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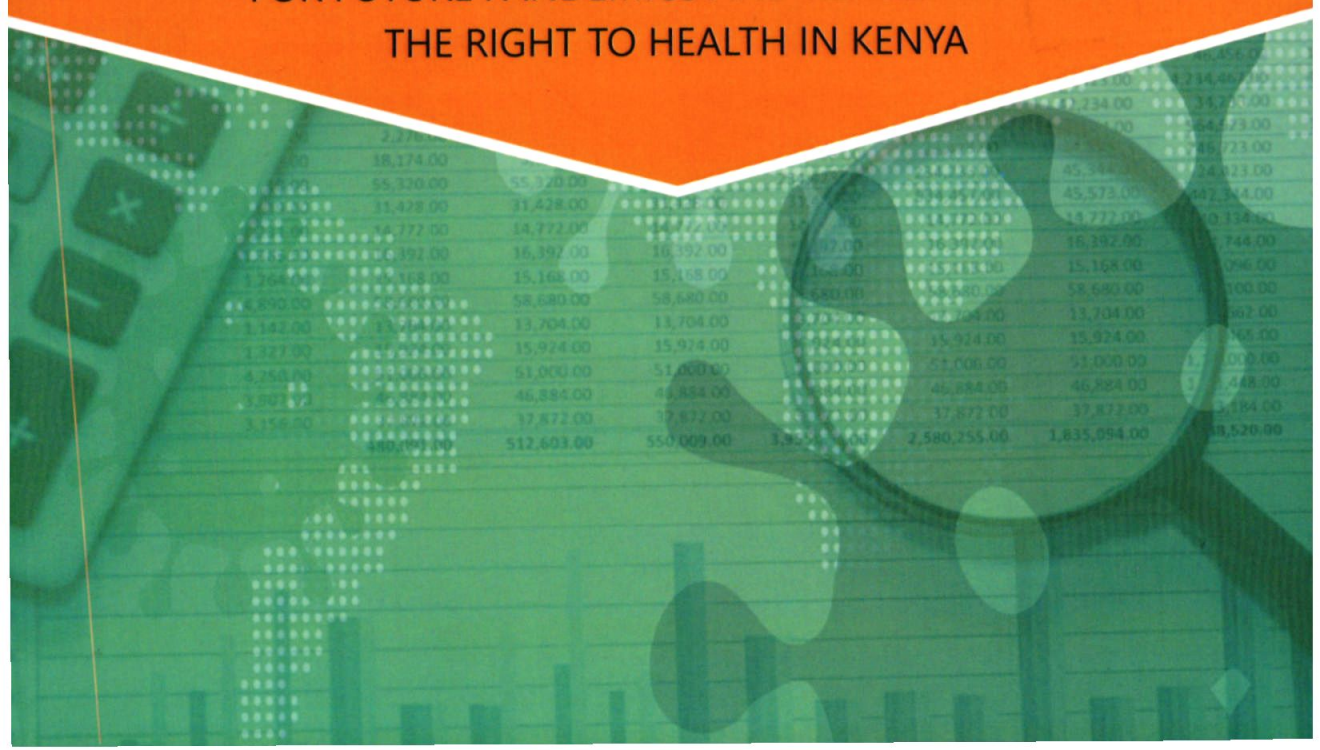
POLICY BRIEF NO.1 OF 2023

PROCUREMENT IN EMERGENCIES:

LESSONS FROM COVID-19 FOR FUTURE PANDEMICS AND REALIZATION OF THE RIGHT TO HEALTH IN KENYA



POLICY BRIEF NO. 1 OF 2023:

Procurement in Emergencies: Lessons From Covid-19 for Future Pandemics and Realization of the Right to Health in Kenya

A publication of **Economic and Social Rights Centre – "Haki Jamii"**
P.O. Box 11356 - 00100 Nairobi.
Tel. +254 726 527 876
E-mail: esrc@hakijamii.com
Website: www.hakijamii.com

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This policy brief is published by Hakijamii in the public interest to champion policies to advance the interests of marginalized groups in Kenya, including their rights to health. It is informed by research on health procurement, its impact on the cost of healthcare, and the realization of the right to health in Kenya in the context of COVID-19. It also seeks to develop consensus on how to handle future health pandemics and guarantee the right to access health among marginalized communities. The Substantive framing of this study was provided by Economic & Social Rights Centre-Hakijamii. We appreciate the coordination and support from the staff especially Clinton Nyamongo, Lucy Baraza, Zipporah Muthama, Peter Karachu, Mercy Kipkemoi, Ijait Aluku, Teresia Boke, David Adipo, Lucy Wangari and Amina Hashi. Hakijamii acknowledges the contributions of Yogo Kenneth (Lead Consultant), David Oburu and Orwa Michael of Miale Public Affairs.

We are also grateful for the insights from stakeholders in Mombasa, Nairobi, and Kisumu counties. The Mombasa team includes members of the County Assembly, Civil Society Organizations (CSOs)—such as Coast Women in Development (CWID), Kituo Cha Sheria-Chapter, and Dream Achievers' Youth Organizations (DAYO)—and health practitioners drawn from the public and private sectors. The Nairobi team includes Transparency International (TI-K), Kituo Cha Sheria, People's Health Movement in Kenya (PHM-Kenya), CHVs and Ministry of Health. The Kisumu teams included CHVs, health practitioners in the private and public sectors, as well as various CSOs. We would also like to thank the stakeholders who participated in the validation workshop for their input.

We dedicate this publication to all the healthcare workers and Kenyans, particularly the marginalized groups, who died as a result of COVID-19 disease in the line of duty and due to lack of medication during the peak of the pandemic. We hope that decision-makers and other key stakeholders in the health sector will consider and implement these policy recommendations to ensure the right to health care in future pandemics.

ACRONYMS AND ABBREVIATIONS

AGPO	Access to Government Procurement Opportunities
AMREF	African Medical and Research Foundation
C19RM5	COVID-19 Response Mechanism
CERCs	County Emergency Response Committees
CHVs	Community Health Volunteers
COVID	Corona Virus Disease
CS	Cabinet Secretary
CWID	Coast Women in Development
CWID	Collaboration of Women in Development
DAYO	Dream Achievers' Youth Organization
FBOs	Faith Based Organization
FGDs	Focus Group Discussions
GoK	Government of Kenya
IT	Information Technology
KCS	Kituo Cha Sheria
KEMSA	Kenya Medical Supplies Authority
KIIs	Key Informant Interviews
KNBS	Kenya National Bureau of Statistics
KRC	Kenya Red Cross
Ksh	Kenya Shillings
NERC	National Emergency Response Committee
NGOs	Non-governmental Organization
OAG	Office of the Auditor General
OIG	Office of the Inspector General
OSA	On Shelve Availability
PHEIC	Public Health Emergency International Concern
PPDA	Public Procurement and Disposal Act
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
ToR	Terms of References
USD	United States Dollar
WHO	World Health Organization

1.0 EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

COVID-19 outbreak had unprecedented effects on key sectors of the economy in most countries across the world, including exerting major strain on the health sectors. Even countries with superior health systems such as China, the United States (US), United Kingdom (UK), Germany, Italy, and Brazil could not manage to control the pandemic. As a result, measures were put in place to curb the effects of COVID-19, including mandatory social distance, working from home, lockdowns in some countries, and travel restrictions. The COVID-19 pandemic necessitated massive procurement procedures that were sought to herald the curbing of the novel Covid-19 virus. Unfortunately, these procurement processes were tainted with malpractices that rubberstamped the state of corruption in Kenya. As the study found out, the procurement processes were flawed to a great extent leading the rise of 'Covid Billionaires' in Kenya. This glaring malpractice prompted certain state institution, including The Senate Public Investment Committee, The Office of the Auditor General (OAG), and Ethics and Anti-Corruption Commission (EACC), to act within their respective mandates.

In response, as a Civil Society Organization (CSO), Hakijamii, through a joint partner project on promoting health service delivery through inclusive and accountable health governance, commissioned this research to monitor the efficacy of the procurement process during covid-19 pandemic and its impact of the right to health in the country with a view of collecting lessons and best practices to inform accountability in future crises as well as realisation of economic and social rights.

1.1 Summary of key findings

a) New gains and success stories during and post pandemic period

   (i) Actors outside government outperformed government and its agencies in responding to COVID-19 pandemic.

