Delivering Primary Health Services in Devolved Health Systems of Kenya

Challenges and Opportunities

Final Report

September 2014

Renewed focus on Primary Health care

As Kenya is going through a transformational change with the devolution and government's strong commitment to provide Universal Health Coverage (UHC) for all Kenyans, it is time to introspect how Kenya will put in place the building blocks required. We tried to reflect how Kenya can achieve this noble goal building on its primary health service delivery system.

There is strong evidence that provision of primary health care is critical for achieving the health outcomes. Selective scaling up of primary health care services was a common feature among 30 low and middle income countries that achieved highest average yearly reduction of under-five mortality and high coverage for skilled attendance at birth[1]. The family health program in Brazil helped to reduce Infant mortality rates by 13% between1999-2004[2] . The experiences shared at the recent High Level Forum on health in Kenya by Brazil also highlight the continued emphasis the country gives on primary health care despite huge decline in maternal and child mortality rates. Brazil supplements such primary health care facilities with a network of hospitals to provide referral care rather than every municipality having a specialty hospital.

Primary health care is also found to be cost efficient and improve access to basic health services, which is an important requirement for achieving UHC. A study in India has shown that an additional 2% increase in resource allocation for primary health care was associated with an increase in patient load (63.5%), cost effectiveness (50.8%), medicine supply (49.4%) and patient satisfaction (12.7%)[3]. The preliminary results from the household healthcare utilization and expenditure in Kenya (2013) also show that sustained focus on primary care in Kenya helped to double out-patient utilization in the past decade (2003-2013). Per-capita outpatient visits have increased during this period from 1.7 to 3.1. More importantly, the findings suggest that such services are more equitable and public sector facilities remain a main source (66%).

What makes Kenya different

With a population of over 40 million people, Kenya is one of the most promising democracies in East Africa and shares several common charters of its neighbors. Stubbornly high levels of maternal mortality and stunting among children are continuing more or less at the same levels over the past two decades. Non-communicable diseases in Kenya are beginning to rise and contribute to a significant part of hospital admissions. Public expenditures on health remains low and further declined from 8 to less than 5 percent due to crowding out by donors who are keen to support Kenya's efforts to control priority communicable diseases. High levels of out of pocket expenditure continue, which is inequitable and inefficient.

What makes Kenya different is the unique ability to innovate and try out homemade solutions that help the poor and its openness to promote the private sector participation in delivery of public goods. M-pesa while addressing the challenge of rural banking also provided platform for M-health. The health workers in Kenya now use smart phones to report every week the data on communicable diseases. Kenya has a thriving local pharmaceutical industry and often is the first port of call for providing referral care for

[1] Rhode et al (2008). Lancet 372: 950-961
[2] Macink et al (2007). Social Science and Medicine 65: 2070-2080
[3] Varatharajan et al (2004). Health Policy and Planning 19(1): 41-51.

serious illnesses in the East African region. The faith based organizations are well integrated with public health delivery systems, and government diligently seconded health staff and provided essential commodities to complement public service delivery in remote rural areas. Private franchises are rapidly increasing to provide quality health in rural Kenya. Both the Kenya Medical Supplies Agency (KEMSA) and the National Hospital Insurance Fund (NHIF) partner with private sector to deliver essential medicines and provide health services respectively. Finally, the new constitution of Kenya provides a clear mandate for devolution and commitment to improve health of all Kenyans.

Despite its impressive growth in the services sector, Kenya faces a number of serious problems, including widespread poverty and income inequality. While nearly half of Kenyans continue to be poor, large out of pocket payments push more Kenyan families every day into poverty. The recent policy pronouncements by the National government to eliminate payments at point of delivery for public primary health care and free maternity services at all public facilities are in the right direction and meet the priority needs of Kenyans. But the challenge remains in their effective implementation as Kenya still struggles to provide access to basic health care services for its growing population, especially those living in rural communities and the densely populated urban slums.

Kenya's re-focuse on improving delivery of Primary Health Services

Effective delivery of primary health care services requires four important inputs. Availability of a network of facilities and making the network functional with competent and motivated staff, supplies of essential medicines and ensuring funds for operation and maintenance reach the facilities in time. The separation of Ministry of Health and creation of the Ministry of Public Health and Sanitation in 2007 provided renewed focus on primary health care in Kenya, which got further boost with the Economic Stimulus Package.

