

## THE TRANSFORMING HEALTH SYSTEMS FOR UNIVERSAL CARE PROJECT IN KENYA: A REVIEW



MINISTRY OF HEALTH

With support from the World Bank, the Global Financing Facility, and the Government of Japan, Kenya is implementing the Transforming Health Systems for Universal Care Project (THS-UCP) to improve reproductive, maternal, newborn, child, and adolescent health (RMNCAH) outcomes in the country. THS-UCP is led by the Ministry of Health (MOH), with support from the Council of Governors (COG). One hundred and thirty million of the US\$ 191.1 million project is structured as performance-based financing to Kenya's 47 counties, who are responsible for implementing project-funded activities. ThinkWell developed this brief to provide an overview of the performance-based financing component of THS-UCP with inputs from MOH and key stakeholders.

### OVERVIEW OF THS-UCP

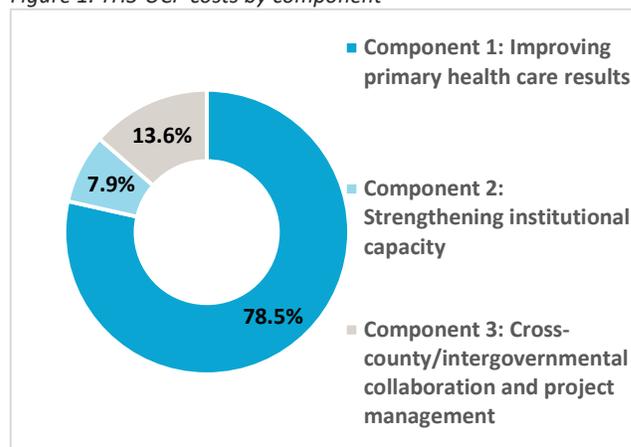
**THS-UCP is a five-year project that aims to improve the utilization and quality of primary healthcare services with a focus on RMNCAH services (World Bank 2016).** It commenced in June 2016 and is scheduled to run until September 2021. The THS-UCP scope is aligned with Kenya's RMNCAH investment framework (Government of Kenya, Ministry of Health 2016).

**Worth US\$ 191.1 million, THS-UCP is co-financed by the World Bank, the Global Financing Facility, and the Government of Japan.** The World Bank provides 78.5% of the funds through a credit from the International Development Association, while 20.9% of the funding comes from the Global Financing Facility Trust Fund grant. The rest comes through a grant from the Japan Policy and Human Resources Development Fund.

**One hundred and thirty million of these funds are structured as performance-based financing from the National Government to county governments under component 1 of the project, as outlined in the THS-UCP's Project Appraisal Document (PAD).**

Component 2 focuses on building quality systems and capacity, while component 3 focuses on cross-county and intergovernmental collaboration and project management (Figure 1).

Figure 1. THS-UCP costs by component



Source: World Bank 2016

**THS-UCP is jointly implemented by existing national and county entities (Figure 2):** the MOH Departments of Intergovernmental Affairs, Quality, Family Health, Monitoring and Evaluation (M&E), and Universal Health Coverage (UHC);<sup>1</sup> Kenya

<sup>1</sup> Names of the MOH departments changed since inception. The updated names of the MOH

departments are: the Department of Health Sector Coordination and Intergovernmental Affairs; the

Medical Training Colleges; Civil Registration Department; Kenya Medical Supplies Agency (KEMSA); 47 county departments of health (CDOHs), and the COG<sup>2</sup> (World Bank 2016).

**A Project Steering Committee, set up under the Intergovernmental Forum for Health, oversees the project at the highest level.** The Committee is co-chaired by the Principal Secretary of MOH and the COG Chief Executive Officer (Chuma 2019). The Committee, which replaces a project sub-technical working group, was created after the midterm review<sup>3</sup> in response to a need for expedited resolution of county issues, regular meetings, and increased stakeholder participation.