   (ii) Procurement technology was used to track and analyze data to inform government decisions and involve civil society and communities.

   (iii) Social protection programs were introduced during the COVID-19 pandemic to help vulnerable groups.

   (iv) Reduction of communicable diseases, such as such as diarrhea, influenza, and flu, among others, in public and at household levels.

   (v) Improvement and upgrade of the health infrastructure at the county level are latent consequences of the government and other stakeholders' responses to the COVID-19 pandemic.

b) Challenges and gaps evident during and after the pandemic period

(i) The study found that adherence of existing procurement policies and laws were not met, leading to inadequate oversight and accountability for public funds used during the pandemic.

(ii) Kenya's COVID funding absorption rate was 51% at the end of the grant period, due to protracted procurements.

(iii) KEMSA's financial controls remain insufficient, leading to the misappropriation of public and donor monies during the COVID-19 epidemic. This has remained unsolved due to the lack of legal frameworks to prevent the theft of public funds.

(iv) Low levels of awareness, cost of vaccine administration, neglect, and discrimination led to inequitable access to COVID-19 vaccines, exacerbated by inadequate supply chain controls.

(v) There was widespread inequitable access to COVID-19 vaccines due to low levels of awareness, cost of administration, neglect, and discrimination. Supply chain controls led to 16% variances in batch numbers and 908,000 LLIN stock balance disparities.

(vi) COVID-19 caused significant delays in procuring key commodities for HIV, tuberculosis, malaria, and COVID-19 programmes, leading to a lack of preparedness and strain on existing medical infrastructure, hence many people could not access Medicare, reproductive health, tuberculosis, and HIV treatment, as well as support for victims of gender-based violence.

(vii) COVID-19 pandemic significantly reduced financial access to households' health and firms' earnings and employment, while there was no public participation in decision- making on how public funds were used or how state actors responded.

(viii) COVID-19 had an impact on social and mental health on vulnerable groups of the population.

(ix) A gap in social protection programming was evident in some counties during the pandemic.

1.2 Summary of key recommendations

(i) Strengthening financial systems by the national government and its agencies through open disclosures and monitoring of grants, public, donor and private sources directed to address any future pandemic to ensure accountability. This should also include improvement of government agencies' technical capacity of understanding the utilization of the public and donor funds.

(ii) Strengthening financial systems by the national government and its agencies through open disclosures and monitoring of grants, public, donor and private sources directed to address any future pandemic to ensure accountability. This should also include improvement of government agencies' technical capacity of understanding the utilization of the public and donor funds.

(iii) Amelioration of the compliance mechanisms across government agencies by seconding Auditor General Officers to various state agencies at the national and county levels for an enhance continuous monitoring and advice on procurement processes.

(iv) The county governments need to employ the use of e-procurement and online portals for open-source as an alternative during emergency to improve reporting mechanism to ensure sound procurement processes that are elaborate in all the phases – pre-tendering, tendering and post-tendering.

(v) Strengthening the oversight mechanisms and tools used by stakeholders and oversight bodies to enhance accountability of public funds, as well as buttressing the capacity of the media and civil society to conduct social audits for enhanced openness and accountability.

(vi) Ensuring synergy and a collective voice among the civil society organizations and actors in the health sectors in monitoring the origin, allocation and distribution of medical and emergency materials, and reporting and documenting malpractices along the supply chain, thus increasing oversight and accountability related procurement processes during pandemic.

(vii) Donor funding to CSOs and other health actors to undertake research for knowledge generation on health emergency preparedness, and develop a robust public engagement strategy for holding government accountable during emergencies.

(viii) Establishment of an emergency fund for health sector to reduce future vulnerability and inability of the health sector to respond to health emergencies.

(ix) Support innovation and encourage production of health and emergency equipment in the country by local manufacturers.

(x) Initiate training and capacity-building programmes for communities and other key players in the health sector.

(xi) Strengthen the prosecution mechanisms and capacities of agencies that deal with runaway corruption cases and related cases, such as bribery cases, witnessed during the pandemic.

(xii) Restructure and review the mandate of KEMSA to include expanding county stakeholders' representations and making procurement of health supplies competitive.

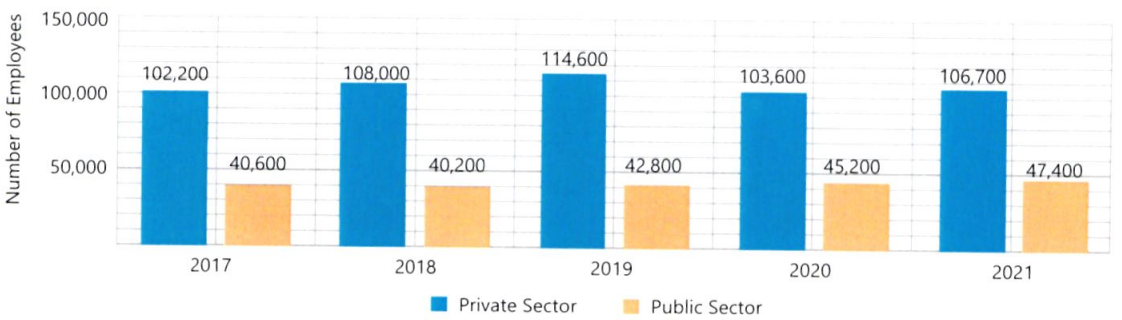
2.0 THE CONTEXT

2.1 An Overview

Kenya is a low-middle-income country that serves as a regional and economic hub for East and Central Africa, with a population of 47 million people with majority living in rural areas (KNBS,2019).The public health care system is fully devolved to 47 counties, save for the development of health policies and regulations and the management of four national referral facilities: the Kenyatta National Hospital (KNH), the Moi Teaching and Referral Hospital (MTRH), the Mathari Mental and Teaching Hospital, and the National Spinal Injury Hospital. Out of these four national health facilities, KNH and MTRH were equipped soon after the pandemic was reported in Kenya to conduct COVID-19 tests (Muoki, 2020). In terms of facility classification, the country has 36 Level-5 hospitals and eight referrals including KNH, spread across the 47 counties.

At the onset of the pandemic began, the country had only 8 infectious disease beds, and 37 beds were set aside for COVID-19 patients, while at least 227 beds were required. At the time, there were only 297 functional ventilators available in the entire country, with only 90 of these found in public health facilities (TI, 2021). The number of health facilities decreased by 3.2% to 14,137 from 14,600 in 2020, while the number of hospital beds and cots increased from 91,037 in 2020 to 100,183 in 2021 (KNBS, 2021). The inadequate supply of COVID-19 medical equipment and technologies as well as the decrease in the number of functional health facilities were partly attributed to the failure of the procurement process during the pandemic. Many people were denied access to health care, a right guaranteed by article 43(a) (1) of the constitution and outlined in the Sustainable Development Goals (SDGs), regional and international health instruments. Human health and social work sectors are the fourth biggest employers in the public sector, after education, public service, and agriculture (KNBS, 2022), but most are employed in the private sector as depicted in figure 2.1 below.