The Government of Kenya introduced the Health Sector Services Fund (HSSF) launched in 2010 to expand the supply of health care and strengthen primary health care. The HSSF aims to improve the delivery of quality essential health services in an equitable and efficient manner as envisaged by Kenya Vision 2030 (Kenya's development program covering 2008 to 2030), the Kenya Health Policy framework 1994–2010, and the Ministry of Public Health and Sanitation Strategic Plan 2008–2012. This initiative was a direct policy response by the Government of Kenya to the findings of the Public Expenditure Tracking Survey of 2005, that little or no funds provided for the primary health facilities actually reach them and, as a result, the delivery of health services is adversely affected.

The HSSF is an innovative financing approach to health services provision in Kenya. It is a revolving fund that provides direct cash transfers to primary health care facilities that include dispensaries and health centers. The local communities represented by the Health Facility Management Committee (HFMC) manage the funds received and prioritize their use responsive to their health needs. The HSSF mobilizes additional resources from the government and its development partners to improve service delivery. It ensures expeditious and direct cash transfers to primary health facilities run by the government and faith-based organizations, and supports an equitable distribution of resources. More important, the HSSF empowers local communities to take charge of their health by actively involving them through the HFMCs in the identification of their health priorities, and in planning and implementation of initiatives responsive to the identified priorities. The program also has a strong focus

on better accountability in the use of resources provided through both grants and those generated through cost sharing. Thus, the HSSF is well aligned with the principles of devolution and access to services as described in Kenya's constitution, which expects the state to ensure reasonable access to its services to all parts of the republic.

The HSSF program has been expanded to all Government primary health care facilities and is currently covering 787 health centers and 2,427 dispensaries. As per the information provided by the HSSF Secretariat, the fund that has so far been disbursed is K.Sh 1.695 billion (about US$20 million) and K.Sh 757 million. out of this was disbursed to GoK levels 2 and 3 facilities during FY2012-13. Some visible improvements in the service delivery at the health facilities was noted by the independent Citizen's Report Card exercise undertaken by Family Care International (October 2012) in Kitui and Nakuru

Figure 1. Availability of work plans and facility management committee

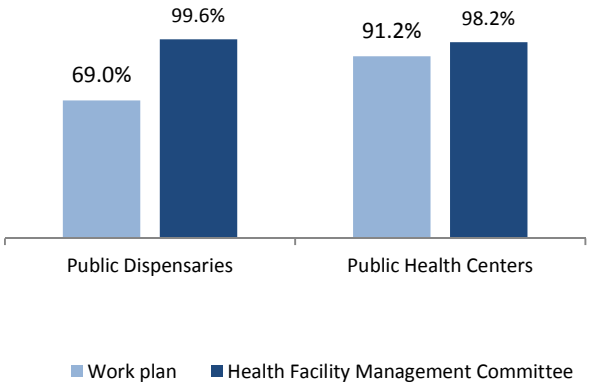
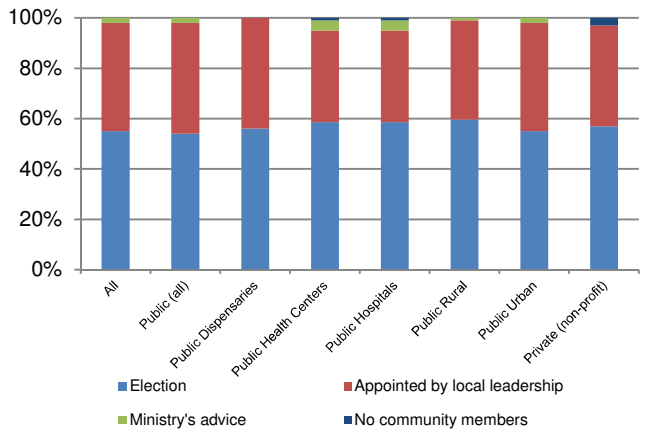


Figure 2. A health facility board displaying expenses and revenue sources

Counties. A majority of the 599 clients interviewed stated that the overall quality of service, waiting time, cleanliness and the state of the health centers had improved compared to the past one year.

