SP4PHC
Strategic Purchasing for Primary Health Care

A REVIEW OF AFYA CARE - THE UNIVERSAL HEALTH COVERAGE PILOT PROGRAM - IN ISIOLO COUNTY

THINKWELL

The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care 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 family planning and maternal, newborn, and child health services.

In late 2018, the Government of Kenya launched the *Afya Care* Universal Health Coverage (UHC) pilot program in four counties in Kenya. Under the initiative, county governments discontinued all user fees at secondary public hospitals and, in return, received commodities and additional funds from the National Government. The Isiolo County Department of Health (CDOH) and ThinkWell undertook a rapid review of the pilot program in Isiolo, which is also one of three focus counties for the SP4PHC project. This brief documents Isiolo county's experience to capture learnings that can inform the countrywide scale-up of the Afya Care program.

BACKGROUND

In 2013, Kenya transitioned to a devolved system of government, under which 47 newly created county governments oversee delivery of primary and secondary health care services at levels 1 to 5 (Box 1). Counties' main sources of revenue are: their share of national revenue received in the form of a block grant from the National Government; local revenue that includes funds that public health facilities generate from user fees and health insurance reimbursements; and conditional grants from the National Government and donors (Tsofa et al. 2017; McCollum et al. 2018). Counties also have the authority to decide if public facilities can retain and spend own-source revenue as per the 2012 Public Finance Management Act (The Republic of Kenya, n.d.).

User fees have been an important source of revenue for public health facilities in Kenya for nearly three decades (Mbuthia et al. 2019). As shown in Figure 1, health services in the public sector were free until 1989, when user fees were introduced to raise additional revenue for the health sector (Chuma and Thomas 2013; Mwabu and Mwangi 1986). Although during the 1990s, the government introduced exemptions and waivers for certain services, evidence suggests that user fees represented a significant barrier to access (Mwabu, Mwanzia, and Liambila 1995; Moses et al. 1992). In 2004, the government abolished user charges for primary care, and adopted a single flat registration fee of 10 and 20 Kenyan shillings (KSh.) at level 2 and level 3, respectively (Chuma et al. 2009). In 2009, to compensate for the loss of user fees at public health facilities, the Government and development partners jointly set up mechanisms to channel money directly to public health facilities: the Health Sector Support Fund for level 2 and 3 facilities and the Hospital Management Support Fund for hospitals (Tama et al. 2017; Ramana, Chepkoech, and Workie 2013). As of 2012, revenue from user fees accounted for 70% and 53% of the

Box 1. Levels of health care providers

- *Level 1: Community health units*
- *Level 2: Dispensaries*
- *Level 3: Health centers*
- *Level 4: Primary hospitals*
- *Level 5: County referral hospitals*
- *Level 6: National referral hospitals*

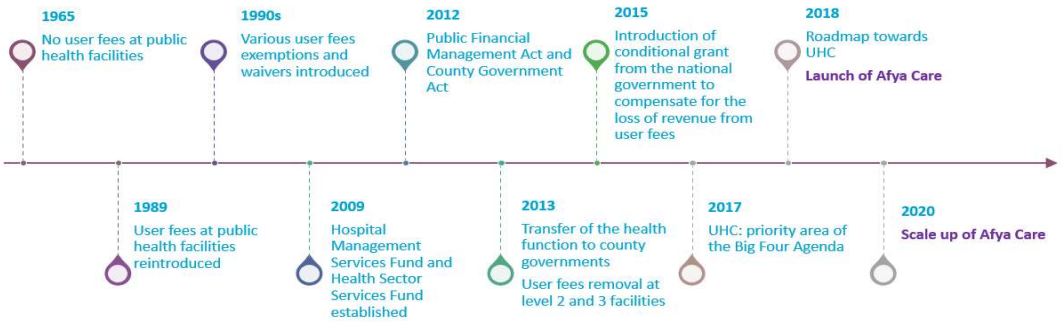
Providers in levels 1-5 fall under the purview of county governments, while level 6 is managed by the National Government.

operating budget of public sector hospitals, and health centers and dispensaries, respectively (Onsomu et al. 2014).

