SCANNED

REPUBLIC OF KENYA

TWELFTH PARLIAMENT (FIFTH SESSION)

THE SENATE

STANDING COMMITTEE ON HEALTH

FIRST PROGRESS REPORT ON THE COVID-19 SITUATION IN KENYA

Clerk's Chambers,

First Floor,

Parliament Buildings,

NAIROBI.

10th March, 2021

ABBREVIATIONS

CoG	-	Council of County Governors
COVID19	-	Coronavirus Disease 2019
CPAP	-	Continuous Positive Airway Pressure
CHAK	-	Christian Healthcare Association of Kenya
EPHAK	-	Environmental Public Health Association of Kenya
HRH	-	Human Resources for Health
IRA	-	Insurance Regulatory Authority
KMPDC	-	Kenya Medical Practitioners and Dentists Council
KMA	-	Kenya Medical Association
KEMSA	-	Kenya Medical Supplies Agency
KEMRI	-	Kenya Medical Research Institute
KEBS	-	Kenya Bureau of Standards
KMPDC	-	Kenya Medical Practitioners and Dentists Council
KMLTTB	-	Kenya Medical Laboratory Technicians and Technologists Board
KMPDU	-	Kenya Medical Practitioners and Dentists Union
KPA	-	Kenya Pharmaceutical Association
KPS	-	Kenya Prisons Services
KACP	-	Kenya Association of Clinical Pathologists
KNUN	-	Kenya National Union of Nurses

KCOA	-	Kenya Clinical Officers Association
KUCO	-	Kenya Union of Clinical Officers
KHPA	-	Kenya Health Professionals Association
KNUMLO	-	Kenya National Union of Medical Laboratory Officers
KHF	-	Kenya Healthcare Federation
KPNA	-	Kenya Progressive Nurses Association
MoH	-	Ministry of Health
NHIF	-	National Health Insurance Fund
NNAK	-	National Nurses Association of Kenya
NUBEK	-	National Union of Biomedical Engineers in Kenya
PPE	-	Personal Protective Equipment
PPB	-	Pharmacy and Poisons Board
PSK	-	Pharmaceutical Society of Kenya
UHC	-	Universal Health Coverage
RUPHA	-	Rural Private Hospitals Association
WHO	-	World Health Organization

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PREFACE

Mr. Speaker Sir,

The Senate Standing Committee on Health is established under standing order 218(3) of the Senate Standing Orders and is mandated to, *"consider all matters relating to medical services, public health and sanitation."*

Committee Membership

The Membership of the Committee is composed of the following:

1. Sen. (Dr.) Michael Mbito, MP.
2. Sen. Mary Seneta, MP.
3. Sen. Beth Mugo, EGH, MP.
4. Sen. Beatrice Kwamboka, MP.
5. Sen. (Prof.) Samson Ongeri, EGH, MP.
6. Sen. (Dr.) Abdullahi Ali Ibrahim, MP.
7. Sen. Fred Outa, MP.
8. Sen. Millicent Omanga, MP.
9. Sen. Ledama Olekina, MP.

This report comes within the background of a soaring number of COVID-19 confirmed cases and deaths in Kenya, escalating deaths amongst health workers attributable to COVID-19, and threats of industrial action by various health worker unions.

With a view towards gaining a clear understanding of the COVID-19 pandemic situation and charting a way forward, the Standing Committee met with at least twenty-eight (27) stakeholder groups drawn from various government agencies and departments, health regulatory bodies, health worker representative groups at national and county level, and key private sector players.

The Committee wishes to thank the Offices of the Speaker and the Clerk of the Senate for their support in enabling them undertake this important assignment.

The Standing Committee on Health also wishes to thank Sen. Aaron Cheruiyot, MP, Senator, Kericho County, and Sen. Falhada Dekow, MP, whose statements on the non-payment of COVID-19 claims by NHIF, and cases of COVID-19 infections in correctional facilities respectively greatly enriched the development of this report.

The Committee further wishes to thank the various stakeholders who came before the Committee and submitted their memoranda including: Ministry of Health (MoH), Ministry of Interior and Coordination of National Government (MICNG), Council of Governors (CoG), Kenya Prisons Services, Kenya Medical Research Institute (KEMRI), Kenya Bureau of Standards (KBS), National Health Insurance Fund (NHIF), Kenya Medical Practitioners and Dentists Council (KMPDC), Pharmacy and Poisons Board (PPB), Insurance Regulatory Authority (IRA) and the Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB), Kenya Medical Association (KMA), Kenya Medical Practitioners and Dentists Union (KMPDU), Kenya Association of Clinical Pathologists (KACP), Pharmaceutical Society of Kenya (PSK), Kenya Pharmaceutical Association (KPA), National Nurses Association of Kenya (NNAK), Kenya National Union of Nurses (KNUN), Kenya Union of Clinical Officers (KUCO), Kenya Clinical Officers Association (KCOA), Kenya Health Professionals Association (KHPA), Kenya National Union of Medical Laboratory Officers (KNUMLO), Environmental Public Health Association (EPHAK) and the National Union of Biomedical Engineers in Kenya (NUBEK), the Kenya Healthcare Federation (KHF), Lancet Kenya, the Christian Health Association of Kenya (CHAK) and the Rural Private Hospitals Association (RUPHA).

It is now my pleasant duty and privilege to present this report of the Standing Committee on Health, for consideration and approval by the House pursuant to Standing Order No. 226(2) of the Senate Standing Orders.

Signed..... .....

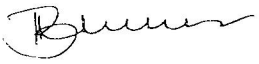
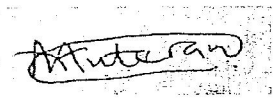
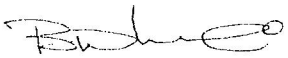
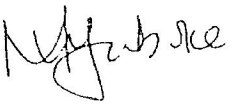
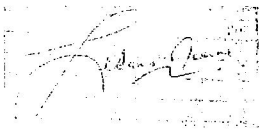
Date.....**10th March, 2021**.....

SEN. MBITO MICHAEL MALING'A, MP

CHAIRPERSON, STANDING COMMITTEE ON HEALTH

ADOPTION OF THE REPORT OF THE STANDING COMMITTEE ON HEALTH OF THE SENATE

We, the undersigned Members of the Standing Committee on Health of the Senate, do hereby append our signatures to adopt the Report-

1. Sen. (Dr.) Michael Mbito, MP ..... 
2. Sen. Mary Seneta, MP ..... 
3. Sen. Beth Mugo, EGH, MP 
4. Sen. Beatrice Kwamboka, MP .....  .....
5. Sen. (Prof) Samson Ongeri, EGH, MP .....  ...
6. Sen. (Dr) Abdullahi Ali Ibrahim, MP ...  .....
7. Sen. Fred Outa, MP ...  .....
8. Sen. Millicent Omanga, MP .....  .....
9. Sen. Ledama Olekina, MP .....  .....

EXECUTIVE SUMMARY

The World Health Organisation (WHO) declared the COVID-19 outbreak a Public Health Emergency of International Concern on 30th January, 2020. On 13th March, 2020, the Ministry of Health (MoH) announced the first confirmed case of COVID-19 within Kenyan borders.

Globally, as of 1 November, 2020, there had been 45,942,902 confirmed cases of COVID-19 with 1,192,644 deaths reported by the World Health Organisation (WHO). Of these, Africa reported 1,324,258 confirmed cases, with 29,785 deaths.

In Kenya, as of 1 November, 2020, there were 55,192 confirmed cases of COVID-19 with 996 deaths in Kenya. This translated to 1,062.42 confirmed cases and 18.25 deaths per 1 million population respectively. Comparatively, during the same period, WHO reported 12,495 confirmed cases of COVID 19 with 111 deaths in Uganda; 5,137 confirmed cases with 35 deaths in Rwanda; 96,169 confirmed cases with 1,469 deaths in Ethiopia; 589 confirmed cases in Burundi; and, 509 confirmed cases and 21 deaths in Tanzania.

At its peak, Kenya reported 1,332 new confirmed cases in a single day (28 July, 2020). This was followed by a steady decline in incidence during the months of August and September. However, in the background of a relaxation of lockdown measures, and the public's loosening of precautionary behaviours, a steep increase in the daily incidence of COVID-19 has been experienced since the month of October with the Ministry of Health (MoH) reporting 1,395 new confirmed cases with 15 deaths on 1 November, 2020. This represented Kenya's highest ever number of new confirmed cases of COVID-19 reported on a single day, and led to fears that Kenya was in the midst of experiencing a second wave of the COVID-19 pandemic.

It was within this background of a soaring number of COVID-19 confirmed cases and deaths in Kenya, escalating deaths amongst health workers attributable to COVID-19, and threats of industrial action by various health worker unions that the Standing Committee on Health sought to gain a clear understanding of the COVID-19 pandemic situation, and chart a way forward. Towards this end, the Committee considered Statements regarding the non-payment of

COVID-19 claims by NHIF, and cases of COVID-19 infections in correctional facilities by Sen. Aaron Cheruiyot, MP, Senator, Kericho County and Sen. Falhada Dekow, MP, respectively. Further, the Committee met with at least twenty-eight (27) stakeholder groups drawn from various government agencies and departments, health regulatory bodies, health worker representative groups at national and county level, and key private sector players.

Following deliberations, the Committee made the following observations:

a) Status of National Preparedness and Response

1) The Committee noted that following the COVID-19 outbreak in Kenya, the Government instituted a dusk-to-dawn curfew on 26th March, 2020. This was followed by two subsequent extensions of the containment measures by the National Government, albeit with the relaxation of curfew hours, and travel restrictions.

2) The Committee further noted that following an upsurge of confirmed cases of COVID-19 in the months of October and November, 2020, there had been growing fears that the country was experiencing a second wave of the pandemic, and was headed for a third wave.

3) In view of the rising cases of COVID-19, the Committee observed that tighter containment measures may be necessary to break the chain of transmission, and allow for the health system to adapt and respond appropriately. However, with any restrictions to be implemented, due consideration must be given to their impact on the economy and the livelihoods of common *wananchi*.

4) In addition, there is a need for the MoH and KEMRI to prioritise and expedite the development of the ChAdOx1 nCoV-19 vaccine candidate at KEMRI. Noting that according to the MoH, the vaccine had already posted promising results during early phase trials, the Committee observed that the roll-out of a locally-produced vaccine was potentially better suited for Kenya, as well as other African countries, than other vaccines.

b) County Performance and Level of County Preparedness

5) The Committee observed that according to the MoH and KMPDC, counties had a total capacity of 7,587 isolation beds, and 319 ICU beds against a requirement of 13,144 isolation beds, and 506 ICU beds respectively.

6) The Committee further noted that according to the submissions of the KMPDC and health worker representative groups who appeared most counties remain ill-prepared for the COVID-19 pandemic as evidenced by lack of basic oxygen equipment at most county health facilities, and lack of the requisite personnel to run ICU and isolation facilities.

7) The Committee further observed that according to the testimony of the COG, most pandemic preparedness and response interventions in the counties had been hampered by lack of adequate resources owing to delayed exchequer releases from the National Treasury contrary to Article 219 of the Constitution.

c) Non-Payment of COVID-9 Related Claims by NHIF and Private Medical Insurers

8) The Committee took note that in the early stages of the pandemic, the National Government through the MoH had made a commitment to meet the cost of treatment and care for COVID-19 patients in public health facilities under the UHC Scheme within the NHIF. However, in a subsequent meeting, it vacated this position.

9) The Committee observed that in line with the Government's objective to achieve universal health coverage, there was a need for the NHIF to provide comprehensive medical cover, inclusive of COVID-19 related treatment and care, for all its beneficiaries and health workers.

10) In order to enable NHIF meet the cost burden of COVID-19 testing, treatment and care, the Committee observed that there was need for the National Government, through the National Treasury and the MoH, to facilitate NHIF in meeting the cost of COVID-related

treatment and care, through the reimbursement of all pandemic-related expenses at specifically accredited hospital facilities: According to MoH and NHIF, the estimated cost implications to NHIF for COVID 19-related treatment and care (inclusive of PPEs), would be KShs. 4.82 B in the best case scenario, and KShs. 22.51 B in the worst case scenario.

11) The Committee further noted that in order to make meeting the cost of treatment more financially viable for the NHIF, there was a need for private hospitals to rationalise and reduce the cost of COVID-19 related treatment and care.

12) The Committee further noted that there was an urgent need for NHIF to approve the accreditation of the more than 500 health facilities awaiting accreditation with a view towards expanding access to COVID-19 treatment and care especially in rural, underserved areas.

