# Moving toward UHC

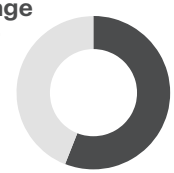
## Kenya

NATIONAL INITIATIVES, KEY CHALLENGES, AND THE ROLE OF COLLABORATIVE ACTIVITIES

# Kenya's snapshot

**UHC Service Coverage Index** *(SDG 3.8.1, 2015)*

56%



**Catastrophic OOP health expenditure incidence at the 10% threshold** *(SDG 3.8.2, 2005)*

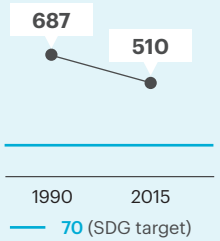
5.8% of households

**Results of Joint External Evaluation of core capacities for pandemic preparedness** *(JEE, 2017)*

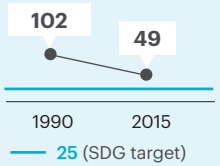
| Score (for capacity) | | # of indicators (out of 48) |
|---|---|---|
| 5 | Sustainable | 0 |
| 4 | Demonstrated | 7 |
| 3 | Developed | 15 |
| 2 | Limited | 22 |
| 1 | No capacity | 4 |

## Health results

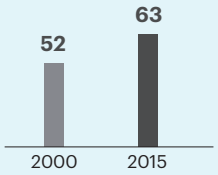
**Maternal Mortality Ratio** *(WHO)*
Per 100,000 Live Births




**Under-Five Mortality Rate** *(WHO)*
Per 1,000 Live Births




**Life Expectancy at Birth** *(WHO)*




**Wealth Differential in Under-Five Mortality** *(PHCPI, 2008)*

**27.8**

More deaths in lowest than highest wealth quintile per 1,000 live births

## Performance of service delivery – selected indicators

*(PHCPI, 2013-2015)*

| | Kenya | LMIC average |
|---|---|---|
| Care-seeking for symptoms of pneumonia | 65.7% | 61.5% |
| Dropout rate between 1st and 3rd DTP vaccination | 7.3% | 7.5% |
| Access barriers due to treatment costs | 36.7% | 47.4% |
| Access barriers due to distance | 22.7% | 35.8% |
| Treatment success rate for new TB cases | 87% | 80.1% |
| Provider absence rate | 27.5% | 28.9% |
| Caseload per provider | 15 per day | 9 per day |
| Diagnostic accuracy | 72.2% | 47.9% |
| Adherence to clinical guidelines | 43.7% | 33.6% |

*See page 8 for References and Definitions.*

# Existing national plans and policies to achieve universal health coverage (UHC)

## SERVICE DELIVERY REFORMS

In line with the Constitution of Kenya (2010) and Kenya Vision 2030 long-term development goals, Kenya is committed to achieving UHC and providing quality health care for all. The Kenya Health Sector Strategic and Investment Plan 2014–18 defines health system strengthening priorities to achieve these objectives. Key investments are necessary to (i) build a robust and resilient health system that can withstand the shocks of disease outbreaks and address the epidemiological transition, and (ii) ensure critical enhancements in health information systems to measure health system performance as well as generate data for evidenced-based reforms.

To enable Kenyans to realize their constitutional right to health, the government of Kenya (GoK) is prioritizing universal access to primary care with a focus on reproductive, maternal, and newborn health services. An essential package defines services that should be available to the population, and efforts have been made in recent years to broaden the range of services. The GoK has also invested in the District Health Information System 2 (DHIS2) platform, which is the main database where both private and public health facilities are required to enter monthly data on service delivery. Information can be analyzed and aligned with other databases and sources of information (for example, the World Bank SDI program) to track progress. There have been efforts to introduce electronic systems at the point of care to streamline management and make information on quality of care available.

## HEALTH FINANCING REFORMS

The government of Kenya has instituted a number of reforms to improve health financing and financial protection. These include:

- National Hospital Insurance Fund (NHIF): Established in 1966, this currently covers both formal and informal workers (20% of the population). The government has revised the contribution rates for the first time in 25 years and expanded the benefit package to include outpatient services as well as coverage for selected noncommunicable diseases.

- Health Insurance Subsidy for the Poor (HISP): To extend financial protection to Kenya's poorest citizens, the government launched the HISP pilot in 2014. This program provides a comprehensive package of outpatient and inpatient services to the neediest families in Kenya, both in public and accredited private facilities.

