probability and the resulted effects.
129. Risk Response Planning through the establishment of procedures to minimize threats & enhance opportunities related to the project objectives. Monitoring and control through residual risk, new risks emerge along project planning.
130. The methodology of approaches, methods sources of information to be used and applied in the Organizational positions, responsibilities & authorities. The Risk management activities budget and timing i.e., time of the event and frequency etc. During project product life cycle through the threshold level of upper Limit for Operation. The reporting system in all Kinds of reports applied to monitoring & assessment and controlled through conclusions and action.

- a) **Documentation Reviews-** Experience survey of past undertaken projects conclusions and Recommendations, information gathering techniques, brainstorming, Delpy, swot, interviews, diagramming techniques Ishikawa, Pareto, flow chart etc.
 - b) **Avoidance** - To change the project plan in order to eliminate the risk and or the cause and or to protect the objectives out of the consequences by reallocation of resources by changing subcontractor etc.
 - c) **transference** - To Transfer the Risk and the result to a "Third Party". Note that the transference does not eliminate the risk (Financial, Insurance, Performance Bond, Fines Etc.).
 - d) **Mitigation-** Minimization of the probability and the results of the risk event to an acceptable level. Steps to avoid the risk are better of those to fix it. By preference of better supplier rather than a cheapest one, additional time and/or resources.
 - e) **Acceptance-** The project manager decides not to take any action and not to change the project characteristics by "Draw Plan", Milestones Control, Emergency allowance etc.
131. List of risks, Cause and possible effects, budget, response scheduling and draw Plan. The residual risks are those risk left after elimination of the core and prioritized risks and the secondary risk are those risks which emerge from the elimination of the primary risks. Contractual agreements are to establish in the contract the type of the risks to be covered by the responsible partner and inputs to a revised project plan with additional resources to be allocated.
132. Periodic project risk reviews through periodic meetings and revised priorities by earned value analysis as performance indicator. Technical performance measurement by technical & engineering levels, scheduling milestones and additional risk response planning in case that new risks emerge out of the primary action.
133. Implemented to overcome emerge risks through ccorrective actions in application of a "Draw Plan". Updates to the risk response plan by immediate updating of "Draw Plans" in risk database is a collection of past experienced data through uupdates to the identification checklist by updating components of the checklist.
134. Risk probability & impact is the possibility level that the risk will happen e.g., high, low, average, in a Percent of 1 – 10 Scale and Binary Scale of 1,2,4,8. Project assumptions testing e.g., the stability of the assumption, vulnerability, alternative assumptions. Data precision ranking by risk understanding, data availability, quality of data and reliability of data.
135. The overall risk ranking is the relative risk related to other projects that can be applied to hr. allocation, facilities, equipment etc. The list of prioritized risks is categorized by time table, cost, resource allocation, function and the list of risks for additional analysis is in Preference to risk type of higher priority.
136. Interviewing of stakeholders and experts through scenarios of optimistic, Pessimistic, Most Likely. Sensitivity analysis is like what? If? approach. decision tree analysis through alternative decision making of Simulation like "Monte Carlo" Method. Break even the quantity that its profit margin covers the fixed costs (Investment), the quantity of which the profit through the "make or buy" decision.

CHAPTER FOUR

COMMITTEE OBSERVATIONS

The Committee makes the following observations: that,

1. The Ministry of Health in Israel has units that monitor quality and patient safety in hospitals and additional settings, provide national leadership in health information technology, promote health equity and address issues of competition within health care. The role of public health insurance, national health expenditures accounted for 7.4 percent of GDP, a figure that has remained stable during the last two decades. In 2017, 63 percent of health expenditures were publicly financed, a share that is one of the lowest among Organisation for Economic Co-operation and Development (OECD) countries.
2. Israel's NHI system is funded primarily through an earmarked, income-related health tax (5% of income for individuals age 22 and older) in combination with general government revenues, which are funded primarily through progressive income taxation paid by individuals. Married women, children, and all those who are excluded from the NHI (such as soldiers) are exempt from the health tax.
3. The government distributes the NHI budget among the four health plans primarily through a capitation that accounts for sex, age, geographic distribution of their members and five chronic, expensive-to-treat diseases.
4. In Israel the Role of private health insurance includes the voluntary health insurance which financed 14 percent of national health expenditures in 2016. Residents can obtain voluntary health insurance from the four NHI non-profit plans as well as from for-profit commercial plans. The NHI plans cannot reject applicants, and premiums are based on age only. Commercial private plans tend to be more comprehensive, more individually tailored, and more expensive, and can be purchased by individuals or groups, such as employers, unions, or kibbutzim.
5. Nearly all individuals purchase private insurance from either the NHI plans or commercial insurers, or both. In 2016, 84 percent of Israel's adult population was enrolled in an NIH private insurance plan, and 57 percent were enrolled in a commercial private insurance plan.
6. Voluntary health insurance plays a complementary role, covering benefits excluded from the NHI scheme (dental care for adults, certain medications, alternative medicines), as well as a supplementary role, expanding access to NHI-covered benefits, offering access to private providers, and providing improved amenities and faster access to care. The high number of those with voluntary health insurance coverage reflects a general lack of confidence in the NHI system's capacity to fully fund and deliver all services needed in cases of severe illness.
7. The mandated NHI benefit package includes the Hospital care, Primary and specialty care, Prescription drugs, Certain preventive services, Mental health care, Dental care for children and the elderly aged 75 and above, Diagnostic exams, Maternity care, Allied

