SP4PHC
Strategic Purchasing for Primary Health Care

A REVIEW OF EDUAFYA

THINKWELL

The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care (PHC) services, with a focus on family planning and maternal, newborn, and child health. The project is supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell and partners in five countries: Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda. In Kenya, the project is collaborating with key government stakeholders to strengthen health purchasing policies and practices at the national- and county-levels that can improve delivery of PHC, especially family planning and maternal, newborn, and child health services.

The SP4PHC project team in Kenya undertook a rapid review of EduAfya, a scheme launched by the Government of Kenya to provide health insurance coverage to public secondary school students. This brief assesses how the program is working, drawing on implementation experience from the perspective of health and education stakeholders in four counties in Kenya. It also explores whether the scheme is being used by its beneficiaries to access reproductive health services since generating insights about purchasing approaches that are best suited to improve access to such services among adolescents is a central part of SP4PHC's learning agenda.

BACKGROUND

In December 2017, President Kenyatta announced that a new health insurance scheme – EduAfya – would be introduced to cater for public secondary school students in Kenya. The program, which covered 2.7 million students in 2019 (NHIF 2020), aims to improve the health of secondary school students and inculcate in them an appreciation for the value of health insurance from a young age. The Ministry of Education, Science, and Technology (MoEST) and the National Hospital Insurance Fund (NHIF) signed a contract in April 2018 and students started accessing services from May 2018. In fiscal year 2018/19, the EduAfya scheme had a budget of KES 4 billion based on a premium of KES 1,350 per student per year (PSCU 2018). 95% of the EduAfya budget was spent (NHIF 2020). The scheme is reviewed on an annual basis and renewed through agreement by the MoEST and the NHIF.

METHODOLOGY

The purpose of this brief is to provide an overview of the EduAfya scheme, exploring the following topics:

- How the EduAfya scheme is working in practice, and the contextual and operational factors that enable or inhibit the scheme at county level;
- Whether the EduAfya scheme is currently being used by its beneficiaries to access contraceptive services;
- The alignment of sectors and stakeholders for the achievement of policy and development objectives.

This brief has drawn on both primary and secondary sources of information. The team reviewed publicly-available government documentation about the scheme, namely NHIF's brochure about the EduAfya scheme (NHIF 2019) and a presentation on the MoEST website (NHIF and

Ministry of Education 2018). The brief also drew from education and health policies of relevance to adolescents, as well as any articles about the scheme in the popular media. The team collected primary data through site visits and stakeholder interviews in four counties and an interview with the MoEST. Social franchise private health facilities participating in EduAfya were identified through Marie Stopes Kenya and Population Services Kenya. Public sector and non-franchised private sector health facilities were identified by respective county directors of health (CDoHs). Health facilities ranged from hospitals (level 5) to dispensaries (level 2) in order to gauge scheme performance at different levels of care. Education sector stakeholders included county directors of education (CDoEs) and school head teachers. The number of visited sites and stakeholder interviews conducted are outlined in Table 1. Data was collected between July and August 2019.

Table 1. Sites visited and stakeholders interviewed by county

County	A	B	C	D
Total number of health facilities visited	**10**	**10**	**9**	**14**
Public	4	8	3	10
Private	6	2	6	4
Number of schools visited	2	3	2	1*
Total number of stakeholders interviewed	**20**	**31**	**23**	**25**
Health stakeholders (health facility managers and CDoHs)	17	25	19	23
School stakeholders (CdoEs and head teachers)	3	6	4	2

**Two other schools were closed at the time of the visit.*

Findings have been organized around key themes related to the objectives of the study. Counties have not been referred to by name but have been coded as A, B, C, and D in order to protect the identity of the respondents. These counties are based in the coastal, eastern, and western regions and, therefore, may not be reflective of EduAfya experience in other regions of Kenya.