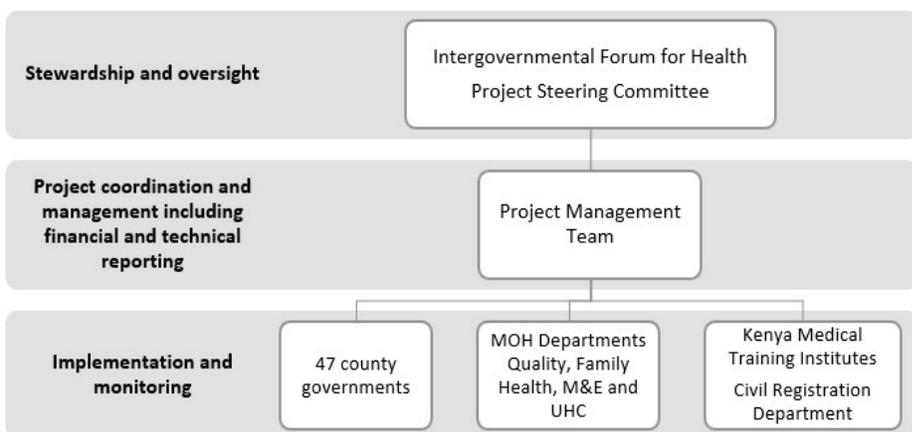
**The Project Management Team (PMT), which is led by a project manager, coordinates the efforts of various implementation entities (Figure 2).** The component 1 coordinator and four county project assistant coordinators, each providing technical assistance to a cluster of 11-12 counties, are embedded within the Health Committee of the COG Secretariat (World Bank 2016). The PMT is supported by subject matter experts from MOH to

ensure the technical soundness of project activities, regular monitoring, and intergovernmental collaboration (Chuma 2019).

## PERFORMANCE-BASED FINANCING TO COUNTY GOVERNMENTS

**The remainder of this brief focuses on component 1 of THS-UCP, wherein the National Government provides performance-based financing to county governments for the delivery of RMNCAH services.** The objective is to review the experience to date and to document lessons that can contribute to further improvement of THS-UCP and inform the evolution of performance-based conditional grants. Kenya’s devolution reform started in 2013 and, as such, the country is still refining the necessary systems, processes, and capacity. The conditional grant mechanism, wherein the National Government channels earmarked funds to counties is relatively new. This review is meant to capture lessons from the experience of one of the main conditional grants in the health sector and is not intended to be an evaluation of the impact of THS-UCP.

Figure 2. THS-UCP’s institutional and implementation arrangements



Source: Chuma 2019

Department of Standards, Quality Assurance, and Regulation; the Division of Family Health; the Division of M&E; Health Research Development and Informatics; and the UHC Secretariat.

<sup>2</sup> The COG is a non-partisan, intergovernmental organization whose mandate includes providing a mechanism for consultation amongst county

governments, sharing county performance information, facilitating capacity building for governors, and considering reports from other intergovernmental forums on national and county interests.

<sup>3</sup> The midterm review was conducted in April 2019.

**ThinkWell developed this brief in collaboration with MOH and key stakeholders, based on information from a desk review, engagement with the PMT, and notes from semi-annual performance review meetings.** ThinkWell conducted this work under the Strategic Purchasing for Primary Health Care (SP4PHC) project, which is supported by a grant from the Bill & Melinda Gates Foundation. SP4PHC is supporting MOH and COG to monitor how counties are using THS-UCP funds for RMNCAH services under this component. SP4PHC also provides targeted technical assistance to the county governments of Isiolo, Kilifi, and Makueni<sup>4</sup> to improve the use of THS-UCP funds.