13) The Committee further noted that there was a need for NHIF to ensure that health facilities are reimbursed for services rendered in a prompt and timely manner.

d) Cases of COVID-19 Infections and COVID-19 Related Deaths in Correctional Facilities

14) The Committee noted that according to submissions made by the Ministry of Interior and Coordination of National Government (MICNG), as of 10th November, 2020, out of a total prison population of 20,211, there had been 2,992 confirmed cases of COVID-19; 2,398 recoveries and 3 deaths across all prisons in the country.

15) The Committee further noted that according to submissions made by the MICNG, the total budget for COVID mitigation for KPS in the FY 2020/2021 was KShs. 200,000,000.00. However, of this, only KShs. 78,930,817.00 had been utilised owing to delayed exchequer releases.

16) The Committee further noted that the Kenya Prisons Services (KPS) had identified capacity constraints at Kenyan prisons as a key factor limiting its ability to strictly adhere to MoH protocols and guidelines for COVID-19 prevention and care.

e) Human Resources for Health Management

17) Health workers face unique challenges in relation to the COVID-19 pandemic owing to a high occupational risk of infection.

18) In response to escalating deaths amongst health workers attributable to COVID-19, various health workers including doctors, nurses and clinical officers had issued strike notices, or otherwise threatened to strike within the immediate future owing to various unresolved and longstanding grievances.

19) Key issues and challenges raised by health workers with regard to the COVID-19 pandemic situation include but are not limited to:

a) The lack of comprehensive medical cover by the National Health Insurance Fund for all health workers in Kenya;

b) Lack of adequate compensation mechanisms for the motivation and welfare of health workers including risk allowances;

c) Severe shortages of critical health staff to run ICUs and isolation facilities;

d) Unemployment of thousands of health workers despite the critical and acute need during this pandemic period;

e) Lack of provision of adequate and quality PPEs;

f) Lack of priority testing of health workers for COVID-19 despite the high risk of infection that they face;

g) Long standing labour disputes in some counties which have resulted in poor health service delivery e.g in Laikipia and Kirinyaga;

h) Delayed salaries, and failures by County Governments to remit statutory deductions, welfare contributions, bank loans and trade union dues in a timely manner, thus causing pecuniary embarrassment to health workers, and limiting their access to credit facilities;

i) Lack of guaranteed access to treatment and care for health workers through specially designated isolation and ICU facilities;

j) Lack of adequate training and capacity building for health workers particularly in the counties;

k) Unfair and exploitative employment terms for health workers on contract;

20) Undue intimidation and harassment of health workers, especially those who have tested positive for COVID 19 etc

21) The Committee noted that most of the issues and demands raised by the health workers are reasonable, and can be amicably resolved in a prompt and timely manner provided that there is political goodwill and commitment from both the National and County Governments.

22) The Committee further noted that there may be need for a centralised, coordinated mechanism for the management of human resources for health with a view towards standardising the management of health workers across the counties, and addressing the perennial challenge of industrial action by health workers.

e) Availability of Personal Protective Equipment

23) There is an urgent need for the MoH and County Governments to act urgently to ensure that adequate quantities of Personal Protective Equipment (PPEs) are provided to counties and health facilities in accordance with their forecasted and quantified need.

24) There is an urgent need for KEMSA to immediately release the huge stockpiles of PPEs lying in its warehouses to counties for purposes of ensuring that they are able to meet the increased demand.

f) Regulation of PPEs

25) With regard to the regulation of PPEs, the Committee observed that the preclusion of PPB from regulating medical consignments at ports of entry *vide* circular, Ref. OP/CAB

9/83A, dated 4th June, 2019, had led to duplication of efforts, confusion and conflicts of mandate with KEBS.

26) The Committee further observed that the involvement of a multiplicity of agencies in the regulation of PPEs (e.g. KRA, KEBS, DCI, the Anti-Counterfeit Authority and National Police) had created regulatory inefficiencies, and hampered the work of the PPB thus hampering access to critically needed PPEs in the market.

27) The Committee further observed that there was need for the MoH to expedite the establishment of a single health regulatory body as contemplated in section 62 in the Health Act, 2017.

g) Testing and Diagnostic Capacity

28) The Committee observed that whilst KEMRI had a current testing capacity of up to 10,000 tests/day using both its manual and automated systems, it was currently operating at only 4700 tests per day owing to staff shortages, erratic supply of laboratory reagents and consumables, and lack of adequate PPEs.

29) The Committee further noted that KEMRI was operating on a budgetary deficit of approximately KShs. 790 Million being the cumulative cost of additional resources that the Institute needed for: recruitment and training of additional staff for laboratory screening, vaccine development and diagnostics (KShs. 100,156,620.00); purchase of laboratory reagents and materials for COVID-19 screening and testing (KShs. 40,000,000.00); financing of high-impact research on COVID-19 (KShs. 500,000,000.00); and, procurement of various equipment for purposes of enhancing screening capacity, kits production and vaccine development e.g. freezers, autoclaves, DNA synthesisers, protein synthesizers, Guillotine, Illimuna Sequencer and HPLC (KShs. 150,000,000.00).

h) Telemedicine/Telehealth

30) In relation to the COVID-19 pandemic, the Committee observed that telehealth/telemedicine services have the potential to create a huge impact on enhancing

access to specialist services, addressing existing disparities in access to care and promoting quality affordable care.

31) Further, the Committee observed that within the current context of the COVID-19 pandemic, the adoption of technology and mobile health solutions will have the potential impact of increasing the speed and delivery of health services, while minimising risk to health workers.

32) Additionally, the utilisation and adoption of telemedicine/ telehealth services is expected to enhance access and availability of care for non-COVID essential services.

Based on the foregoing, the Committee made the following recommendations:

1. The MoH and KEMRI prioritise and expedite the development and eventual nationwide rollout of a COVID-19 vaccine;

2. The National Treasury act urgently to ensure the prompt and timely disbursement of county shareable revenue in accordance with the provisions of Article 219 of the Constitution;

3. That the Senate convene a consultative forum between the COG, MOH, National Treasury, NHIF and other key stakeholders with a view towards addressing issues and challenges arising from the lack of preparedness amongst counties to respond to the COVID-19 pandemic;

4. County Governments and the COG act urgently to ensure that adequate basic oxygen equipment is made available at all Level 2, 3, 4 and 5 health facilities;

5. The MoH, COG and County Governments should act expeditiously to ensure that expanding ICU and isolation infrastructure across the counties is matched with the availability of requisite specialised personnel including ICU nurses, medical anaesthesiologists, anaesthetists etc.

6. The National Government through the MoH and National Treasury act urgently to ensure that NHIF is facilitated to meet the cost of COVID-related treatment and care for all its beneficiaries (including health workers), through the reimbursement of all pandemic-related expenses at accredited hospital facilities;

7. NHIF act urgently to ensure that it pays all pending reimbursements to health facilities in a prompt and timely manner;

8. The NHIF Board act expeditiously to process the applications of the more than 500 health facilities awaiting accreditation with a view towards expanding access to COVID-19 treatment and care especially in rural, underserved areas;

9. The MICNG and KPS act to ensure strict adherence to MoH protocols and guidelines for COVID-19 prevention and care in correctional facilities;

10. The National and County Governments act urgently to address the issues and demands raised by health worker unions with a view towards avoiding any industrial action during this critical period of the COVID-19 pandemic outbreak;

11. The MoH and KEMSA act to immediately release the huge stockpiles of PPEs lying in KEMSA warehouses to counties for purposes of ensuring that they are able to meet the increased demand;

12. The MoH, MICNG, Ministry of Trade and Industrialisation and National Treasury act urgently to harmonise the regulation of PPEs and other medical consignments at gazetted ports of entry under a single regulatory body with a view towards addressing regulatory inefficiencies, and increasing access to critically needed PPEs in the market;

13. The MoH and National Treasury act urgently to address the KSHs. 790 million budgetary deficit at KEMRI with a view towards enabling the Institute to: recruit and train additional staff; purchase laboratory reagents and materials for COVID-19 screening and testing; finance high-impact research on COVID-19; and, procure various equipment that they need.

The Committee therefore determined that:

1. This report be dispatched to the Ministry of Health for purposes of rolling-out a nationwide COVID-19 vaccination drive, and ensuring the immediate release of the huge stockpiles of PPEs lying in KEMSA warehouses with immediate effect:

2. This report be dispatched to the Ministry of National Treasury and Planning for purposes of taking the necessary steps and measures to ensure the timely and prompt disbursement of county shareable revenue in accordance with the provisions of Article 219 of the Constitution within **one (1) month** receipt of this report;

3. This report be dispatched to the Ministry of Health, Council of Governors and the 47 County Governments for purposes of taking the necessary steps and measures to ensure the availability of basic infrastructure, oxygen equipment and requisite health personnel at all Level 2, 3, 4 and 5 health facilities with immediate effect;

4. This report be dispatched to the National Treasury, Ministry of Health and National Health Insurance Fund (NHIF) for the purposes of taking the necessary steps to ensure that NHIF is enabled to meet the cost of COVID-related treatment and care for all its beneficiaries (including health workers), through the reimbursement of all pandemic-related expenses at accredited hospital facilities; and recommend appropriate action **within one (1) months** of receipt of this report;

5. This report be dispatched to NHIF for the purpose of informing the Committee what steps and measures it intends to make to expedite the payment of all pending reimbursements to health facilities, and accreditation of the more than 500 health facilities awaiting accreditation with a view towards expanding access to COVID-19 treatment and care particularly in rural, underserved areas, and report back to the Committee within **one (1) month** receipt of this report;

6. This report be dispatched to the Ministry of Interior and Coordination of National Government for purposes of taking the necessary steps and measures to ensure strict adherence to MoH protocols and guidelines for COVID-19 prevention and care at all correctional facilities with immediate effect;

7. This report be dispatched to the Ministry of Health, the Ministry of Interior and Coordination of National Government, Ministry of Trade and Industrialisation and National Treasury for purposes of expediting the harmonisation of the regulation of PPEs and other medical consignments at gazetted ports of entry under a single regulatory body, and recommend appropriate action within two (2) months receipt of this report; and

8. This report be dispatched to the MoH and National Treasury for purposes of recommending and implementing urgent steps and measures to address the KSHs. 790 million budgetary deficit at KEMRI with a view towards enabling the Institute to: recruit and train additional staff; purchase laboratory reagents and materials for COVID-19 screening and testing; finance high-impact research on COVID-19; and, procure various equipment that they need.

CHAPTER ONE

INTRODUCTION

A. Establishment, Mandate and Membership of the Committee

The Senate Standing Committee on Health is established under standing order 218(3) of the Senate Standing Orders and is mandated to, "*consider all matters relating to medical services, public health and sanitation.*"

The Membership of the Committee is composed of the following:

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B. Background

1. About the Coronavirus Disease (COVID-19)

Coronaviruses are a large family of viruses that can cause illness in animals or humans. In humans, several known coronaviruses can cause respiratory infections ranging from the common cold to more severe diseases such as Severe Acute Respiratory Syndrome (SARS) and the Middle East Respiratory Syndrome (MERS).

COVID-19 is a disease caused by a novel strain of coronavirus that was first described in Wuhan, China in December, 2019. It literally stands for, 'CO' - corona; 'VI' - virus; 'D' - disease. It was formerly referred to as the '2019 novel coronavirus' or '2019-nCoV'.

The symptoms of COVID-19 may be similar to the flu or common cold and include: fever, cough and shortness of breath. Other symptoms may include: aches and pains, sore throat, diarrhoea, conjunctivitis, headache, loss of taste and/or smell, skin rashes and discolouration of fingers and toes. In severe cases, the disease causes shortness of breath, difficulty in breathing, chest pain of pressure, loss of speech and/or movement, and even death.

The virus is spread through direct contact with respiratory droplets of an infected person (mostly through sneezing and coughing), and touching your face, eyes, mouth or nose after contact with contaminated surfaces. The virus may survive on surfaces for several hours, but is easily killed by simple disinfectants. Older people, and persons with chronic medical conditions such as heart disease, diabetes and hypertension are most at risk of contracting the disease, and developing severe symptoms.

Covid-19 transmission from one person to the next can be slowed or stopped. As with the flu, preventive actions such as handwashing, frequent cleaning surfaces and objects, covering the mouth when coughing and sneezing, social distancing etc, are critical to slowing the spread of the disease.

There are currently no known therapies. However, several vaccine trials have produced promising results.

2. Declaration and Evolution of the COVID-19 Pandemic in Kenya

The World Health Organisation (WHO) declared the COVID-19 outbreak a Public Health Emergency of International Concern on 30th January, 2020. On 13th March, 2020, the Ministry of Health (MoH) announced the first confirmed case of COVID-19 within Kenyan borders.

Globally, as of 1 November, 2020, there had been 45,942,902 confirmed cases of COVID-19 with 1,192,644 deaths reported by the World Health Organisation (WHO). Of these, Africa reported 1,324,258 confirmed cases, with 29,785 deaths.