- Health Insurance Programme for the Elderly & People with Disabilities: This scheme is based on a cash transfer program. An annual budgetary allocation of 500 million Kenyan shillings is provided by the government to purchase health insurance coverage through the NHIF. Beneficiaries are entitled to a package similar to those of formal employees covered by the NHIF.





- Free maternity services and removal of user fees at the primary level. The government has also removed user fees in all public dispensaries and health centers, and maternity services are provided for free in public and contracted private facilities (both for-profit and not-for-profit).

## GOVERNANCE REFORMS

Kenya has recently gone through a rapid devolution. The Constitution of Kenya devolved power and accountability to deliver essential health services to its 47 county governments and provided for transfer of about two-thirds of the health budget to counties as part of their equitable share of national revenue. Counties are now responsible for deciding how much to allocate to the health sector and how to spend these resources in the delivery of health services.

The Health Act passed in 2017 aims to further streamline service delivery systems, and there is significant emphasis on coordination between the national government and county health systems. The Act also provides for the establishment of public-private partnerships in the health sector and for financing to support progressive financial access to UHC, while ring fencing the funds for health.

# Key challenges on the way to UHC

## WEAKNESSES AND BOTTLENECKS IN SERVICE DELIVERY

**Coverage of essential health services.** Although Kenya has shown improvement in the coverage of essential health services, important gaps persist. Disparities between urban and rural communities are stark for access to family planning, antenatal care services, and vaccination coverage, which remains too low overall. These gaps underscore the need for increased investments in service delivery and broader coverage to promote greater equity in access to care.

**Quality of care.** The World Bank (WB) Service Delivery Indicators (SDI) program (2013) showed high provider absence (28% on average) from health facilities and low adherence to clinical practice guidelines, including for the management of maternal and neonatal complications (only 44% of providers followed the guidelines approved by the World Health Organization). In addition, there were deficits in commodities and infrastructure: essential drugs were available in only 67% of facilities; a fourth of all facilities lacked minimum pieces of basic equipment such as a thermometer, scale, or sterilization equipment; and almost half of dispensaries lacked basic infrastructure (clean water, adequate sanitation, and electricity).

**Pandemic preparedness.** While pandemic preparedness in Kenya is relatively advanced, Kenya has a wide range of challenges, as demonstrated through the Joint External Evaluation (JEE) conducted in March 2017. The JEE revealed strengths in areas such as: laboratory testing for detection of priority diseases; indicator- and event-based surveillance systems; analysis of surveillance data; and national vaccine access and delivery. This evaluation also emphasized continued challenges in a number of areas, including in preparedness; notably, Kenya lacks a multi-sectoral and multi-hazard public health emergency plan, which could guide efforts to bolster both public and animal health systems against the threat of disease outbreaks and pandemics. A wide array of recommendations is proposed, including fast-tracking the completion, testing, and dissemination of the all hazards plan aligned with the National Disaster Management Unit's Emergency Response Plan.

## HEALTH FINANCING CHALLENGES

Public health expenditure, as of 2012–13, was 6.1% of total government expenditure (Kenya National Health Accounts, 2012–13), which is still comparatively low. While the government contribution has increased, available resources remain limited vis-a-vis current and future needs. Out-of-pocket (OOP) payments are a major barrier to access and push close to two million Kenyans into poverty. Co-payments do not reflect patients' ability to pay. Fragmented health financing arrangements create challenges for pooling, increase costs for administration, and incentivize inefficiencies. Purchasing arrangements are largely passive; there is no purchaser-provider split and provider payments are ill defined.

## GOVERNANCE CHALLENGES

**Challenges linked to devolution.** Devolution presents significant governance challenges for the health sector. The national government provides conditional grants to counties with level 5 hospitals to compensate for services rendered to people from other counties; however, compensation is far below past levels and does not match actual needs. In addition, other conditional grants from the national government, including reimbursements for removing user fees in primary care facilities and providing free maternity services—initially channelled directly to facilities—are currently transferred through the county revenue fund (CRF). Such an arrangement, although aligned to the country's Public Financial Management Act and the Constitution, potentially leads to delays in funds transfers and undermines service delivery.

**Health Management Information Systems (HMIS).** In Kenya, as in many low and middle income countries (LMICs), the HMIS is not fully developed and does not allow for full monitoring and assessment of progress. Household surveys provide population-level estimates and enable disaggregation by socioeconomic status, but are periodic and expensive. In addition, facility surveys are carried out to provide the full picture of service provision at the facility level. Although these databases and surveys provide useful data, better value could be generated by integrating and strengthening capacity for timely generation and use of quality data.