HOW THE SCHEME WORKS

Registration of beneficiaries

The EduAfya scheme offers comprehensive medical insurance coverage for students in public secondary schools registered with the National Educational Management Information Systems (NEMIS).[1] The number of NEMIS registered students was estimated at 2.2 million by the NHIF as part of its EduAfya sensitization materials (NHIF and Ministry of Education 2018). However, this appears to be out of a projected population of 3 million public school students targeted by the program as was initially set out in the Presidential announcement (PSCU 2018). It is unclear if the difference in estimated students presents a real gap.

Based on stakeholder interviews in the four counties, all health care providers indicated that they had a proportion of their claims disapproved due to the lack of a valid NEMIS number and that this continued to be an ongoing issue. From county education counterparts, the reasons provided for the lack of a NEMIS number included network issues, the lack of internet technology (IT) and/or IT "savvy" to register students on NEMIS; lack of birth certificates for some students; keying errors

[1] NEMIS is the management information system under the MoEST. It captures the details of every student, as well as teaching and non-teaching staff (i.e. auxiliary staff).

resulting in invalid NEMIS numbers; transmission lag of NEMIS numbers due to student transfers; and, ultimately, low motivation on the part of school heads to lead registration of students to NEMIS. This varied by school and was largely dependent on the motivation of the head teacher. To ensure improved enrolment, MoEST has pegged the student capitation reimbursements to schools on the enrolment of students on NEMIS from May 2019. NEMIS registration as a means of accessing health services was intended to be a stop gap measure. Originally, students were to be issued with a NHIF card for EduAfya. However, according to all stakeholders interviewed, students had not received NHIF cards a year into the program in the visited counties.

Additionally, many health care providers indicated that they require letters from the head teachers in order to attend to students. Although the official purpose of these letters is to ensure that students without NEMIS numbers have access to EduAfya (NHIF 2020), this additional step has implications for access during holiday periods, when students return to their homes from boarding facilities. The letter, or other form of teacher approval, also has implications for student privacy and confidentiality as students need to state the reason for seeking health care before they can get permission from the school to access services. In the sites visited, most of the students were aged 11-19 years and the schools varied in terms of day, boarding, boys only, girls only, and mixed secondary schools. Some of the schools maintain a clinic or sanitarium -using their buget from MoEST - to cater for medical emegencies by engaging a nurse or clinical officer. These facilities are not included within EduAfya nor are they registered with the NHIF. Some also engage a school matron or a senior teacher from whom students in need of health services must seek permision to go to an EduAfya facility for treatment. Some of the schools are located near health facilities, while in other cases students have to travel some distance to the health facility.

Benefit package

The EduAfya scheme offers a comprehensive benefit package. It was reported at the launch of EduAfya that *"the comprehensive medical Insurance cover for the students has been negotiated between the Education ministry and NHIF, taking into account the uniqueness of the population to be insured"* (PSCU 2018). In practice, it is unclear how unique the insurance coverage is as it has been modelled on the civil servants' scheme. EduAfya, in accordance with the civil servants' scheme, includes outpatient services, inpatient services, daycare surgical services, local road ambulance, and emergency air rescue services. Cases that require overseas air evacuation, general and specialised services, overseas management for cases not treated in the country, funeral expenses, and group life are also part of the package. Optical and dental benefits are covered only in public facilities as a cost containment measure (NHIF 2020).

Contracted facilities

Health facilities with existing NHIF contracts are eligible to provide services to students. No separate contract is issued for EduAfya. NHIF guidance indicates that outpatient services are provided on a choice-basis at any contracted facilities. Students access ward bed facilities for inpatient services in any accredited facilities. This includes accredited mission/faith-based healthcare providers and accredited private hospitals, except for high-cost private facilities. Inpatient care is on a referral basis from the selected outpatient care facility. It is assumed that all referral health facilities are included within the EduAfya scheme, as they are NHIF accredited.