In Kenya, as of 1 November, 2020, there were 55,192 confirmed cases of COVID-19 with 996 deaths in Kenya. This translated to 1,062.42 confirmed cases and 18.25 deaths per 1 million population respectively. Comparatively, during the same period, WHO reported 12,495

confirmed cases of COVID 19 with 111 deaths in Uganda; 5,137 confirmed cases with 35 deaths in Rwanda; 96,169 confirmed cases with 1,469 deaths in Ethiopia; 589 confirmed cases with death in Burundi; and, 509 confirmed cases and 21 deaths in Tanzania.

At its peak, Kenya reported 1,332 new confirmed cases in a single day (28 July, 2020). This was followed by a steady decline in incidence during the months of August and September. However, in the background of a relaxation of lockdown measures, and the public's loosening of precautionary behaviours, a steep increase in the daily incidence of COVID-19 has been experienced since the month of October with the Ministry of Health (MoH) reporting 1,395 new confirmed cases with 15 deaths on 1 November, 2020. This represented Kenya's highest ever number of new confirmed cases of COVID-19 reported on a single day, and has led to fears that Kenya may be in the midst of experiencing a second wave of the COVID-19 pandemic.

C. Methodology

In seeking to address the issues and challenges that have been brought about by the COVID-19 pandemic situation, the Committee adopted a three-pronged approach which included: responding to specific requests for statements by Senators', inviting submissions from various key stakeholders, and conducting county visits as described below:

i. Responses to Senators' Requests for Statements

The Committee prioritised for consideration, **two (2)** requests for Statements by Senators on pertinent issues relating to the COVID-19 pandemic situation as follows:

a) Request for a statement by Sen. Falhada Dekow, MP, on cases of COVID-19 infections in correctional facilities in Kenya, particularly the Nairobi Remand Prison; and,

b) Request for a statement by Sen. Aaron Cheruiyot, MP, on the non-payment of COVID-19 claims by the National Health Insurance Fund (NHIF) and private medical insurance companies.

Further to the above, pursuant to the provisions of Article 118 of the Constitution and the Senate Standing Orders on public participation, between 11th and 26th November, 2020, the Committee invited various key stakeholders in the health to submit written and oral memoranda relevant to the COVID-19 pandemic situation as follows:

a) Government Agencies and Departments

1. Ministry of Health (MoH),
2. Ministry of Interior and Coordination of National Government (MICNG),
3. Council of Governors (CoG),
4. Kenya Prisons Services (KPS)
5. Kenya Medical Research Institute (KEMRI),
6. Kenya Bureau of Standards (KBS),
7. National Health Insurance Fund (NHIF)

b) Regulatory Bodies and Authorities

8. Kenya Medical Practitioners and Dentists Council (KMPDC),
9. Pharmacy and Poisons Board (PPB),
10. Insurance Regulatory Authority (IRA)
11. Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB)

c) Health Worker Representative Groups at National and County Level

12. Kenya Medical Association (KMA),
13. Kenya Medical Practitioners and Dentists Union (KMPDU),
14. Kenya Association of Clinical Pathologists (KACP),
15. Pharmaceutical Society of Kenya (PSK),
16. Kenya Pharmaceutical Association (KPA),
17. National Nurses Association of Kenya (NNAK),
18. Kenya National Union of Nurses (KNUN),
19. Kenya Union of Clinical Officers (KUCO),

20. Kenya Clinical Officers Association (KCOA),
21. Kenya Health Professionals Association (KHPA),
22. Kenya National Union of Medical Laboratory Officers (KNUMLO),
23. Environmental Public Health Association (EPHAK) and the
24. National Union of Biomedical Engineers in Kenya (NUBEK)

d) Key Private Sector Players

25. the Kenya Healthcare Federation (KHF),
26. Lancet Kenya,
27. The Christian Health Association of Kenya (CHAK) and the
28. Rural Private Hospitals Association (RUPHA).

Minutes of the stakeholder meetings as well as written submissions presented to the Committee have been annexed to this Report.

3. County Visits

In the next phase of its inquiry over the COVID-19 pandemic situation in Kenya, the Committee intends to embark on visits to various counties with a view towards establishing the actual situation on the ground.

A summary of the Committees' findings, observations and recommendations arising from the statements sought as described above, and from the stakeholder meetings have been captured in subsequent sections of this report.

CHAPTER TWO

COMMITTEE PROCEEDINGS

A. Responses to Senators' Requests for Statements

The Committee prioritised for consideration, **two (2)** requests for Statements by Senators on pertinent issues relating to the COVID-19 pandemic situation as follows:

1) Request for a statement by Sen. Falhada Dekow, MP, on cases of COVID-19 infections in correctional facilities in Kenya, particularly the Nairobi Remand Prison; and,

2) Request for a statement by Sen. Aaron Cheruiyot, MP, on the non-payment of COVID-19 claims by the National Health Insurance Fund (NHIF) and private medical insurance companies.

B. Stakeholder Engagement Meetings

Further to the above, 11th and 26th November, 2020, the Committee held a series of meetings with various key stakeholders in the health sector from both levels of Government, health regulatory bodies, health professional associations and societies, health worker unions and the private sector.

The following section provides a summary of the submissions presented before the Committee by the various stakeholders.

A. Responses to Senators' Requests for Statements

1. *Request for a statement by Sen. Falhada Dekow, MP, on cases of COVID-19 infections in correctional facilities in Kenya, particularly the Nairobi Remand Prison*

Background: At the sitting of the Senate held on Wednesday, 7th October, 2020, Sen. Falhada Dekow, MP, requested a statement from the Senate Standing Committee on Health, concerning cases of COVID-19 infections in the Nairobi Remand Prison, and the general state of preparedness to deal with the pandemic in correctional facilities in the country. In the Statement, the Senator sought the following information-

i. State the measures put in place by the Government to isolate and treat prisoners infected with COVID-19 at the Nairobi Remand Prison;

ii. Elucidate on the measures deployed by Prison authorities to ensure the safety of prisoners in all prisons across the country, particularly against infection by COVID-19;

iii. Explain the measures taken by the Government to prevent gross management failures, negligence and leadership voids that could lead to infections and deaths arising from preventable diseases within correctional facilities in the country, including COVID-19; and

iv. Explain whether adequate medical personnel have been deployed across all prisons to aid in combating the spread of COVID-19 in the correctional facilities.

At the sitting of the Committee held on 15th October, 2020, the Committee considered the statement and resolved to invite the Ministry of Interior and Coordination of National Government (MICNG), and the Kenya Prisons Services (KPS) to submit written responses to the issues raised. The Committee further invited the MICNG and the KPS to a meeting on Friday, 22nd October, 2020.

A summary of the submissions made by the MICNG and KPS is provided below:

1. Meeting with the Ministry of Interior and Coordination of National Government (MICNG) and the Kenya Prisons Services (KPS)

The Committee met with the Ministry of Interior and Coordination of National Government (MICNG) led by Hon. Amb. Hussein Dadho, Chief Administrative Secretary, and the Kenya Prisons Services (KPS) led by Mr. Wycliffe Ogalo, Commissioner General (Prisons) on Friday, 22nd October, 2020 via the Zoom online meeting platform.

According to the MICNG and KPS, the Government had taken several measures to isolate and treat prisoners infected with COVID-19 at correctional facilities, including: banning of all prisons visits; appointment of station multidisciplinary COVID-19 response committees; conversion of the Nairobi Medium Prison into an emergency evacuation isolation center; imposition of a complete lockdown of prisons; temporary suspension of all new admissions; imposition of a mandatory 14-day quarantine for all newly admitted prisoners; placement of all asymptomatic COVID-19 prisoners in mandatory isolation; referrals of symptomatic COVID-19 patients to Kenyatta University Hospital for specialised treatment; and, implementation of enhanced infection prevention and control measures (IPC).

Further to the above, MICNG and KPS submitted that in order to ensure the safety of prisoners against COVID-19, the Government had taken steps towards ensuring: enhanced leadership and management towards COVID-19 control; robust implementation of infection prevention and control programs; implementation of quarantine, testing and isolation programs; and, efficient transport and emergency evacuation and referral systems.

The MICNG and KPS further submitted that the Government had taken specific measures to reduce infections and deaths arising from management failures by: establishing daily structured virtual meetings for all prisons' leadership; taking measures to ensure adherence to, and enforcement of MoH protocols and standards; facilitating support supervisory visits by County Commissioners etc.

Further to the above, the MICNG and KPS submitted that there were a total of 65 registered public health facilities within prisons countrywide.

Notably, the KPS admitted to being unable to strictly adhere to MoH protocols and guidelines for COVID-19 prevention and care owing to capacity constraints.

With regards to issues raised concerning the budget for the mitigation of COVID-19 in Kenyan prisons, MICNG submitted in a supplementary statement dated 10th November, 2020, that the total budget for COVID mitigation for KPS in the FY 2020/2021 was KShs. 200,000,000.00. However, of this, only KShs. 78,930,817.00 had been utilised owing to delayed exchequer releases.

Further, in the aforementioned supplementary statement, the MICNG indicated that out of a total prison population of 20,211 people, there had been 2,992 reported cases of COVID-19; 2,398 recoveries and 3 deaths across all prisons in the country.

Copies of the written submissions by MICNG and KPS have been attached hereto as Annex 3.

2. *Request for a statement by Sen. Aaron Cheruiyot, MP, on the non-payment of COVID-19 claims by the National Health Insurance Fund (NHIF) and private medical insurance companies*

Background: At the sitting of the Senate held on Wednesday, 3rd November, 2020, Sen. Aaron Cheruiyot, MP. requested a statement from the Senate Standing Committee on Health, regarding the non-payment of COVID-19 claims by the National Health Insurance Fund (NHIF) and private medical insurance companies (a copy of the Statement is attached for your reference). In the statement, the Senator sought the following information-

i. Explain why the National Health Insurance Fund (NHIF) has declined to meet the treatment costs of its members who have been diagnosed with COVID-19 disease;

ii. State why private medical insurance companies have also declined to cater for treatment costs for their clients suffering from COVID-19; and,

iii. State the official position of the Insurance Regulatory Authority of Kenya (IRA) with regard to obligations of the NHIF and private insurance companies in meeting the treatment costs of their members who have contracted COVID-19.

At the sitting of the Committee held on 4th November, 2020, the Committee considered the statement and resolved to invite the Ministry of Health (MoH), the National Health Insurance Fund (NHIF), the Insurance Regulatory Authority (IRA) and the Association of Kenya Insurers (AKI) to submit written responses to the issues raised. The Committee further invited the MoH, NHIF, IRA and AKI to a meeting on 12th November, 2020, 2020.

A summary of the submissions made by NHIF, IRA and AKI are provided below. Kindly note that the submissions made by the MoH have been captured in the next section under *'Stakeholder Meetings'*.

1. Meeting with the National Health Insurance Fund (NHIF)

The Committee met with the National Health Insurance Fund (NHIF) led by the Chief Executive Officer, Dr. Peter Kamunyo, 12th November, 2020 via the Zoom online meeting platform.

According to Dr. Kamunyo, NHIF had been constrained to meet the treatment costs of its members who had been diagnosed with COVID-19 owing to the fact that pandemics and epidemics are exclusions in health insurance due to their nature in terms of cost and risk modelling.

He further submitted that according to recommendations by the World Health Organisation (WHO), the National Government had the overall responsibility for prioritizing and guiding the allocation and targeting of resources in pandemic situations, as well as for providing additional resources for national pandemic preparedness, capacity development, and response measures.

He stated that NHIF service contracts only covered health services, and that epidemics and pandemics were general exclusions under clause 8, subsection 8.2.12. Additionally, that clause 2.21, subsection 2.21.3 exempted the Fund from undertaking Government-coordinated epidemic and pandemic responses as was the case globally.

Additionally, according to NHIF, it was possible to control for the cost of treatment and care in private health facilities through the enforcement of sections 36, 38 and 42 of the Public Health Act which empower the Director of Medical Services to requisition any buildings, equipment, land, property or supplies necessary to mount a national pandemic preparedness and response plan.

With regard to the cost implications to NHIF if it were to take up the financial responsibility of the pandemic, he indicated that caseload modelling based on current prevalence data had resulted in two possible scenarios each with a significant cost burden to the Fund, as follows:

a) *Scenario 1:* Based on current NHIF reimbursement costs for general care and reported market costs for critical care, excluding provisions for PPEs, the Fund

would be met with an estimated treatment cost of KShs. 1.17 B – KShs. 5.44 B for the treatment of COVID-19 amongst insured beneficiaries.

b) *Scenario 2:* Based on treatment costs inclusive of PPEs, the Fund would be met with an estimated treatment cost of KShs. 4.82 B – KShs. 22.51 B, amongst the NHIF insured beneficiaries.