In 2013, the government abolished all user fees at level 2 and 3 facilities in the public sector as well as user fees for deliveries at all public facilities (Chuma and Thomas 2013). At the same time, the National Government set aside funds to compensate public facilities for the user fees foregone. The Ministry of Health (MOH) initially paid facilities directly but given the constitutional requirement for national funds to be transferred into the County Revenue Fund[1], the reimbursements for user fees foregone were converted into conditional grants to the county in fiscal year (FY)[2] 2015/16 (Office of the Controller of Budget n.d.). The National Government releases the conditional grant to counties with instructions on how much should be transferred to specific level 2 and 3 facilities, based on service utilization data from the health information system. The Health Sector Support Fund financed by the Danish International Development Agency (DANIDA) was discontinued, and DANIDA changed its support to a conditional grant where county governments are required to channel the funds to level 2 and 3 facilities. These facilities can use the conditional grants, either funded by the National Government or DANIDA, for operations and maintenance.

In December 2018, President Kenyatta announced the launch of Afya Care – the UHC pilot program – to give Kenyans access to quality health care services without suffering from financial hardship (Ministry of Health 2018). The four pilot counties – Isiolo, Kisumu, Machakos, and Nyeri – were selected because they are characterized by high incidence of both communicable and non-communicable diseases, maternal mortality, and road traffic injuries (Nzwili 2018). The pilot was intended to run for one year starting December 13, 2018 (MOH 2020). The National Government stated the intent to scale up the program to the rest of the country following the review of the pilot, with the final goal of reaching 100% population coverage by 2022 (Nzwili 2018).

Figure 1. Key health sector reforms in Kenya



Source: By authors, based on Waweru et al. 2016; Tsofa et al. 2017; MANI Project, Options, and Marie Stopes International 2018; Ministry of Health 2018

[1] According to the 2012 Public Finance Management Act, each county government established a County Revenue Fund, into which all money raised or received by or on behalf of the county government should be paid.

[2] The Kenyan FY runs from July 1 to June 30 of the next calendar year.

METHODOLOGY

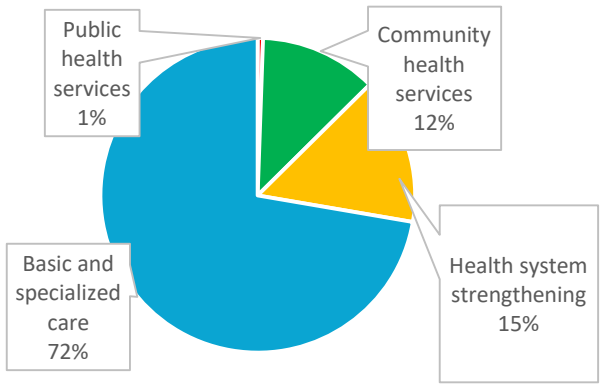
The purpose of this brief is to provide an overview of how the UHC pilot has been working in practice in Isiolo, one of the four pilot counties which is also supported by ThinkWell through the SP4PHC project. This brief has drawn on both primary and secondary sources of information. The team reviewed the publicly available documentation about the UHC pilot program and collected information through key informant interviews conducted in Isiolo county. Between August and December 2019, the team conducted 20 interviews with the UHC pilot program coordinator, county health accountants, county pharmacist, subcounty health administrators, community health strategy focal person, facility managers and accountants.

THE UHC PILOT PROGRAM DESIGN

The design of the scheme involved households in Isiolo, Kisumu, Machakos and Nyeri registering for Afya Care. Following registration, households would receive a card that would entitle them to access free services in public facilities. The card would also prevent residents from other counties in Kenya from accessing services in the four pilot counties.

As per the agreement between the National Government and the counties, Isiolo, Kisumu, Machakos, and Nyeri county governments would discontinue user fees at level 4 and 5 facilities. The National Government would use conditional grants to reimburse the four counties for the lost revenue from the user fees foregone, with support from development partners (Mbuthia et al. 2019).