### Context

**In 2013, Kenya transitioned to a devolved system of the government under which 47 newly created county governments oversee delivery of primary and secondary health care services.** Counties derive revenue from four main sources: counties' share of national revenue received in the form of a block grant from the National Government;<sup>5</sup> local revenue that includes funds that public health facilities generate from user fees and health insurance reimbursements; conditional grants from the National Government that are ear-marked for certain purposes; and conditional grants from donors (Tsofa et al. 2017; McCollum et al. 2018; Mbutia et al. 2019). County governments use these funds to finance service delivery through a network of public providers as well as other population health services. According to the 2012 Public Finance Management Act, each county established a County Revenue Fund (CRF) into which all money raised or received by or on behalf of the county government should be paid (The Republic of Kenya, n.d.).

**As a result of devolution, prior arrangements wherein resources would flow directly from the MOH to facilities in the public sector were**

**discontinued.** In 2009, the World Bank and the Danish International Development Agency (DANIDA) assisted the Government of Kenya to set up the Health Sector Support Fund to compensate primary care facilities<sup>6</sup> for the loss of user fees due to the 10/20 policy<sup>7</sup> (Ramana, Chepkoech, and Workie 2013). On a quarterly basis, a fixed amount of money was directly transferred to facilities' bank account from the National Treasury through a parallel funding mechanism (Tsofa et al. 2017; Nyikuri et al. 2017; DANIDA n.d.; Waweru et al. 2016). A similar mechanism was established for hospitals through the Hospital Management Support Fund (Tama et al. 2017). Following devolution, the Health Sector Support Fund/Hospital Management Support Fund mechanisms were deemed inappropriate.

**Donors have since transitioned their financial support for promoting service delivery to align with post-devolution systems and rules.** DANIDA was the first to move to channeling funds to primary care facilities through the county systems. Under DANIDA's Universal Health Care program, funds flow through the Special Purpose Account (SPA), a single ring-fenced account for conditional grants from donors. As a prerequisite for receiving DANIDA funds, counties must operate these funds through the Integrated Financial Management System (DANIDA n.d.) and channel the funds to PHC facilities to use for covering their operational and maintenance costs.

**Kenya also has a long history of testing results-based financing approaches with support from donors.** For example, between 2014 and 2018, Kenya implemented a performance-based financing program in 21 counties with support from the World Bank. Funds flowed from the National Government to the CRF, and then to the SPA. Counties used these funds to pay primary health facilities who

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<sup>4</sup> These three counties were selected based on inputs from MOH and COG.

<sup>5</sup> This is referred to as the equitable share. These are unrestricted funds, which means counties can allocate at their discretion.

<sup>6</sup> Primary care facilities comprise of dispensaries and health centers.

<sup>7</sup> In 2004, the government abolished user fees for primary care services and adopted a single flat registration fee of 10 and 20 Kenyan shillings at public dispensaries and health centers, respectively – also known as the 10/20 policy (Chuma et al. 2009).

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### Box 1. County allocation criteria

Performance indicators:

1. Percentage of children younger than 1 year who were fully immunized (third dose of pentavalent)
2. Percentage of pregnant women attending at least four antenatal care visits
3. Percentage of births attended by skilled health personnel
4. Percentage of women between 15-49 years currently using a modern family planning method
5. Percentage of inspected facilities meeting safety standards
6. Percentage of women attending antenatal care supplemented with iron and folic acid supplements

County revenue allocation ratio: population (45%), basic equal share (25%), poverty (20%), area (8%), and fiscal responsibility (2%)

Source: World Bank 2016

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achieved performance targets (World Bank 2014a; 2014b).

**Although THS-UCP does not channel funds to health facilities, its design took into account the experiences and insights from past and ongoing projects to channel resources to the frontlines.** It used the conditional grant mechanism to channel funds to counties, much like the DANIDA project and the World Bank funded performance-based financing program. However, unlike the other two programs, it does not require counties to transfer resources to facilities, though counties may opt to do so.

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<sup>8</sup> Only if the SPA was not already opened under previous results-based financing approaches.

<sup>9</sup> The need is measured as a function of (1) proportion of births not attended by a skilled health professional as per the 2014 Kenya Demographic and Health Survey, and (b) government's county revenue allocation ratios.