Based on the above scenarios, the CEO, NHIF submitted that it would not be financially viable for NHIF to finance treatment of COVID-19 for the current National or Enhanced Medical Scheme members of the Fund, or a National COVID-19 response modelled under UHC, without external financing specific to the reimbursement of the pandemic related expenses, and at specific hospitals.

According to NHIF, it was however, possible to mitigate against the high cost of COVID-19 care and treatment by adopting home-based care protocols as this would result in shorter lengths of stay on admission, and lower average costs of care per day.

Copies of the written submission by NHIF has been attached hereto as Annex 5

2. Meeting with the Insurance Regulatory Authority (IRA)

The Committee met with the Insurance Regulatory Authority led by the Commissioner of Insurance, Mr. Godfrey Kiptum, on 12th November, 2020 via the Zoom online meeting platform.

According to IRA, pandemics and epidemics were standard exclusions in insurance policies the world over. However, except for two insurers, all other private insurers in Kenya had not expressly excluded them in their policies thereby implying that COVID -19 was covered.

Dr. Kiptum submitted that the Authority had issued guidelines to urge private medical insurance companies to extend protection to individuals, households and businesses, in line with the policy contracts signed with their clients.

He further submitted that the Authority had remained vigilant in monitoring the financial soundness and operational resilience of insurers with a view towards supporting the protection of policyholders and maintenance of financial stability of insurers.

Additionally, the Authority had pursued a range of regulatory and supervisory measures aimed at providing operational relief to insurers in the wake of covid-19, as well as the flexibility to maintain their safety and soundness, whilst delivering essential services to policyholders and the economy.

On the question of why private medical insurance companies had declined to cover the treatment costs of COVID-19 patients, IRA submitted that coverage for medical insurance was dependent on the terms and conditions of the policy. As such, COVID-19 related claims would be dealt with in accordance with the terms and conditions stipulated in the policies.

Further, according to the IRA, the Authority had engaged private medical insurance companies in regard to settling of COVID-19 insurance claims. Accordingly, statistics collected from the industry between April and August, 2020 indicated that insurers had paid claims worth Ksh 134.4 Million during that period. However, continued payment of

COVID-19 related claims by insurers was no longer sustainable without government support owing to the continued surge in infections, and rates of hospitalization.

Copies of the written submission by IRA have been attached hereto as Annex 11.

3. Meeting with the Association of Kenya Insurers (AKI)

The Committee met with the Association of Kenya Insurers led by the Executive Director, Mr. Tom Gichuhi, on 12th November, 2020 via the Zoom online meeting platform.

According to Mr. Gichohi, because of the infrequent nature of epidemics and pandemics, there was no adequate data to help insurers come up with risk modelling necessary to enable pricing for epidemics and pandemics.

He further submitted that by their very nature, epidemics and pandemics were catastrophic events, with such huge cost implications that no insurer could reasonably expect to meet the cost of claims. That notwithstanding, he submitted that when the pandemic was first declared in Kenya in march, 2020, private medical insurers and IRA came together and agreed to find a way of assisting their long-time customers. They had further resolved to seek the support of accredited private hospitals.

He further submitted that AKI had established the average cost of treating COVID-19 related claims in private hospitals at Ksh 750,000 - Ksh 1.5 Million per patient. As these costs were not sustainable to the insurers, AKI had approached Tier Two hospitals willing to provide a manageable package for COVID-19 related claims.

B. Stakeholder Engagement Meetings

Further to seeking responses to requests for Statements by Senators' as outlined above, between 11th and 26th November, 2020, the Committee held a series of meetings with various key stakeholders in the health sector from both levels of Government, health regulatory bodies, health professional associations and societies, health worker unions and the private sector.

Below is a summary of the submissions presented before the Committee by the various stakeholders.

A. Government Agencies and Departments

1. Ministry of Health (MoH)

The Committee met with the Ministry of Health, led by the Cabinet Secretary, Hon. (Sen.) Mutahi Kagwe, on 11th November, 2020 via the Zoom online meeting platform.

With regard to the status of the COVID-19 outbreak situation in the country. Hon. Mutahi Kagwe submitted that as of 01st November 2020, Kenya had reported **55,878** confirmed cases of COVID-19, with **37,194** recoveries and **1,013 deaths** in all the 47 counties. Of the confirmed cases, there were 1665 frontline healthcare workers affected, with nineteen mortalities.

As part of the pandemic response measures, the Government had heightened surveillance at all points of entry, health facilities and communities across the country. In addition, the Government has put in place various interventions, including:

a) Coordination of the Pandemic Response

The Government had adopted a whole-of-Government, multi-agency approach in accordance with Executive Order No. 2 of 2020 which was issued by H.E. the President on 28th February, 2020. Accordingly, a National Emergency Response Committee had been established to coordinate the pandemic response.

b) Activation of the Public Health Emergency Operations Centre (PHEOC)

The Public Health Emergency Operations Centre had been fully activated for purposes of coordinating response measures, and providing daily situation reports. Further, the PHEOC was responsible for investigating any alerts of COVID-19, and contact-tracing.

Further, in collaboration with the World Health Organisation (WHO), the MoH had conducted capacity-building of sub-county rapid response and contact-tracing teams in thirty-four counties, namely, Nairobi, Mombasa, Marsabit, Wajir, Turkana, Kajiado, Kilifi, Isiolo, Mandera, Busia, Kiambu, Kwale, Nakuru, Kitui, Garissa, Tana River, Migori, Taita Taveta, Bungoma, Kakamega, Murang'a, Meru, Siaya, Kisumu, Nyeri Uasin Gishu, Machakos, Laikipia, Narok, Kericho, Kisii, Makueni, Bomet and Trans Nzoia.

c) Diagnostic Capacity

The Government had acted to scale-up diagnostic capacity to a total of thirty-nine (39) public and private laboratories across twelve (12) counties, including: Nairobi, Kisumu, Mombasa, Kilifi, Wajir, Kericho, Uasin Gishu, Machakos, Busia, Nakuru, Kajiado and Trans Nzoia. Accredited laboratories were identified as follows: National Influenza Centre (NIC) and the National HIV Reference laboratory at the National Public Health Laboratories, Kenya Medical Research Institute (KEMRI) laboratories in Nairobi, Kilifi, Kisumu and Alupe, KEMRI Nairobi HIV Laboratory, KEMRI CDC Nairobi, KEMRI CMR, KEMRI Walter Reed Kericho and Kisumu, ILRI, Kenyatta National Hospital, Moi Teaching and Referral Hospital, Coast General Teaching and Referral Hospital, Wajir County Referral Hospital, Machakos County Referral Hospital, Busia County Referral Hospital, Kitale County Referral Hospital, Malindi County Referral Hospital, Wajir County Referral Hospital, Nairobi West Hospital, Aga Khan University Hospital, Nairobi Hospital, Lancet Kenya, AMREF, Mombasa Hospital, Kenyatta University Teaching Research and Referral Hospital, IOM, PathCare Kenya Ltd, Meditest Diagnostic Services, Nairobi South Hospital, IOM Mombasa, Coptic Hospital, CA Medylinks Kenya and Mama Lucy Kibaki Hospital.

In addition to the above accredited laboratories,the MoH had deployed two mobile laboratories in Mai Mahiu and Namanga border points. Cumulatively, as of 1st November, 2020, a total of six hundred and ninety-nine thousand five hundred and twenty **(699,520)** samples had been tested. Further, procurement of reagents and sample collection kits was ongoing.

d) Travel Restrictions

A countrywide dusk-to-dawn curfew (2300hrs to 0400hrs) was established on 26th March, 2020 and remained in force.

e) Establishment of Isolation/Quarantine Facilities

The National and County Governments had established a total of 7411 isolation beds and 319 ICU beds across the counties. These were expected to contribute towards the achievement of Universal Health Coverage (UHC) and medical tourism beyond the COVID-19 pandemic period.

f) Vaccine Development

KEMRI was in the process of conducting local trials for the ChAdOx1 nCoV-19 Vaccine candidate. The ChAdOx1 nCoV-19 had already reached phase 3 trials in the United Kingdom, Brazil and South Africa with very promising results in the early phase trials. To ensure availability and access to the vaccine as and when it became available in the market, the MoH and the Ministry of Foreign Affairs were engaging with GAVI so as to take advantage of the COVID-19 Global Vaccine Access Facility (Covax Facility).

g) Community Involvement

The Government had fully engaged *Nyumba Kumi* initiative committees to support outbreak response measures. The Ministry was also utilizing community health volunteers (CHVs) to enhance COVID-19 detection and reporting at household level. Thirty-four million community members have been reached with COVID-19 messages.

h) Social Distancing and Use of Face Masks

The Government had implemented multiple strategies to limit person to person transmission of COVID-19 in the country. These included: closure of learning institutions; postponement of

large gatherings and events; and, maintenance of 60% maximum sitting capacity in public and private conveyances to minimize crowding of persons. Further, the Government was also enforcing mandatory use of face masks in public places as an additional measure to curb the spread of the virus.

i) Development of a COVID-19 School Surveillance System

In readiness for the reopening of schools for in-person learning after the COVID-19 pandemic, the MoH was in the process of developing a COVID-19 surveillance system for the Ministry of Education aimed at collecting daily data from both students and staff (teaching and non – teaching) with a view towards identifying suspected COVID-19 cases for rapid public health action.

With regards to issues raised on the non-payment of COVID-19 related claims by NHIF and private medical insurers, he reiterated that the cost burden of financing Covid-19 testing and treatment for NHIF beneficiaries both in the National Scheme and the Enhanced Medical Schemes would not be financially viable since it was not envisaged in the current NHIF premiums computation and the existing benefits package. He further reiterated that the Government was subsidising the cost of COVID-19 treatment and care through the provision of PPEs, and testing.

Copies of the written submission by MoH have been attached hereto as Annex 2.

2. Council of Governors (CoG)

The Committee met with the Council of Governors, led by Gov. James Ongwae, on 26th November, 2020 via the Zoom online meeting platform.

With regards to the status of preparedness amongst counties in the COVID-19 pandemic response, COG submitted as follows:

a) Access to Treatment and Referral Services

According to COG, in order to ensure access to appropriate hospital services for all COVID-19 patients, Counties had taken the following intervention measures: support of home-based care; sensitisation and enforcement of COVID-19 guidelines and protocols at county health facilities; establishment of emergency operations centers; operationalisation of quarantine facilities for suspected cases; stocking of county health facilities with PPEs; provision of dedicated ambulance and emergency referral services for COVID-19 patient; and, procurement of additional ventilators for the management of severely ill COVID 19 patients.

b) Testing Capacity

Through collaboration with KEMRI and the MoH, counties had acted to scale up testing through contact-tracing of COVID-19 infected patients; setting-up sample collection centers at sub-county level; and, ensuring the availability of the requisite laboratory supplies such as sample collection kits and testing reagents.

c) Availability of ICU Facilities

According to COG, counties were acting to increase ICU bed capacity through renovation of existing facilities, and purchase of new ICU beds. Additionally, counties had put in place measures to ensure that there were adequate numbers of health workers with the requisite critical care skills to meet the increased demand for ICU care by providing capacity-building to health workers on operating ICU beds, ventilators, CPAP and bi-level positive air pressure machines.

Additionally, counties were reported to have recruited 9858 additional health workers to meet the increasing demand.

With regards to fast tracking the procurement of ventilators, CPAP machines and oxygenators as a contingency measure, COG reported that counties were in the process of mobilising resources from the National Government and development partner to procure additional ventilators and oxygenators.

d) Availability of Oxygen Supply

According to COG, counties had taken several measures to ensure adequate supply of oxygen at county health facilities including: procurement of additional oxygen cylinders; installation of bulk liquid oxygen supply systems; procurement of oxygen from BOC; installation of oxygen plants in county referral facilities; and, connecting beds to piped oxygen.

e) Personal Protective Equipment

Counties had put in place contingency measures to ensure the responsible and accountable use of PPEs by: ensuring regular forecasting and monitoring of stock status of PPEs; ensuring prompt reordering of PPEs; mobilising support from donors, National Government and local companies; designating focal persons to ensure rationale use of PPEs and commodities control; designating quality assurance officers to assess the quality of PPEs; and, encouraging rational use of PPEs by health workers.

f) Availability of Essential Drugs and Supplies

For purposes of ensuring the maintenance of adequate stocks of essential drugs and supplies, counties had set aside adequate budget allocations, as well as instituted proper forecasting, quantification and inventory management of essential medicines and supplies. Further, counties were acting to ensure timely ordering of essential drugs and supplies, as well as maintaining buffer stocks in county stores.

g) Human Resources for Health (HRH)

In relation to addressing arising issues and challenges in HRH management, COG submitted that some counties had made budgetary provisions to recruit additional health workers. In addition,

counties had put in place several measures to ensure the motivation and welfare of health workers in light of the occupational risk they face in contracting COVID-19, including: provision of comprehensive health insurance for all health workers in the counties; free treatment of COVID-19 infected health workers; regular testing; and, use of designated treatment facilities for infected health workers and their families. In addition, counties had acted to ensure that health workers and first responders were prioritised in the distribution of PPEs.