Figure 2. Allocation of UHC pilot program funds



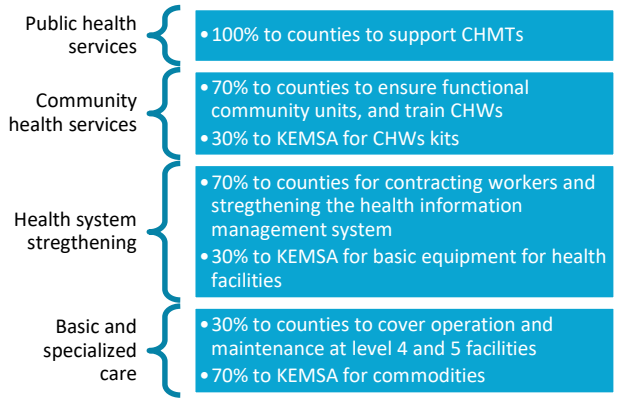
Source: MOH 2018a

The four pilot counties – Isiolo, Kisumu, Machakos, and Nyeri – would receive KSh. 3.1 billion in total, divided across four areas. Most funds were allocated for the delivery of basic and specialized care services (72%), followed by activities for health system strengthening (15%), community health services (12%), and public health services (1%) (Figure 2).

MOH provided additional guidelines on the use of funds under each of the four categories (Figure 3). Resources under the category of public health services were exclusively allocated to County Health Management Teams (CHMTs) for service quality control, data collection, and surveillance. The funds for community health services were intended to support training of and supplies for community health workers (CHWs). Most of the funds under the category of health system strengthening were allocated to support recruitment of health workers, preferably on a contract basis. The remainder of funds were for the provision of basic medical equipment in health facilities through the Kenya Medical Supplies Authority (KEMSA). The guidelines stated that a minimum of 5% of the resources for health system strengthening must be used for performance-based financing (PBF) at the facility level (60% allocated to health workers and 40% allocated to improve the working conditions in health facilities). MOH provided further guidance for implementation of this PBF mechanism. The lion's share of the pilot funds was earmarked for basic and specialized care. While 70% of funds for basic and specialized care services were to flow to KEMSA for medicines and other supplies, the remining 30% went to counties to cover operations and maintenance at level 4 and 5 facilities (MOH 2018a).

Fund recipients were required to develop workplans for the use of funds. CHMTs were required to develop a workplan for the use of public health services, community health services and health system strengthening funds, and to develop monthly, quarterly, and annual reports on activities. The same requirements applied to health facility management teams, but their workplans had to be first approved by CHMTs. At the county level, CHMTs were to carry out the implementation of the UHC pilot program under the guidance of CDOH (MOH 2018a).

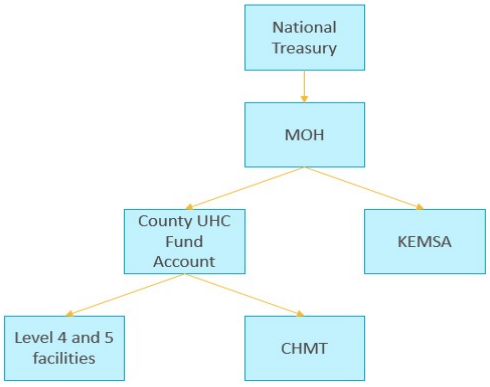
Figure 3. Allocation of funds across the four areas supported by the UHC pilot program



Source: MOH 2018a

As per MOH guidelines, funds for the UHC pilot program flowed from the National Treasury to MOH and then were disbursed to the County UHC Fund Account, except for the funds to KEMSA set aside for each of the four pilot counties (Figure 4). Counties were required to open an UHC Fund Account to directly receive the MOH funding for the UHC pilot program and not go through the County Revenue Fund. Every quarter, within 5 days of reaching the county UHC fund account, funds for the level 4 and 5 facilities were intended to be sent to the facility's respective bank account, while funds for public health services, community health services, and health system strengthening were supposed to be sent to CHMT account. Every quarter, MOH was supposed to transfer funds directly to KEMSA within 5 working days (MOH 2018a).