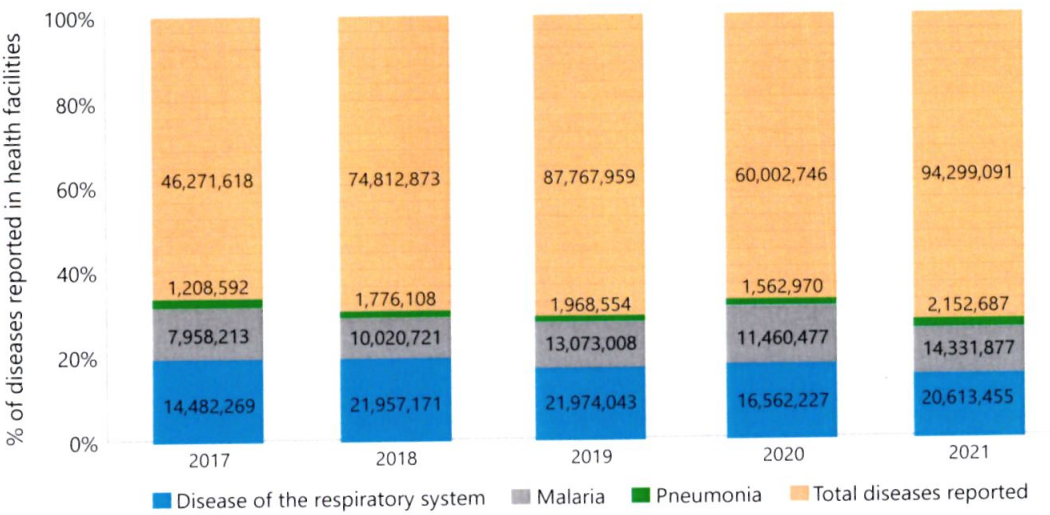
Figure 2.1: Wage employment by human health and social work sector, 2017- 2021



Source: Computed from KNBS (2022) data

By July 22, 2021, when the World Health Organization (WHO) had declared the COVID-19 outbreak a Public Health Emergency International Concern (PHEIC), there were 191,773,590 cases and 4127693 deaths reported worldwide, with 4,688,762 and 194310 cases reported in Africa and Kenya, respectively (KMPDU, 2021). Previous research also shows that pneumonia, followed by malaria, cancer, and HIV/AIDS, continued to be the leading causes of death in Kenya (KNBS, 2017). In 2021, reported cases of diseases of the respiratory system and malaria accounted for 21.9 percent and 15.2 percent of cases reported in health facilities, respectively. There was a drop in the total number of cases of disease reported, including respiratory and pneumonia, in 2020, when the pandemic struck and limited access to health facilities during the year. In 2021, diseases of the respiratory system and pneumonia increased from 16,562,227 and 1,562,970 cases in 2020 to 20,613,455 and 2,152,687 cases, respectively; while the total cases of diseases reported increased by 34,296,345 or 57% (See, figure 2.2).

Figure 2.2: Cases of Diseases Reported in Health Facilities, 2017-2021



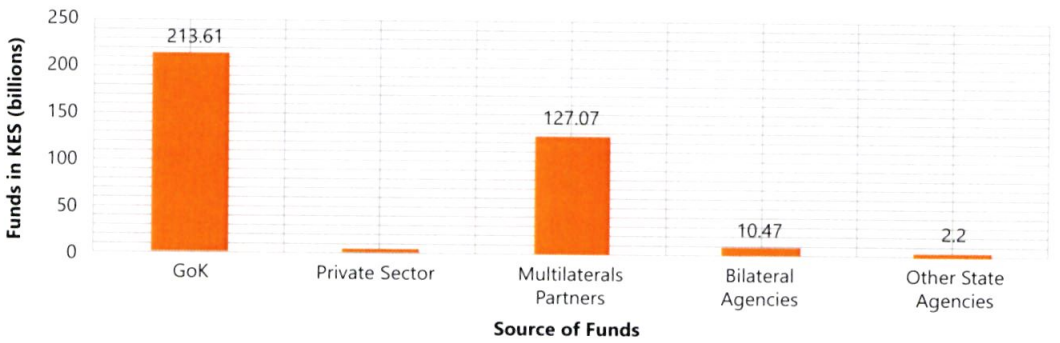
In contrast to cases of diseases reported in health facilities, the utilization of health services for pneumonia, upper respiratory infections, and other diseases decreased during this period, thereby denying many people their constitutional right to access health care. The utilization decreased by 11.36%, 9.77%, and 83.82%, respectively, for children under five, except for tuberculosis (David, Macharia, Wanjala, Kirui, & Olwanda, 2021). For persons over five years, there was a general decrease in the utilization of these services by 8.29%, 18.64%, 35.2%, and 13.75%, respectively.

2.2 Government and Stakeholders response to the pandemic

The Kenyan government established a national taskforce on COVID-19 response to review the developing risk and advise the government on suitable steps for readiness, prevention, and response in order to limit the public health implications of the COVID-19 pandemic. The main challenges were observed with the identification and purchase of several products critical to viral management, such as testing kits and personal protective equipment. The Ministry of Health was in charge of overall response coordination, while the Kenya Medical Supplies Authority (KEMSA) was in charge of purchases of medical supplies, including consumables and non-consumables.

Overall, the Ministry of Health was involved in the coordination of the response, while the Kenya Medical Supplies Authority (KEMSA) procured medical supplies, both consumables and non-consumables. During this period, the Government of Kenya (GoK) raised approximately KSH 357.8 billion (USD 3.25 billion) from various sources between March and November 2020. Figure 2.3 shows that GoK and multilateral agencies each contributed KSH 213.61 billion and KSH 127.07 billion, respectively. It (Figure 2.3) also shows that bilateral agencies, the private sector, and other state agencies each contribute KSH 10.47 billion, KSH 4.47 billion, and KSH 2.2 billion, respectively. In a similar spirit, stakeholders working on the Kenya emergency response project planned to raise money to build national public health preparation systems and to prevent, identify, and respond to COVID-19 risks based on seven components. The Senate also established a committee to provide oversight on activities and measures taken by the national and county governments.

Figure 2.3 : Amount of funding (KES billions) contributed by different entities



2.3 Legal and policy frameworks

The Constitution of Kenya 2010 under article 227 provides a basic framework for the procurement of public goods and services as well as health management laws. These set of laws include, but not limited to: the Public Finance Management Act, 2012, the Public Finance Management Regulations of 2015, the Public Procurements and Disposal Act 2015, the KEMSA Act No. 20 of 2013, the Health Laws (Amendment) Act, 2019, and executive orders and Access to Government Procurement Opportunities (AGPO) (see, Figure 2.4). **The Public Finance Management Act, 2012,** provides for the effective management of public finances by the national and county governments, as well as placing responsibility on accounting officers for the proper and efficient management of finances. An enabling regulation to the act is **the Public Finance Management Regulations of 2015,** which gives effect to Section 205 of the PFM act and places a duty on accounting officers to ensure public funds are used only for the purpose they were intended to. **The Public Procurements and Disposal Act 2015 (Revised, 2016 and 2022)** provide procedures for efficient public procurement and for asset disposal by public entities such as direct procurement in cases of emergency under section 103(2)(b) of the act. The Kenya Medical Supplies Authority (KEMSA) is a state corporation established under **the KEMSA Act No. 20 of 2013** whose function is to procure, warehouse, and distribute drugs and medical supplies. **The Health Laws (Amendment) Act, 2019,** which is No. 5 of 2019, also gives KEMSA powers over the supply and distribution of medical supplies to national and county governments. Kenya's Ministry of Health has published a list of legal instruments relevant to the COVID-19 pandemic procurement context. The list includes **executive orders and Access to Government Procurement Opportunities (AGPO).** The AGPO program is based on Article 227 of Kenya's 2010 Constitution, which was intended to ensure affirmative action in procurement processes.

Figure 2.4: Legal Instruments used during COVID-19 pandemic

PFM Act, 2012	Effective management of public finances by the national and county governments
PFM regulations, 2015	It gives effect to Section 205 of the act, and places a duty on accounting officers to ensure public funds are used only for the purpose they were intended to.
PPDA Act, 2015	It is the primary legislation governing public procurement and asset disposal.
KEMSA Act,No. 12 of 2013	It states under 6(3) that a national or county public health facility shall, in the procurement and distribution of drugs and medical supplies, obtain from the Authority.
AGPO	To ensure affirmative action in the procurement processes and give opportunity to women, youth, and people with disabilities
Executive Order, No. 2 of 2018	Exempted procurement data arising from the declaration of a national emergency or national disaster.
Health Laws (ammended) Act, 2019	Gives KEMSA powers over the supply and distribution of medical supplies to national and county governments

Source: Author/consultant

However, these laws and regulations were not adhered to due to the severity of the pandemic and poor procurement practices. As a result, breach of procurement processes characterized operations of state institutions, such as KEMSA, and county governments. For instance, these agencies purchased items without entering into valid contracts with suppliers, while other counties purchased without conducting market research (Otieno, 2021). In addressing these anomalies, certain state institutions, such as the PIC of the Senate and the Office of the Auditor General, conducted an inquiry and a special audit, respectively.

Accordingly, Hakijamii, commissioned this study to assess the efficacy of the procurement process during the COVID-19 pandemic and its impact on the right to health, as well as lessons and best practices on accountability in future crises. This Policy Brief is a product of this study that was conducted from November, 2022 through February, 2023.