<sup>10</sup> CRA is an independent government institution in charge of proposing how revenues raised nationally should be shared between the national and the county

### Fund allocation

**The criteria used by the National Government to make allocations to counties have different components and they have evolved over the years.**

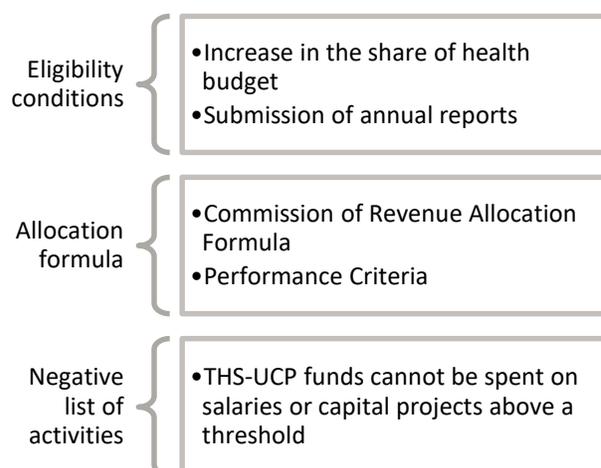
In Year 1 of the project, each county had to meet a set of minimum financial and administrative conditions, namely submitting a supplementary budget for approval by the County Assembly; developing the county annual workplan for health; opening a SPA at the Central Bank of Kenya;<sup>8</sup>; appointing county focal persons, county project accountants, and auditors; and signing an intergovernmental participation agreement with the National Government. After fulfilling this set of minimum conditions, counties were eligible to receive seed money based on need<sup>9</sup> and the Commission of Revenue Allocation (CRA)<sup>10</sup> ratio<sup>11</sup> to jumpstart implementation (World Bank 2016). In fiscal year (FY) 2016/17<sup>12</sup>, all counties met the minimum conditions described above, so they were eligible to receive THS-UCP allocations, which were calculated as planned. However, in FY 2016/17 no disbursements were made to counties due to various reasons as described in Table 1. The THS-UCP's PAD states that for each subsequent year, counties were required to meet the following conditions in order to be eligible to receive THS-UCP funds: (a) the share of the county budget allocation (for Year 2) and expenditure (for Years 3-5) for health is no less than 20% and is higher than the previous year, and (b) the annual project financial and technical report for the previous financial year is submitted to the National Treasury and MOH within 30 days of the end of the financial year.

governments, and among the county governments. The national legislature makes the final decision as part of the budget process.

<sup>11</sup> The CRA ratio takes into account population (45%), basic equal share (25%), poverty (20%), area (8%), and fiscal responsibility (2%).

<sup>12</sup> The fiscal year in Kenya runs from July 1 to June 30 of the following year.

Figure 3. Mechanisms to allocate THS-UCP funds to counties



Source: World Bank 2016

The allocation of funds in Years 2-5 were based on the CRA ratio and performance indicators (Box 1)<sup>13</sup> (World Bank 2016). Figure 3 summarizes THS-UCP’s approach to fund allocations. However, the midterm

review revealed that several counties were already allocating more than 30% of their overall budget to health – which is not sustainable over time. In addition, the review found that expenditure data was not always available on time across the 47 counties, which led to the need for the eligibility conditions to be revised. Therefore, the eligibility conditions were changed as follows: (a) allocation of funds would be based on budget not expenditure data, (b) counties already allocating more than 30% of their budget to health would not be required to increase the allocation in subsequent years, and (c) the THS-UCP county annual allocation would be adjusted based on transfer of the full amount of money from the CRF to the SP A within the stipulated time period – also called the public financial management requirement (Chuma 2019). Between FY 2017/18 and FY 2019/20, counties generally met the conditions to be eligible to receive THS-UCP funds.