A recent public expenditure tracking survey covering randomly selected health facilities undertaken by the Kenya Institute for Public

Figure 3. Selection of Facility Management Committees



Policy and Research (KIPPRA) as a part of the Public Expenditure Tracking and Service Indicators Study for the MoH has shown that a majority of the sampled public health centers (95%) and over three fourths of the public dispensaries (75.7%) received HSSF grants and 92% and 69% of health centers and dispensaries had annual operational plans in place (Figure 1). This trend could be due to the fact that the inclusion of public dispensaries started only in 2012. All sampled public dispensaries started receiving the HSSF grants only in FY 2012-13. Most (98%) of the primary health facilities had health facility management committees (HFMCs) in place and over half of such committees were elected (Figure 3). The HFMCs in over 80% of sampled public primary health facilities met every quarter. Over three fourths of the facilities (77%) disclosed financial information to the public (Figure 2) and there is nearly 20% lesser probability of receiving funds if a facility failed to submit quarterly financial reports suggesting that the HSSF program has put in place some internal controls. However, the study identified the need to strengthen financial record keeping at the facility level. Over a quarter of dispensaries and about a tenth of the health centers did not have proper records.

The Pull System of Supplying Essential Medicines and Medical Supplies

The "pull system" is a demand-based approach for ensuring the reliable availability of health commodities at all service delivery points within a health system. In Kenya, under the National Health Sector Strategic Plan II (2005–2012) the government (Ministry of Health) has established virtual "drawing rights" for health facilities to move toward the "pull" system of supply in which facilities order their required supplies and commodities based on actual need rather than receiving centrally determined numbers of medicine kits (referred to as the "push" system of supply).

Each public dispensary and health center has annual drawing rights established by the ministry through the above-mentioned resource allocation criteria. In 2011–12, new resource allocation criteria for rural health facilities were developed, and the allocation of drawing rights is done at two levels—national to district and district to health facilities. National to district: Allocation criteria are based on district workload, district population, number of dispensaries and health centers in the district, and the district poverty index. Each component has individual weights. District to facility: The allocation criterion is primarily based on the facility workload.

By 2013, all public primary health care facilities in Kenya were covered by the "pull system" of supply with the facilities making orders based on their drawing rights. The Kenya Medical Supplies Authority (KEMSA) supplied the facilities based on their orders placed using commodities procured under the GoK funds provided under the Economic Stimulus Package and IDA through the Kenya Health Sector Support Project (KHSSP). The MoH reimbursed KEMSA based on documented evidence of supply to primary

health facilities (proof of deliveries) using GoK and DANIDA funding. The reimbursement to KEMSA aims at establishing a pool of fund for supplying EMMS to primary health care facilities. Out of the total invoices of K.Sh2.7 billion raised by KEMSA, the MoH has reimbursed K.Sh1.6 billion. A case study undertaken by the World Bank assessed the effect of the reform process in improving the provision of essential medicines to poor counties. This was done by regressing KEMSA supplies with district level poverty data. The study has shown that per capita value of supplies made by KEMSA were marginally higher in districts with highest proportion of the poor (75%) compared to districts where about a quarter of the population was living below poverty line (K.Sh99 vs. K.Sh86). However, the study has shown that it costs KEMSA more to ship supplies to poorer districts compared to better-off districts, probably due to dispersed location of facilities in such districts. Finally, determining the drawing rights based on utilization trends could be disadvantageous to poorer districts with dispersed populations having limited transport access to fixed health facilities. While the study advises caution in drawing policy conclusions, it provides some useful leads such as: (a) need for budgeting higher transport costs for poorer districts; and (b) linking supply chain to community strategy in the poorer districts where communities are more widely dispersed with limited transport to access fixed health facilities.