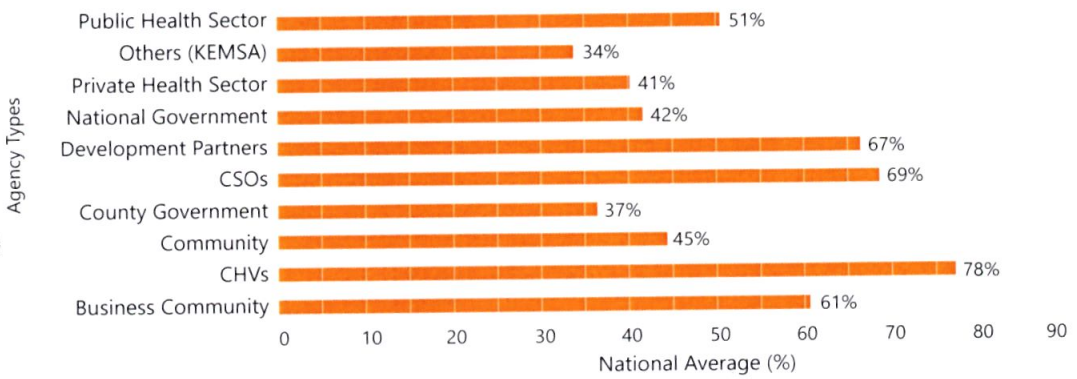
3.0 KEY FINDINGS

3.1 New gains and success stories during and post pandemic period

3.1.1 Actors' outside government outperformed government and its agencies in responding to COVID 19 Pandemic period

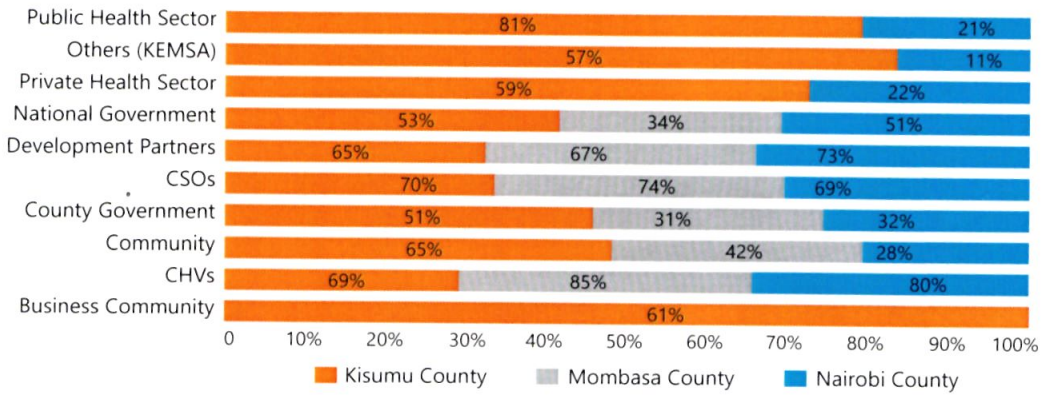
The "stakeholders," who were classified as either actors or agencies, were evaluated based on their contribution and response to the COVID-19 epidemic. CHVs, CSOs, development partners, and the business community were ranked high for better performance, with 78%, 69%, 67%, and 61%, respectively, while the public health sector, community, the national government, private health sector, county government, and others such as KEMSA performed poorly, with ratings of 51%, 45%, 42%, 41%, 37%, and 34%, respectively, as shown in figure 3.1. below.

Figure 3.1: National Rating (%) vs Agency type



Similarly, these stakeholders were ranked by the nature of their performance across counties as assessed by different actors in the three counties—Mombasa, Kisumu, and Nairobi—as shown in figure 3.2. In Mombasa County, the practitioners in the public health sector performed well, ranking 81%, followed by CSOs, CHVs, the community, development partners, and practitioners in the private health sector (ranked 70%, 69%, 65%, and 59%, respectively), while the community, national and county governments performed dismally and ranked 42%,34% and 31%, respectively. In Kisumu County, the public health practitioners performed well and ranked at 81%, followed by CSOs, Development Partners, the community, the private sector, others (KEMSA), the national government, and county government (70%, 69%, 65%, 65%, 59%, 57%, 53%, and 51%, respectively). In Nairobi County, too, CHVs, development partners, and CSOs performed well, earning ratings of 80%, 73%, and 73%, respectively, while the county government, the public health sector, and others (KEMSA) performed poorly, earning ratings of 32%, 22%, 21%, and 11%, respectively.

Figure 3.2: Rating of different agencies performance by county (%)



3.1.2 Use of technology in procurement processes and management of public affairs (i.e. legislations)

Usage of technology in procurement due to the specific conditions of the COVID19 virus, which required social distancing and remote working, promoted the rise of technology use and development of e-procurement. Makueni County Government is one of the few counties that expanded its open contracting portal which published data and incorporated COVID-19 procurement data. The idea was tagging all Covid-19 tender data in the system and track and analyse data to inform government decisions, as well as involve civil society and communities in emergency procurement processes. Some counties, like Mombasa, passed legislation to allow virtual meetings at the height of the pandemic. *"After COVID 19, we realised that we did not have that policy that we should be holding virtual meetings sometimes when need be. So we made a motion, so it was now put in our standing orders that we can hold virtual meetings."*

3.1.3 Introduction of social protection programmes to cushion vulnerable groups

At the height of the pandemic, various kinds of social protection programmes were introduced to cushion the vulnerable groups in the community by various actors, including the government, NGOs, such as the Kenya Red Cross (KRC), Practical Action, Child Fund, and Kisumu Urban Apostolate Programme (KUAP), SHOFCO, and business communities. In Kisumu County, food was distributed to some vulnerable residents in Nyalenda A and B by certain NGOs. Others introduced the Cash Transfer (CT) programme and food packages. KUAP supported child nutrition by providing nutritious porridge flour, as well as hand washing, food, and water.

3.1.4 Reduction of communicable diseases in public and at household levels

The joint response to the pandemic by various actors, including state and non-state actors, contributed to reduction of communicable disease such as diarrhea, influenza, and flu, among others. This also prompted the public to embrace a new culture of wearing masks, getting accustomed to regular habit of washing hands, and keeping their foods clean and safe. For example, one participant observed that, *"In Mombasa, it was so common. Diarrhea outbreaks [happen] all the time, here and there, but now they actually went down. You don't find diarrhea a lot along the villages and wherever because they are used to cleaning their hands properly. People have gotten used to handling the food properly and they are now handling the food in the right manner. They are not handling them with germs. So these are some of the things we must appreciate and ensure that the people are told so."*

3.1.5 Improvement and upgrade of the health infrastructure at the county level

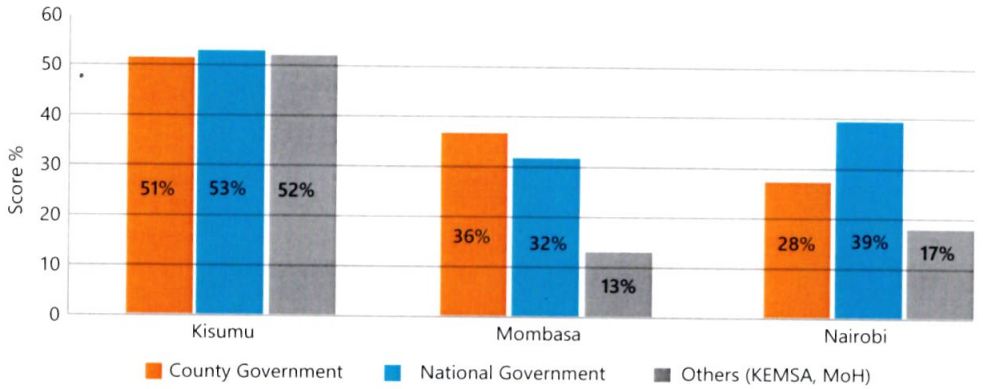
The state response to pandemic had varied consequences, including a positive impact on the health sector. The most notable one was establishment of new COVI9 19 test centres and upgrading of some health facilities from level 2 to level 5. In Mombasa County, for example, COVID 19 test facilities or centres were established at Makadara Health Centre and Shimo La Tewa at the height of the pandemic. This also saw the upgrading and improvement of Makadara Health Centre from a level 2 to a level 5 health facility, thereby increasing the number of services being provided to the public in a wider geographical area. *"So that [was] the time it was given the rise and it was serving the entire coast. That is what cost a bit of problem because you find people from Lunga Lunga, Lamu, Tana River, they [were] all coming to Makadara," observes participant 1.*

3.2 Challenges and gaps evident during and after the pandemic period

3.2.1 Management of national and selected county procurement process (%) during covid-19 pandemic was poor

The handling of procurement processes by the county, national, and other government agencies like KEMSA, which was solely tasked to lead in the procurement exercise, was generally poor. At the national level, procurement procedures were badly handled at the national, county, and other government agency (KEMSA) levels, with ratings of 45%, 40%, and 29%, respectively. Apart from Kisumu County, where all these agencies scored slightly above the 50% mark by a margin of 1% to 3%, other county governments and government agencies (such as KEMSA) scored badly in managing procurement processes, with county scores of 36% and 28% for Mombasa and Nairobi, respectively, while other government agencies scored 17% and 13% in Nairobi and Mombasa, respectively, as shown in figure 3.3.