Figure 4. UHC pilot program flow of funds



Source: By authors, adapted from MOH 2018a

ISIOLO'S EXPERIENCE WITH THE UHC PILOT PROGRAM

Registration of households

The residents of Isiolo county needed to present their national identity card to register under the UHC program. The County Government, the National Hospital Insurance Fund (NHIF), and Living Goods supported door-to-door registration of households, which took place in the second half of November 2018. In the second half of January 2019 and the first half of February 2019, the remaining families not reached during the first round were registered. CHWs used smartphones to register households and Living Goods provided the digital platform to collect registration information, which was processed by the NHIF. Information on the actual population reached (172,000 people registered out of approximately 185,000), as well as the socio-economic status of households was captured on the digital platform. There were no charges for registering and households received information on the benefits of having an UHC card. NHIF issued cards attesting households' registration under the UHC program, which were distributed by MOH to facilities and then by CHWs to households. People were also able to collect cards from nearby health facilities. However, not all cards were distributed to dispensaries, as people opted to collect their card when referred to a higher-level facility.

One person per household – the principal member – received the UHC card. Typically, households were comprised of the principal member, spouse, and dependents. There was no limit on the number of people to be registered from a household. Children over 18 years of age were considered independent and received a separate card. Details about all beneficiaries were not physically included on the card, but this information was available in the registration system. Often not all information on beneficiaries from a household was listed correctly (i.e. name, identification number, and/or photo). Interviewed stakeholders considered that the time allocated for planning the registration process was not sufficient to anticipate such issues.

Allocation of funds at the county level

While half the funds allocated for Isiolo county were received in a timely way during the first half

of 2019, the remaining funds were delayed. The funds were sent from the National Treasury to MOH and then to Isiolo county UHC Fund Account. As per MOH records, Isiolo county was supposed to receive approximately KSh. 285 million or 39% of the total UHC program allocation for Isiolo; MOH was to transfer the remaining funds to KEMSA directly (Table 1). According to the County Governments Annual Budget Implementation Review Report for FY 2018/19, Isiolo received half of these funds by July 2019 (Office of the Controller of Budget 2019). Although the funds were supposed to be transferred on a quarterly basis, no further transfers were received in the second half of 2019 (i.e. the first two quarters of FY 2019/20) (Office of the Controller of Budget 2020). According to the Isiolo CDOH, which carried out the UHC program implementation under the guidance of CHMT, the remaining funds were received in May 2020.

Table 1. Allocation of UHC pilot program funds in Isiolo county (KSh.)

	Isiolo	KEMSA	Total
Public health services	4,191,489	-	4,191,489
Community health services	14,504,558	6,216,239	20,720,797
Health system strengthening	98,801,679	42,343,577	141,145,256
Basic and specialized care	167,898,463	391,763,081	559,661,544
Total	**285,396,190**	**440,322,897**	**725,719,086**

Source: MOH 2018a

Communication to public providers

All three hospitals in the county – Isiolo County Referral Hospital, Garbatulla and Merti subcounty hospitals – received written communication about the UHC program from the Isiolo UHC coordinator. The Isiolo County Referral Hospital was the only facility equipped to electronically verify the UHC card and patients were asked to pay for services in its absence. The subcounty hospitals provided health services without verifying the cards, as they had no means to do any verification. When the UHC pilot program started in December 2018, the subcounty hospitals stopped charging user fees based on written communication from the County Coordinator for the UHC program. This is similar to Kisumu, another pilot county, where health facilities stopped charging user fees (County Government of Kisumu 2019). As per local NHIF branch verbal communication, facilities in the county stopped offering services under the Linda Mama program and no reimbursements were made as of February 1, 2019. Later, NHIF sent formal written communication as well. In the past, only the Isiolo County Referral Hospital submitted claims and received reimbursements for services provided under the Linda Mama program, so health facilities in the county did not lose too much money when NHIF stopped paying claims. In contrast, health facilities in Kisumu lost significant revenues by not receiving Linda Mama reimbursements and not charging user fees during the pilot program (County Government of Kisumu 2019).

Work planning, budgeting, and allocation of funds at the facility level

The health facility management committees developed workplans, which were sent to the County Health Accountant to review and then to the Health Chief Officer to approve and give authority to incur expenditure. The health facility management committees met on a regular basis to plan activities, as minutes from these meetings had to be submitted to obtain the Health Chief Officer's approval. The County Coordinator for the UHC program, the Health Chief Officer, and the County Executive Committee Member determined the amount of funds to be received by health facilities. In theory, the funds allocated to each facility were supposed to be based on budget, workload, and catchment population. However, in practice, these criteria were not fully applied to increase the allocation of funds to Garbatulla and Merti subcounty hospitals, which otherwise would have received a small amount of money.