COG further submitted that elderly and vulnerable health workers had been exempted from providing COVID-19 related treatment and care, and had been tasked with mainly administrative duties.

In addition, in order to ensure adequate training and capacity-building amongst health workers, counties had conducted training on COVID-19 case management. In addition, appropriate training was being provided at hospital level through the provision of continuous medical education (CME) training, and the provision of regular updates on treatment guidelines and protocols.

In relation to the challenges that counties were facing in mounting effective responses to the pandemic, COG submitted that delayed exchequer releases by the National Treasury were a key challenge. Noting that counties had not received any funding from the National Government in three months at the time of the writing of this report, the COG requested for the Senate to convene a consultative forum between the Ministry of Health, National Treasury, County Governments, COG as soon as practicable.

Copies of the written submission by COG have been attached hereto as Annex 4.

3. Kenya Medical Research Institute (KEMRI)

The Committee met with the Kenya Medical Research Institute, led by the Director-General, Lt. Prof. Yeri Kombe, on 26th November, 2020 via the Zoom online meeting platform.

According to KEMRI, the Institute was working closely with the MoH to contain COVID-19 by supporting testing of suspected cases and training of health personnel on biosafety and sample collection.

KEMRI further reported conducting 4700 tests per day against a current testing capacity of up to 10,000 tests/day using both manual and automated systems. The lower output of tests conducted, against testing capacity was blamed on erratic supply of laboratory consumables and PPE's.

No.	**Laboratory**	Test per day
1.	KEMRI Nairobi	1500
2.	KEMRI Kisumu	1500
3.	KEMRI Busia-Alupe	500
4.	KEMRI Kericho	600
5.	KEMRI Kilifi	500
6.	KEMRI Mandera	100
	TOTAL TESTING CAPACITY	**4700**

KEMRI further submitted that it was supporting counties to undertake tests for COVID-19 through technical support and facilitating the establishment of laboratories. Specifically, actions taken by KEMRI to scale up COVID-19 testing in the counties, included:

	Activities	Status
1.	Training & technical support	- KEMRI had trained laboratory managers and directors from 46 counties on sample collection and biosafety. - KEMRI had conducted laboratory validation and assessment of laboratories in readiness for COVID-19 testing in Machakos, Coast General, Malindi Hospital, Embu and IPR Laboratory.
2.	KEMRI Laboratory support to counties	- In Mandera county KEMRI in collaboration with county leadership had established a laboratory in conducting COVID-19 testing - A similar process was going on in Turkana County, and plans were underway to include Kakamega county - In the private sector KEMRI had provided training to Gertrude Children Hospital, Shelter-Afrique etc.
3.	Laboratory Disaster Preparedness Training	- KEMRI was providing training for laboratory personnel across the 47 counties in disaster preparedness with financial support of JICA.

In response to issues raised regarding allegations of huge backlogs in COVID-19 testing across counties, KEMRI submitted that it was attributable to staff shortages, erratic supplies of laboratory reagents and consumables, inadequate testing machines and lack of prioritisation of samples at collection sites. Accordingly, KEMRI recommended that additional technical and scientific staff be hired; measures be taken to ensure the provisions of sustained laboratory supplies; additional testing machines be procured; and, that COVID-19 samples be prioritised at collection sites.

In response to concerns raised with regards to what measures KEMRI had put in place to ensure that COVID-19 tests were sensitive and specific, KEMRI submitted that it had been mandated by the MoH to undertake validation and evaluation of commercial test kits. Accordingly, KEMRI

Laboratories were being used to validate and optimise new test kits, and new batches before release for testing of actual patient's samples. Further, KEMRI was undertaking Proficiency Testing and External Quality Assurance for various COVID-19 testing laboratories.

In response to questions raised as to the potential role of rapid diagnostic tests, KEMRI responded that while WHO-accredited Antigen Kits could be used for screening, PCR was still the gold standard. KEMRI further submitted that Antibody tests were not accurate, and had limited diagnostic use. However, they could be useful in carrying out serosurveillance for purposes of estimating the spread of COVID-19 amongst populations.

Further, KEMRI submitted that it was in need of an additional budgetary allocation of KShs. 790,156,620 for purposes of recruiting and training additional staff for laboratory screening, vaccine development and diagnostics (KShs. 100,156,620.00); purchase of laboratory reagents and materials for COVID-19 screening and testing (KShs. 40,000,000.00); financing of high-impact research on COVID-19 (KShs. 500,000,000.00); and, procurement of various equipment for purposes of enhancing screening capacity, kits production and vaccine development e.g. freezers, autoclaves, DNA synthesisers, protein synthesizers, Guillotine, Illimuna Sequencer and HPLC (KShs. 150,000,000.00). Please see *Annex 6b* for a detailed breakdown of KEMRIs' budgetary allocation needs.

Copies of the written submissions by KEMRI have been attached hereto as Annex 6.

B. Health Regulatory Bodies

1. Kenya Medical Practitioners and Dentists Council (KMPDC)

The Committee met with the Kenya Medical Practitioners and Dentists Council led by the Chief Executive Officer, Mr. Daniel Yumbya on 24th November, 2020 via the Zoom online meeting platform.

In his presentation, the KMPDC CEO presented the executive summary of a technical report on *'MoH Technical Assistance to the County Governments for the Mitigation of the COVID-19 pandemic and strengthening of health systems for UHC in the counties" (see Annex 7a).* However, having been taken through the report, the Committee noted that it had been published in August, 2020 and within the context of the highly evolving nature of the COVID-19 pandemic, its findings no longer applicable.

The KMPDC further presented a schedule of the updated list of isolation centers in the counties (*see Annex 7b*) which indicated that counties had a total capacity of 7,587 isolation beds, and 319 ICU beds against a requirement of 13,144 isolation beds, and 506 ICU beds respectively.

The Council further called for the establishment of a constitutional Health Services Commission for purposes of resolving the various HRH management challenges that had arisen from the devolution of healthcare.

Copies of the written submissions by KMPDC have been attached hereto as Annex 7.

2. Pharmacy and Poisons Board (PPB)

The Committee met with the Pharmacy and Poisons Board (PPB) led by the Chief Executive Officer, Dr. Fred Siyoi, on 24th November, 2020 via the Zoom online meeting platform.

Dr. Siyoi submitted that the PPB is Kenya's medical regulatory agency and is established under the Pharmacy and Poisons Act Cap 244 to: license and control the manufacture, import, export, sale, distribution, promotion and advertising of health products; supervise and control clinical trials; assess the safety, effectiveness and quality of health products; conduct post-market surveillance; monitor adverse events; and, inspect manufacturers, importers, wholesalers and dispensers. Within the context of the COVID-19 pandemic situation, PPB had acted to support the MoH through ensuring the availability of quality, safe and effective PPEs.

a) Measures taken to ensure that PPEs being supplied to counties adhere to the minimum acceptable quality and standards

In order to ensure that PPEs supplied to counties adhered to the minimum acceptable quality and standards PPB had developed and implemented various guidelines including 'Guidelines for Emergency and Compassionate Use Authorization of Health Products and Technologies' (April, 2020) aimed at enabling fast-tracked regulatory approval processes for COVID-19 PPEs whilst ensuring their quality, requiring proof of quality and allowing for the issuance of import permits.

The PPB had further developed and implemented 'Standards for Personal Protective Equipment and Materials (April, 2020) and the 'Final Guidelines for Medical Devices and IVDs'.

b) Post-Market Regulation

Further, PPB was monitoring the market for purposes of ensuring compliance to specifications for PPEs. In relation to this, the PPB had conducted inspections of all MEDS and KEMSA depots, all national referral hospitals, and all Level 4 and 5 hospitals in South Rift, North Rift, Central, Upper Eastern, Lower Eastern and Coast regions. Further inspections were ongoing in Nairobi and North Eastern regions. Notable findings from the inspections visits included:

- Majority of the premises visited had complied with laid-down COVID-19 prevention measures;

- Most public hospitals lacked adequate space, storage conditions and qualified personnel; and,

- KEMSA did not adequately comply with the stipulated Good Distribution Practices.

c) Post-Market Surveillance and Testing

PPB has conducted post-market surveillance to assess the quality status of PPEs in KEMSA, MEDS, healthcare facilities and stores (e.g. pharmaceutical outlets, hospitals, supermarkets, central stores, hawkers etc. in the following counties: Kirinyaga, Muranga, Nyeri, Nyandarua, Kiambu, Marsabit, Isiolo, Meru, Embu, Tharaka-Nithi, Laikipia, West Pokot, Trans Nzoia, Baringo, Elgeyo-Marakwet, Uasin Gishu, Kericho, Bomet, Nakuru, Nandi, Narok, Kisumu, Migori, Homabay, Siaya, Nyamira, Kisii, Bungoma, Busia, Kakamega, Vihiga, ombasa, Kwale, Kilifi, Taita Taveta, Makueni, Kitui and Machakos.

Out of a total of two-hundred and thirty-six (236) samples collected, comprising a total of thirty-five thousand and four hundred (35,400) pieces, 94.3% complied with the specifications for surgical masks. For products that failed to comply with the stipulated specifications, PPB had undertaken to remove the products from the market, and to build the capacity of the manufacturers through physical visits with a view towards ensuring compliance with subsequent batches.

d) Capacity Building

To support the availability of PPEs to the counties, PPB had conducted several quality audits and on-site training of local manufacturers of PPEs. Further, in order to facilitate the local production of PPEs, PPB had undertaken to build the capacity of local manufacturers on the quality of raw materials for the manufacture of PPEs in accordance with ISO specifications and Kenyan standards.

e) Control of Importation and Exportation

With regard to the control of importation and exportation of PPEs, PPB submitted that it was a requirement for medical supplies to be imported via gazetted ports of entry. Accordingly, the Board had stationed its inspectors at the gazetted ports of entry for purposes of providing

verification of medical consignments. However, *vide* a circular,(from Office of the President) OP/CAB 9/83A dated 4th June, 2019, PPB was recategorised to a category 4 government agency, thus effectively precluding it from operating at ports of entry, or intervening in the verification of medical consignments. These roles were transferred to the Kenya Revenue Authority and the Kenya Bureau of Standards (KBS) thus hampering the work of the Board.

Additionally, the involvement of other agencies in a mandate that had been given to PPB by legislation had had the effect of causing undue delays, and driving up the costs of pre-verification and verification processes. In addition, it had created a 'double regulation' scenario for PPEs and hampered access of critically needed PPEs in the market.

Copies of the written submissions by PPB have been attached hereto as Annex 8.

1. Kenya Bureau of Standards (KBS)

The Committee met with the Kenya Bureau of Standards, led by the Managing Director, Lt. Col. (Rtd) Bernard Njiraini, on 26th November, 2020 via the Zoom online meeting platform.

a) Measures taken to ensure adherence to minimum acceptable quality and standards for PPEs

With regards to the measures that KEBS had undertaken to ensure that PPEs supplied to counties adhered to the minimum acceptable quality and standards, KEBS submitted that all PPEs are subjected to quality checks and certification before being allowed into the Kenyan market. Where goods failed to meet the minimum quality and performance requirements, KEBS rejected and re-shipped or destroyed the goods at the owner's costs. Examples of consignments that had been rejected on the basis of being substandard included face masks from Upfield Kenya (Netherlands), Hamburg Movers Co. (China), Nokia Solutions (China), Ministry of Health (China) and Tridem Pharma K Ltd (China).

a) Pre-export Verification of Conformity to Standards (PVoC)

As provided for under Legal Notice No. 78 of 28th April, 2020, KEBS in partnership with contracted inspection agencies (that is, SGS, BV, CCIC, COTECNA and INTERTEK) was acting to ensure that all goods, including PPEs, were inspected, tested, and certified in their country of origin prior to being allowed for import. Where goods did not have the requisite certification from the country of origin, KEBS was undertaking destination inspection and testing at the port of entry for compliance to set standards before the goods were released. Further, KEBS was also undertaking post release market surveillance to withdraw non-compliant products from the market.

b) Quality Assurance of Locally Manufactured PPEs

On the quality assurance status of locally manufactured PPEs, KEBS submitted that the quality of locally manufactured products was assured through a KEBS Product Certification Scheme in line with ISO/IEC 17065. In this regard, KEBS had inspected and certified a total of sixty-three firms manufacturing PPEs and one-hundred and seven firms manufacturing face masks.

c) Post-production/Import Market Surveillance

According to KEBS, all certified goods were monitored for quality through market surveillance. Products found not conforming to the standards were withdrawn from the market, and their permits to manufacture also withdrawn until corrective measures were put in place.

d) Seizures

Continuous surveillance on masks was ongoing, and several brands of masks had been seized for failure to adhere to the critical performance parameter of Aerosolized bacterial filtration efficiency. They included 37,000 face masks produced by Wandas Ltd with an approximate value of KShs. 3,700,000.00.