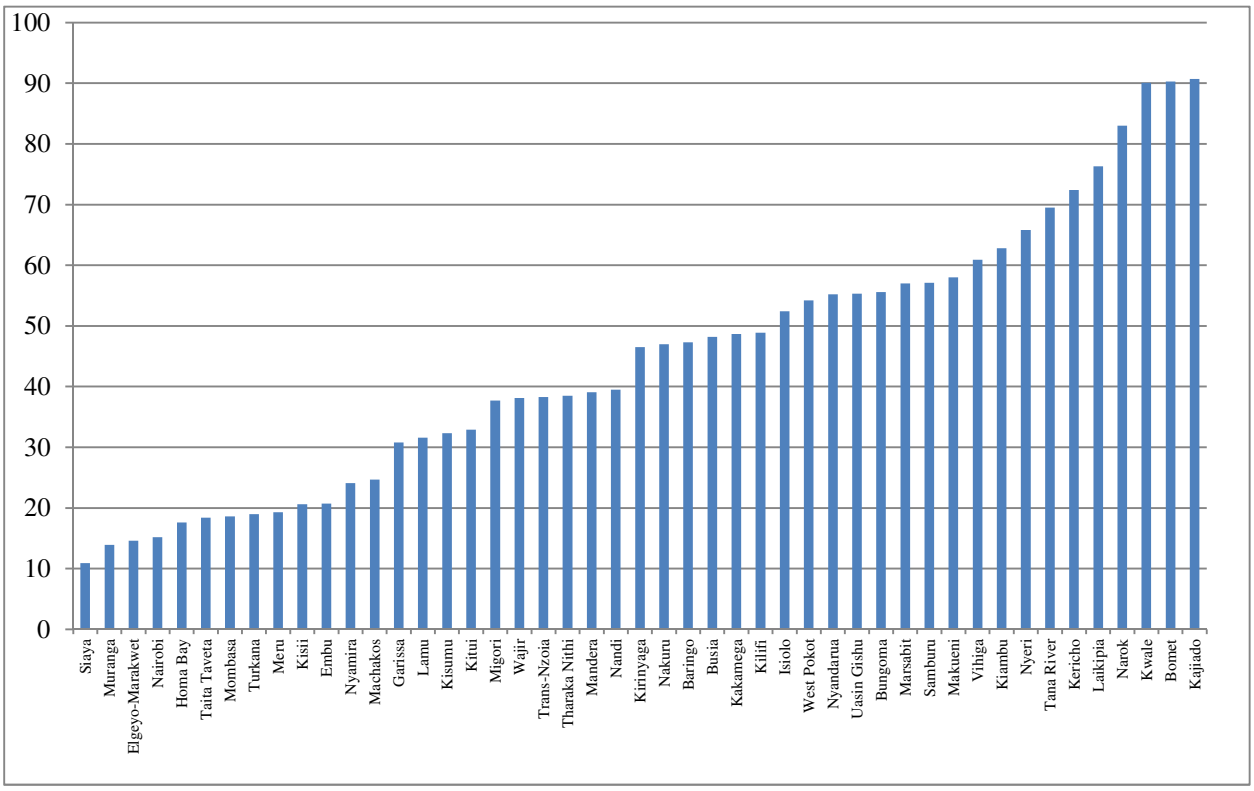
Reforms were also undertaken to improve Human Resources for Health (HRH) with the launching of a new HRH strategic plan. A devolved recruitment was undertaken with the resources made available through the government's fiscal stimulus package. The districts were authorized to recruit the staff and over 3000 nurses were recruited. In addition, contract staff provided by Development Partners has been deployed to the most deprived, underserved provinces. Staff were also seconded to Faith based Organizations (FBOs) by the Ministries of Health. The contract health workers have helped improve the service coverage and quality of care. However, shortfalls remain among nurses, clinical officers, and laboratory technicians in many deprived districts.

Thus, some sincere efforts were made by the Government of Kenya to improve the delivery of primary health care services.

Kenya's improvement on delivery of primary health services in a devolved health system

Several challenges in delivery of primary health care services still persist in Kenya. As done by several other low and middle income countries, Kenya can get better value for money by first focusing on making existing primary health facilities functional to deliver quality health services. While the county fact sheets suggest that over a tenth of the existing primary health care facilities are non-functional, the real situation appears to be worse. Further, there is lack of data on functionality of over one thousand primary care facilities built under the Constituency Development Fund.