medical care (physiotherapy, Occupational therapy, Nutrition, Speech therapy), Some durable medical equipment (wheelchairs, orthopaedic aids), Limited coverage of palliative and hospice services, Dental care for adults, optometry and hearing aids are excluded.

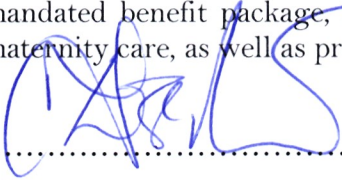
8. Means-tested institutional long-term care, infant developmental screenings and vaccinations, and postpartum care like breastfeeding guidance are covered by the Ministry of Health, but separately from NHI.
9. **Cost-sharing and out-of-pocket spending:** In 2016, out-of-pocket spending accounted for 22 percent of national health expenditures. Most of this was for voluntary health insurance (38%), adult dental care (22.5%), and pharmaceuticals (15%). The remainder was for other services not included in the NHI benefit package, including vision care and medical equipment, as well as cost-sharing for NHI-covered services.
10. NHI health plans are allowed to impose user charges for certain services. These include a flat quarterly copayment rate for visits to specialists and allied medical professionals and for imaging diagnostic exams; a user charge for after-hours emergency care in the community; and coinsurance for pharmaceuticals (see table below). User charges, which are regulated by the Ministry of Health, constituted about 6.5 percent of health plan income in 2016. There are no copayments for primary care visits, preventive care, cancer screenings, or hospital admissions. There are also no quarterly or annual deductibles with NHI coverage.
11. **Safety nets:** Safety nets include an annual cap on the health tax at NIS 43,370 (USD 11,565). In addition, individuals with low incomes (60% of average income or less) pay a reduced health tax rate of 3 percent, compared to 5 percent paid by individuals with higher incomes. The unemployed and others without income pay a minimum flat health tax of approximately NIS 100 (USD 27) per month.
12. Israel also has caps on user charges and discounts for older adults, the chronically ill, and other vulnerable populations, as shown in the table below.

CHAPTER FIVE

5. COMMITTEE RECOMMENDATIONS

The Committee recommends the following: that,

1. The training should be provided to Hon. Members of the Committee in order to equip them with desired knowledge in their daily work of good policy formulation from an informed position.
2. For the success of Universal Health Cover, the government through Ministry of Health should allow all residents choose from competing non-profit health plans that provide a mandated benefit package, including hospital, primary, specialty, mental health, and maternity care, as well as prescription drugs and other services in the country.

SIGN:  DATE: 11/12/2023

THE HON. DR. ROBERT PUKOSE, M.P.

CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

 THE NATIONAL ASSEMBLY PAPERS LAID	
DATE: 05 DEC 2023	DAY: Tuesday
TABLED BY:	Hon. Dr. Robert Pukose (Chairperson, Health Committee)
CLERK OF THE TABLE:	Inzafu Mwale

**ANNEX 1: MINUTES ON THE PROCEEDINGS OF
THE COMMITTEE**

**MINUTES OF HUNDRED AND FOURTY FIRST (141ST) SITTING OF THE
DEPARTMENTAL COMMITTEE ON HEALTH HELD IN TRAVELLERS' HOTEL,
MOMBASA ON SATURDAY 2ND DECEMBER, 2023 AT 2.00 PM.**

PRESENT

1. The Hon. Dr. Pukose Robert, M.P – **Chairperson**
2. The Hon. Sunkuli Julius Lekakeny Ole, EGH, EBS, M.P
3. The Hon. Prof. Jaldesa Guyo Waqo, M.P
4. The Hon. Mathenge Duncan Maina, M.P
5. The Hon. Owino Martin Peters, M.P
6. The Hon. Lenguris Pauline, M.P
7. The Hon. Mary Maingi, MP
8. The Hon. Oron Joshua Odongo, M.P