A copy of the written submission by KEBS has been attached hereto as Annex 9.

5. Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB)

The Committee met with the Kenya Medical Laboratory Technicians and Technologists Board led by the Registrar/CEO, Mr. Abdullatif, on 26th November, 2020 via the Zoom online meeting platform.

In his statement, the Registrar/CEO stated that, by the time of the meeting, KMLTTB had validated and approved six (6) reverse transcription polymerase chain reaction (RT-PCR) kits and three (3) antigen kits.

He further stated that there were 6000 private and public medical laboratories recognised by KMLTTB. Of these, there were 41 COVID-19 approved testing sites, including 15 faith-based institutions, and 26 public facilities including research institutions.

Counties with approved COVID-19 testing sites were provided as follows: Nairobi, Mombasa, Machakos, Busia, Kilifi, Kajiado, Uasin Gishu, Wajir, Trans Nzoia, Nakuru, Kisumu and Kericho. And more laboratories were in the process of being audited for suitability for providing molecular testing of COVID-19 on a continuous roll-out basis.

With regards to what arrangements the Board had put in place to scale up testing across the counties, KMLTTB submitted that it was in the process of: auditing and upgrading existing sites; partnering with CPD providers to train laboratory officers in COVID-19 testing; validating and verifying in-vitro diagnostic devices for COVID-19 testing; considering novel methods for COVID-19 testing such as antigen-based rapid testing; removing taxation on laboratory commodities; and, waiving charges for all validation costs for COVID-19 kits.

With regards to what arrangements the Board had put in place to address an alleged backlog of COVID-19 testing in the counties, KMLTTB submitted that it was in the process of: assessing and upgrading more testing facilities; training the requisite personnel; deventralising COVID-19 testing to the counties; recruiting qualified and competent personnel; facilitating the adoption of antigen rapid tests and point of care platforms with short turn around times; and, twinning testing facilities within close proximity with each other. The Board further submitted that it was acting to ensure that applications for COVID-19 testing were processed in a timely and prompt manner.

For purposes of ensuring that COVID-19 tests were sensitive and specific, KMLTTB submitted that it was strictly implementing and enforcing the regulatory requirement for validation of *in vitro* diagnostic devices, as well as overseeing an External Quality Assurance program for COVID-19 testing between the National Public Health Laboratory and molecular testing sites.

Further, the Board had been granted authority by the Ministry of Trade to implement pre-shipment verification of conformity for all *in vitro* diagnostic devices to ascertain the quality of diagnostic test kits.

For purposes of clearing imported products and ensuring vigilance at ports of entry, KMLTTB called for the Board to be granted access to the single window system for Emergency Use Listing in accordance with ISO 13845, and global best practice as guided by WHO.

On the role of rapid diagnostic test kits in the COVID-19 pandemic, KMLTTB submitted that antigen rapid diagnostic tests could be appropriately deployed for use: in responding to suspected outbreaks of COVID-19 in remote settings, to support outbreak investigations, to monitor trends in disease incidence and for detection and isolation of positive cases in widespread community transmission. The advantages of antigen rapid diagnostic test kits were further provided as follows:

- Potential for use as triage tests to rapidly identify patients who are very likely to have COVID-19;
- Appropriate for use in: schools to screen pupils, students and teachers; border points for screening long truck drivers, travelers crossing border points; airports for screening pilots and air hostesses; ferry crossing points and ports; and, prisons.
- Quick and easy to perform – 15 minutes to 2 hours – and require little or no additional equipment;
- Are designed for use with individual or a limited number of samples making them more economical in low throughput laboratories;
- Timely results (a few minutes) leading to timely treatment interventions;

- Sustainability due to its low cost;
- Easy storage at room temperature for extended periods of time; and,
- Appropriate for use in remote settings.

Key limitations in the use of antigen-based rapid diagnostic test kits were outlined, including, high user dependence, poor sensitivity and false positive results.

Advantages in the use of antibody-based rapid diagnostic tests were outlined as follows: critical use in vaccine development and epidemiology and easy useability. It was however noted that antibody-based rapid test antigens had several disadvantages including: weak, late or absent antibody responses in some patients; limited diagnostic use owing to the need to allow the body mount an antibody response; cross-reaction with other pathogens leading to false-positive results and limited utility in acute illness to inform clinical interventions.

In addition, KMLTTB identified the issues and challenges that it was facing in mounting an appropriate response to the COVID-19 pandemic as follows:

1. There were competing interests between PPB and KMLTTB in the regulation of in vitro diagnostic devices;
2. Conflict of roles between KMLTTB and KEBS in the implementation of the PVOCs for in vitro diagnostic devices;
3. Lack of access to the single window system by the National Treasury; and,
4. Lack of financial support from the National Treasury.

Copies of the written submissions by KMLTTB have been attached hereto as Annex 10.

C. Health Worker Representatives at National and County Level

1. Kenya Medical Association (KMA) & Kenya Medical Practitioners and Dentists Union (KMPDU)

The Committee met with the Kenya Medical Association (KMA) led by its President, Dr. Andrew Were, and the Kenya Medical Practitioners and Dentists Union (KMPDU) led by its Chairperson, Dr. Samuel Oroko, on 19th November, 2020 via the Zoom online meeting platform.

In their submissions, both KMA and KMPDU stated that since the declaration of the COVID-19 pandemic in Kenya in March, 2020, health workers had been subjected to difficult working conditions. Further, that despite extensive engagement with relevant Government Ministries, County Governments, the Council of Governors and Parliament (Senate and the National Assembly), several human resource issues relating to doctors remained unresolved, including:

a) Provision of a Comprehensive Medical Cover by NHIF to all doctors working in Kenya;

b) Comprehensive Group Life, last expense, enhanced work injury benefits and Group Personal Accident cover for all doctors working in Kenya;

c) Employment of at least 2,000 doctors (medical officers, pharmacists and dentists) on permanent and pensionable terms;

d) Payment of call allowances to all doctors working in the MoH;

e) Payment of all applicable allowances to doctors working in University Health Service units and academic staff;

f) Enhancement of risk allowances;

g) Provision of adequate and standard personal Protective Equipment in all healthcare facilities in Kenya;

h) Immediate reinstatement of doctors in Laikipia and Kirinyaga Counties;

i) A constitutional Health Services Commission;

j) Conversion of all contractual employment terms to permanent and pensionable; and,

k) A dedicated health facility in each County for the treatment of doctors and other health workers.

They further submitted that in accordance with Article 41 of the Constitution, the union had issued a 21-day strike notice to the MoH, the 47 County Governments, health sector Semi-Autonomous Government Agencies (SAGAs), Kenyatta National Hospital, Moi Teaching and Referral Hospital, and all public universities which was set to expire on 6th December, 2020.

Copies of the written submissions by KMA/KMPDU have been attached hereto as Annex 12 and 13.

2. Kenya Association of Clinical Pathologists (KACP)

The Committee met with the Kenya Association of Clinical Pathologists (KACP) led by its Secretary, Dr. Noelle Orata, on 26th November, 2020 via the Zoom online meeting platform.

In their statement, KACP noted that PCR tests remained the gold standard in diagnosing COVID-19. However, there had been incidences of false negatives from PCR tests arising from poor specimen quality, poor transportation and early incubation period for the virus. To mitigate against false positive results, KACP recommended that all PCR testing runs should include controls, and that all laboratories should participate in an external quality assurance program, or inter-laboratory comparison.

With regard to antibody tests, KACP noted that they had limited utility in diagnosis. However, they could be used for disease surveillance, vaccine development and for identifying potential donors for convalescent plasma.

KACP further called for the adoption of telepathology in COVID-19 testing, noting that it had several benefits including: removing barriers of time and distance, addressing professional shortages, reducing disparities in access to care, improving quality of care and accountability of healthcare workers, reducing costs of delivery and improved convenience.

Noting that telemedicine was already recognised in the Kenya National e-Health Strategy, KACP called for the passage into law of Telehealth, noting that in laboratory medicine, it would allow for technologists and other health workers to access pathologists in complex cases.

In addition, KACP called for the strengthening of laboratory systems noting that there was a need for Kenya to develop the capacity to detect, investigate and report potential public health emergencies of international concern.

However, several challenges limiting the establishment of efficient and reliable health laboratory systems in the country were identified, including: empirical treatment by health workers leading to misdiagnosis, inappropriate treatment and poor patient outcomes; drug resistance; wastage of already scarce resources; poor infrastructure, lack of relevant policies and quality management systems; inadequate funding and human resources; and, uninked inter-facility services and

referral systems. Key priority areas for strengthening laboratory systems were identified as follows::

1. Integration of laboratory services and systems across the public and private sector.
2. Strengthening of human resources for laboratory systems.
3. Strengthening of national laboratory governance and management structures.
4. Strengthening of infrastructure and equipment management systems.
5. Establishment of quality management systems and accreditation.
6. Strengthening of laboratory supply chain systems.

KACP further called for the recognition of pathologists as the specialist leads in diagnostic laboratories, proper regulation of the tier system of medical laboratories, mandatory employment of pathologists, and NHIF coverage of basic tests in cancer diagnosis including immunohistochemistry and flow cytometry.

Copies of the written submissions by KACP have been attached hereto as Annex 11.

3. National and County Level Representatives for Nurses

The Committee met with national and county level nurse representatives, on 23rd November, 2020 via the Zoom online meeting platform as follows:

a) National Nurses Association of Kenya (NNAK)

b) Kenya National Union of Nurses (KNUN)

c) Kenya Progressive Nurses Association

In their statements, the nurses' highlighted the vulnerability of nurses in the COVID-19 pandemic response as frontline health workers. Noting that nurses comprised at least 55% of the reported health worker deaths attributable to COVID-19, they identified key challenges facing nurses as summarised below:

a) Lack of a comprehensive medical cover.

b) Inadequate provision of PPEs

c) Lack of workmans' compensation.

d) A risk allowance that was not commensurate to risk exposure.

e) Inadequate human resources for health.

f) Unfair contractual terms of employment.

Based on the foregoing, they made the following recommendations:

a) Ensure the provision of comprehensive medical cover for all health workers.

b) Ensure the provision of adequate and standard PPEs at all health facilities countrywide.

c) Provide for the recruitment of at least 8000 nurses on permanent and pensionable terms.

d) Compensation for nurses who had lost their lives in the line of duty.

e) Declaration of COVID-19 as an occupational hazard under WIBA.

f) Enhancement of existing risk allowances for nurses to KSHs. 30,000.00.

g) Strengthening of public health facilities to enhance quality service provision.

h) Establishment of a Health Services Commission as a constitutional body.

Copies of the written submissions by NNAK, KNUN and KPNA have been attached hereto as Annex 15.

4. National and County Level Representatives for Clinical Officers

The Committee met with national and county level representatives of clinical officers, on 23rd November, 2020 via the Zoom online meeting platform as follows:

a) Kenya Union of Clinical Officers (KUCO)

b) Kenya Clinical Officers Association (KCOA)

In their submissions, the clinical officer representatives at national and county level highlighted the following key challenges facing clinical officers in public service:

a) Refusal by the MoH and County Governments to conclude Collective Bargaining Agreement negotiations.

b) Obsolete schemes of service for clinical officers

c) Lack of designated health facilities to isolate and treat COVID-19 infected health workers.

d) Inadequate training in infection prevention and control COVID-19 protocols.

e) Lack of adequate quality PPEs with health workers being compelled to reuse N95 masks.

f) Lack of, or delayed payment of contract staff under UHC.

g) Pending promotions with many clinical officers stalling in the same job group for 6-12 years.

h) Lack of comprehensive medical cover.

i) Delayed NHIF remittances.

j) Unfair working conditions for vulnerable health workers such as pregnant women, and health workers above 55 years of age.

Copies of the written submissions by KUCO and KCOA have been attached hereto as Annex 16.

5. Kenya Health Professionals Association (KHPA)

The Committee met with the Kenya Health Professionals Association (KHPA) on 23rd November, 2020 via the Zoom online meeting platform.

In their submissions, KHPA highlighted the vulnerability of all health workers in the COVID-19 pandemic response as frontline health workers and called for fair compensation, the provision of adequate, standard and quality PPEs, and harmonisation of risk allowances across the cadres.

