Improving Health Outcomes and Services for Kenyans

Sustainable Institutions and Financing for Universal Health Coverage

Kenya Health Policy Forum

18-20 March, 2014, Windsor Hotel, Nairobi

FINAL REPORT ON THE PROCEEDINGS

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Abbreviations

EMMS	Essential Medicines and Medical Supplies
FBOs	Faith Based Organizations
HLF	High Level Forum
HSSF	Health Sector Services Fund
KEMSA	Kenya Medical Supplies Agency
KENAS	Kenya Accreditation Services
KQMH	Kenya Quality Model for Health
LMICs	Low-and-middle income countries
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoF	Ministry of Finance
NCDs	Non Communicable Diseases
NHIF	National Hospital Insurance Fund
OOP	Out-of-pocket
PETS+	Public Expenditure Tracking and Service Delivery Indicators Survey
PPP	Public Private Partnership
THE	Total Health Expenditure
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WBG	World Bank Group

I. EXECUTIVE SUMMARY

Kenya is currently going through transformational changes in its health system with the ongoing devolution and strong commitment shown by the Kenyan Government to achieve Universal Health Coverage (UHC). The Kenyan Ministry of Health (MoH), in collaboration with the World Bank Group (WBG) and United States Agency for International Development (USAID), convened the Kenya health policy high level forum (HLF) in March 2014 to share national and international experiences and find options for achieving UHC. The HLF specifically focused on four themes:

- Delivering services to improve health outcomes among women and children, with emphasis on poorer segments of the population;
- Enhancing governance and effectiveness of the health system to deliver quality health care in a devolved setting;
- Ensuring sustainable health financing to achieve UHC; and
- Promoting client safety and quality of health care.

The forum was guided by the following principles:

- Leadership by Kenyan experts and institutions with global experts and institutions sharing knowledge and experiences;
- Learning with emphasis on practical know-how from countries with devolved health systems (e.g., Brazil, Ghana, India etc.); and
- Providing analytical and advisory inputs to inform pros and cons of different options, and ensuring that choices are compatible with the Kenyan context.

The HLF brought together Kenyan and international experts to share their hands-on experiences to help Kenya in identifying options that will ensure sustainable institutions and financing to achieve UHC. Representatives from national and county levels of Government actively participated in the HLF and experiences from Brazil, Ethiopia, Ghana, India and Mexico provided insightful directions for Kenya. The high level participation from the WBG, USAID and other key partners supporting the health sector reflects strong commitment from development partners to support Kenya's vision to achieve UHC.

KEY MESSAGES AND POLICY OPTIONS FOR THE MoH

SERVICE DELIVERY

Key messages:

1. Over 60% of Kenyans use public primary health care services, which are most equitable.
2. Ensuring functional primary health care system that delivers quality essential health services remains most critical for achieving UHC and improving health outcomes.

3. There is need for transparent and timely information that provides credible data on service delivery.
4. The Kenyan public hospitals need to improve their efficiency. Networking of public hospitals would help to rationalize resources and strengthen referral.
5. Kenya is uniquely placed to harness partnership with the private sector to improve service delivery.

Policy Options:

1. Focus on improving the delivery of primary health care services with county health teams taking lead, working in close partnership with the National Government, to address specific gaps in service delivery identified by the recent Service Readiness Assessment and the public expenditure tracking and service delivery indicators survey (PETs+), for achieving Vision 2030 and Millennium Development Goals (MDGs).

2. Develop an investment case and seek additional resources, both domestic and donor, to make existing primary health care services fully functional in all counties.

3. Introduce Conditional Grants to counties linked to improved delivery of primary health care.

4. Optimize hospital efficiency through networking and effective referral systems. Additional investments in hospitals should be linked to improved efficiency and access to underserved populations.

5. Develop a roadmap in consultation with counties to sustain ongoing successful engagement with faith based organizations (FBOs) in the devolved health system.

6. Build on the existing dialogue with the private sector healthcare providers and test different models of public private partnerships (PPP) to inform appropriate policies and regulatory frameworks.

HEALTH FINANCING

Key Messages:

1. Healthcare utilization in Kenya is improving but out of pocket (OOP) expenditure continues to be high, which is inequitable and inefficient.

2. Each country needs to evolve a health financing system relevant to its context and sustainable for achieving UHC.

3. Tax based financing from domestic resources will be necessary to subsidize the poor and informal sector to reduce inequities.

4. Fiscal space is limited and there are competing demands which pose an important constraint for achieving UHC.

5. UHC requires strong political commitment and leadership. Kenya currently has both, which provides a unique window of opportunity.

6. UHC cannot be achieved without effective and transparent institutions and strong regulatory systems providing oversight. High administrative costs are not desirable in UHC.

Policy Options:

1. Provide leadership to finalize the healthcare financing strategy and prepare a roadmap for UHC, describing the milestones and targets.

2. Start with a small benefit package that is affordable, and ensures access to quality basic health services for all.

3. Ensure sustainable domestic financing by demonstrating efficient use of budgeted resources and seek additional resources from both the Government of Kenya and partners by demonstrating tangible results.

4. Proactive engagement of MoH with the Counties and the National Treasury is essential to get more domestic resources for health including innovative approaches for raising revenues.

5. Reform and regulate National Hospital Insurance Fund (NHIF) to provide a strong institutional base for achieving UHC with improved legal framework and required capacity, especially information technology for claim processing and rationalizing human resources to effectively play its role.

DEVOLUTION

Key messages:

1. Devolution requires good understanding of the change process and new roles and responsibilities. This will involve building relationships and finding accountable ways of working together by all stakeholders at both levels of government.

2. The two levels of government should maintain a well-coordinated health system guided by the national priorities as identified by country's health policy and strategic vision to achieve national and global commitments such as Vision 2030 and MDGs.

3. Timely supply of quality commodities is essential for delivering quality health services. Most public procurement and supply chain management systems face

challenges in timely flow of finances, poor demand forecasting and weak supply chain management.

4. A shorter cycle for ordering and fewer layers in distribution help to improve forecasting and availability of commodities at health facilities.

5. Implementation research coupled with transparent and credible monitoring and evaluation systems helps to inform and improve reform policies to scale-up evidence based interventions.

Policy Options:

1. Develop an effective communication strategy to inform all stakeholders in the health sector about devolution, and their complementary roles and responsibilities.

2. Strengthen the dialogue between two levels of government through the newly established intergovernmental and chief executives of health forums by strengthening liaison mechanisms.

3. Ensure that the national health policy guides strategic planning and budgeting at both levels of government with credible monitoring and evaluation systems in place to assess performance in a transparent way.

4. Ensure commodity security for national priority programs building on the gains made by the Kenya Medical Supplies Authority (KEMSA), and involve counties in KEMSA's governance structures.

5. Counties need to focus on enhancing capacity at facility level for demand forecasting, making ordering cycles shorter and ensuring rational use.

6. Counties also need to allocate adequate budgets for essential medicines and medical supplies (EMMS), and make timely payments to suppliers to sustain the supply chain.

7. Monitor the availability and quality of EMMS at all public facilities.

CLIENT SAFETY AND QUALITY STANDARDS

Key messages:

1. Government has a clear role in setting standards of care at different levels and putting in place systems for regulation and enforcement of quality. This however needs to be complemented by approaches that promote the drive for quality such as accreditation.

2. Each country needs to evolve a framework for accrediting health facilities with appropriate institutional arrangements to improve quality of care.

3. Incentives and recognition of improved quality of care through accreditation can improve the provider behaviour and reduce the gap between the knowledge and practice.

4. Credible systems need to be put in place to monitor the quality of care objectively.

Policy Options:

1. Review and amend relevant laws and strengthen existing regulatory bodies to ensure effective enforcement.

2. Support existing institutions such as Kenya Accreditation Service (KENAS) to develop tools and build capacity for accrediting health facilities.

3. Create incentives for improved quality through Results Based Financing (RBF), and provider enrolment for providing UHC.

4. Ensure that NHIF focusses on its core competencies of pooling and purchasing services, while dedicated agencies such as KENAS will gradually take over the role of accreditation.

II. CONTEXT

The Kenyan health system is currently undergoing transformation in line with devolution

With the devolution, decision-making, finance and responsibilities for delivery of essential health services in Kenya are now transferred to the newly created 47 county governments. The national government is now responsible for policy formulation, capacity building and providing oversight for the national referral facilities. The Kenya Health Policy 2012-2030 identifies policies and actions required to achieve health goals and specifies institutional and management arrangements required under the devolved health system. Timely and effective implementation of the policies and actions under the new health policy will be critical for Kenya to sustain health gains made in the last decade and further improve health outcomes envisaged by its Vision 2030.

The current government, which came to power in April 2013, is keen to ensure that there is a smooth transition to a devolved health system and that all Kenyans enjoy the right to health as stipulated by the Constitution. UHC is among top priorities identified by the government to achieve these noble goals. Such renewed strong political commitment to achieve UHC requires Kenya to ensure effective coverage for essential health services while ensuring financial protection. The country needs to take strategic decisions to: (a) implement well-tailored programs relevant to the Kenyan context to improve equitable access to quality health services, especially for the rural poor; (b) enhance governance and efficiency of the

health systems and relevant institutions to get better value for money; and (c) provide more domestic funding for the sector.

Kenya has made steady and significant progress in improving health outcomes and utilization of essential services

Kenya achieved notable reduction in child mortality and effectively reduced the burden of major communicable diseases during the past decade. As shown in the Table 1, infant and under-five mortality declined by nearly a third during the period 2003 to 2008. During the same period, the proportion of children fully immunized increased by a tenth. The recent data suggests that the prevalence of HIV among Kenyan adults declined from 7.2 % in 2007 to 5.6 % in 2012. The ownership of bed nets increased threefold and tuberculosis treatment success rates are now close to 90%.