Figure 4. Distribution of counties by share of health facilities ready to offer Basic Emergency Obstetric Care



The recent policy to offer free maternity services at all public health facilities is a step in the right direction to improve access to skilled care at child birth, which is known to reduce maternal deaths and thereby achievement of MDG4. However, the Service Readiness Assessment Survey[4] suggests wide variation in proportion of health facilities offering basic emergency obstetric care[5] across counties. Basic emergency obstetric care is much easier to offer compared to comprehensive emergency obstetric care which requires specialists, equipment, blood storage and an operation theatre.

[4] Ministry of Health (2013). Kenya Service Availability and Readiness Assessment Mapping.

[5] A facility that offers parental antibiotics and uterotonic drugs, parental anti-convalescents for eclampsia and pre-eclampsia, manual removal of placenta, removal of retained products, assisted vaginal delivery and basic neonatal resuscitation. Monitoring Emergency Obstetric Care –A hand book WHO, UNICEF, UNFPA and AMDD -2009 ISBN 978 92 4 154773 4

Figure 2. Know do gap by type of providers

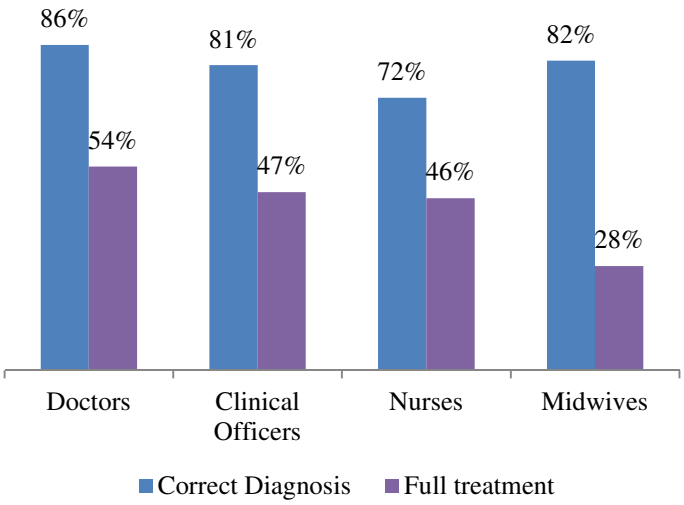
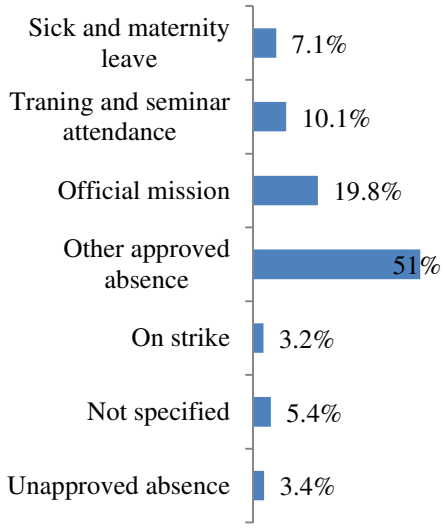


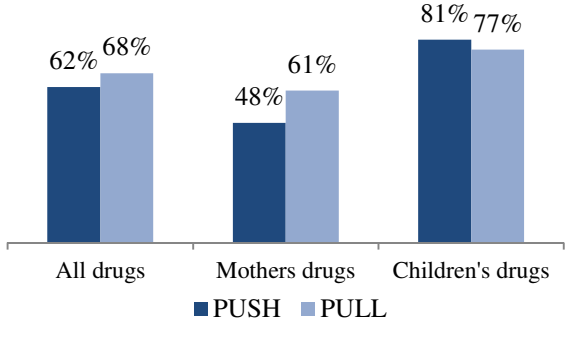
Figure 6. Reasons for authorized absence



The recent public expenditure tracking survey[6] has shown that Kenyan health providers have much better knowledge compared to several other countries in the region (Figure 5). Nearly 80% of health staff could correctly diagnose five common health conditions and are aware how to manage them. But, such knowledge is not optimally getting translated into service delivery as only 40% of them were actually offering full treatment. Similarly about a third of health staff are absent on a day of unannounced visit and over 80% of such absences were authorized (Figure 6).