Table 1. Allocation of THS-UCP funds at county level, FY 2016/17 - FY 2019/20

Fiscal Year	THS-UCP funds allocation at county level
FY 2016/17	<ul style="list-style-type: none"> <li>All counties met the minimum conditions stated in the THS-UCP’s PAD, so they were eligible to receive seed money to jump-start implementation upon setting up the administrative and financial structures in readiness for the project.</li> <li>Allocations were calculated as planned, i.e., based on need and CRA ratio.</li> <li>No disbursements were made to counties due to various reasons, including difficulties in amending the County Allocation of Revenue Act (CARA)<sup>14</sup> that impeded disbursement of conditional grants to counties in FY 2016/17, limited capacity to manage the government’s Integrated Financial Management System, or multiple leadership changes at the county government level.</li> </ul>
FY 2017/18	<ul style="list-style-type: none"> <li>Eligibility was based on the stated conditions in the THS-UCP’s PAD for Years 2-5 and maintenance of minimum conditions from Year 1.</li> <li>Allocations were based on CRA ratios and need (as defined in Year 1), but not performance given that no funds were disbursed at the county level in the previous year.</li> <li>As all counties met the minimum requirements for seed money, disbursements matched allocation.</li> </ul>

<sup>13</sup> The last two performance indicators listed in Box 1 were not used in Years 2-5 of the project.

<sup>14</sup> The CARA is an annual budget legislation passed by parliament that lists funds allocated to each county

from the national government, including conditional grants.

Fiscal Year	THS-UCP funds allocation at county level
FY 2018/19	<ul style="list-style-type: none"> <li>Eligibility was based on the stated conditions for Years 2-5 in the THS-UCP's PAD and maintenance of minimum conditions from Year 1.</li> <li>County allocations were based on CRA ratios. There was a waiver of the performance-based allocation due to poor performance on indicators.</li> <li>Funds were disbursed based on statements of expenditure and if counties met the public financial management requirement. Three counties did not meet this requirement and received 75% of allocated funds.</li> </ul>
FY 2019/20	<ul style="list-style-type: none"> <li>Eligibility was based on the stated conditions for Years 2-5 in the THS-UCP's PAD and maintenance of minimum conditions from Year 1. Five counties that failed to maintain the minimum set of conditions from Year 1 as stated in the THS-UCP's PAD had to submit supplementary budgets reflecting increased allocations to health to become eligible.</li> <li>County allocation based on CRA ratio and performance indicators.</li> <li>Funds were disbursed based on statements of expenditure. FY 2018/19 funds were disbursed to counties in three tranches. Non-compliance with the public financial management requirement of transferring money from the CRF to the SPA on the first two tranches attracted a penalty in the third and last tranche, which is reflected in subsequent disbursements for FY 2019/20.</li> </ul>

Source: World Bank 2016; 2019; Chuma 2019; MOH 2019c

**The THS-UCP's financial data is tracked through the government's Integrated Financial Management Information System and the World Bank's own system.** Table 2 summarizes the allocations and disbursements between FY 2017/18 to FY 2019/20, showing that whereas all funds for FY 2017/18 were disbursed, only 70% of FY 2018/19 funds were disbursed and FY 2019/20 disbursements were delayed by about half a financial year. As of June 2019, the project disbursed 31% of the total funds (Chuma 2019). As of December 2019, disbursements to counties amounted to KES 3.2 billion (Table 2).

Table 2. Total THS-UCP county allocations and disbursements, FY 2017/18 – FY 2019/20 (KES billion)

Fiscal Year	Allocated	Disbursed
FY 2017/18	1.25	1.25
FY 2018/19	2.7	1.9
FY 2019/20	2.6	No disbursement as of December 2019

Source: MOH Office of the Principal Secretary 2019; 2020

**Notably, data on county allocations and disbursements vary across government information sources.** In Annex 1, we compare data on funds allocated and disbursed to the three SP4PHC project counties for multiple fiscal years from three official sources: CARA, the THS-UCP accounts maintained by COG and MOH, and the Annual County Governments Budget Implementation Review issued by the Controller of Budget (COB)<sup>15</sup>. The county allocations reported in the CARA and the COB report largely align with one another (except for Isiolo in FY 2017/18 and Kilifi in FY 2019/20). However, the data on county allocation from project accounts maintained by COG and MOH do not align with the allocation figures from the other two data sources. Instead, data on county allocation from the project accounts resemble COB's estimates of cumulative disbursement. This is because the THS-UCP's PMT is required to submit indicative figures on the county allocation to the National Treasury in November of the previous FY, and there is no opportunity to revise these later. Therefore, THS-UCP funds