Table 1. Kenya's Achievements in the Health Sector

Health outcome/output	KDHS 2003	KDHS 2008	Change
Under 5 mortality rate	115	74	Decreased by 36%
Infant mortality rate	77	52	Decreased by 32%
Children fully immunized	57	68	Increased by 11% points
Contraceptive prevalence rate	39	46	Increased by 7% points
Prevalence of HIV (population 15-49 years)[1]	7.2	5.6	Decreased by 1.6% points
Women receiving antenatal care	88	92	Increased by 4% points
Ownership of Bed nets	22	61	Increased by 39% points
TB treatment success rate (World Development indicators)	80	87	Increased by 7% points

Despite notable achievements in child health and control of communicable diseases, indicators on maternal health and nutrition stagnated and Kenya is now facing a dual burden of disease.

a. Maternal mortality ratio remains high and estimated to be around 448 per 100,000 live births in 2008 and the UN estimates[2] suggest that nearly 7,900 women die every year due to pregnancy related causes.
b. Utilization of maternal health services continues to remain low with less than a half of pregnant women receiving skilled care at child birth, while the proportion of women making at least four antenatal visits declined from 64% in 1993 to 52% in 2003 and to 47% in 2008.
c. Over a third of Kenya children (35%) are shorter for their age, which adversely affects their future economic productivity and this statistic did not significantly change since early 90s.

[1] Kenya AIDS Indicator Surveys 2007 and 2012
[2] Trends in maternal mortality 1990-2008, WHO, UNFPA, UNICEF and the World Bank

d. The burden of non-communicable diseases (NCDs) in Kenya is increasing faster than the global average. NCDs related deaths in Kenya are higher at 624 per 100,000 compare to 573 deaths per 100,000 globally.
e. Kenya is estimated to have more deaths due to injuries compared to the global average (116 vs. 78 deaths per 100,000).
f. Current life expectancy in Kenya is comparable to life expectancy of China in late 1960s while the total fertility rates are comparable with Brazil in early 1970s (Figures 1 and 2 below).

Figure 1: Life Expectancy of African Countries in 2011 compared to China

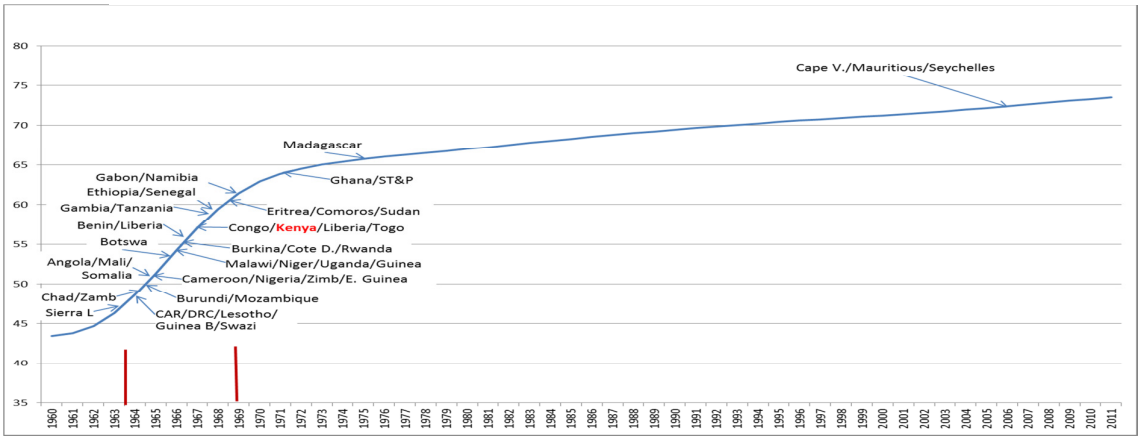
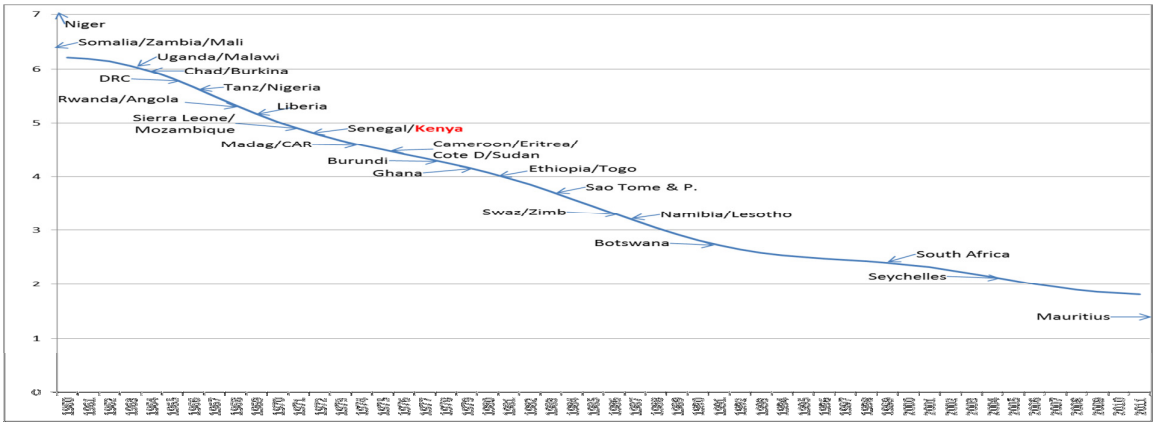


Figure 2: Total Fertility of African Countries in 2011 compared to Brazil



Kenya still faces significant challenges in health service delivery

The Kenyan health system faces several challenges typical of many low-and-middle-income countries (LMICs). Some of these challenges include:

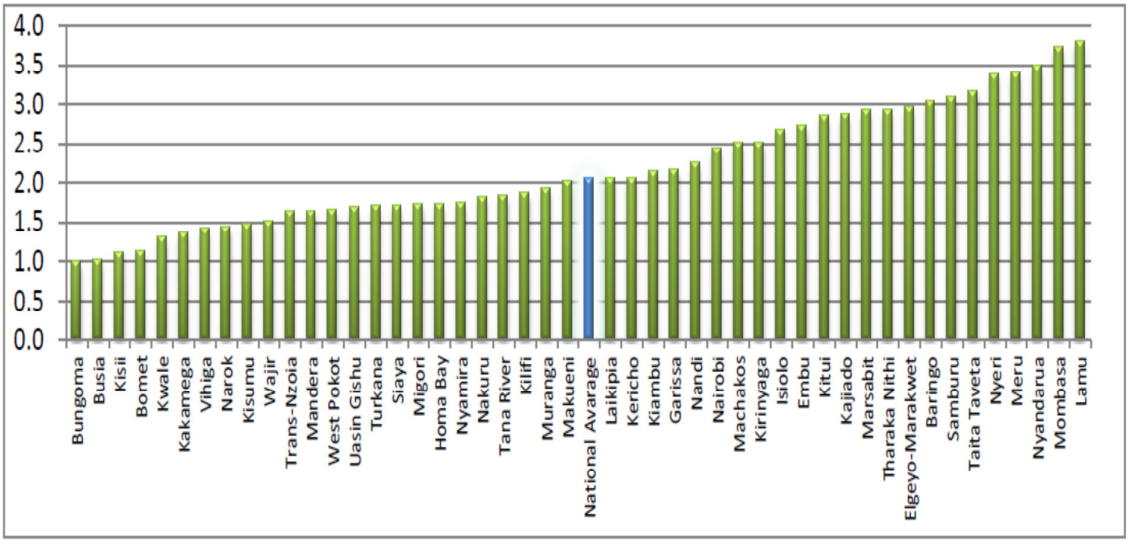
a. Geographical and socioeconomic inequities in access to health care services

The number of health care facilities per 10,000 populations compares to the World Health Organization (WHO) recommendation of two facilities, and is above that of many countries

in the region. For example, health facility density per 10,000 populations in Tanzania, Zambia, and Burkina Faso is estimated as 1.5, 1.3, and 1.6 respectively.

The main challenge for Kenya is wide disparities between counties. Bungoma had the lowest facility density of less than one facility per 10,000 persons, while Mombasa had the highest density of over 3.5 facilities per 10, 000 population (Figure 3). The national average facility density was 2.04 facilities per 10,000 persons.

Figure 3: County Health Facility density, per 10,000 populations



About half of the Kenyan population lives more than five kilometers away from the nearest health facility (Figure 4). Wide disparities exist between regions, ranging from 20.2% in Nairobi to 85.7% in North Eastern.

The poorest populations have limited access to health care services and report poorer health outcomes (Table 2). Only one woman out of five from the poorest wealth quintile was delivered by a skilled birth attendant during their recent deliveries, compared to four out of five women (81.4%) in the highest quintile. Wide disparities are also reported for access to antenatal care and family planning. Further, child mortality and stunting are much higher among the poorest households.