Initial challenges with the selection of facilities have since been addressed. Originally, selection of health facilities was done by the head teachers of the approximately 9,000 secondary schools in the country (Business Daily 2017). Head teachers would then forward the selected health facilities to the NHIF branch through the CDoEs. While this was the initial practice, it proved problematic as enterprising facilities vied for contracts with schools, even if this did not make geographic sense. Implied in this arrangement were backhanded deals between the schools and health facilities. This situation seems to have corrected itself as there are no longer limitations on which health facilities schools may send students to, which has reduced the likelihood of gatekeeping. While in all counties there were some, mainly private, providers with a lot of schools attached to their facility, these were within their

catchment area. In cases where they were not and the facility was offering outreach services to the schools, these were justified on the basis that there were no participating EduAfya facilities nearby, in 'interior' locations of the four counties.

The level of engagement of providers in EduAfya varied by county and by facility type and level. The differences in engagement were mostly seen in public providers, whereas all private providers visited were active under the scheme. The level of engagement in the public sector was largely attributed to the public financial management arrangements in place. Specifically, this related to whether a public facility could retain NHIF reimbursements and had the authority to incur expenditure, i.e. pay expenses or make improvements to their facilities/services.

- In Counties A and C, PHC facilities and some hospitals received NHIF reimbursements directly and had the authority to incur expenditure, using reimbursements from EduAfya and other NHIF schemes. In response, these facilities had employed additional casual workers, e.g. young people with IT and accounting skills, to follow up NHIF reimbursements and promote their facilities within their communities (schools in the case of EduAfya and pregnant women in the case of Linda Mama). There was a palpable sense of teamwork and active engagement around the schemes, and a recognition that EduAfya clients were a benefit and not a burden to the facility.
- In contrast, in county D, there was less active and more mixed engagement on EduAfya. For example, only two of six public health centers visited were participating in EduAfya despite being located near schools. As this county had a lower number of private providers, schools tended to use the hospitals for EduAfya in lieu of public health centers.
- In County B, lower level public facilities were not participating while higher level facilities were. In this context, dispensaries were attending to students but not claiming for services, despite the same facilities being active on the Linda Mama scheme. This county used a common software in hospitals that allows facilities to track the payer for each service offered, a practice that is useful in promoting coherence in the use of funds at the facility level under universal health coverage (UHC) and strategic purchasing for PHC.

There is increasing awareness about the importance of offering youth-friendly services among facility managers, but their readiness to do so is mixed. In county A, for example, all three adolescent- and youth-friendly centers[2] visited were either closed or found to not have any staff, youth, or adolescents in attendance. These sites attend to students in the outpatient department, mainly for common ailments. This suggests that the youth-friendly centers may not be working optimally, nor is there effort to connect youth-friendly centers with EduAfya, despite having the same target population. In all counties, it was found that some providers, both public and private, were trying to be more adolescent-friendly by giving students priority attention, including hiring additional health personnel so that students could be seen quickly.

Payment to facilities

EduAfya services are reimbursed on a fixed-fee-for-service basis. This ranges from KES 1,000 to KES 1,500 for out-patient and KES 1,500 to KES 4,000 daily rebate for in-patient services depending on the size of health facility and the NHIF contract. Through discussions with providers, there was a sense that EduAfya rates were generally fair and better than what is provided for under other NHIF schemes, such as the national scheme's capitation rate. However, there were concerns voiced that reimbursement rates were not transparent between facilities and that the NHIF had reduced rates for some facilities abitrarily.[3] For example, some facilities visited in County A noted that their rate was reduced from KES 1,500 per out-patient service to KES 1,000 without any prior communication or

[2] The youth-friendly centres visited were standalone facilities located on the grounds of larger health facilities but accessed separately. These were constructed with USAID support.

[3] These were contracts for NHIF in- and out-patient schemes as no separate contract is in place for EduAfya. The reimbursement schedule indicated the change in EduAfya rates.

rationale. This is demotivating for providers and undermines the working relationship between providers and the NHIF.

Reimbursements suffer from similar bureaucratic issues as other NHIF schemes. All providers were challenged by delays in reimbursement. Many providers also reported receiving partial payments without any remedy to address the remaining balance. Some of these unpaid balances are significant and had been 'on the books' for some time. A lot of unpaid balances were related to issues with student NEMIS numbers. In all counties, providers reported that they are told to treat students missing NEMIS numbers and that the payment would be sorted out later. Payment on these manual claims have not been paid, since NHIF now only accepts claims made through the EduAfya management information system. However, as a lot of communication remains informal with the NHIF branch office, providers do not feel that they have recourse to formal action. When providers do formally engage at the NHIF branch level, often they are told that this is an issue for the national level.