# Collaborative efforts to accelerate progress toward UHC

## EXISTING INITIATIVES SUPPORTED BY EXTERNAL PARTNERS

There are several partners engaged in Kenya to support the attainment of UHC, including building resilient health systems and strengthening monitoring and evaluation of health system performance. These partners providing support to the government of Kenya include the Tokyo Joint UHC Initiative, supported by the government of Japan and led by the World Bank (WB), in collaboration with the Japan International Cooperation Agency (JICA), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO). Additionally, the U. S. Agency for International Development (USAID), the German Agency for International Cooperation (GIZ), the German Development Bank (KfW), and the Korean government are all significant partners in this agenda.

Existing initiatives also include the UN H6 initiative in counties with the highest burden of maternal mortality. This initiative focuses on improving health systems to deliver integrated reproductive, maternal, newborn, child and adolescent health (RMNCAH), with a focus on referral systems, demand creation for utilization of RMNCAH services, improving quality of care through routine inspection and supervision, nursing and midwifery trainings, and improvement of vital statistics.

The Global Financing Facility (GFF), a multi-stakeholder country-led partnership, is working with key stakeholders to improve coordinated investments in RMNCAH and monitor results. The GFF uses RMNCAH as an entry point to UHC by ensuring that all women, children, and adolescents can have healthy and productive lives and aims to align donors around the shared vision of UHC. The GFF also supports domestic resource mobilization through the GFF Trust Fund cofinanced project, encouraging county governments to allocate at least 20% of their budgets to health.

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## PLANS FOR FUTURE COLLABORATIVE WORK

### Policy and Human Resources Development (PHRD)-funded advisory support

In Kenya, the joint work under the Tokyo Joint UHC Initiative will focus primarily on two key areas. The first area is addressing key gaps in HMIS by undertaking a combination of advisory and analytical services to inform the design of a strengthened and better integrated monitoring and evaluation system. Activities will include: a critical analysis of various routine and nonroutine HMIS and other data sources from an interoperability perspective; analytical work and advisory services to inform the design of an interoperability platform; and knowledge sharing and dissemination. The second area is strengthening health system resilience through support to the government to develop and cost the first multi-sectoral pandemic preparedness plan, which will provide a framework for how Kenya can increase investments in both public and animal health to ensure that it is better prepared to prevent, detect, and respond to disease outbreaks and pandemics. This activity will also involve the establishment of a national multi-sectoral governance framework to improve national- and county-level capacity for coordinating and implementing the plan. Furthermore, the joint work will closely cooperate with other investments in health, such as the Global Fund and Gavi, to contribute to health system strengthening. Considering that other sectors such as nutrition and water and sanitation compose the foundations of heath for all, challenges in these fields also will be considered under the joint work. Future efforts can build on initial work, to generate evidence for mobilizing resources, including under IDA 18.

## References & Definitions (page 1 indicators)

***UHC Service Coverage Index (2015)*** – WHO/World Bank index that combines 16 tracer indicators into a single, composite metric of the coverage of essential health services. For more information: WHO/World Bank (2017). Tracking UHC: Second Global Monitoring Report.

***Catastrophic out-of-pocket (OOP) health expenditure incidence at the 10% threshold (Single data point, year varies by country)*** – WHO/World Bank data from Tracking UHC: Second Global Monitoring Report (2017). Catastrophic expenditure defined as annual household health expenditures greater than 10% of annual household total expenditures.

***Results of the Joint External Evaluation of core capacities for pandemic preparedness (2016/17, year varies by country)*** – A voluntary, collaborative assessment of capacities to prevent, detect, and respond to public health threats under the International Health Regulations (2005) and the Global Health Security Agenda. 48 indicators of pandemic preparedness are scored using five levels (1 is no capacity, 5 is sustainable capacity). https://www.ghsagenda.org/assessments

***Life Expectancy at Birth (2000-2015), Maternal Mortality Ratio (1990-2015), Under-five Mortality Rate (1990-2015)*** – WHO Global Health Observatory: http://apps.who.int/gho/data/node.home

***Wealth Differential in Under-five Mortality (Single data point, year varies by country)*** – Indicator used by the Primary Health Care Performance Initiative (PHCPI) to reflect equity in health outcomes. For more information: https://phcperformanceinitiative.org/indicator/equity-under-five-mortality-wealth-differential

***Performance of service delivery – selected indicators (Single data points, years vary by country)*** – Indicators used by the Primary Health Care Performance Initiative (PHCPI) to capture various aspects of service delivery performance. PHCPI synthesizes new and existing data from validated and internationally comparable sources. For definitions of individual indicators: https://phcperformanceinitiative.org/about-us/our-indicators#/


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