Figure 4: Proportion of people living 5 Km or further from the nearest health facility[3]

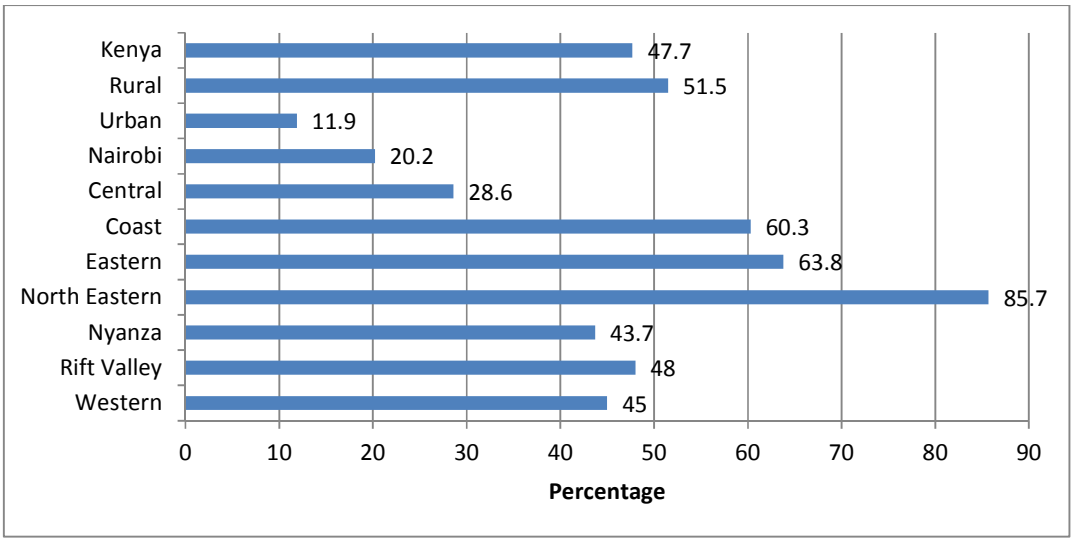


Table 2: Socioeconomic inequities in coverage of key services and health outcomes[4]

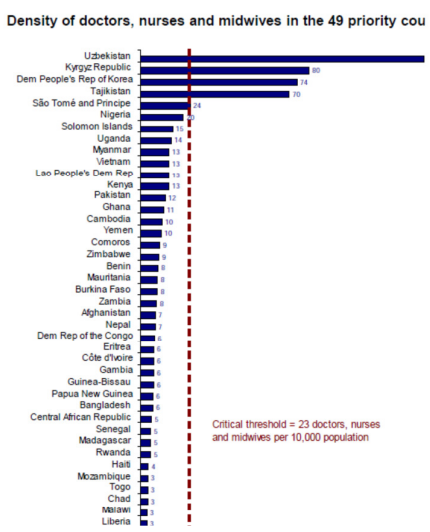
Socio-economic quintile	Skilled birth delivery	Unmet need for family planning	Infant Mortality Rate	Neonatal Mortality rate	Child Mortality Rate	% of stunted children
Lowest	20.3	20.1	98	39	34	44.4
Second	31.3	15.8	102	33	40	39.2
Middle	41.9	10.6	92	31	26	34.4
Fourth	52.9	11.0	51	41	12	29.1
Highest	81.4	8.7	68	29	13	24.5

b. Inadequate numbers of health workers, unequal distribution and poor skills mix

Kenya is estimated to have a total of 16.8 health workers for 10,000 populations, which is less than the minimum density recommended for achieving the health related MDGs[5]. The WHO estimates that countries with fewer than 23 doctors, nurses and midwives per 10,000 population as unlikely achieving health related MDGs. In 2010, Kenya had about a half of the recommended doctors, nurses and midwives (Figure 5).

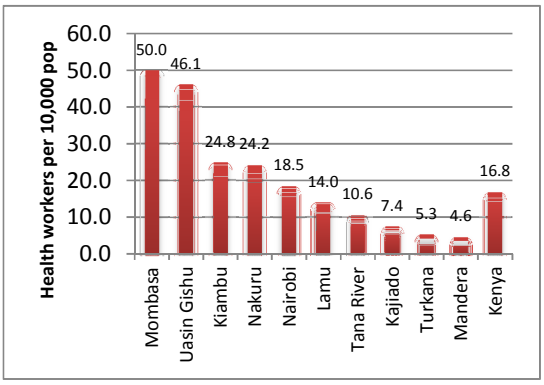
[3] Kenya Integrated Household and Budget Survey 2005/06
[4] Kenya Demographic Health Survey 2008-2009
[5] Kenya Service Availability and Readiness Assessment Mapping (SARAM) 2013

Figure 5: Density of doctors, nurses and midwives in 49 WHO priority countries



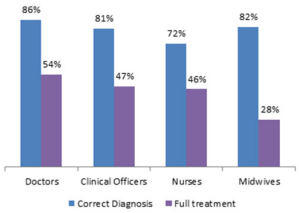
The bigger problem is the uneven distribution of the existing workforce as shown in Figure 6. While the counties in Northern Kenya tended to have lowest availability of health personnel per population, Mombasa and Uasin Gishu had the relatively higher staff availability.

Figure 6: Number of health workers per 10,000 population[6]



The recent PETS+ showed that about a third of the health staff were absent from duty on an unannounced visit. The Kenyan providers were found to have much better knowledge in diagnosing and treating common health conditions. However, such knowledge is not getting translated in to better health due to a large gap in translating such knowledge into actual practice (Figure 7[7]). Close to 90% of doctors are able to reach the correct diagnosis but only 54% give the full treatment required for the condition.

Figure 7: Know-do-gap



c. Need to get better value for investments made in the health sector:

Hospitals still receive the largest share of the health budget compared to primary health care facilities, which are critical for delivering essential healthcare and known to be more equitable. In 2010/2011 Financial Year, the Ministry of Public Health and Sanitation, which was responsible for primary health care services, received 40.5% of funds allocated to the health sector. Further, the absorption of allocated funds remained low in the sector and both public and private facilities operate

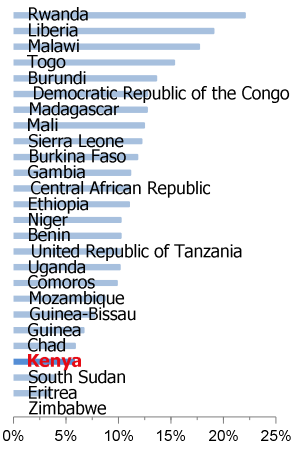
[6] Kenya Service Availability and Readiness Assessment Mapping (SARAM) (2013)
[7] Health Service Delivery Indicators and Public Expenditure Tracking in Kenya, PETS Plus (2012)

below their maximum levels of efficiency. For example, in 2011/2012, total absorption capacity was 87.1%. Absorption capacity for development expenditure was much lower at 65.3%.

High levels of OOP payments, low levels of government spending on health, and high dependency on external funding characterize the Kenyan health financing system

There is very limited risk pooling and prepayment in Kenya. OOP payments continue to remain an important source of health care funding, accounting for 36.7% of Total Health Expenditure (THE) in 2009/2010[8]. Government funds accounted for 28.8% of THE, while donor funding accounted for 34.5%. The share of government spending on health has continued to increase in absolute terms. In 2010, total government spending on health amounted to US$1,047 million, compared to US$ 788 million in 2005/2006. However, government spending on health as a percentage of the THE has recorded a declining trend from 8.0 % in 2001/02 to 4.6 % in 2009/10, which is relatively low compared to other countries in the region (Figure 8). A large share of donor funds is channelled off-budget to support priority national disease control programmes. Heavy reliance on external funds that support national priority national programs contributes little towards overall health systems strengthening and has negative implications for sustainability including the risk of contingent liabilities. Clearly, the need to reform the health financing systems and increase domestic resources for health has never been greater.

Figure 8: Share (%) of governments' allocation to the health sector



Devolution presents opportunities to address existing challenges

Kenya's devolution has been described as one of the most ambitious implemented globally[9]. Devolution presents opportunities to address challenges in the Kenyan health system, by taking resources closer to the people, promoting accountability, improving equity and efficiency. But devolution also poses new challenges for the country especially the rapid transition to devolved systems due to political compulsions. International experiences show that creating the right governance and accountability structures, clarifying functions, policies and legislations and establishing strong working relationships between local and national governments are critical in making devolution successful.

[8] Kenya National Health Accounts 2009/10
[9] Decentralisation and Sub-National Regional Economics (World Bank)

Kenya can draw from lessons from countries with devolved health systems

Several Low-and-Middle Income Countries (LMICs) including Ethiopia, Ghana, India, Mexico, and Thailand have implemented devolution with differing degrees of success and some have made remarkable progress in reforming their health financing systems for UHC. Pathways need to be explored based on lessons from these countries as well as innovations undertaken within Kenya to find appropriate mechanisms for improving health outcomes, pooling resources, making strategic purchasing and establishing sustainable institutions for achieving UHC. Recent decisions taken by the Government to eliminate payment at the point of primary health care service delivery and free access to maternal health services are in the right direction. The challenge however is in delivering these important commitments under a devolved health system and ensuring sustainable financing for UHC.

III. SCOPE OF THE REPORT

The HLF provided an opportunity for Kenya to draw on local and international lessons, by bringing together experts to share experiences, deliberate and identify the way forward for Kenya. This report summarises discussions from the HLF, and draws on these deliberations to provide policy options for Kenya for achieving UHC including identification of potential areas of WBG's support over the medium term to the Kenya health sector. The report is structured around the four key themes guiding the HLF.

IV. EMERGING GLOBAL EXPERIENES FOR ACHIEVING UHC

The main message in the opening session was that health systems reforms for UHC should be context specific, informed by social, economic and political environment and responsive to country needs, while drawing on lessons within Kenya and from countries that made progress towards to UHC.

In the opening remarks, made on behalf of Mr. James Macharia, Cabinet Secretary for Health, Dr. Masasabi, Head, Directorate of Policy Planning and Health Care Financing, noted that UHC is a major priority in Kenya. He reported that devolution presents new challenges and opportunities for service delivery in the country, and emphasized that the HLF should help Kenya to identify new ways to respond to these challenges and to better utilize opportunities. The importance of linking outcomes from the HLF to the Kenya Health Policy (2012-2030) was also highlighted.

Dr. Tim Evans, Director, Health, Nutrition, and Population Network, World Bank, noted that there is no magic bullet to achieve UHC, but implementation experiences show that challenges across countries are similar. He also emphasized the importance of country leadership for making UHC a priority and meeting expectations of the people. UHC involves making fragmented health systems better integrated to ensure continuum of care while providing financial protection for the worse off. There is now strong evidence to show that investing in health is a wise investment for economy and health should no longer be

considered as a consumption sector. He summarized the key issues that need to be considered for UHC based on global implementation experiences (Box 1).