Health facilities faced several difficulties with the work planning and budgeting process. Some health facility managers reported that they have not received a template or any instructions on how to prepare the workplan. Other health facility managers claimed that several requests were never approved, though this is not confirmed by the County Health Accountant. Some health facilities had considerable funds in the bank account, but the approval process to withdraw these funds was

tedious. Health facility managers were authorized to withdraw the funds, but they were required to travel to Isiolo town and physically present the request to be able to withdraw the funds.

The Isiolo County Referral Hospital had a more coherent process for developing workplans compared to the two subcounty hospitals. The hospital management team developed the workplan. Next, the hospital executive committee and the finance and audit committee of the hospital board reviewed it, though this happened only occasionally. Finally, the hospital board approved the workplan before sending to the County Health Accountant and then to Health Chief Officer. The board of the two subcounty hospitals were minimally involved in the planning and budgeting process.

As the Isiolo County Referral Hospital is the biggest health facility in the county, it benefited the most from the UHC program funds. While Isiolo County Referral Hospital received KSh. 31 million per quarter, each subcounty hospital received KSh. 5 million per quarter. Funds were transferred to the hospitals' bank account for operational, maintenance, and blood services in two instalments[3]. The Isiolo County Referral Hospital and the two subcounty hospitals received funds under the UHC program in the first two quarters of 2019; the total funds received amounting to KSh. 82 million, half of the initial allocation.

Use of funds

Health facilities in Isiolo used the UHC funds they received to undertake a range of activities. These included both facility- and community-based actions as described in this section.

As a result of receiving additional funds, the Isiolo County Referral Hospital, and Garbatulla and Merti subcounty hospitals offered blood transfusion services. The Isiolo County Referral Hospital organized blood campaigns in partnership with Meru satellite for the National Blood Transfusion Centre. They conducted 25 campaigns in military camps, schools, and open-air crowded places, and these seem to have tremendously improved the availability of blood in Isiolo county. Notably, no maternal deaths have been reported at the Isiolo County Referral Hospital since the campaigns started while the lack of blood previously led to a significant number of maternal deaths.

Public providers also used UHC funds to undertake facility upgrades and maintenance. Isiolo County Referral Hospital made several infrastructural developments to improve service delivery and automated the health information system. Ambulances were repaired so that emergency patients were easily transferred from one facility to another. In addition, the electricity bills were paid for all three hospitals in Isiolo, and cleaning and security companies were contracted. Facilities also used the funds to purchase dental equipment. UHC pilot program funds were also used at the county-level to construct facilities for continuous medical education and CHMT offices.

All facilities, regardless of their level, reported an increase in their workload during the implementation of the UHC pilot program. The number of outpatient visits in Isiolo county doubled compared to the previous year (277,572 visits in 2018 versus 572,528 visits in 2019). For comparison, the other three pilot counties (Kisumu, Machakos, and Nyeri) also reported an increase in workload, but not as high as Isiolo (MOH undated). Out of 135 new staff that were supposed to be employed in Isiolo county, only 23 new staff were hired. These were not sufficient to keep up with the increased number of patients. This compromised the quality of services provided. For example, patients were not always sent to do all the investigations required for diagnoses, because this meant that they would come back to the health facility with the results and create larger queues. Instead patients were diagnosed based on the described symptoms. Mothers were frequently discouraged from accessing services due to queues. Patients were often sharing beds due to the lack of space at the facilities. Currently, Isiolo is in the process of hiring the remaining 112 new staff using money transferred in May 2020.