Figure 3.3: Management of national and selected county procurement processes (%) during Covid-19 pandemic



3.2.2 State agencies breached procurement laws and policy during COVID-19 pandemic period

This study established that the requisite thresholds spelled out in existing procurement policies and laws were not met during the procurement of medical supplies when the COVID-19 pandemic was rife. KEMSA engaged in illegal procurement. According to the PIC of the Senate report, KEMSA management erred and breached the PPDA law by commencing procurement processes without putting systems and guidelines in place that are required for direct procurement, which they had opted for in their case.

> *"The management of KEMSA commenced procurement of COVID-19 related items on 18th March 2020 using alleged retrospective Direct Procurement method without putting systems and guidelines in place to guise the use of retrospective Direct Procurement contrary to Section 69(2) and Section 45(1) of the PPDA Act," noted GoK (2021).*

Additionally, the PIC report observed that KEMSA too failed to do due diligence and failed to follow the procurement process as outlined in the PPDA law. The Senate Pic is remembered for observing:

> *"There was inconsistency in the procurement processes, with some entities going through the bidding process and filling out tender documents before supplying KEMSA, while other supplies were based on their commitment letters and filled out tender documents later." Companies like Harleys Limited*

and Nairobi Enterprise Limited rightfully refused to sign a commitment letter from KEMSA and insisted on using the procurement process outlined in the Procurement Act (2015)," noted on page 10 of the Public Investment Committee Report on its Consideration of the Special Audit Report on the Utilization of COVID-19 Funds by KEMSA.

The Public Investment Committee (PIC) has found that KEMSA breached the laws governing procurement processes using public funds. In other areas, the procurement processes were utterly opaque. Since the procurement was not transparent, it was also difficult to differentiate between donations and what was procured. "Anyone who had a gift donated it to a pool, but there are no records of what was received, and since the procurement was not transparent, it was also difficult to differentiate between donations and what was procured," observed KI-5.

3.2.3 Aggravated pre-existing programmatic challenges in other health programmes – TB, HIV, and reproductive health

COVID-19 has affected health programs and exacerbated pre-existing programmatic challenges by hindering the continuity of essential and non-essential health services, for example, which resulted in the reduction of medical assistance offered to MCH, TB, and HIV patients as focus shifted towards the COVID-19 response (Ogira, Bharali, Onyango, Mao, McDade, & Kokwaro, 2022). Even so, through adapting and innovating, TB and HIV programs were able to resume during H2 2020. For malaria, the planned 2020 mass distribution campaign of long-lasting insecticidal nets was delayed by a year. Still, several challenges abound, including missing TB cases, which constitute about 40% of the total, and inefficiencies in the HIV testing approach as well.

In Mombasa County, other health programmes, such as reproductive health services, were affected as well. It was noted, for instance, that *"women and youths were not able to access reproductive health services,"* and therefore, at the height of the pandemic, reproductive health was not factored in as an essential health service. *"Any girl child who had been exposed to HIV or sexual violence was then required to seek such services within 72 hours,"* KI-3 opined. All of these activities violated women's and youth's constitutionally protected right to reproductive health care[1]. In Kisumu County, for example, cases of GBV were also reported at the domestic level during the pandemic, and this was attributed to job losses and the inability of household heads to provide livelihoods for their families.

1 See, article 43(1)(a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; In GoK. (2010). The Constitution of Kenya . Republic of Kenya.

3.2.4 Inadequate supply chain controls and management during the COVID-19 pandemic

Inadequate supply chain controls deteriorated, owing mostly to inefficiency and pandemic interruptions. Some of these inadequacies are also attributed to inconsistencies between the Ministry of Health's list of permitted institutions and KEMSA's inventory system, which resulted from lax internal controls over the organization's inventory system. Poor Information Technology (IT) system controls jeopardize data dependability and contribute to poor stock management. It was also clear that KEMSA had previously had lax internal controls on warehousing and inventory management, resulting in 16% variances in batch numbers validated and 908,000 LLIN stock balance disparities between actual and projected stock balances. These supply chain deficiencies may have become worse. Other failures in supply chain controls were identified in the selection of companies to supply COVID-19 material. In the Public Investment Committee Report on its Consideration of the Special Audit Report on the Utilization of COVID-19 Funds by KEMSA, for example, it was established that there were no technical or financial evaluations carried out to determine the capacity of companies that supplied COVID-19 materials (GoK, 2021). KESMA opted to use commitment letters issued by companies stating their ability to supply the required items.

3.2.5 Procurement turnaround times were lengthy during the COVID-19 pandemic period

Procurement delays were caused by long turnaround times, which affected program implementation so profoundly. More so, this affected KEMSA, which obtains most of its HIV, tuberculosis, malaria, and COVID-19 commodities from Global Fund programs. In-country procurement and distribution processes are not adequately ensuring that COVID-19 Response Mechanism (C19RM5)-funded commodities are procured and delivered on time; for example, C19RM5 procurements take on average 349 days from initiation by the Ministry of Health to delivery. Hence, only half of the funds were spent by the end of the grant in June 2021. Other two principal recipients of Global Funds, i.e., the African Medical and Research Foundation (AMREF) and Kenya Red Cross (KRC), also experienced delays procuring COVID-19 commodities as follows: up to 180 and 182 days for KRC and AMREF, respectively.

3.2.6 Inequity in access to COVID 19 vaccines was widespread at the beginning of the pandemic

In the early days of the COVID pandemic, inequitable access to COVID-19 vaccines was widespread for a number of reasons, including low levels of awareness, the cost of vaccine administration, neglect, and discrimination, among others. The initial cost of vaccine administration posed a challenge. The cost of administration of COVID-19 vaccines in some facilities was prohibitive, with prices ranging from KES 6,000 to KES 8,000 in the private health facilities, while the MOH charged KES 2000 at the time. *"I paid KES 6,000 [for vaccination] in May, and by that time the*

cost of vaccines was between KES 6,000 and KES 8,000... (Ministry of Health) MoH was [charging] KES 2, 000," remarked one KI-3. FGD-5 observed, too, that *"most vaccines, the ones that were administered like Johnson and Johnson, were preserved for those who had money." "It was therefore not available."*

While Kenya's 2010 Constitution[2] protects people from discrimination on various grounds, it was reported that people with disabilities (PwDs) were disadvantaged in accessing COVID-19 vaccines, medical assistance, and auxiliary support and services due to neglect, being overlooked, or discrimination **(Box 1)**. Similarly, this account illustrates that a PwD was denied emergency medical treatment contrary to Article 43(3) [1], which spells out that *"a person shall not be denied emergency medical treatment."* Additionally, inadequate knowledge about vaccine administration, cost, and type also led to inequity in access on the one hand, while on the other, it was not accessible due to cost, as FDG-5 observed here. *"For example, there have been rumours and myths that Modena and AstraZeneca can cause death and that many people have not recovered from their side effects."* As a result, basic knowledge of COVID-19 vaccines determined the nature or type of access observed. AstraZeneca was the most widely used vaccine, followed by Moderna in second place, Pfizer, Johnson & Johnson, and Johnson & Johnson in third and fourth place, respectively. And these vaccines were accessible in this order.