While making a strong case for UHC in Kenya, he summarized the key lessons from UHC implementation experiences emphasizing the importance of country driven reforms, managing the political economy, and credible systems for monitoring progress towards UHC.

Dr. Ariel Pablo-Mendez, Global Health Administrator, USAID, emphasized the great window of opportunity in Africa to further improve health outcomes. Nearly 20 countries in the region, including Kenya, are moving in to middle income status. There has been a huge decline in infant mortality that contributed to saving lives of nearly 100 million infants and the rate of reduction of under-five mortality has nearly doubled in Africa. However, high levels of maternal mortality and fertility still remain major challenges.

BOX 1.
KEY IMEPLEMENATION ISSUES FOR ACHIEIVNG UHC

- Who? Targeting the poor and disadvantaged, mandatory enrolment, information sector and overcoming discrimination (beyond income poverty).
- What services? A prioritized benefit package that goes beyond health MDGS including NCDS based on burden of disease and cost effectiveness
- How to deliver? Addressing supply side constraints (human resources, commodity supply chain, and quality of care), facility vs. community, public vs. private.
- How to finance? Tax based vs. contributory, Using sin tax : Tobacco, Alcohol, low value nutrition foods, high sugar drinks
- How to pool? Large pools more cost effective
- How to pay? Incentive based payments are better associated with improved results

As economies are growing in the region, more resources will be potentially available. This provides a great opportunity for the health sector to leverage such resources to improve health outcomes. He encouraged Kenya to: (i) support collaborative efforts to address high OOP payments for health which are known to be an important contributor for impoverishment; and (ii) promote PPP and other innovations to improve access to new technologies.

While celebrating the health gains, there is urgent need to focus on eliminating extreme poverty and it is possible to further reduce preventable maternal and child deaths. The UHC is timely and provides a wise way forward to address these two challenges. He encouraged strong South-South collaboration and learning and emphasized the criticality of mobilizing more domestic resources for health.

V. SERVICE DELIVERY

a. Key messages

Kenya can derive more from current investments to the health sector by reducing inefficiency. Ensuring functional primary health care system that delivers quality essential health services remains most critical for achieving UHC and improving health outcomes. Networking of public hospitals would help to rationalize resources and strengthen referrals. Health systems reforms for UHC should take advantage of the rapidly growing private sector

and existing networks of FBOs by developing partnerships to optimally use available health care resources.

b. Detailed discussions from presentations and panel discussions

Dr. Patrick Amoth from the MoH presented achievements and key challenges in service delivery. He highlighted Kenya's achievements in improving various health outcomes, but effective delivery of essential health services still remains a challenge. The main service delivery challenges faced by Kenya are : (a) suboptimal human resources for health due to shortage, mal-distribution, unfavourable working conditions and low motivation; (b) inadequate equipment that gets further compounded by poor maintenance and rapidly changing technologies; (c) poor supply chain management leading to frequent stock-out of essential medicines; (d) weak leadership and management at all levels with limited cross sector coordination and community participation; and (e) low levels of investment in the sector as well as poor efficiency in allocating and using budgets provided to the sector. These supply side challenges get further compounded by poor demand for essential health services due to socioeconomic, cultural and geographic barriers, resulting in low and inequitable coverage of essential health services and poor health outcomes. Scaling up high impact interventions, strengthening county health systems, promoting public-private partnerships, and enhancing accountability were identified as potential mechanisms for addressing existing challenges.

Results from the recent PETs+ showed that supply side constraints are enormous in the health sector but often do not receive required attention. While physical constraints such as availability of basic infrastructure including water and sanitation and essential commodities are high, quality related constraints including absenteeism, large knowledge practice gap and underutilization of existing infrastructure are also considerable. Dispensaries and health centres are more constrained compared to hospitals.

The efficiency study undertaken by Dr. Urbanus Kioko, University of Nairobi, revealed that Kenya can derive more value for money by improving efficiency in both public and private health sectors. While inefficiencies exist in the public and private sectors, the private sector is generally more efficient for higher levels of care, while the public sector is relatively more efficient at the level of health centres. Despite limitations in data availability and scope of the analysis, findings of the study clearly highlighted that UHC initiatives should be accompanied by efforts to strengthen health systems and reduce inefficiencies. Such efforts should involve a detailed assessment of the causes of inefficiencies, redistribution of resources across geographical regions and levels of care where necessary. It is however important not to lose the equity focus in public sector provision and link payments to performance. Both individual and institutional incentives need to be built into health financing arrangements to improve efficiency and contribute to better health outcomes.

The panel discussion following the formal presentations highlighted the importance of adopting a holistic approach to service delivery through PPP and the need for a PPP framework, which creates a conducive environment for mutual benefit. The existence of a

thriving private sector and the strong network of FBOs in Kenya present a great opportunity for collaboration and drawing combined resources to undertake innovations to address service delivery challenges. The need for engaging with the private sector in the provision of publicly funded essential services was highlighted.

Experiences of the African Medical Research Foundation (AMREF), Kenya, showed that the private sector can make significant contributions for improving maternal and child health outcomes through community based primary health care interventions. Key lessons drawn from AMREF's experience working in challenging settings are: (a) promoting collaboration between the MoH and implementing partners; (b) engaging the community early on as an important partner for delivering services; and (c) encouraging local innovations and adopting interventions to local settings is also critical. All panellists stressed potential opportunities to improve efficiency and achieve better health outcomes from a well-structured PPP including sharing equipment, training of health workers, supply chain management and common quality standards. Building health workers' capacity and monitoring quality should be important aspects of any intervention.

The FBOs represented by the Christian Health Association of Kenya emphasized their commitment to improve service delivery and achieve UHC. FBOs are widespread in Kenya and operate in some of the remotest parts of the country. The FBOs have much stronger footprint in remote parts of the country and have been actively engaged in service delivery by the MoH in the past by seconding staff and provision of essential medicines to deliver affordable health services in marginalised areas. The devolution however has posed some new challenges for these ongoing partnerships and FBOs are uncertain on how this partnership will continue in the devolved health system.

H. E. Capt. Ali Ibrahim Roba, the Governor of Mandera, who represented the Council of Governors, shared early experiences of county governments including initiatives to improve service delivery. He specifically focused on the practical challenges being faced by marginalised counties in delivering essential health services. Such counties inherited non-functional health systems from the national government and health indicators were poor. Devolution presented an opportunity to address service delivery challenges through, for example, reviving non-functional health facilities by employing additional staff, and purchasing equipment and supplies that are responsive to local health needs. However, counties urgently need capacity and support to translate health policies into effective service delivery. He also emphasized the importance of credible monitoring and evaluation systems to inform ongoing strategies to enable mid-course corrections and promoting synergy among all counties for achieving national outcomes.

During the Questions and Answers session, the participants emphasized the need for purposeful investments for making the health systems functional and importance of having an effective referral backup. They also stressed that all counties are not equal and special needs of some counties needs to be addressed to bring them on par with others. For the PPPs to effectively function, there is need for honesty from both the public and private sectors. Some practical questions were also raised regarding the contractual staff recruited under the

Economic Stimulus Package; inclusion of FBOs under the free maternity care; and who will pay for warehousing and distribution costs for national program supplies being made by KEMSA.

VI. ENSURING SUSTAINABLE FINANCING

a. Key messages

There is 'no one size fits all' solution to UHC. Health systems in each country are unique and UHC reforms should be designed based on country's own experiences and specific needs. The reforms should also be dynamic so that they can respond to implementation experiences. Mandatory health insurance remains the primary vehicle to expand UHC but it requires complementary interventions to expand coverage. Regardless of the approach adopted, tax based financing plays a critical role by providing subsidies for the poor and informal sector to improve equity. A strong national risk pool and a well-managed single purchaser institution that ensures efficient and transparent use of resources are important features of success stories.

b. Detailed discussions from presentations and panel discussions

Mr. Elkana Ong'uti, Chief Economist, MoH, in his presentation on health financing challenges and efforts towards UHC in Kenya highlighted that a UHC agenda is in line with the right to health as articulated by the Kenyan constitution and the Vision 2030. There is an agreement among stakeholders that UHC is the way to go and a strong political will currently exists in the country. This political will along with coordinated support from development partners presents a policy window, which can be used to fast track the implementation of UHC. Moving away from OOP payments to risk pooling is an important step towards realization of these rights. Low levels of government funding, fragmentation in health financing and service delivery, limited absorptive capacity and uncertainty related to devolution are some of the challenges hindering the progress to UHC. Earmarking tax funds for UHC, improving efficiency in revenue collection and service delivery, having a single national risk pool and improving governance of institutions responsible for revenue collection and purchasing can help to address these challenges.

Mr. Stephen Muchiri, Chief of Party, Health Policy Program-Kenya shared the preliminary results of the Health Expenditure and Utilization Survey (2013) that covered 34,000 households from 44 counties. These results showed overall increased utilisation of health care services. The outpatient visits increased from 1.9 annual visits per capita in 2003 to 3.1 in 2013. The inpatient admissions also increased from 15 to 38 per 1000 population. During this period the proportion of sick not seeking healthcare decreased from 22.8% to 12.7%. Inability to bear the cost still remained the main barrier for accessing care. The public sector remains the main source of health care services for the majority of Kenyans, accounting for more than 60% of outpatient and inpatient visits. Even though OOP payments have declined over the past decade, they still remain high and potentially contribute to impoverishment of

about a tenth of the Kenyan households. Coverage for health insurance remains low, especially among the poorest compared to the richest quintile (3% vs. 42%).