6. Kenya National Union of Medical Laboratory Officers (KNUMLO)

The Committee met with the Kenya National Union of Medical Laboratory Officers on 23rd November, 2020 via the Zoom online meeting platform.

In their statement, KNUMLO called for the following:

a) Recognition of their national and branch unions as a constitutional right.

b) Autonomy from the rest of the health system with an independent Director of Medical Laboratory Services at the county level due to the highly specialised nature of their work.

c) Representation of medical laboratory officers at director level at both the national and county level.

d) Special PPEs for medical laboratory officers due to their high risk of exposure to biohazardous material.

e) Payment of biosafety, security and biorisk allowances to all medical laboratory officers.

f) Enhancement of risk allowances for medical laboratory officers.

g) Payment of call and non-practicing allowances for medical laboratory staff.

h) Scaling-up of training and capacity-building for laboratory staff.

i) Enforced compliance of medical laboratory policies and standards by the MoH and County Governments.

Copies of the written submissions by KNUMLO have been attached hereto as Annex 17.

7. Environmental Public Health Association of Kenya (EPHAK)

The Committee met with the Environmental Public Health Association of Kenya on 23rd November, 2020 via the Zoom online meeting platform.

In its statement, EPHAK noted that Kenya had escaped the full brunt of the COVID-19 pandemic owing to robust preventive, protective and promotive health services. They further noted that public health officers were at the frontline of COVID-19 control efforts. On the impact of COVID-19 on public health officers, EPHAK noted the following:

a) Public health officers had experienced psychological trauma and burnout arising from their duty to supervise COVID-19 burials, and heavy workload.

b) Critical shortage of public health officers.

c) There were inadequate PPES with some counties issuing just one PPE kit per week.

d) PPEs were generally of low quality, especially face masks.

e) Poor access to COVID-19 testing by public health officers with priority being given only to symptomatic cases.

f) Lack of resources for community engagement in the COVID-19 response.

g) Outsider status in the healthcare system, and being classified as 'others'.

EPHAK therefore recommended the following:

a) Re-classify public health officers outside of 'others'.

b) Deployment of a public health officer in each sub-location, and at each health facility as a minimum requirement.

c) Scale-up training and capacity-building of public health officers.

d) Provide high-quality standard PPEs for all health workers.

e) Increase COVID-19 testing for health workers, including those who are asymptomatic.

f) Institutionalise reward and motivation mechanisms for public health officers owing to their crucial role in curbing community spread of COVID-19.

g) Sustain good hand hygiene practices beyond the COVID-19 period.

Copies of the written submissions by EPHAK have been attached hereto as Annex 18.

8. National Union of Biomedical Engineers in Kenya (NUBEK)

The Committee met with the National Union of Biomedical Engineers in Kenya (NUBEK) on 23rd November, 2020 via the Zoom online meeting platform.

In its statement, NUBEK called for increased employment opportunities for biomedical engineers countrywide, enhanced risk allowances, formal recognition of the cadre by the MoH, improved working conditions, compensation for biomedical engineers who had died in the line of duty, provision of adequate and standard PPEs to all health workers, provision of comprehensive medical cover, and the establishment of a Health Services Commission as a constitutional body.

Copies of the written submissions by NUBEK have been attached hereto as Annex 19.

9. Kenya Pharmaceutical Association

The Committee met with the Kenya Pharmaceutical Association (KPA) on 23rd November, 2020 via the Zoom online meeting platform.

In its statement, KPA highlighted the vulnerability of all health workers in the COVID-19 pandemic response, and noted that mortality and morbidity amongst health workers remained under-reported.

The KPA further noted that pharmaceutical technologists had been deliberately neglected by the MoH and County Governments, with most being overlooked in terms of motivation, recognition, fair compensation, payment of applicable allowances, provision of PPEs and capacity-building

and training. KPA further reported that its members had been subjected to delayed salaries and understaffing. It therefore made the following demands:

a) Provision of sufficient, quality and appropriate PPEs for all pharmaceutical technologists.

b) Payment of risk allowances for all pharmaceutical technologists.

c) Provision of comprehensive medical cover.

d) Provision Workman's compensation.

e) Scaling up of training and capacity-building for all pharmaceutical technologists.

f) Improvement of working conditions.

g) Recruitment of additional pharmaceutical technologists.

h) Timely and prompt payment of salaries.

i) Review of contractual terms of employment for all pharmaceutical technologists to permanent and pensionable.

j) Review of the schemes of service for pharmaceutical technologists to enhance career growth.

k) Establishment of a Health Services Commission as a statutory body.

Copies of the written submissions by KPA have been attached hereto as Annex 18.

D. Private Sector

1. Kenya Healthcare Federation (KHF)

The Committee met with the Kenya Healthcare Federation (KHF) on 25th November, 2020 via the Zoom online meeting platform.

In its statement, KHF stated that as of 24th November, 2020, Kenya had compared favourably to many developed countries in terms of total confirmed cases with 78, 512 confirmed cases against 12,829,263 in the US, 5,216,049 in India, 6,090,157 in Brazil, 2,153,815 in France, 2,138,836 in Russia and 1,606,905 in Spain. However, in East Africa, it was leading in incidence having been surpassed only by Ethiopia in the region.

With regards to the role of the private sector in the COVID-19 pandemic response, KHF submitted that it had leveraged its existing structure to mobilise a COVID-19 response team that was actively involved in engaging various stakeholders towards response efforts including the MoH, the National Emergency Response Committee and the KEPSA COVID-19 response team.

KHF further submitted that the private sector had played a role in boosting response efforts through donations to the MoH including provision of transport to health workers, provision of portable testing booths for COVID-19 mass screening, and provision of transport for pregnancy-related emergencies during curfew hours.

KHF further identified priority health sector challenges and proposed solutions in relation to the COVID-19 pandemic as follows:

No.	Key Issue	Impact	Proposed Solution
1.	Poor quality and costly PPEs by KEMSA	Use of ineffective kits and PPEs leading to high infection rates.	Need for intense post-market surveillance of PPEs to ensure effectiveness.

2.	Cartels at Afya House engaging in corrupt acquisition and sale of PPEs and other medical equipment	High costs of medical supplies and negative impact on cost and quality of care	Get rid of corruption at Afya House and KEMSA to enable efficient use of resources.
3.	Non-payment of COVID-19 related claims by NHIF, as well as delayed contracting of health facilities by NHIF.	Stranded patients at public hospitals and high out-of-pocket spending.	- Need for NHIF to clearly state how much it will cover for COVID-19 in public hospitals, and offer the same package in private hospitals. - Need for a policy document on medical insurance during pandemics. - Need for NHIF to engage contracting providers to improve services.
4.	Weak public health facilities, susceptibility of essential services during pandemics and high financial barriers to healthcare for citizens.	Poor access to health care due to overwhelmed health system overwhelmed; high costs of care	Strengthen public health system and strengthen and fund NHIF to allow for affordable and accessible services during and after COVID-19.
5.	Need for approval of the proposed digital health regulations.	High risk of improper care of patients and	Need for the MoH to fast track the endorsement and publication of the Digital Health Regulations.

		increased malpractice in the absence of guidelines, and lack of data for decision-making.	
6.	Low levels of training and capacity-building for health workers in the community	Increased risk of mortality amongst COVID-19 patients owing to lack of proper care.	Increase resources for training and capacity-building for health workers in the community; need for the MoH to scale-up training and adopt technology over in-person training.
7.	Unavailability of PPEs and community usage and home-based care.	High risk of COVID-19 infection in the community;	Need for provision of adequate PPEs for community use and home-based care.

Copies of the written submissions by KHF have been attached hereto as Annex 21.

2. Christian Health Association of Kenya (CHAK)

The Committee met with the Christian Health Association of Kenya (CHAK) on 25th November, 2020 via the Zoom online meeting platform.

In its statement, CHAK submitted that it was part of a Faith-Based Health Services Network comprising a national network of health facilities, Community-Based Health Care programmes and 38 medical training colleges and universities providing medical, nursing and health systems management programs. And further, that the Kenya Faith Based Health Services Consortium (KFHSC) was the FBO coordination framework bringing together key players including CHAK, KCCBV, SUPKEM and MEDS.

With regards to the role that CHAK had played in the COVID-19 pandemic response, Dr. Mwenda stated that it had been engaged in dissemination of messaging for COVID-19 prevention through its existing structures and health facilities.

In addition, as an FBO, CHAK had been involved in the COVID-19 response structures at national and county level. Further, CHAK had set up COVID-19 isolation units with beds and oxygen facilities, and established referral linkages with County COVID-19 response structures for referral of test samples, patients, contact-tracing and reporting of suspected and confirmed COVID-19 cases.

Several challenges facing faith-based care in Kenya were identified, including: inadequate PPEs for health workers, lack of government funding for COVID-19 mitigation, decreased utilization of health facilities due to COVID-19 containment restrictions, high incidences of COVID-19 infection amongst health workers, high levels of fear, anxiety and stigma amongst communities, poor access to, and delays in COVID-19 testing and lack of resources for contact-tracing.

To mitigate against the aforementioned challenges, CHAK requested for government support to faith-based organisations through provision of PPEs, provision of medical cover assistance for health workers, prioritization in accessing the COVID-19 vaccine and funding. He further called for prompt payment of claims by NHIF.

Copies of the written submissions by CHAK have been attached hereto as Annex 22.

3. Rural Private Hospitals Association (RUPHA)

The Committee met with the Rural Private Hospitals Association (RUPHA) on 25th November, 2020 via the Zoom online meeting platform.

In its statement, RUPHA submitted that it was a non-political association of privately owned medical centres and hospitals with a presence in 40 counties, and a membership of 160 health facilities. He further informed the Committee that of the 11,846 registered health facilities, 52% were either mission or privately-owned.

With regard to the constraints facing rural health facilities in mounting COVID-19 responses, RUPHA submitted that rural health facilities overwhelmingly depend on NHIF for financing of healthcare costs. Noting that at least 74% of Kenyans live in rural areas and rely on NHIF-accredited hospitals for medical care, RUPHA posited that with a directed economic stimulus, its membership would be able to rapidly increase its ICU bed capacity, isolation rooms and testing. They thus called for the following measures to be put in place in order to improve the liquidity of the rural healthcare facilities and safeguard access to healthcare by rural populations:

a) That NHIF, in line with the Presidential Directive (14) of 25th March, 2020, immediately pay off all pending claims;

b) That in order to ensure that no Kenyan is denied access to outpatient medical services, NHIF, in line with its contractual obligations to accredited healthcare providers, pays out capitation monies for the April-June quarter within a period of two weeks.

c) That NHIF establishes a fund to cover the cost of care for COVID-19 patients.

RUPHA also submitted that none of the current NHIF health schemes anticipate the emergence of a pandemic and its attendant costs. Further, that the NHIF Inpatient Rebate System was insufficient to cover even a fraction of the costs for ventilator/ICU support for COVID-19 patients.

Further, that in order to increase the footprint of healthcare services in the republic, it was necessary for the MoH, the Office of the Attorney General and the NHIF Board of Management to fast track the accreditation, declaration and gazettement of the close to 500 pending hospital applications countrywide. This would immediately increase the country's hospital bed capacity and create job opportunities for many unemployed health workers.

In addition, RUPHA submitted that the COVID-19 pandemic had placed enormous strain on Human Resources for Health. Noting that there was a global shortage of PPEs with many health workers succumbing to COVID-19 infection, RUPHA called for rural private and mission health facilities to be mainstreamed in COVID-19 training and distribution of PPE donations, and that interventions to train trainers drawn from private and mission hospitals commence immediately, and the Kenya Healthcare Federation to be availed resource persons, PPE donations and the fiscal resources necessary to spearhead the strengthening of HRH protection and preparedness within the private sector.

Copies of the written submissions by RUPHA have been attached hereto as Annex 23.

COMMITTEE OBSERVATIONS

The Committee made the following observations:

b) Status of National Preparedness and Response

1) The Committee noted that following the COVID-19 outbreak in Kenya, the Government instituted a dusk-to-dawn curfew on 26th March, 2020. This was followed by two subsequent extensions of the containment measures by the National Government, albeit with the relaxation of curfew hours, and travel restrictions.

2) The Committee further noted that following an upsurge of confirmed cases of COVID-19 in the months of October and November, 2020, there had been growing fears that the country was experiencing a second wave of the pandemic, and was headed for a third wave.

3) In view of the rising cases of COVID-19, the Committee observed that tighter containment measures may be necessary to break the chain of transmission, and allow for the health system to adapt and respond appropriately. However, with any restrictions to be implemented, due consideration must be given to their impact on the economy and the livelihoods of common *wananchi*.