Cost containment measures appear to include the aforementioned rate reductions as well as service rationing. This may be in response to the perception, real or otherwise, that students were being overtreated in the initial wave of the EduAfya program, when schools were in charge of selecting health facilities. As noted in one of Kenya's dailies, *"with the rollout of EduAfya, we have realized a rise in the cases of students visiting hospitals, which begs the question are they genuine cases or is there an outbreak of some disease?"* (Korir 2019). Common ailments reported by providers in the four counties were similar; some were disease and seasonally related, such as malaria or acute respiratory infections. Other ailments were more of the "silent" nature, conditions that students had been suffering from, such as skin or urinary tract infections, but which had not prompted health seeking. Some providers reported that they were told to curtail their outreach activities and reduce the number of students they were treating per month. This may be perceived as service rationing or rationalization, depending on stakeholder perspective.

ALIGNMENT ACROSS KEY STAKEHOLDERS

The EduAfya scheme could be much more effective if there was better alignment across stakeholders instrumental to its implementation. The program provides a platform for multi-sectoral collaboration through institutional arrangements between the MoEST and NHIF at the national level, as well as practical working arrangements at the county level between schools and health facilities and their respective county executive directorates. However, county visits revealed the following:

- In all counties visited, there was limited stewardship or use of policy instruments by health and education sectors. EduAfya was generally viewed as a program to address curative care of common ailments and the removal of financial barriers associated with these illness; however, more debilitating conditions such as sexually transmitted infections (STIs), teenage pregnancy, and mental health issues were not spoken of despite these having devastating consequences for the individual, the health system and development more broadly.
- In all counties, there was limited "active" management of EduAfya by the NHIF. For example, EduAfya was not included in facility contracts in the sites visited, despite other NHIF schemes being clearly itemised with the assumption that the EduAfya scheme "rides" on the out-patient and in-patient contracts. There was no reference to EduAfya at recent NHIF-led health facility sensitization meetings in counties B and D. It remains unclear if NHIF branch offices actively monitor the performance of EduAfya.
- In all counties, there was evidence of poor communication between sectors and levels of government. For example, there was limited communication between NHIF branches and health facilities and limited communication between directorates (education and health). Most communication was informal, which limited the recourse that health facilities had with the NHIF. It was suggested by stakeholders that national communication on EduAfya was limited and did not guide on operational challenges, such as the NEMIS numbers. This

view was reinforced through the secondary data review which revealed limited documentation on the scheme in the public domain.

- MoEST is using existing forums, such as parent-teacher annual general meetings, for sensitization on EduAfya. The health sector could do more to leverage these same events to increase awareness about adolescent health issues including adolescent sexual and reproductive health (ASRH).

A MISSED OPPORTUNITY FOR ADOLESCENT REPRODUCTIVE HEALTH

High rates of pregnancy among adolescent girls is matter of concern for Kenya. According to the 2014 Demographic and Health Survey, the teenage pregnancy rate in Kenya is 18% nationally and ranges between 20% to 30% in one third of the counties (Kenya National Bureau of Statistics et al. 2015). In terms of level and rate of change, Kenya is doing better than some its neighbors (Uganda and Tanzania) but not as well as others (Rwanda and Ethiopia) (Uganda Bureau of Statistics and ICF 2018; Ministry of Health, Community Development, Gender, Elderly and Children et al. 2016, Central Statistical Agency and ICF 2016; National Institute of Statistics of Rwanda, Ministry of Health, and ICF International 2015). Reproductive health conditions and complications during pregnancy are the second leading cause of death for 15 to 19-year-old girls in Kenya (Chatterjee 2019).