The Panel discussion identified the urgent need for additional resources for achieving UHC, while ensuring that such resources need to be equitably distributed to benefit the poorest population. An analysis of fiscal space identified three main ways of finding resources for financing UHC: (i) rationalizing current health financing by reducing wastage; (ii) increasing tax revenue by improving tax compliance and introducing new taxes that target the rich in society (e.g., consumption tax on luxury items, capital gains tax, etc); and (iii) increasing borrowing as Kenya is still within the sustainable levels, but such borrowing should be done from external sources rather than internal borrowing with higher interest payments. The role of domestic resources for sustaining priority national programs such as HIV/AIDS was also discussed. Currently, 85% of the HIV financing comes from partners. Potential sources of funding identified included health insurance contributions, establishment of a trust fund supported through 1% of total government revenue, innovative financing mechanisms such as charging airtime levy and taxes on remittances from Kenyan diaspora among others. The important advocacy role the civil society could play for increased domestic funding for HIV/AIDs and other priority programmes was also highlighted. The findings of a benefit incidence study highlighted that inequities in outpatient and inpatient care had declined over the years. However, wide income and geographical inequalities still exist for the hospital care. The FBOs and public primary health care facilities actually serve the poorest population more. The findings suggest that outpatient care could also be quite catastrophic highlighting the importance of including it in the national health insurance cover.

International experiences from India and Mexico clearly showed the role of political economy in driving UHC. The Indian experience highlighted the need for a strong autonomous regulatory institution, with adequate power to enforce regulations. This could be done through an existing institutional mechanism such as the broader Insurance Regulatory Authority (as done in case of India) or creating a dedicated institution for regulating health insurance (as done in Chile and Columbia). Effective regulation will help to safeguard against systemic risks, prevent market misconduct and anti-competitive behaviour, minimize information asymmetry and make sure that social objectives are being achieved. Such regulation requires appropriate legal framework and the agency should have independent source of financing. The MoH however still needs to play a role in product regulation by defining the benefit package and provide leadership for regulating the provider market. The Indian experience also highlighted the need to start with a limited benefit package, which can be expanded as the economy grows, as an option for countries facing resource constraints. The challenges of controlling provider irregularity, containing cost, purchasing services through private health insurance, with no capacity to monitor them, also came out clearly. There were also challenges in institutional and managerial capacity, inadequate consumer information and too much emphasis of quality assessments of structures and staffing rather than processes.

Mexico over the past few years moved in to a single national social health insurance scheme with a strong stewardship role played by the MoH. This helped to address the large

inequalities between insured and non-insured as well as between states resulting in poor overall health outcomes. The popular health insurance for basic health services caps the administrative cost at 6% and the country maintains a catastrophic health insurance fund for covering highly complex interventions. The key achievements are: everyone is covered with a fully funded benefit package, reduced inequalities and steep increase in public expenditure on health. However, the OOP payments still remains high and contribute to nearly half of the total health expenditures. Experiences from Mexico clearly highlight the importance of political economy of engaging with sub-national governments and the role of the national government in providing stewardship including setting quality standards. Engaging the Ministry of Finance (MoF) at early stages of the process improves political buy-in. The Mexican experience also emphasized the importance of long-term investments in research that generate evidence for policy. Having a sufficiently funded and staffed economic analysis unit within the MoH equipped the ministry with evidence to support negotiations between the MoF and MoH on matters related to increasing fiscal space for health. Adopting "a phased approach" to implementation based on resource availability and promoting harmonization of risk pools from the start is important as it is difficult to subsequently harmonise a fragmented system.

Global experiences highlight that UHC is a concrete and funded reform and requires fundamental changes. Cosmetic changes and continuing to do business as usual will not help. Tax based financing is a must for UHC and health insurance remains the primary vehicle. Experiences from the Philippines suggest that giving local governments the responsibility of funding services for the poor can be challenging. The country therefore ended up recentralising health care funding for the poor and earmarking a part of health care funds for expanding effective coverage.

VII. ENHANCING GOVERNANCE AND EFFECTIVENESS OF THE HEALTH SYSTEMS TO DELIVER QUALITY HEALTH CARE

a. Key messages from the session

Devolution calls for different governance, organizational and management structures, including new institutions, new relationships and new ways of working, which should ensure transparency, responsiveness and mutual accountability. The two levels of government should maintain a well-coordinated health system guided by the national priorities as identified by country's health policy and strategic vision to achieve national and global commitments such as Vision 2030 and MDGs. Timely supply of quality commodities is essential for delivering health services. Most public procurement and supply chain management systems face challenges in timely flow of finances, poor demand forecasting and weak supply chain management. National and county governments, health providers and other stakeholders need to be accountable to the people they serve. Without improving governance at all levels, Kenya cannot get full benefits from investments in the health sector. Implementation research coupled with transparent and credible monitoring and evaluation systems helps to inform and improve reform policies to scale-up evidence based interventions.

Detailed discussions from presentations and panel discussion

Dr. S. K. Sharif, Former Director of Public Health and Sanitation, MoH, in his presentation on key health systems governance challenges emphasized the importance of effective management of the political process within a country for improving governance. The key aspects of good governance were listed (Box 2) and the need to identify policy champions who will push the reform agenda highlighted. Improved governance and commitment should start from the highest level and that all stakeholders should be accountable to communities they serve. For improving accountability, there is urgent need to strengthen capacity at the county level.

Several tools exist in Kenya to monitor governance and collect evidence to inform reforms. These include regular PETS and National Health Accounts and Citizen Report Cards. Results from these tools have informed the design of reforms to improve accountability and efficiency. Based on such assessments the Kenyan government introduced new interventions to promote good governance in the public health sector. Key among these are the Health Sector Services Fund (HSSF), which provides direct funding to primary health care facilities and addresses the constraint of operation and maintenance funds not reaching rural health facilities identified by successive PETS. Introduction of the pull system of supply chain management coupled with capitalization and reforms of KEMSA to improve timely availability of high quality and appropriate medicines and medical supplies at health facilities.

Dr Ruth Kitetu, from the MoH, presented the opportunities and challenges of devolution in Kenya. She noted that the country has made significant progress in implementing different aspects of devolution (Table 3) and emphasized MoH's commitment towards ensuring that health policies are aligned to the constitution. Challenges remain at all levels and relate to limited finances, lack of clarity on roles, functions and responsibilities and weak leadership and management capacity at the national and county levels. Successful transition to devolved health systems will largely depend on: (a) clarifying functions, policies and regulations, (b) establishing strong working relationships between county and national governments, and (c) investing in capacity building.

Table 3: Progress in health systems building blocks under devolved health system	
Leadership • Assignment and transfer of functions between the two levels of government • Restructuring the national level to be more responsive to county needs • Establishment of County Executives and Health Management Teams • Establishment of the health sector Inter-governmental Forum	**Policy and Strategy** • Development of the Kenya Health Policy (2012-2030), Strategic Plan and Draft Health Law • Development of the Functional Assignment Policy Paper to guide devolution process
Finance • Budgets disaggregated to match newly transferred functions • Conditional transfer grants for Level 5 hospitals • Removal of user fee for primary health care • Free maternal health at all public health facilities	**Human Resources for Health (HRH)** • Transfer of HRH payroll to counties • Establishment of County Public Service boards

Box 2: Key aspect of good governance

- **Policy Direction**: Maintaining the strategic direction of policy development and implementation;
- **Intelligence gathering:** Detecting and correcting undesirable trends and distortions;
- **Collaboration and coalition :** Articulating the case for health in national development;
- **Regulating** the behaviour of a wide range of actors - from health care financiers to health care providers;
- **System design:** Ensuring a fit between strategy and structure and reducing duplication and fragmentation.
- **Establishing transparent and effective accountability mechanisms.**

Commodities and shared services • All Counties have signed Memorandum of Understanding with KEMSA and started placing orders • Counties have been given authority to manage level 5 hospitals that provide referral services for clusters of counties	

Experiences shared by Chief Executives from counties showed that counties have made good progress in developing strategic plans and ensuring continuity in service delivery. Presentations by two County Executive Committee Members for Health from Busia and Kisumu counties Dr. Maurice Siminyu and Dr. Elizabeth Ogaja respectively, noted that devolution has enabled counties to improve management systems, provide closer supervision to staff, generate information for better planning and allow closer interactions between

community members, local leaders and county governments. Despite some challenges such as limited understanding within the health sector, weak leadership and governance, limited fiscal space, low revenue allocation and limited capacity, the devolution presented huge opportunities to prioritize county needs and work with local implementing partners. It also facilitated better stakeholder participation in county level planning to improve service delivery. Establishment of County Assembly health committees helped in lobbying and resource mobilization. Increased government allocations to the health sector, development of norms and standards and county capacity development in legislation and management were identified as important for addressing implementation challenges at the county level.

In the panel discussion, Dr. James Nyikal from the Parliamentary Health Committee noted that lack of clarity on roles and responsibilities and limited interactions between county governments and parliament have contributed towards challenges in devolution of health care services. The parliamentary health committee can play an active role in designing the right legislations and lobbying for more resources allocations to the sector. Effective communication and sensitization are identified as critical factors to enable people to understand their entitlement as well as the health staff and other stakeholders to understand the new governance structures in devolved health systems to maximize benefits. The provisions in the Kenyan constitution are based on principles of UHC and he encouraged MoH and other stakeholders to make use of these provisions to promote accountability and support the implementation of UHC. There is need for effective engagement between MoH and county governments for improving governance, efficiency and service delivery.

Dr. Dabar Abdi from the Transitional Authority noted that while progress has been made to transfer health functions based on institutional assessments and legal notices, there have been challenges related to numerous pieces of legislation that are difficult to understand and implement. Limited sensitisation of devolution process contrary to expectations, political interference, and delayed transfer of payroll to county level also adversely affects service delivery. Improved communication and stakeholder involvement, development of relevant policies to clarify issues and improvement in human resource management are important for successful transition. He called for more public education on what the Constitution provides for in devolution, and the roles of both levels of government.