<sup>15</sup> The COB is an independent constitutional body which has the mandate to oversee budget

implementation by the national and county governments.

allocation presented in CARA and COB differs from the county allocation from the THS-UCP accounts.

### Annual work plan implementation

**Once disbursed, THS-UCP funds flow into the CRF and, from there, to a county SPA to finance project activities (World Bank 2016).** County-level activities are implemented through existing county government structures, such as CDOHs, county health management teams, hospital boards (level 4 and 5), and health facility management committees (level 2 and 3) (World Bank 2016).

**THS-UCP activities are integrated in the county annual work plans, which indicate the specific budget line items funded by the project in compliance with health sector planning, budgeting, and review guidelines.** Typically, THS-UCP county activities include procurement of medical equipment and supplies, training, review meetings, community outreach for increased utilization of facility services, and supportive supervision. The project manager convenes draft work plan reviews before submission to the World Bank, then the World Bank either clears the proposed activities to be supported by THS-UCP funds or recommends reviewing certain activities and budget items. The PMT then conducts a technical appraisal of the work plans before disbursing funds in line with the MOH guidelines.

### Performance monitoring

**THS-UCP has a set of indicators to track performance (Box 1).** Some of these indicators were revised after the midterm review to ensure that internationally recognized indicators are used, reduce measurement errors, adjust baseline values and targets, and focus on public facilities.

**Monitoring of THS-UCP results happens at different levels.** Counties track indicators on a monthly basis using data recorded in the District Health Information System 2 (DHIS2) and aggregate these monthly numbers into an annual report (World Bank 2016; Chuma 2019). The PMT and the county's focal persons for THS-UCP use data from the health management information systems (HMIS) to prepare quarterly, biannual, and annual reports. The PMT uses this information to populate THS-UCP dashboards, which allows it to identify gaps and explore course corrections where anomalies such as underperformance are detected. For example,

further investigation revealed that stockouts were the cause of the poor reports. As a response, the Division of Family Health intensified negotiations with MOH and National Treasury to regularize annual budget allocation for consistent family planning commodity supplies (MOH 2019b). In addition, MOH contracts the University of Nairobi to conduct an annual county data verification exercise to assess indicators' performance, which is used to determine county funds allocations and gives counties the opportunity to strengthen their HMIS.



*THS-UCP team conducting the annual data quality audit in 2019 (Photo credit: Benter Owino)*

### IMPLEMENTATION CHALLENGES

**THC-UCP implementation is influenced by broader health system challenges.** While adjustments to the project design were made to improve the way THS-UCP functions, a series of challenges related to the health system still affect its implementation.

#### Recurring delays in disbursements to counties

**A range of different issues have led to delays in disbursements from the National Government to counties every year of the project.** This includes protracted electioneering periods which held up appointments of county officials, delayed National Assembly approval of County Allocation of Revenue Bills to enable the National Treasury to disburse funds to counties, and delays in submission of expenditure statements by counties. Delayed or irregular disbursements lead to carry forwards as well as reduced absorption capacity given the short implementation period, which in turn perpetuates

the cycle of delays of subsequent disbursements and reduced implementation periods.