Kenya adopted an ASRH policy in 2015 that aims to improve health outcomes among adolescents and, in turn, enable them to realize their full potential in the context of national development. The policy emphasizes the need to address the high levels of unprotected sexual activity, STIs (including HIV infection), early pregnancy, and abortion among adolescents (MOH 2015). This need was recognised by some stakeholders in the visited counties. The issue of teenage pregnancy has garnered considerable media attention, as well as recognition from some political leaders (Obiria 2020; Atieno 2017).

The EduAfya scheme, designed to be a comprehensive health scheme for secondary school students, does not prioritize ASRH. While the benefit package covers outpatient services broadly, there is no explicit reference to ASRH services within the EduAfya benefit package. The process for students to access services under the program – specifically the requirement that a student needs a letter of approval from the head teacher in order to access services-poses an additional impediment. A process that ensures the security of the student while also allowing them greater privacy would be preferable. Through the county visits, it was established that most providers are *not* offering ASRH services to students under the EduAfya scheme. In some instances, providers indicated that they did provide adolescents, including students, with contraception but not under EduAfya. One private provider in County C openly acknowledged that the facility offered students contraception and claimed this service on EduAfya. This was the only provider that reported doing this from the visited counties.

CONCLUSION AND RECOMMENDATIONS

EduAfya has no doubt improved access to some health services for secondary school students in Kenya but could be improved further to effectively address the health needs of secondary students, including ASRH. In the visited counties, EduAfya appears to have removed financial barriers associated with accessing health services for bona-fide secondary school students. However, services accessed were more curative than preventive in nature and did not address the ASRH needs of students. Health and education stakeholders appreciated the program's potential for multi-sectoral action to address the health problems of adolescents but did not make the connection with ASRH policy. At a programmatic level, EduAfya recognizes the importance of investing in young people, which is viewed as a means of transforming the nation. Kenya's health policy also recognizes these objectives. However, there remains a disconnect between program and policy as EduAfya has been viewed largely as a curative health program, attending to common ailments and is passive about ASRH, which is left to the initiative of individuals. Stewardship by both the health and education sectors has been serendipitous, while the NHIF has passively administrated the program

without actively acting as a strategic purchaser for adolescent health.

Based on this review, we offer the following recommendations to improve the EduAfya scheme:

- **Provide greater procedural clarity for providers.** There is need for more proactive and consistent management of EduAfya so that procedural delays can be reduced for participating providers. This is acutely needed for claims processing and reimbursement delays. This is also needed for contracting of providers under the program. The assessment noted that the terms and conditions of the EduAfya benefit packagewere missing in the new contracts covering the period 2018-2022. This needs to be corrected to ensure that EduAfya remains a priority program within accredited facilities. This can be further clarified by the development of a handbook on EduAfya, as has been done of other NHIF schemes under NHIF such as Linda Mama and the national police service.
- **Provide greater procedural clarity for schools and students**. There is a need to explore ways for students to access all services that they may need under the EduAfya scheme, including ASRH services. While head teachers have a function to play in safe guarding students, which may have led to the current practice of students requiring permission to visit a health facility, reasons for seeking care should remain private so that students can seek more sensitive services should they require these. For this to happen, students would need to know that these are available and offered confidentially.
- **Address barriers to participation by public providers.** For EduAfya to achieve its potential as a multi-sectoral platfrom for adolescent health, public providers need to engage in the scheme. This is particularly important where private sector alternatives are not available within catchment areas and as a means of enforcing pathways to care, i.e. not by-passing PHC facilities and overloading hospitals. The assessment highlighted that where public financial management processes allow for facility autonomy, public providers are active under the scheme and are able to use EduAfya resources to improve services.
- **Harness EduAyfa for the priority health needs of secondary students.** While EduAfya is seen as a vehicle for UHC, for it to do so requires that it addresses student health issues holistically, particularly those that have sigificant health burden and consequences for educational attainment, including STIs, unwantfed pregnancy and abortion. These are sensitive matters in the Kenyan context. They require stewardship and multi-sectoral engagement, including with parents. If left unstewarded, individuals may not be supported to access the care they need by the EduAfya scheme and wider health system.

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