BOX 1: Case of discrimination at a health facility during the COVID-19 pandemic

"And... then, during the same COVID period, people with disabilities really suffered when it came to transportation." I remember when there was COVID and there was a transportation challenge, so for a person with a disability to access the health care facility was a challenge. I remember very well the first case of COVID, when there was a person with disabilities just near Mlaleo Health Centre. Nobody wanted to touch that client because, for one, he was deaf, and he was also epileptic, and then he had a fit. So, it was like nobody wanted to touch or help at that particular time. They then began to wonder who would assist this deaf patient now that he had been determined to be COVID-positive. So that boy, because he was a boy, stayed there throughout the night and into the morning without anyone providing help because the nurses said they did not have a sign language interpreter. So there was no one who could understand him. It is during COVID, and he suffered a fit, and no one wanted to touch him [Interruption] "So it was a very bad scenario," narrated by FGD-5

COVID-19 vaccines were not widely available in public and private health care facilities. At the height of the pandemic, vaccines could only be found in private health facilities; AstraZeneca (AZ) was available at the onset, but many people in the informal sector did not go for it. The government used CHVs, who were often overworked and without any support during the

2 See, 82(2) Subject to subsections (6), (8), and (9); and Section 82(3) of the GoK (2010), all of which relate to various shades of discrimination, including disability. In GoK. (2010). The Constitution of Kenya . Republic of Kenya.

pandemic, to conduct mobilization. *"I did not sleep after the vaccination."* There were cases of vaccine apartheid in distribution that allegedly benefited countries in the West. *"South Africa was manufacturing vaccines, like Johnson and Johnson, but they were being shipped outside of Africa, i.e., primarily Europe." "Here, the focus was on producing for people outside of Africa, so the vaccines that became available later were left-overs, and their expiration dates were approaching,"* FGD-5 explained. The cost of vaccine administration and certification after the COVID-19 test also limited access; for example, FGD-5 observed that *"my son was asked to give KSh 4,000 at the district hospital to get a certificate."*

3.2.7 In many instances, during the COVID-19 pandemic, the legal system and framework were ineffective

The COVID-19 pandemic period was characterized by confusion, as it came about as a consequence of ineffective legal frameworks. Despite the fact that numerous legal instruments existed and were used during the pandemic period to guide procurement, public safety, movement, and so on, they fell short of addressing challenges that were evident during the pandemic, such as improper safe distance and a lack of access to other reproductive health and other medications. KI-3 observed, for instance, that *"even women could not secure or access reproductive health services at various health facilities."*

BOX 2: Violation of procurement procedures

"KEMSA management ignored the Ministry of Health advice on the items to be purchased using the Ksh 758,690,583.25 from World Bank. Having committed to purchase supplies for which the authority did not have budget for, the KEMSA CEO bypassed the parent ministry and wrote the National Treasury on 2nd June, 2020 seeking budgetary support amounting to Ksh. 5,140,943,000."

Indeed, women and youth were most vulnerable at the height of the pandemic, while their lives remained at in the event of any exposure or being a victim of sexual violence. *"Women and youths were not able to access reproductive health services,"* and therefore, at the height of the pandemic, reproductive health was not factored in as an essential health service. *"Any girl child who had been exposed to HIV or sexual violence then was required to seek such services within 72 hours,"* KI-3 noted.

In the case of KEMSA, the authority PIC of the Senate established that the authority ignored the advice by MOH-Kenya on items to be purchased using by WB funds amounting to Ksh 758,690,583.25 on the one hand; and on the other, it committed to make purchases, bypassed the parent ministry, and sought funds from treasury seeking budgetary support.

3.2.8 Corruption was widespread in public health sector during the COVID-19 pandemic period

Corruption was rife during the COVID-19 pandemic period and appeared to have occurred in nearly all stages of the public procurement process, especially at KEMSA. It occurred mainly in three phases, including the pre-tendering and tendering phases as well as the post-tendering phase, in which various statutory requirements were flouted as follows:

At the national level, particularly within KEMSA, the Public Investment Committee Report on its Consideration of the Special Audit Report on Utilization of COVID-19 funds by KEMSA observed that the authority procured these items at inflated prices comparatively to what other public agencies procured similar items at. For example, the report demonstrated that through analysis of other government agencies, such as the COVID-19 task force, Kenya Airport Authorities (KAA), Kenya National Highway Authority (KeNHA), Kenya Medical Practitioner and Dentists Council (KMPDC), and Kenya Red Cross (KRC), that bought COVID-19 related items during the period under inquiry, that is, between March and June, 2020, did so at much lower prices than KEMSA.

Some of the companies that were contracted to supply COVID-19-related items flouted the tax law, according to the report. Indeed, different tax statuses were declared to the Kenya Revenue Authority (KRA), the only tax and revenue regulator, by the suppliers of COVID-19 goods. While a number of companies were reported to have declared the volume of goods supplied and taxes paid in that regard, on the other hand, a section of companies declared tax-exempt suppliers to the regulator, and most companies did not disclose to the regular any supplies that they made to KEMSA[3].

There were several instances where citizens were forced to pay for expenses incurred during the quarantine period without adequate consultations or assessments of their ability to afford the fees being charged, raising further concerns about whether funds for COVID-19 response efforts were effectively prioritized, allocated, and used. In other instances, there was arbitrary police harassment for alleged breaches of COVID-19 prevention rules, the irregular purchase of health items using public funds, and the pilferage of relief foods that were meant to cushion vulnerable groups in society, among others. *"Masks were meant to be free, and yet they were being sold." "Police who were meant to provide security instead opted to arrest people left, right, and centre." Relief food ended up in people's houses. The majority of those who received were "haves,"* KI-3 opined.

Other incidences of corruption that were witnessed during the COVID-19 pandemic were primarily perpetuated by the duty-bearers, especially the political class, who saw an

3 See, submission by KRA at Section 2.7, paragraph 238, 239, 240, and 241 on page 60 of the report. GOK (2021).

opportunity to pilfer public resources as they engaged in public initiatives to respond to the pandemic. In Kisumu County, for instance, there was little information sharing on procurement and COVID-19-related issues. The county government established a recourse committee, but little or no information was provided. "We went to a meeting with the county government for three days, and the county government cannot account for how much was raised or what was done," observed FGD-5.

BOX 3: Politicisation and corruption in the tendering of COVID-19 items

"What we saw in COVID 19 was this politicization of COVID 19 because of anything that was being done, including the wash points. It was politicians procuring and distributing them, and if you look at it, they were taking advantage of the crisis. You see, when it comes to procurement, the tendering process can be flouted, which means you can go to single sourcing. So it gave them an opportunity to steal, and if you look at health care workers in terms of issues to do with PPEs (Personal Protective Equipment), they were not there, or even if they were, it was very expensive. People took advantage because there were no measures on how to get them; some of them we bought, but they are still in the stores and cannot be used. "That is a waste of public resources," the author observed in FGD-5.

3.2.9 Inadequate and a lack of public participation

The response to the COVID-19 pandemic by state actors did not include public participation. KI- 4 observed that "There was no public participation because people were afraid". Therefore sensitisation was done through the media. "Sensitization was done in the county through radio talk shows, and printed materials on the COVDI-19 pandemic were distributed, although these activities were not sustained," observed FGD-5. "We used to wait for Mutahi Kagwe (Cabinet Secretary for Health), and the moment we see him on TV, we know things are not right," observed FGD-5. In Mombasa, a taskforce was established to address issues related to the COVID-19 pandemic but failed to institute a framework and structure for public participation. "Manual public participation was discouraged, and instead they resorted to written memoranda, which had little impact on the context of Mombasa due to high illiteracy levels," observed KI-5. In Kisumu, CSOs, with the support of KELIN Kenya, filed a petition in court asking for public participation on how to address the COVID-19 pandemic.

3.2.10 Inadequate medical infrastructure and a lack of preparedness for COVID-19 treatment

In terms of preparedness, nearly all the state apparatus were unprepared, and all response initiatives were characterized by confusion. In Mombasa, it was reported that there were not only no laboratories to undertake the COVID-19 test but also no adequate medical facilities to respond to and no gear to protect health personnel. In Kisumu County, too, health care workers were not accessing PPEs at the height of the pandemic. Kenyan health officials feared a wave of infectious disease similar to the one that ravaged India in April and May 2021 was looming over Kisumu County (Dahir,2021).