When the UHC pilot program started, health facilities in Isiolo reported some delays in

[3] Each quarter, level 2 and 3 facilities received KSh. 27,500 and KSh. 127,500 respectively in the form of a conditional grant from DANIDA. These allocations went directly in the level 2 and 3 facilities' bank account.

commodities from KEMSA, but the situation improved with time (except in specialized units). KEMSA sent to counties the quarterly updated request form which included the available medicines and supplies and associated costs. Health facilities in Isiolo used this form to place orders at the subcounty level. Twenty staff were trained to forecast the need of medicines and essential supplies to be ordered from KEMSA. The consolidated requests were sent at the county-level, where the County Pharmacist confirmed orders before sending them to KEMSA. Delivery notes and supply documents are filed at facility-level. Although at the time of data collection there were no stockouts in any of the facilities in Isiolo and they generally received commodities on time, several specialized units indicated that small medical supplies for dental and renal units, and small basic equipment were received late. KEMSA did not deliver all the CHW kits, and the delivery was delayed until February 2020. Kisumu county's experience was more uneven in comparison to Isiolo. KEMSA delivered commodities on time only in the first two quarters of the UHC pilot program implementation (County Government of Kisumu 2019). Although pharmaceuticals availability at health facilities in Kisumu increased during the UHC pilot program, they still faced stockouts (County Government of Kisumu 2019).

Under the UHC pilot program level 2 and 3 facilities benefited from medicines and other supplies from KEMSA. DANIDA funds were mainly spent on casual workers' salaries and stationaries.

With only half of the funds allocated for CHWs related activities received, Isiolo county spent most of these funds on trainings, including health education activities at community level. Around 500 out of 720 CHWs were trained on technical modules using funds from the UHC pilot program. The county decided to offer a monthly stipend to CHWs based on performance as measured by a tool designed by Living Goods. However, the county is using its own funds to provide the monthly stipends to CHWs. In addition, eight new community units were formed using funds from the UHC pilot program.

Although under the UHC pilot program, health facilities and health workers were supposed to be incentivized based on performance-based criteria, this mechanism was not implemented in Isiolo county. Some of the interviewed stakeholders were not aware of it, perhaps due unclear communication from MOH.

CONCLUSION

While this review was not designed to be a systematic evaluation of the UHC pilot in Isiolo, it documents many significant achievements of the scheme. First, the UHC pilot program managed to reach the majority of Isiolo's population, granting them access to services free of charge. The community played an important role in the registration process, as well as Living Goods. Second, UHC funds flowed down to health facilities, which used them to improve infrastructure so that they provide better services. Third, stockouts of medicines and supplies at health facilities reduced considerably during the pilot.

However, Isiolo faced several challenges during the implementation of the UHC pilot program, which are worth taking into account for the scale-up. First, funds were received with a delay resulting in partial implementation of activities under the UHC pilot program. Second, several interviewed stakeholders suggested that a simplified process to access and use funds will most likely lead to better performance. Third, they also mentioned that the UHC steering committee that was supposed to be formed at county-level, was not constituted because of the lack of funds allocated to support this. In addition, the technical working groups for the UHC pilot program were formed but never met also due to lack of funds and lack of coordination as the UHC steering committee was never constituted. Stakeholders indicated that a county-level committee to manage funds was supposed to be formed, but this never happened due to the lack of clear guidelines regarding membership and responsibilities. Fourth, while some health facilities had a better process for developing their workplans, others had difficulties due the lack of guidance or templates to develop these workplans. In addition, workplans were not strictly followed due to changing priorities not only at facility level, but also at county level. CHMT could have played a bigger role in planning and implementation of the program. Fifth, only a few new staff were hired at

the facility-level, which resulted in increased workload of existing staff. The process of hiring was slow because of the delay in reconstituting the new county public service board after the term of the members in office ended, and a delay in appropriation of resources. Lastly, there were issues around the correctness of the card holders' information and not all health facilities had a verification system in place.

Going forward, the Afya Care program presents an opportunity for strengthening strategic purchasing at the county-level. During the pilot, the Isiolo county health system received more funds from the National Government, which resulted in improvements in delivery of health services. In the future, the county government could explore ways to use the funds more strategically to influence provider behavior and address the population health needs. For example, the county could revise the criteria for allocating funds to providers to better reflect the needs at the facility level. It could use a PBF mechanism to incentivize health facilities and health workers; this was something that the UHC pilot program envisioned but did not happen in practice. Such actions would ensure delivery of quality health services to the Kenyan population. Kenya has identified strategic health purchasing as an important lever for making progress towards UHC (MOH 2018b), and Afya Care offers an opportunity for translating that ideal into policy and practice at all levels of government.

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For questions, please write to us at **sp4phc@thinkwell.global**.

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