Discussions on governance of pharmaceutical supply chain systems in Kenya revealed that the KEMSA has achieved some notable success in strengthening pharmaceutical supply chain management. However, more efforts should be directed towards health facilities to improve quantification, ordering and rational use of medicines. Other challenges such as inadequate capacity, related to sub-optimal management and coordination skills, lack of criteria to allocate budgets for medicines supply at the central level and weak capacity of EMMS management at the county level should also be addressed. While devolution presents opportunities for increased public participation and competition in the supply chain, it is important to build capacities in supply chain management to avoid waste.

Global experiences shared by Prof Prashant Yadav, Director, Healthcare Research, University of Michigan noted that supply chain systems in many settings face similar challenges being encountered by Kenya (Box 3). These include how to leverage public and private investments and how to be responsive to patients. Mixed models of pharmaceutical supply exist, but in most countries supply chain is managed by semi-autonomous agencies regulated by the government. The major challenge of medical supplies chain is frequent uncertainties in financial, demand, and physical flows. Other challenges include: weak incentives for performance management; poor information flows; lack of transparency; and poor or no consumption tracking. Shorter cycles for forecasting and fewer layers in the distribution system can improve accountability and efficiency, and reduce wastage. He highlighted the need to derive strategies to manage uncertainties in the supply chain system by understanding health facility demand and establishing a well-managed financial and procurement process. Currently KEMSA has systems in place that are comparable with best global practices and these structures should be protected. In addition, some competition should be encouraged and governments should recognise the private sector's role in supplying essential commodities, as they are often effective and can reach the remotest parts of the country better with well aligned incentives.

Box 3: Key questions faced by supply chain systems globally

- How to leverage public and private investments to build, strengthen and improve mixed pharmaceutical supply networks?
- How to build patient-centric medicine supply chains?
- How to optimize supply networks to suit the growing and changing needs of the health system e.g. UHC?
- How to listen to "signals of demand" and in them into the supply chain planning process?
- How to keep track of flows through the supply chain?

"If you are overseeing or implementing an important health policy or program, you should have an implementation research agenda". Prof David Peters, Head, International Health, John Hopkins University

Prof. David Peters, Head, International Health, John Hopkins University shared international lessons on delivering health services. He emphasized that there is no 'magic bullet' to successful implementation. While countries follow their own implementation path, good outcomes require enabling contexts, evidence based interventions and effective implementation. He highlighted the important role of innovation and organization change, flexible and inclusive planning and problem solving in effective implementation. Learning by doing underlies successful implementation in many settings. An implementation research agenda that is supported by a team of experts and which engages key stakeholders is critical for ensuring that investment in UHC policies will work.

Experiences from India, Ghana, Ethiopia, Brazil and elsewhere highlighted that effective implementation of reforms requires an enabling context,

political commitment and evidence based interventions. The Indian experience emphasized that money in itself is not enough. Carefully designed institutions, which allow flexibility and timely flow of resources from the treasury to the local level, and which have the right mix of human resources are important determinants of success. The need to strengthen supply and have a robust monitoring and evaluation framework to match demand side interventions also came out clearly from the Indian experience. Assignment of functions, clarity of roles, simplicity in guidelines, and flexibility in operation are also critical.

Ethiopia and Brazil shared their experiences of strengthening primary health care services and the positive impacts on health outcomes arising from these reforms. Infant Mortality Rate (IMR) in Ethiopia declined from 133 per 1,000 live births in 1999 to 59 in 2010, while in Brazil a 10% increase in Family Health Teams (i.e. primary health care units) decreased IMR by 4.56 and reduced maternal mortality by 41 per cent. Brazil also recorded 126,000 fewer hospitalizations related to diabetes and respiratory diseases in three years, saving the country an equivalent of US$ 63 million. The Brazilian experience also emphasized the importance of political support beyond technical aspects of primary health care. Retaining human resources in remote rural areas and providing facilities with financial incentives are keys to success. The Ethiopian experience also emphasized the need for strong governance structures and a well-coordinated system that is built on one health plan. The need for shared strategic priorities and targets at all levels also enabled realization of effective primary health care in Ethiopia.

Box 4: Primary Health Care in Brazil: Key design features

- Additional funding for Family Health Units (new buildings, equipment, health workers etc.)
- Financial incentives from the national government for Family Health Teams to help municipalities retain health workers in rural areas
- Continuous training of teams in partnership with academic institutions, drawing heavily on use of ehealth, including telemedicine.

Ghana's experiences further reiterated the need for a health system that effectively engages the community in planning and a systematic process of translating research findings into national health programme. Effective coordination of development partners that included a common health sector reform agenda, joint annual planning and review summits, agreed sector-wide indicators and common management arrangements played a critical role in transforming the Ghanaian health systems towards UHC.

VIII. PROMOTING CLIENT SAFETY AND QUALITY OF HEALTH SERVICE DELIVERY

a. Key messages

Government has a clear role in setting standards of care and putting in place systems for regulation and enforcement of quality. This however needs to be complemented by approaches that promote the drive for quality such as accreditation. Each country needs to

evolve a framework for accrediting health facilities with appropriate institutional arrangements to improve quality of care. Systems need to be in place to monitor the quality of care objectively. Incentives and recognition of improved quality of care through accreditation can improve provider behaviour and reduce the gap between the knowledge and practice.

b. Detailed discussions from presentations and panel discussion

Dr Pacifica Onyancha, Head, Directorate of Health Standards Quality Assurance and Regulation (DHSQAR) Safety of the MoH noted that quality of care remains important constraint for achieving better health outcomes in Kenya. Limited capacity for inspection of facilities and periodic review of provider competence; inadequate resources to effectively implement quality assurance systems; lack of a central agency for regulating training; and lack of a national accreditation framework and fragmented quality improvements activities were identified as important challenges for improving quality and patient safety. Quality can be improved by implementing step-wise innovative and realistic quality assurance programmes for healthcare providers and facilities. To address quality challenges, a Directorate of Health Standards, Quality Assurance and Regulations that is responsible for quality assurance, norms and standards, regulations and patient safety, has been established within the MoH. The Kenya Quality Model for Health (KQMH), an integrated approach to improved quality of health care, has also been put in place.

Ms. Doris Mueni, Assistant Director, Health and Safety, the Kenya Accreditation Service (KENAs) noted that currently KENAS does not provide accreditation of health facilities due to a lack of an accreditation framework in the country. Currently accreditation of health services in Kenya is limited to private medical laboratories. The KENAS works closely with established regulators across different sectors. Discussions with the MoH and other stakeholders on a way forward for accreditation of health facilities in Kenya are ongoing. She emphasized that accreditation improves quality of internal operations, safeguard credibility of results and enhance market image of providers.

Experiences from the National Hospital Insurance Fund (NHIF), presented by Ms. Julia Ouko, Senior Benefits and Quality Assurance officer, highlighted that the NHIF act gives the fund mandate to accredit health facilities to deliver health services for NHIF beneficiaries. The NHIF is currently working with IFC and PharmAccess to integrate and implement the *SafeCare* quality accreditation process that places health facilities on a quality improvement trajectory and works with facilities to improve quality to an acceptable standard. A step-wise accreditation approach (Box 5) that eventually leads to certification is being implemented by NHIF to improve quality of services.

Box 5: NHIF step-wise accreditation process

- Step 0 – Entry level- poor quality
- Step 1 – Very Modest Quality- continuous need for technical support
- Step 2 – Modest Quality Strength- requires medium technical assistance
- Step 3 – Medium Quality Strength- acceptable but vulnerable to changing environment.
- Step 4 – Strong Quality Systems- quality systems in place
- Step 5 – Continuous Quality Improvement- evident long term commitment to quality
- Step 6 – Excellent Quality Systems- Accreditation

International experiences in measuring Quality and Safety, shared by Mr. Jishnu Das, of The World Bank revealed that the link between increased health care spending and improved health outcome is weak. He noted that quality of care is the missing link between health care spending and improved health outcomes. Drawing on the Indian experiences Mr Jishnu noted that while increase in both demand and supply side health financing have dramatically increased deliveries in health facilities. However, health outcomes such as IMR and Neonatal Morality Rate have not improved much due to poor quality of care. Hence, Kenya will need to focus more on quality of care along with the increased focus on improving access of care to reduce inequalities between counties. Incentives for improved performance may work but can also distort treatment away from what doctors may consider optimal.

He noted that data collection on quality remains a challenge due to the multidimensional nature of quality. Improving quality of care requires simple but relevant measurement indicators that can be monitored over time to improve performance. Examples of how quality can be measured include Generalized, Reducible Metrics indicators of care that lead to higher rates of correct diagnosis and treatment for all illnesses or tracer conditions that allows for better measures of diagnosis and treatment. The Kenyan health providers are more knowledgeable relative to other countries, but such knowledge is not getting translated in to practice. A pilot study exploring different approaches to measurement is ongoing in different parts of the country.

"You can't improve what you don't measure."

Mr. Jishnu Das, The World Bank

Ms. Nicole Spieker, Director SafeCare, PharmAccess Foundation shared experiences of using a step-wise quality improvement process tailored to small and medium-sized health care providers. She noted that quality improvement based on realistic standards for health care providers contributes to trust for willingness to pay (by various financiers and users), sustainability of quality improvement, and accountability. Introducing standards enables healthcare facilities in resource-restricted settings to measure and improve quality, safety and efficiency of their services and allows for benchmarking of providers across the health system.