3.2.11 COVID-19 had an impact on social and mental health on vulnerable groups of the population

COVID-19 saw an increase in the cost of medication, food insecurity, and interference with public projects, as well as disruption of social fabric. The cost of treatment was exorbitant and uncontrolled, especially in the private sector. "We deposited Ksh 150,000 for treatment which was not accounted for, and what Medicare was used for," noted FGD-5 participant. Curfews and lockdowns led to restrictions on movement and a subsequent rise in food prices. There was also a major disruption of social fabric across communities, where there was an increase in child labour as children went out to look for tasks or jobs while out of school. Some people experience mental stress or illness as a result of job loss.

3.2.12 Gaps in social protection programming in some counties during the pandemic

Social protection programming by government during the pandemic was poorly prioritized and organized denying the most vulnerable groups in the urban setting to benefit from programme. In Mombasa County, for instance, urban residents in Bamburi area who had lost their source of livelihood or jobs were ignored while attention was given to residents of Mwakirunge who did not require social protection according to CSOs assessments. *"The people of Mwakirunge had their maize in the barns, but Mwakirunge in the books of government is considered poorer compared to Bamburi. So we are carrying and taking food to those who have food supplies, leaving those who are lacking,"* according to participant 1.

4.0 CONCLUDING RECOMMENDATIONS

4.1 National Level and Ministry of Health

Strengthen financial systems at agency and government levels: The national government and the ministry of health should prioritize the strengthening of financial systems and procurement regulations. In many instances, the study showed that existing financial frameworks were flouted as various accountability mechanisms were equally ignored, leading to pilferage of resources that were received from various sources, including the public, donors, and private sources. Addressing this morass, moving forward, would require enhancement of financial controls and improvement of the absorption of any other emergency health pandemic funds, such as the C19RM funds' financial management controls, which might be improved in the future for greater accountability. And, while overall program absorption rates increased in the last semester of grant implementation, the country's ability to utilize its COVID-19 financial allocation, including C19RM and government counterpart money, on time remained relatively low.

Improve public spending and revenues in the health care sector: The national government should increase public expenditures and income to support the economy and healthcare systems through targeted actions that can respond appropriately. The government should endeavour to adhere to the Abuja declaration commitments requiring a 15% of the public finance to be directed to the health sector. MoH should also exploit the provisions of PFM systems that allow some flexibility in utilizing existing budget allocations through reprioritizing line items or within budgetary programme resource envelopes. Because most legal frameworks allow the executive to activate contingency funds in emergency situations, finance laws must be revised via supplementary budgets to provide resources in the event of a similar or greater magnitude emergency, such as the COVID-19 pandemic.

Establishment of an emergency fund for health sector: The pandemic exposed the vulnerability and inability of the health sector to respond to health emergencies. Many examples occurred at county level, which demonstrated a lack of preparedness and inadequate protection equipment in a number of health facilities. To avoid a repeat of such occurrences, the national government should establish an emergency fund for the health sector to enhance preparedness, protection, and timely response to health pandemics. *"... creating an emergency fund specifically for [the] health sector so that whenever we are faced with an emergency then we have emergency funds for preparedness, protection, and response. So that is something perhaps you can give as [a] recommendation to the national government of establishing an emergency fund for the health sector," one participant rightly observed.*

Improve government agencies capacity to utilize project funds: The national government and MOH should improve duty holders' understanding of fund utilization and how the government can get the most out of public and donor funds. At the end of their respective grant periods, development partners noted that Kenya was unable to absorb COVID-19 funds in a timely manner and registered only a 51 percent absorption rate while the country needed these funds. This called for not only improvement in the utilization of COVID-19 funds but flexibility in future grant allocation to ensure a significant improvement in fund absorption in emergencies and pandemics.

Introduce and encourage government-to-government agreements during pandemics: There are numerous examples of governments using government-to-government agreements in critical sectors such as defence and key infrastructure projects, which are said to be more efficient than traditional procurement or public-private partnerships. This procurement approach, i.e., G2G, is seen as a "cleaner alternative" to other international procurement methods. G2G agreements have also been said to reduce the risk of corruption and fraud like those witnessed during the COVID- 19 pandemic period in Kenya. Additionally, embracing G2G in emergency cases and in the health sector, which is a critical sector, would cut out the middlemen and lengthy, corruption prone tendering processes.

Establish health specific procurement policies so as to keep the national government accountable: The health sector is so unique and has special procurement requirements that are very different from what is normally procured by the government for other sectors.

Support innovation and production of health equipment in the country by local manufacturers: The COVID-19 pandemic also exposed the health sector in Kenya to vulnerability, including the absence of response mechanisms and emergency equipment that were to be used at various levels. In order to avoid similar crises in the future, the government should encourage innovation at both national and county levels to start production of critical health equipment. The national government should take cue from the Mombasa County government, which had requested the private sector to produce personal protective equipment (PPE).

Initiate training and capacity-building programmes for communities: Previous efforts to build the capacity of communities and that of health workers have been limited to a few initiatives led by CSOs, and yet the national government should take a leading role. "Under the fourth schedule distributes function between national and the county governments, the constitution bestows the role of training and capacity building on county governments." The national government should not only initiate training and capacity building for counties but also include CHVs and the communities through community-led approaches.

4.2 Other government Agencies in health, such as KEMSA

Enhance compliance mechanisms across agencies: Government agencies should with the support of statutory institutions ensure compliance. The study demonstrated that levels of compliance with statutory or legal requirements by KEMSA were low. Hence there is a need to strengthen state agencies compliance mechanisms, including KEMSA offices, at national and county level, to guarantee compliance with procurement policies and laws. Such measures would not only include secondment of Auditor General Officers to various state agencies at national and local level but to continuously monitor and advise on procurement processes.

Strengthen the prosecution mechanisms and capacities of agencies that deal with corruption cases: There was runaway corruption and related cases, such as bribery during the pandemic. In many cases, public officers and other persons who were allegedly involved in stealing money from public coffers or public projects are seldom held liable or held accountable for breaching procurement laws in state projects like was the case in the KEMSA procurement saga. Corruption and fraud have far-reaching consequences for the health sector. "So the question of prosecution needs to be emphasised in this report."

Restructure and review the mandate of KEMSA: Procurement of medical supplies for the public health sector has continued to be centralized under KEMSA even post devolution period, with one county representative sitting at the board. "If you look at the current board of KEMSA, it has only representation of one person from the county government, and 90% of the stakeholders of KEMSA are county governments." This calls not only for restructuring of KEMSA to allow for more county representation on the board but also for devolving of procurement functions and allowing for competitive procurement in the market.

4.3 County Governments

Enable county government to use Open Contracting Portal as an alternative: Use of e-procurement and online portals for open-source procurement were minimal like in the context of Makueni County government, however, this need to be encouraged to increase levels of accountability. It would allow all 47 counties, like in Makueni County Government's experience, to tag all COVID-19 contract data in the system, track and analyse data to guide county government decisions, and include civil society and communities in emergency procurement procedures.

Improve the public spending and revenues in the health care sector: The national government should increase public expenditures and income to support the economy and healthcare systems through targeted actions that can respond appropriately. MoH should also exploit the provisions of PFM systems that allow some flexibility in utilizing existing budget allocations

through reprioritizing line items or within budgetary programme resource envelopes. Because most legal frameworks also allow the executive to activate contingency funds in emergency situations, there is a need for finance laws to be revised through supplementary budgets to provide resources in the event of a similar or greater magnitude emergency, such as the COVID-19 pandemic.

Improve the reporting mechanism at county government levels: The procurement processes are elaborate, and each of the three phases—pre-tendering, tendering, and post-tendering—were not adequately reported, hence these raised concerns. County governments should regularly publish lists of their contracts and contractors on their websites and on other platforms to allow for scrutiny and analysis of beneficiaries, hence proper oversight and accountability.

Improve the status of the CHVs in respective counties: It is reported across the three counties that CHVs played very vital roles in the community during the COVID-19 pandemic period, more so at the height of the pandemic, but with little or no support from state agencies at both the county and national level. They were considered first responders whenever COVID-19 cases were reported in their respective areas, and this exposed them so much. In the future, the government should develop a framework on how to support the CHVs so that they can be able to engage with the community during pandemics and emergency situations. This should include training, recognition, standardized training, and stipend allocation.