ABSENT WITH APOLOGY

1. The Hon. Ntwiga Patrick Munene, M.P -**Vice-Chairperson.**
2. The Hon. Dr. Nyikal James Wambura, M.P.
3. The Hon. Titus Khamala, M.P
4. The Hon. Mary Maingi, MP
5. The Hon. Kibagendi Antony, M.P
6. The Hon. Kipngor Reuben Kiborek, M.P
7. The Hon. Wanyonyi Martin Pepela, M.P
8. The Hon. Muge Cynthia Jepkosgei, M.P

COMMITTEE SECRETARIAT

- | | |
|-------------------------|------------------------|
| 1. Mr. Hassan A. Arale | - Clerk Assistant I |
| 2. Ms. Gladys Kiprotich | - Clerk Assistant III |
| 3. Ms. Abigel Muinde | - Research Officer III |
| 4. Ms. Faith Chepkemai | - Legal Counsel II |
| 5. Mr. Benson kimanzi | - Serjeant At Arms |
| 6. Mr.Hiram kimuhu | -Fiscal Analyst |

INATTENDANCE-NATIONAL CANCER INSTITUTE OF KENYA

- | | |
|--------------------------------|--|
| 1. Ms. Mary Muthoni | -PS State Department for Public Health and |
| Professional Standards. | |
| 2. Mr. Elias Melly | -National Cancer Institute of Kenya |
| 3. Ms. Catherine Wachira | - National Cancer Institute of Kenya |
| 4. Ms. Terry c Rotich | -Ministry of Health |
| 5. Mr. Sundley Omwenga | -National Cancer Institute of Kenya |
| 6. Ms. Bethsheba kwamboka | - National Cancer Institute of Kenya |
| 7. Mr. Tom Frank | - National Cancer Institute of Kenya |
| 8. Mr. Moses Rotich | - National Cancer Institute of Kenya |
| 9. Ms. Annette Omwoyo | - KLRC |

MIN. NO. NA/DC-H/2023/546: PRELIMINARIES/INTRODUCTION

The meeting was called to order at 2:30 p.m with a word of prayer by the Chairperson
Hon. Dr. Pukose Robert, M.P.

MIN. NO. NA/DC-H/2023/547: DRAFT REGULATIONS CANCER PREVENTION AND CONTROL

Cancer is the 3rd highest cause of morbidity in Kenya, 7% of deaths per year, after infectious diseases and cardiovascular diseases. Estimate 39,000 new cases of Cancer each year in Kenya with more than 27,000 deaths per year (Globocan 2020)

Gaps in Cancer Continuum of Care

a) Inequitable Access to Cancer Care Services

Challenge: Disparities in socio-economic status often result in unequal access to cancer treatments, with some populations facing financial and geographical barriers to essential services.

Regulatory Need: Regulations can address equity issues by mandating measures that ensure affordable and accessible cancer treatments for all, regardless of economic status.

b) Lack of Standardized Cancer Care

Challenge: Variation in services across healthcare facilities may result in inconsistent care quality and outcomes for cancer patients.

Regulatory Need: Standardized treatment guidelines set by regulations can help ensure uniformity and adherence to evidence-based practices, enhancing the overall quality of cancer care.

c) Lack of a National Comprehensive Cancer Data and Surveillance

Challenge: Incomplete cancer data hinders effective planning, resource allocation, and evaluation of the impact of interventions.

Regulatory Need: Regulations can establish requirements for robust cancer data collection, reporting, and surveillance mechanisms, facilitating evidence-based decision-making and continuous improvement.

d) Limited Public Awareness and Education

Challenge: Insufficient public awareness about cancer prevention, risk factors, and the importance of early detection contributes to late-stage diagnoses.

Regulatory Need: Regulations can mandate public health campaigns and educational initiatives, ensuring that communities are well-informed about cancer, leading to increased awareness and proactive healthcare-seeking behavior.

e) Lack of clear regulations addressing informed consent to research

This deficiency can lead to various forms of discrimination, as certain populations may be disproportionately affected by disparities in access to information, participation in research studies, and the potential benefits of advancements in cancer treatment.