IX. ACCERELATING PROGRESS TOWARDS UHC: THE WAY FORWARD

Achieving UHC is high on the Kenyan Government's policy agenda. This political commitment, existing support from development partners and the global momentum to UHC present an opportunity for Kenya that should not be missed. While it is clear that political commitment currently exists and that UHC is the way to go, there is scope for further improvements in health policies to ensure and sustain efficient, equitable and high quality services, while providing financial risk protection to all Kenyans. This section highlights some of the most important recommendations from HLF.

KEY POLICY OPTIONS

1. SERVICE DELIVERY

Improving coverage and quality of services depends largely on availability of key inputs, how these are combined and distributed across different levels of care and how services are organised and managed to ensure communities can access them, when needed. Policy options to address service delivery challenges in Kenya include:

a. Strengthen primary health care services

Primary health care services are cost-effective and contribute significantly to improved health outcomes more than any other interventions. Devolution provides a unique opportunity to strengthen primary healthcare service delivery in Kenya. With counties now responsible for delivering health care services, some of the chronically persisting weaknesses to make the existing facilities operational will be addressed. Counties like Mandera have taken initiatives to make all 52 primary health care facilities in the county operational by recruiting staff, while Machakos is focusing on improving access to safe deliveries by providing maternity units to all primary health care facilities. Such initiatives are extremely important for improving access to health care services in Kenya and should be encouraged. Potential areas of support include:

- Providing counties with additional funding for primary health care services for construction, equipment, EMMS and recruitment of health workers.
- Equipping primary health care facilities to offer basic emergency obstetric care. The Governors and 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 centres 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.
- Providing incentives to primary health care facilities through conditional grants to help them attract and retain health workers in rural areas, address issues related to absenteeism and other service delivery challenges.

- Continuously engaging county governments to sensitize them on the criticality of addressing gaps in services delivery related to absenteeism and know-do-gap.

b. Create opportunities to engage with the private sector

PPPs enable governments and other organization to work together to reach a common goal by sharing resources and competencies. PPP can involve different levels of engagement including policy and dialogue, public service provision, regulation, financing and information exchange. 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. Key areas that require attention include:

- Developing a roadmap in consultation with counties to sustain ongoing successful engagement with FBOs including support for EMMS and deployment of health workers in resource limited settings.
- Establishing a clear PPP framework to guide policy, procedures, institutions and rules that define and govern the implementation of PPPs at national and county level.
- Testing different models of PPPs to inform appropriate policies.
- Strengthening the institutional framework and the capacity of the PPP unit in the MoH to effectively manage PPPs at national level and to provide similar support to county level.

c. Rationalize hospital resources for improved efficiency

To promote technical efficiency and ensure that resources are allocated where they are needed most, it is important to focus on developing networks of hospitals across counties, rather than directing investments to build high level hospitals in each county. Working closely with counties, the national government should develop comprehensive 5 year plans for efficient hospital resource use. Such a process will require:

- Development of national guidelines for rationalizing hospital services and staff for the whole country and for all levels of care.
- A review of hospital capacity including equipment, hospital beds and occupancy rates and determining reasons for low or high occupancy rates in individual facilities.
- A needs analysis of county health service including an understating of how these needs can be met through provision of health services within or beyond Counties through, for example, implementing contracts with a variety of service providers to meet these needs in a cost-effective way.
- Developing a network of strongly regulated providers that can be contracted by national and county governments to deliver specific services within or outside the public sector, based on agreed targets and in line with the approved county and national budgets.

2. HEALTH FINANCING

a. Develop a vision and strategy for advancing progress towards UHC

A UHC strategy highlights the guiding principles, the actions needed to make progress to UHC and identifies a roadmap based on country's priorities and context. It also provides a guiding framework for all players in the sector. The UHC process requires continuous dialogue, exchange of ideas and coordination of activities. A committee with representation from different stakeholders is essential to spearhead the UHC agenda, including guiding the development of a vision, strategy and a roadmap. The following actions are required for the development and implementation of a UHC strategy in Kenya:

- Bring together stakeholders from FBOs, private sector, non-governmental organisations (NGOs), other ministries, and development partners to contribute towards preparing a roadmap for UHC that describes the milestones and targets.
- Provide leadership to finalize the health financing strategy and effectively manage the necessary changes taking into considerations interests of different stakeholders, while remaining focused on the principles of UHC goals.
- Establish a high-level multi-sectoral of relevant stakeholders with representatives from the MoF, County governments and social protection secretariat. The committee should hold regular meetings and provide feedback to the Cabinet Secretary, through the Head, Directorate of Policy, Planning and Financing.

b. Increase domestic resources for health

Sustainable domestic health financing is central to improved service delivery and UHC. The Kenyan health financing system needs to be re-engineered towards attracting more domestic resources to support priority health programmes and to strengthen health systems. However, advocating for increased domestic resources for health should go hand in hand with efforts to promote efficient use of existing resources.

- The national government should explore ways to increase government revenue through improved revenue collection and innovative taxes that target the richest in society.
- Supporting counties to develop resource allocation formulas that reflect local needs and guide resource allocation process across and within sectors would be useful tools for counties to advocate additional resources from the national level and for the county MoHs to negotiate with treasury.

c. Create a strong legal and regulatory framework for health insurance and reform the NHIF

A strong regulatory framework for health insurance is needed to safeguard the interests of contributors, enforce minimum standards, provide a grievance channel for consumers and ensure that health insurance arrangements significantly contribute to UHC goals.

- Review the Insurance Regulatory Authority (IRA) Act to include both private and public health insurers. Existing laws should be amended to make them explicit in matters related to the health insurance and ensure that they conform to international standards and that the regulatory body has the mandate to sanction and disqualify insurances that fail to abide by the rules.
- Strengthen the capacity of the IRA to regulate the health insurance market in Kenya.
- Establish or strengthen mechanisms for health insurance members to raise complaints related to service provision and financial risk protection to the regulatory bodies.
- Reform the NHIF to make it an efficient purchaser for all Kenyans based on recommendations from the strategic review, the high level task force and other available evidence.

3. CLIENT SAFETY AND QUALITY STANDARDS

Providing people-centered, safe and effective care is at the core of health systems. Patient-centered care improves patient experiences and creates public values for health services. Quality standards are central to supporting the delivery of effective health care services and for ensuring that Kenyans realize the right to health outlined in the constitution. The MoH with support from development partners and other stakeholders should:

- Develop a national quality and patient safety strategy anchored in a core set of principles shared by all stakeholders including national and county governments, provider organizations, consumers and local communities among others.
- Review and amend relevant laws, regulations and frameworks so as to strengthen DHQRS and existing regulatory bodies to ensure effective enforcement of patient safety standards and quality of care.
- Include patient-centred care as a dimension of quality in its own right in strategic and policy documents and feedback about patients' experiences in organizational approaches to quality improvement.
- Support ongoing efforts on quality improvement such as SafeCare, evidence based research and others as key tools for implementing KQMH
- Support existing institutions such as KENAS to develop tools and build capacity for accrediting health facilities
- Adopt valid and reliable quality and patient satisfaction measurement tools and put mechanisms in place to measure and monitor whether adopted efforts contribute to quality of care .

4. CROSS-CUTTING ISSUES ACROSS THE FOUR THEMATIC AREAS

a. Capacity building

Limited capacity remains a major challenge across all four themes discussed at the HLF. Strengthening capacity is crucial for efficient policy and strategy development, financial and

contractual negotiations, regulation, monitoring and evaluation. Such core capacity needs to be developed within different units of the MoH at the national and county level. The MoH in collaboration with stakeholders should work closely with county governments to identify capacity challenges and derive measures to address them.

b. Generate local evidence to inform policy

Evidence will be needed at all stages in the process from informing the vision and strategy for UHC, to implementation and evaluation. The economic analysis of health systems reforms for UHC as well as monitoring and evaluation of programs in a real world setting are needed. In addition, budget preparation at the national and county level needs to be based on sound analysis of issues, evidence and options. Achieving this requires establishing a well-staffed UHC research unit within the MoH, with the technical capacity to generate and use research evidence to inform policy and practice and to manage the UHC implementation process, including capacity for learning from experience and adopting reforms to achieve UHC goal.

X. POTENTIAL AREAS OF WBG SUPPORT

The discussion and priorities arising from the HLF have provided important inputs to the WBG support for Kenya over the medium term. Such support involves a combination of learning and lending activities complemented by relevant technical assistance and South-South exchange initiatives. Some potential areas of proposed support are listed below:

Lending:

Building country capacity for achieving UHC

Implementing Kenyan context specific UHC reforms requires sufficient capacity, continuous dialogue and knowledge exchange to learn from other countries that have implemented UHC. Such experience sharing helps Kenya to avoid some of the mistakes made by other countries while Kenyan experiences help other countries keen to make progress towards the UHC. Specifically the WBG can support Kenya through:

1. Working closely with the MoH and county governments, identify human capacity gaps to develop and implement specific capacity building activities. The potential areas for such capacity building include leadership and management; organizational and human resource development in devolved health system; financial management and procurement; PPPs in service provision, planning, monitoring and evaluation of health service delivery.
2. In collaboration with local training institutions, support flexible capacity building efforts especially targeting the marginalised counties (i.e., Arid and Semi-Arid Lands). This will include the option of scholarships for diploma level nurses and medical technician training to youth with required qualifications selected by county governments and other specific training needs identified through capacity needs assessments.

3. Strengthen existing mechanisms for intergovernmental dialogue such as Intergovernmental Forum on Health and County Chief Executives of Health Forum by strengthening existing liaison mechanisms with the national government.
4. In collaboration with the World Bank Institute, support knowledge exchange programmes on UHC reforms.

Strengthening institutions

1. Identify specific areas of weakness in institutional arrangements, organisational practices and governance set-up of key institutions responsible for health care financing, quality of care and regulation.
2. Provide technical support to address identified areas of weakness collectively with other partners for key institutions that are expected to play an important role in the transition to UHC. The main institutions would include the NHIF, IRA and KENAS.