As it could be seen from the Figure 6, about 7% of the staff were sick or on maternity leave, nearly a tenth were attending trainings or seminars and about a fifth were on official duty. However, there was no clear reason for nearly half of the staff on authorized absence.

Figure 7: Drug Availability



The same survey has shown that nearly two thirds of facilities had essential drugs and supply was marginally better among facilities under pull system (Figure 7). Generally facilities had better availability of essential medicines for childcare compared to maternal care. However, the pull system seemed to have helped to improve the supply of drugs for maternal care.

[6] Health Service Delivery Indicators and Public Expenditure Tracking In Kenya, 2012 (Pets *Plus*)

A recent assessment of technical efficiency of health facilities [7]suggests that generally public primary health centers are more efficient in service delivery, but less than half of the dispensaries need to improve their services.

Quick wins for improving delivery of primary health care services in devolved health systems:

1. **Make existing public primary health care facilities functional**. The devolution provides a unique opportunity to strengthen primary healthcare service delivery. With counties now responsible for delivering primary health care services there is hope that some of the chronically persisting weaknesses to make the existing facilities operational will be addressed. By the end of the first year of devolution some of the initial gains made in improving delivery of primary healthcare services are clearly visible. For example, the Governor of Mandera has taken the initiative to make all 52 primary healthcare facilities in the county operational by recruiting staff. The Governor of Machakos is focusing on improving access to safe delivery services by providing maternity units to all primary health care facilities and positioning ambulances in each ward. Kakamega is giving strategic focus on improving maternal and new born health services. There are several ongoing initiatives in many counties, which are not yet systematically documented. Many counties have undertaken audits of human resources to weed out ghost workers. It is also expected that with the closer oversight, the absenteeism of health staff will reduce.
2. **Fill existing gaps to improve access to Basic Emergency Obstetric care.** The first priority is to make primary health centers and dispensaries with maternity wards to offer basic emergency obstetric care before developing new infrastructure. The Governors and County Chief Executives of Health need to give priority attention to address the existing gaps including effectively coordinating support from partners in their respective counties to achieve this objective. Most primary health centers have 20-30 beds, which are grossly underutilized. Therefore the option of using some beds for servicing pregnant women as maternity waiting beds could be an option, especially in counties where road connectivity is poor and the newly purchased ambulances in some counties cannot reach many locations.
3. **Build on existing partnerships with FBOs and partner with the private sector**. As explained earlier, there is already a strong partnership with FBOs, which complement public health facilities. Counties need to build on this well established relationship. Kenya has a vibrant private sector which is rapidly expanding to rural areas through franchised networks. It is important to effectively leverage such networks for public goods, especially for delivering reproductive maternal, newborn and child health services.

[7] Prof. Urbanus Kioko, The High Level Forum on Health, March 2014, Nairobi, Kenya

4. **Continue HSSF but shift emphasis on accountability to results.** Performance accountability remains corner stone for the devolved health system in Kenya. This now needs to trickle down from top management to sub-county health teams and facility in charges. The experiences of the Results Based Financing pilot in Samburu shows that objective assessment of performance through regular supportive supervision enhances motivation of providers as well as supervisors and improves retention.
5. **Rationalize Hospital infrastructure.** Hospitals are expensive to build and maintain. Countries in central Asia and Brazil realized the importance of rationalizing hospital infrastructure and created hospital networks that optimize efficiency. Clusters of counties now need to collectively work together to develop a well networked hospitals which provide high quality referral back-up to primary care facilities.
6. **Maintain commodity security.** All counties have entered into a Memorandum of Understanding with KEMSA or Mission for Essential Drugs and Supplies (MEDS) an agency which does pooled procurement for FBOs. This will ensure better economies of scale and quality of essential medicines. The KEMSA has now moved into a supermarket mode and entered into memoranda of understanding with all 47 counties. An analysis of ordering patterns showed that 27 out of 44 counties, which ordered from the KEMSA in the 1st quarter of 2013/2014 ordered 50% or more of supplies made to primary health care facilities (Figure 8). While this is a positive trend, more careful security is required by the MoH to carefully track these trends and also compliance with essential drug list.

Figure 8: County share of allocations made to primary health facilities in Q3 of 2011/12, 2012/13 and 2013/14