Strengthen community health strategy in the country: Kenya's National Community Health Strategy, 2020-2025, envisages seven strategic directions, including strengthening management and coordination of community health governance structures at all levels of government and across partners; creating a platform for strategic partnership and accountability among stakeholders and sectors at all levels within community health ensuring the availability and rational distribution of safe and high-quality commodities and supplies (Kenya Ministry of Health, 2021), among others. Because the COVID-19 pandemic exposed weaknesses in the community health strategy, including a lack of standardized training, an MOH's review of the strategy alongside the current CHVs' training will help identify areas for strengthening and development in order for stakeholders to properly handle future crises. This should be done at the national level under the garb of the MOH, but also at the county level because health is decentralized. To do so, both levels should directly include CHVs in community health projects.

Create a facility investment fund at health centre level: Most public health facilities do not have a facility investment fund (FIF), and hence they remain vulnerable and unable to invest in priority areas. County governments that are in charge of health should introduce a charter at the local facility level for small fees or "give a health centre the power to raise its own funds through the charter to ensure self-sustainability," as observed by FGD-4.

Allocate funds to upgrade existing facilities and construct additional facilities: COVID-19 not only exposed the health sector but also stretched the facilities. This will require upgrading and building additional facilities on a need basis in order to either bring services closer to the public or improve the quality of services being offered at these facilities. For example, a participant rightly observed, *"Yes, we should have drugs in the subcounty facilities, as Grace said, so that we can avoid congestion at the major facilities, like the coast general in our case, where we find someone going to the coast general for a cough, and that can be handled at the local facilities, but people do not find drugs, and they end up at the general hospital."* This can also be done through collaboration of the national and county governments so as to improve the quality of primary health care.

4.4 CSOs and Oversight Bodies

Strengthen oversight mechanisms and tools used by stakeholders and oversight bodies: CSOs and oversight bodies play a major role in ensuring the accountability of public funds. Therefore, stakeholders and oversight bodies, such as the Public Investment Committee (PIC) of the National Assembly and the Senate, as well as the Public Procurement and Disposal Authority (PPDA), among others, should strengthen their oversight mechanisms and tools.

Strengthen the capacity of the media and civil society to conduct social audits and inform the public: The law of the land sanctions the right to information while the media and civil society organisation are some of the most critical agencies between government and the public. During the pandemic the media brought to the attention of the public how covid-19 funds were mismanaged leading to public outcry, however, these efforts need to be strengthened by building the capacity of the media and CSO as public watch dogs besides statutory state institutions that are mandated to play such roles. In doing so, the media can continue to bring to public limelight the similar allegations, in which COVID-19 resources were squandered, while the civil society led in generation impetus for openness and accountability.

Establish a framework for conducting social audit on how resources for emergencies are spent: Because the previous COVID pandemic experience was characterized with successes and challenges at the same time, there is a need to undertake policy audits to know what works and what does not as a way to identify policy gaps. This would also include advocacy for a dignified access to affordable services, working closely with NHIF and getting a common understanding of their policies to see how access to free services can be provided to survivors of SGBVs, the majority of whom are poor. A big chunk of NHIF contribution remains unutilized every year, and advocacy for redirection of government support given to private health facilities previously to go public hospitals and upgrade their services.

4.5 Donor Community and Development Partners

Embrace donor-supported Research: Given that the COVID-19 pandemic experience showed that there was little knowledge on how to respond to health-related pandemics, the development partners who have been playing a key role in supporting the health sector and those who were involved in the recent pandemic need to support CSOs, and actors must ensure that proper research is done either ahead of time or, if not, when the pandemic hits on many areas related to health and pandemics to ensure proper sensitization of the public.

Improve their emergency preparedness and implement crisis protocols: For this reason, development agencies under normal operating conditions are well-advised to enhance their emergency preparedness and establish dedicated crisis protocols to manage the rapid disbursement of resources needed in humanitarian settings while minimizing corruption. Transparency International states that *"clear, pre-established procedures for rapid response... help [donor agencies] achieve the optimum balance between the need for speed and the obligation for accountability and transparency during the initial rush to mobilise".*

Introduce systems that allow for greater flexibility in the use of funds during pandemics and emergencies: In the previous pandemic, COVID 19 in particular, it was reported by a number of CSOs that a lot of funds either at the disposal of CSO or government that were meant for other projects were not put to use during the pandemic, and yet some of these actors could have used these resources in covid-19 pandemic response. In future, donors need to establish a framework for utilization and monitoring of such funds during emergencies.

4.6 Other actors and Civil Society Organization in the health sectors

Introduce monitoring tool to track vaccine rollout: Since in the Kenyan context monitoring by both development partners and other stakeholders was lacking, stakeholders can borrow a leaf from the Transparency International chapter in Honduras that had previously set up an online monitoring tool to track the origin, allocation, and distribution of COVID-19 vaccines, which proved to be useful (Rahman, 2021). Other than development partners or donors, other actors and stakeholders in the health sector in Kenya, including CSOs, could develop a versatile online monitoring tool that could track the origin, allocation, and distribution of medical and other emergency material at the time of pandemics in the event of a future occurrence. This could be modelled after what was developed in Honduras, like the site called "Vacunas Abiertas" (Open Vaccines) with live feeds. A similar platform could be created to track and monitor grants and funds used during pandemics and emergencies, generating reports on how grants and donations were used.

Create reporting mechanisms to document malpractices and corruption for eventual audit and accountability in future health pandemics: Since proper audit, oversight, reporting, and monitoring mechanisms are key to ensuring accountability, they were either lacking or so weak or inadequate that it was practically impossible to curb corruption and malpractices during the pandemic in time. Donors and stakeholders can earmark funds in their emergency programme, for example in COVID-19 programmes, for thorough ex-post audits and widely communicate this decision, while also appointing a records custodian. In doing so, development partners or donors, as well as other stakeholders, should emphasize the importance of civic space and whistleblower protection to those raising concerns about corruption in pandemics such as COVID-19, which has caused significant distress in our social, economic, political, and medical spheres. It was also suggested by Jenkins et al. (2020) that whistleblowing, reporting, and grievance channels are particularly important to identify and resolve suspected malfeasance. It was also suggested by participant 1 that *"there is a need to have clarity on what is donated and what is money spent from public coffers."*

5.0 METHODOLOGICAL NOTE

The study employed a mixed methodology detailing a doctrinal approach that entailed a desktop review of primary and secondary data as well empirical methodology that relied on qualitative data collection methods, mainly through key informant interviews (KII) and focus group discussions (FGDs). The research commenced with a thorough desk review and analysis of existing procurement laws, policies, and gray documents on procurement processes employed during the COVID-19 pandemic, followed by a more in-depth assessment of the efficacy of these procurement processes and their impact on the right to health, as well as the overall effect and cost on Kenyan quality of life during KIIs and FGDs.

KII targeted government institutions, stakeholder groups, and selected experts with a semi-structured guide that allows for both closed and open-ended questions. On the other hand, FGDs were conducted among Hakiijamii's stakeholder networks in Kisumu, Mombasa, and Nairobi. For each focus group discussion, about 8–10 participants were needed for each sampled group in Kisumu, Mombasa, and Nairobi to gather qualitative data on three thematic areas. In doing so, we conducted six KIIs and eight FGDs in the three study sites among CSOs, health personnel, community health volunteers (CHVs), community leaders, and members of the county assemblies who are members of the health committees in their respective counties.

The analysis of the data received so far was done using content analysis and triangulated to ensure the completeness, balance, objectivity, and reliability of the information collected. Their responses not only provided answers to the assignment objectives in the Terms of Reference (ToR), but also suggested policy recommendations on the health procurement processes by the national government, county governments, and private health providers for effective implementation of the findings. To account for the sensitive nature of the information that might be discussed during these FGDs and KIIs, confidentiality of the information and identity of the participants were assured, and the consent of different participants was obtained voluntarily.

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HAKIJAMII

ECONOMIC AND SOCIAL RIGHTS CENTRE

P.O. Box 11356 - 00100 Nairobi.

Tel. +254 726 527 876

E-mail: esrc@hakijamii.com

Website: www.hakijamii.com