Supporting health financing reforms for UHC

1. The recently approved additional financing to the ongoing Health Sector Support Project will support the phase I of two key health financing reforms. These two reforms include :
    a. The Results Based Financing design will be further improved based on the lessons learnt from the Samburu pilot and scaled up to 20 counties in arid and semi-arid parts of Kenya.
    b. The Health Insurance Subsidies for the Poor will be piloted in all counties covering 500 households in each county. This will be complemented by targeted initiative to provide similar subsidies for the vulnerable and marginalized populations.
2. The follow-on operation planned in FY 2016 will support the next phase of reforms in Kenya to accelerate progress towards UHC and this will be informed by the findings of the impact evaluation to be undertaken by the WBG. The WBG will also play catalytic role to convene all partners that are keen to support UHC.

Learning:

Supporting evidence based policy making

1. Support capacity building for the design and implementation of evidence based policies. This will be done through supporting the creation of an UHC unit in the MoH, supporting investments in capacity building for the unit and offering technical support when needed.
2. Strengthen partnerships with local training/research institutions (including universities and the Kenya Medial Training Colleges) to generate just in time evidence to inform UHC policies and make midcourse corrections. .
3. Prepare policy briefs and technical papers on various topics related to service delivery, health financing, governance and quality such as:

- Strategic options for improving delivery of quality primary health care services
- Networking to rationalize hospital services for improving access to effective referral care in Kenya based on analysis of distribution of hospitals (including number of beds, large equipment), relative need and utilization patterns
- Qualitative research to identify the main causes of inefficiencies in health service delivery and inform the design of interventions to promote efficiency.
- Innovative options for increasing domestic financing for health based on internal experiences to provide policy options to the MoH and the National Treasury.

Strengthening strategic policy dialogue

- Continue to provide technical support towards developing the UHC vision and strategy through active participation in relevant committees and technical working groups for health financing.
- Catalyse support from key partners committed to support the UHC agenda by identifying common areas of interest including possibility of jointly supported programs.

XI. CONCLUSIONS

The report has highlighted key messages from the HLF and identified areas of consideration and interventions for accelerating progress towards UHC. A clear vision, evidence-based strategy and a well laid out roadmap are essential for making progress towards UHC. Some progress has been made, but much more needs to be done. The political commitment that currently exists in the country presents an opportunity to move forward with this notion that has dominated the health policy agenda in the country for close to a decade. The national and county governments, private sector, NGOs/FBOs, development partners and other stakeholders should all work together to make UHC a reality in Kenya.

XII. Annex 1: Programme

March 18, 2014– Policy Perspectives		
Moderator: Mr. Francis Musyimi, Secretary Administration, MoH		
09:00 –09.55 Chair – Mr. Francis Musyimi, Secretary Administration, MoH	Opening Session: introduction of institutions	Mr. Francis Musyimi, Secretary Administration – Ministry of Health
	Expectations from the Forum	Dr. Masasabi, Directorate od Policy, Planning and Healthcare Financing (15 Mins)
	The Challenge of UHC and its relevance to Kenya	Dr. Timothy Evans, Director, Health Nutrition and Population, The World Bank (15 Mins)
		Dr. Ariel Pablo-Mendez, USAID/ Global Health Administrator (15 Mins)
09.55-10.15	Tea	
10:15-10:30	Summary of expectations	Mr. Elkana Onguti, Chief Economist, Ministry of Health
10:30-13:00	Delivering health services for rural women and children: Access and Quality Panel chair: Mr. Elkana Onguti, Chief Economist, Ministry of Health	• Key challenges in service Delivery- Dr William Maina, MoH (20 Mins) • Key findings from Efficiency Study –Dr Urbanus Kioko, UON (20Mins)
		Panel Discussion: **Kenyan Experiences** 1. Primary Health Care especially maternal health: Challenges and progress: Dr. David Ojakaa, AMREF - (10 Mins) 2. Supply side constraints – Evidence from PETS Plus Survey, 2012: Mr. Thomas Maina, USAID/HPP (10Mins) 3. Role of Private Sector in service delivery: Dr. Sam Thenya, Nairobi Women's Hospital (10 Mins) 4. Role of Faith Based Organizations in service delivery: Dr. Sam Mwenda, CHAK (10 Mins)
		Q & A followed by panel chair Summary (40 Mins)
13:00-14:00	Lunch	
14:00-17:00	Ensuring sustainable financing to achieve universal health coverage for Kenyans Panel Chair: Dr. J. Masasabi Wekesa-Head, Directorate of Policy Planning and Healthcare Financing	• Key health financing challenges and efforts towards UHC - Mr. Elkanah Onguti, Chief Economist, MoH (20 Mins) • Healthcare utilization and expenditure – Evidence from the Household Survey of 2013: Mr. Stephen Muchiri-USAID/HPP (20 Mins)
		Panel Discussion: **Kenyan Experiences** 1. Fiscal space options for Health financing in Kenya– Ms. Benadette M. Wanjala, KIPPRA, Kenya (10 Mins) 2. Sustainable HIV Financing : Ms. Regina Ombam, NACC (10 Mins) 3. Benefits Incidence Analysis: Dr. Jane Chuma, USAID/HPP (10Mins) 4. Health Insurance Subsidies for the poor and Role of NHIF: Ms. Nellie Keriri, NHIF (10 Mins) **International Lessons:**

		5. Lessons from India: Dr. Somil Nagpal, World Bank - Health Insurance Regulation (20 Mins) 6. Developing sustainable health insurance programs - Lessons from Mexico: Mr. Jorge Coarasa, IFC (20 Mins) 7. Global lessons from health financing reform for UHC: Dr. Matthew Jowett, Senior Health Financing Specialist, WHO (20Mins)
		Q&A followed by panel chair summary (40 Mins)
18:00 – 20.00	Reception	All invited Participants.
March 19, 2014 Implementation Perspectives		
8:30-11:00	Enhancing governance and effectiveness of the health systems to deliver quality health care Panel chair: Tawhid Nawaz, Acting Sector Director, Human Development, Africa Region	• Key Health Systems Governance Challenges - Dr. S. K. Sharif, Former Director of Public Health and Sanitation (20 Mins) • Emerging issues on governance in health sector – County experience: Dr. Maurice Siminyu, CEC-Busia County (20mins)
		Panel Discussion: **Kenyan Experience** 1. The role of Parliamentary Health Committee in supporting governance in the health sector: Dr. James Nyikal, MP and member of the Parliamentary Committee on Health (20Mins) 2. Governance in Pharmaceutical supply chain system in the public sector: challenges and opportunities: Dr. Maureen Nafula, Strathmore University (15 Mins) **International Lessons** 3. International experiences in promoting governance in pharmaceutical supply chain: Prof. Prashant Yadav, Director, Healthcare Research, University of Michigan (20mins)
		Q&A followed by panel chair Summary (40 Mins)
11:00-11:30	Tea	
11:30-13:00	Strengthening Health Systems in devolved Setting: The Kenyan challenges Panel Chair: Dr. Sharma Suneeta, Project Director, USAID/HPP	• Kenyan Devolution: Opportunities and challenges for the health system: Dr. Ruth Kitetu – Ministry of Health (20Mins) • Opportunities and challenges in devolution in the health sector, county experience: Dr. Elizabeth Ogaja, CEC – Kisumu County (20Mins)
		Panel Discussion **Kenyan Experiences** 1. Devolution in the health sector. Transition Authority's own experiences and challenges with devolution in the health sector: Dr. Dabar Abdi Maalim, Transition Authority (10 Mins) **International Experiences** 2. Prof. David Peters, Head, International Health, Johns Hopkins University (20Mins)
		Q&A followed by panel chair summary (30 Mins)
13:00-14;00	Lunch	

14:00-17:00	Health Systems in a devolved setting: More Kenyan experiences and International experiences Panel chair: Dr. Olusoji Adeyi, Sector Manager, Health Nutrition and Population, Eastern and Southern Africa.	**International Experiences** 3. Indian experiences in managing devolved health systems. National Rural Health Mission -Ms. Sujatha Rao, Former Secretary of Health, Government of India (20 Mins) 4. Lessons from Ghana in health sector devolution – Dr. Abdulai Tinorgah–Former Director, Health Services, Govt. of Ghana (20 Mins) 5. Brazilian experiences in devolution: Ms. Marcia Huculak – Superintendent of Health - Brazil, State of Parana (20 Mins) 6. Ethiopian experiences in effective delivery of primary healthcare services in devolved health systems: Ms. Roman Tesfaye, Director General - Heath Insurance Agency, Ethiopia (20 Mins)
		Q&A followed by panel chair Summary (40 Mins)

March 20,2014 Service Quality Perspectives		
09:00-11:00	Promoting client safety and quality of health service delivery Panel Chair: Dr. J. Masasabi Wekesa-Head, Directorate of Policy Planning and Healthcare Financing	• Regulatory and Quality assurance challenges in Kenya – Dr. Pacifica Onyancha, MoH (20Mins)
		Kenyan Experience 1. Role of KENAS in regulating quality of health services – Ms. Doris Mueni, KENAS (20Mins) 2. NHIF step-wise accreditation process – Early experiences : Ms. Julia Ouko, Senior Benefits and Quality Assurance officer, NHIF (20Mins) **International Lessons** 3. International experiences in measuring Quality and Safety- Mr. Jishnu Das, The World Bank (20Mins) 4. Experiences on quality improvement in Nigeria and Tanzania – Ms Nicole Spieker, Director of quality, Safecare, PharmAcces Foundation (20 Mins)
11.00-11.30	Tea Break	
11.30-12.15		Q&A followed by panel chair Summary (40 Mins)
12:15-12:45		Way forward – Nzoya Munguti, Deputy Chief Economist (30 Mins)