4) In addition, there is a need for the MoH and KEMRI to prioritise and expedite the development of the ChAdOx1 nCoV-19 vaccine candidate at KEMRI. Noting that according to the MoH, the vaccine had already posted promising results during early phase trials, the Committee observed that the roll-out of a locally-produced vaccine was potentially better suited for Kenya, as well as other African countries, than other vaccines.

b) County Performance and Level of County Preparedness

5) The Committee observed that according to the MoH and KMPDC, counties had a total capacity of 7,587 isolation beds, and 319 ICU beds against a requirement of 13,144 isolation beds, and 506 ICU beds respectively.

6) The Committee further noted that according to the submissions of the KMPDC and health worker representative groups who appeared most counties remain ill-prepared for the COVID-19 pandemic as evidenced by lack of basic oxygen equipment at most county health facilities, and lack of the requisite personnel to run ICU and isolation facilities.

7) The Committee further observed that according to the testimony of the COG, most pandemic preparedness and response interventions in the counties had been hampered by lack of adequate resources owing to delayed exchequer releases from the National Treasury contrary to Article 219 of the Constitution.

c) Non-Payment of COVID-9 Related Claims by NHIF and Private Medical Insurers

8) The Committee took note that in the early stages of the pandemic, the National Government through the MoH had made a commitment to meet the cost of treatment and care for COVID-19 patients in public health facilities under the UHC Scheme within the NHIF. However, in a subsequent meeting, it vacated this position.

9) The Committee observed that in line with the Government's objective to achieve universal health coverage, there was a need for the NHIF to provide comprehensive medical cover, inclusive of COVID-19 related treatment and care, for all its beneficiaries and health workers.

10) In order to enable NHIF meet the cost burden of COVID-19 testing, treatment and care, the Committee observed that there was need for the National Government, through the National Treasury and the MoH, to facilitate NHIF in meeting the cost of COVID-related treatment and care, through the reimbursement of all pandemic-related expenses at specifically accredited hospital facilities: According to MoH and NHIF, the estimated cost implications to NHIF for COVID 19-related treatment and care (inclusive of PPEs), would be KShs. 4.82 B in the best case scenario, and KShs. 22.51 B in the worst case scenario.

11) The Committee further noted that in order to make meeting the cost of treatment more financially viable for the NHIF, there was a need for private hospitals to rationalise and reduce the cost of COVID-19 related treatment and care.

12) The Committee further noted that there was an urgent need for NHIF to approve the accreditation of the more than 500 health facilities awaiting accreditation with a view towards expanding access to COVID-19 treatment and care especially in rural, underserved areas.

13) The Committee further noted that there was a need for NHIF to ensure that health facilities are reimbursed for services rendered in a prompt and timely manner.

d) Cases of COVID-19 Infections and COVID-19 Related Deaths in Correctional Facilities

14) The Committee noted that according to submissions made by the Ministry of Interior and Coordination of National Government (MICNG), as of 10th November, 2020, out of a total prison population of 20,211, there had been 2,992 confirmed cases of COVID-19; 2,398 recoveries and 3 deaths across all prisons in the country.

15) The Committee further noted that according to submissions made by the MICNG, the total budget for COVID mitigation for KPS in the FY 2020/2021 was KShs. 200,000,000.00. However, of this, only KShs. 78,930,817.00 had been utilised owing to delayed exchequer releases.

16) The Committee further noted that the Kenya Prisons Services (KPS) had identified capacity constraints at Kenyan prisons as a key factor limiting its ability to strictly adhere to MoH protocols and guidelines for COVID-19 prevention and care.

e) Human Resources for Health Management

17) Health workers face unique challenges in relation to the COVID-19 pandemic owing to a high occupational risk of infection.

18) In response to escalating deaths amongst health workers attributable to COVID-19, various health workers including doctors, nurses and clinical officers have issued strike

notices, or otherwise threatened to strike within the immediate future owing to various unresolved and longstanding grievances.

19) Key issues and challenges raised by health workers with regard to the COVID-19 pandemic situation include but are not limited to:

l) The lack of comprehensive medical cover by the National Health Insurance Fund for all health workers in Kenya;

m) Lack of adequate compensation mechanisms for the motivation and welfare of health workers including risk allowances;

n) Severe shortages of critical health staff to run ICUs and isolation facilities;

o) Unemployment of thousands of health workers despite the critical and acute need during this pandemic period;

p) Lack of provision of adequate and quality PPEs;

q) Lack of priority testing of health workers for COVID-19 despite the high risk of infection that they face;

r) Long standing labour disputes in some counties which have resulted in poor health service delivery e.g in Laikipia and Kirinyaga;

s) Delayed salaries, and failures by County Governments to remit statutory deductions, welfare contributions, bank loans and trade union dues in a timely manner, thus causing pecuniary embarrassment to health workers, and limiting their access to credit facilities;

t) Lack of guaranteed access to treatment and care for health workers through specially designated isolation and ICU facilities;

u) Lack of adequate training and capacity building for health workers particularly in the counties;

v) Unfair and exploitative employment terms for health workers on contract;

w) Undue intimidation and harassment of health workers, especially those who have tested positive for COVID 19 etc

20) The Committee noted that most of the issues and demands raised by the health workers are reasonable, and can be amicably resolved in a prompt and timely manner provided that there is political goodwill and commitment from both the National and County Governments.

21) The Committee further noted that there may be need for a centralised, coordinated mechanism for the management of human resources for health with a view towards standardising the management of health workers across the counties, and addressing the perennial challenge of industrial action by health workers.

e) Availability of Personal Protective Equipment

22) There is an urgent need for the MoH and County Governments to act urgently to ensure that adequate quantities of Personal Protective Equipment (PPEs) are provided to counties and health facilities in accordance with their forecasted and quantified need.

23) There is an urgent need for KEMSA to immediately release the huge stockpiles of PPEs lying in its warehouses to counties for purposes of ensuring that they are able to meet the increased demand.

f) Regulation of PPEs

24) With regard to the regulation of PPEs, the Committee observed that the preclusion of PPB from regulating medical consignments at ports of entry *vide* circular, Ref. OP/CAB 9/83A, dated 4th June, 2019, had led to duplication of efforts, confusion and conflicts of mandate with KEBS.

25) The Committee further observed that the involvement of a multiplicity of agencies in the regulation of PPEs (e.g. KRA, KEBS, DCI, the Anti-Counterfeit Authority and National Police) had created regulatory inefficiencies, and hampered the work of the PPB thus hampering access to critically needed PPEs in the market.

26) The Committee further observed that there was need for the MoH to expedite the establishment of a single health regulatory body as contemplated in section 62 in the Health Act, 2017.

g) Testing and Diagnostic Capacity

27) The Committee observed that whilst KEMRI had a current testing capacity of up to 10,000 tests/day using both its manual and automated systems, it was currently operating at only 4700 tests per day owing to staff shortages, erratic supply of laboratory reagents and consumables, and lack of adequate PPEs.

28) The Committee further noted that KEMRI was operating on a budgetary deficit of approximately KShs. 790 Million being the cumulative cost of additional resources that the Institute needed for: recruitment and training of additional staff for laboratory screening, vaccine development and diagnostics (KShs. 100,156,620.00); purchase of laboratory reagents and materials for COVID-19 screening and testing (KShs. 40,000,000.00); financing of high-impact research on COVID-19 (KShs. 500,000,000.00); and, procurement of various equipment for purposes of enhancing screening capacity, kits production and vaccine development e.g. freezers, autoclaves, DNA synthesisers, protein synthesizers, Guillotine, Illimuna Sequencer and HPLC (KShs. 150,000,000.00).

h) Telemedicine/Telehealth

29) In relation to the COVID-19 pandemic, the Committee observed that telehealth/telemedicine services have the potential to create a huge impact on enhancing access to specialist services, addressing existing disparities in access to care and promoting quality affordable care.

30) Further, the Committee observed that within the current context of the COVID-19 pandemic, the adoption of technology and mobile health solutions will have the potential impact of increasing the speed and delivery of health services, while minimising risk to health workers.

COMMITTEE RECOMMENDATIONS

Based on the foregoing, the Committee recommends that:

1. The MoH and KEMRI prioritise and expedite the development and eventual nationwide rollout of the COVID-19 vaccine;

2. The National Treasury act urgently to ensure the prompt and timely disbursement of county shareable revenue in accordance with the provisions of Article 219 of the Constitution;

3. That the Senate convene a consultative forum between the COG, MOH, National Treasury, NHIF and other key stakeholders with a view towards addressing issues and challenges arising from the lack of preparedness amongst counties to respond to the COVID-19 pandemic;

4. County Governments and the COG act urgently to ensure that adequate basic oxygen equipment is made available at all Level 2, 3, 4 and 5 health facilities;

5. The MoH, COG and County Governments should act expeditiously to ensure that expanding ICU and isolation infrastructure across the counties is matched with the availability of requisite specialised personnel including ICU nurses, medical anaesthesiologists, anaesthetists etc.

6. The National Government through the MoH and National Treasury act urgently to ensure that NHIF is facilitated to meet the cost of COVID-related treatment and care for all its beneficiaries (including health workers), through the reimbursement of all pandemic-related expenses at accredited hospital facilities;

7. NHIF act urgently to ensure that it pays all pending reimbursements to health facilities in a prompt and timely manner;

8. The NHIF Board act expeditiously to process the applications of the more than 500 health facilities awaiting accreditation with a view towards expanding access to COVID-19 treatment and care especially in rural, underserved areas;

9. The MICNG and KPS act to ensure strict adherence to MoH protocols and guidelines for COVID-19 prevention and care in correctional facilities;

10. The National and County Governments act urgently to address the issues and demands raised by health worker unions with a view towards avoiding any industrial action during this critical period of the COVID-19 pandemic outbreak;

11. The MoH and KEMSA act to immediately release the huge stockpiles of PPEs lying in KEMSA warehouses to counties for purposes of ensuring that they are able to meet the increased demand;

12. The MoH, MICNG, Ministry of Trade and Industrialisation and National Treasury act urgently to harmonise the regulation of PPEs and other medical consignments at gazetted ports of entry under a single regulatory body with a view towards addressing regulatory inefficiencies, and increasing access to critically needed PPEs in the market;

13. The MoH and National Treasury act urgently to address the KSHs. 790 million budgetary deficit at KEMRI with a view towards enabling the Institute to: recruit and train additional staff; purchase laboratory reagents and materials for COVID-19 screening and testing; finance high-impact research on COVID-19; and, procure various equipment that they need.

The Committee therefore determined that:

1. This report be dispatched to the Ministry of Health for purposes of rolling-out a nationwide COVID-19 vaccination drive, and ensuring the immediate release of the huge stockpiles of PPEs lying in KEMSA warehouses with immediate effect;

2. This report be dispatched to the Ministry of National Treasury and Planning for purposes of taking the necessary steps and measures to ensure the timely and prompt disbursement of county shareable revenue in accordance with the provisions of Article 219 of the Constitution within **one (1) month** receipt of this report;

3. This report be dispatched to the Ministry of Health, Council of Governors and the 47 County Governments for purposes of taking the necessary steps and measures to ensure

the availability of basic infrastructure, oxygen equipment and requisite health personnel at all Level 2, 3, 4 and 5 health facilities with immediate effect;

4. This report be dispatched to the National Treasury, Ministry of Health and National Health Insurance Fund (NHIF) for the purposes of taking the necessary steps to ensure that NHIF is enabled to meet the cost of COVID-related treatment and care for all its beneficiaries (including health workers), through the reimbursement of all pandemic-related expenses at accredited hospital facilities; and recommend appropriate action **within one (1) months** of receipt of this report;

5. This report be dispatched to NHIF for the purpose of informing the Committee what steps and measures it intends to make to expedite the payment of all pending reimbursements to health facilities, and accreditation of the more than 500 health facilities awaiting accreditation with a view towards expanding access to COVID-19 treatment and care particularly in rural, underserved areas, and report back to the Committee within **one (1) month** receipt of this report;

6. This report be dispatched to the Ministry of Interior and Coordination of National Government for purposes of taking the necessary steps and measures to ensure strict adherence to MoH protocols and guidelines for COVID-19 prevention and care at all correctional facilities with immediate effect;

7. This report be dispatched to the Ministry of Health, the Ministry of Interior and Coordination of National Government, Ministry of Trade and Industrialisation and National Treasury for purposes of expediting the harmonisation of the regulation of PPEs and other medical consignments at gazetted ports of entry under a single regulatory body, and recommend appropriate action within two (2) months receipt of this report; and

8. This report be dispatched to the MoH and National Treasury for purposes of recommending and implementing urgent steps and measures to address the KSHs. 790 million budgetary deficit at KEMRI with a view towards enabling the Institute to: recruit and train additional staff; purchase laboratory reagents and materials for COVID-19 screening and testing; finance high-impact research on COVID-19; and, procure various equipment that they need.