Draft Regulations

- 1) The Cancer Prevention and Control (Standards of Care) Rules, 2023

- 2) The Cancer Prevention and Control (Public Awareness and Education) Rules, 2023
- 3) The Cancer Prevention and Control (Cancer Registries) Rules, 2023
- 4) The Cancer Prevention and Control (Consent to Research) Rules, 2023
- 5) The Cancer Prevention and Control (Inspection and Certification) Rules, 2023

MIN. NO. NA/DC-H/2023/548: COMMITTEE COMMENTS

- a) There is poor implementation of current cancer policies, strategy and guidelines and the legislative framework is weak. There is need reviewing the existing policies and guidelines.
- b) National Cancer Control Program (NCCP) to transfer functions, operations and budget line to National Cancer Institute.
- c) The National Health Insurance Fund (NHIF) did not provide comprehensive cover for cancer treatment and some screening services were only covered within the managed schemes. The NCI should be advocates of the new Social Health Insurance Fund to ensure the inclusion cancer fund and diagnostic care.
- d) The National Cancer Institute should do the mapping of equipment's to enable patients know where to seek treatment.
- e) The National Cancer Institute should do research on radioactive materials and identify when can radioactive materials be destroyed.
- f) The National Cancer Institute is a top-notch research institute therefore it should identify a land from Ololua to build their structure in order to carry out research and other activities.
- g) On the functions of the National Cancer Institute word "encourages" be replaced, it was indicated that the functions should be achievable.
- h) The National Cancer should have a team of experts and have a program to develop a standardized protocol for cancer treatment and the Ministry of Health to support in the implementation of the standardized protocol in the hospitals.
- i) The National Cancer Institute should ensure patients are treated with dignity (care should be within a communities).
- j) Accurate figures of cancer patients should be generated to ensure proper planning in each county.
- k) On the distribution of the cancer in the country the National Cancer Institute should look on the distribution of cancer and identify the type of cancer in every part of the country, the institute should focus on probable causes in those areas and the associated factors and give knowledge and information to the population.
- l) The National Cancer Institute should do more research on Traditional Medicines and Alternative Medicines.

- m) Palliative care centres should be set up in every county.
- n) Strengthen the Legislative Framework on Cancer Prevention and Control by reviewing the existing policies and guidelines, review and Amendment of the Cancer Prevention and Control Act of 2012 and enact relevant regulations in order to:
- i. Fully Operationalize the National Cancer Institute;
 - ii. Strengthen the Institute's Regulatory, Research and Training Function;
 - iii. Enable establishment of a Cancer Fund; and
 - iv. Regulate and Coordinate Cancer Management Services

MIN. NO. NA/DC-H/2023/549: ADOPTION OF THE REPORTS

The following foreign reports were adopted;

- 1) The Committee adopted the report on the health system management training in galilee international management training institute in Israel after it was proposed by Hon. Lenguris Pauline, M.p and seconded the Hon. Prof. Jaldesa Guyo Wago, M.P
- 2) The Committee adopted the report on the delegation to the 76th World Health Assembly from at the palais des nations in Geneva, Switzerland after it was proposed by the Hon. Sunkuli Julius Lekakeny Ole, EGH, EBS, M.P and seconded the Hon. Mary Maingi, MP

MIN. NO. NADC-H/2023/550: ADJOURNMENT

There being no any other business, the Chairperson, adjourned the meeting at exactly 4.30 p.m.

Sign.....Date.....5/11/2023

HON. DR. ROBERT PUKOSE, M.P.

CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

ANNEX 2:REPORT ADOPTION LIST



THE NATIONAL ASSEMBLY

13TH PARLIAMENT – SECOND SESSION (2023)

DIRECTORATE OF DEPARTMENTAL COMMITTEES

DEPARTMENTAL COMMITTEE ON HEALTH

REPORT ADOPTION LIST OF THE DEPARTMENTAL COMMITTEE ON HEALTH ON THE
TRAINING ON HEALTH SYSTEMS MANAGEMENT IN GALILEE INTERNATIONAL
MANAGEMENT INSTITUTE ISRAEL.

We, the undersigned Members of the Departmental Committee on Health do hereby append our
signatures to adopt this Report

Date: 2nd December, 2023

NO	NAME	SIGNATURE
1.	The Hon. Dr. Pukose Robert, M.P -Chairperson	
2.	The Hon. Ntwiga Patrick Munene, M.P -Vice-Chairperson.	
3.	The Hon. Dr. Nyikal James Wambura, M.P.	
4.	The Hon. Titus Khamala, M.P	
5.	The Hon. Sunkuli Julius Lekakeny Ole, EGH, EBS, M.P.	
6.	The Hon. Prof. Jaldesa Guyo Waqo, M.P.	
7.	The Hon. Owino Martin Peters, M.P.	
8.	The Hon. Wanyonyi Martin Pepela, M.P	
9.	The Hon. Lenguris Pauline, M.P	
10.	The Hon. Mary Maingi, MP	
11.	The Hon. Muge Cynthia Jepkosgei, M.P	
12.	The Hon. Oron Joshua Odongo, M.P.	
13.	The Hon. Kibagendi Antony, M.P.	
14.	The Hon. Mathenge Duncan Maina, M.P	
15.	The Hon. Kipngor Reuben Kiborek, M.P	