### **Initial suboptimal flow of funds at the county-level**

**Counties have experienced a variety of challenges related to the flow of THS-UCP funds.** The type of bank account operated has posed challenges for counties, so that counties with commercial bank accounts in addition to a SPA have easier access to funds for operational costs (e.g., travel, allowances) than those solely with a SPA with the Central Bank of Kenya. However, THS-UCP funds are supposed to flow through the SPA to be easily tracked through the Integrated Financial Management System. During the midterm review, it was agreed that the project account will develop guidelines on the type and value of expenditures that can be paid from the commercial bank accounts, define, and implement system to avoid misappropriation of funds (MOH 2019b). Also, when THS-UCP funds are mixed with other funds in the commercial banks or the SPA, problems related to accounting arise. This challenge has been addressed following the midterm review as counties are receiving support to ensure that the SPA is only holding THS-UCP and DANIDA funds (World Bank 2019). Moreover, with the introduction of the public financial management requirement, the flow of funds at the county level has improved considerably.

**Under THS-UCP, there is a provision for funds to flow from counties to health facilities, but this is dependent on the county's workplan and happens infrequently in practice.** Across all three SP4PHC counties, there is little evidence of any THS-UCP funds having gone to the facilities in the form of financial transfers to allow them to spend according to their work plans.

### **Inadequate documentation of expenditures**

**Counties have been slow to submit statements of expenditure, which is required for them to receive subsequent disbursements in the fiscal year.**

Incomplete and late expenditure reporting by counties is attributed to counties' low fiduciary capacity, heavy workload caused by paperwork, and

delayed approvals within and between MOH and county governments.

### **Lack of administrative infrastructure within county health systems**

**Counties have been slow to operationalize and maintain administrative structures that support service delivery since Kenya transitioned to a devolved system of government in 2013.** County public service boards, hospital boards for level 4 and 5 facilities, and health facility management committees for level 2 and 3 facilities have not been fully operational in all counties. Variations in operations of these structures are due to counties' different levels of autonomy to appoint relevant staff, which ultimately affect actual management and oversight of health structures.

### **Stockouts of family planning commodities**

**Family planning commodities and vaccines are inadequately funded by the national and county governments.** When devolution commenced in 2013, the National Government stopped allocating resources for family planning and other health commodities because counties were expected to budget for them. However, counties did not do so because there was no explicit direction in the constitutional transition documents. This policy lapse caused a significant gap in funding.

**Donors – including THS-UCP – have stepped in to fill the gap.** THS-UCP pays for a part of the national stock of family planning commodities procured centrally by KEMSA (MOH 2016). THS-UCP's funds for commodities are spread across five fiscal years (FY 2016/17 to FY 2020/21), on a decreasing scale (Table 3), with the rest of the budget requirements expected to be funded by the National Government and other partners. In FY2019/20, the Government of Kenya allocated US\$ 7 million for family planning commodities, representing 40% of total funding for such commodities (CHAI 2020).<sup>16</sup>

**Commodity supplies have fluctuated, which have resulted in stockouts since FY 2018/19.** If unresolved, this situation could affect the achievement of family planning and immunization

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<sup>16</sup> At the time of writing, information regarding the government's allocation for family planning in FY 2020/21 was not available.

indicator targets since there are already indications of dropping modern contraceptive prevalence rates (PMA Kenya 2019).

Table 3. Funding for family planning commodities against the national budget requirements, FY 2016/17 – FY 2020/21 (US\$ million)

	FY 2016/17	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21
Budget requirement	14.0	14.0	14.7	14.5	15.3
THS-UCP funding	6.0	5.0	4.0	3.0	2.0
% funded by THS-UCP	42.9%	35.7%	27.2%	20.7%	13.1%

Source: MOH 2016; 2019a

## REFLECTIONS AND RECOMMENDATIONS

**THS-UCP, which is widely credited for channeling resources for the delivery of high priority RMNCAH services across the country, offers important lessons for improving performance-based financing within Kenya’s devolved system of government.**

While the project draws funding from donors, it has been implemented by government agencies and actors at the national and sub-national levels. It is also fully integrated into government processes and procedures, which is laudable. However, given that Kenya transitioned to a devolved system of government recently, mechanisms for intergovernmental financial transfers and county-led project implementation are relatively new. The purpose of this review is to foster ongoing project improvement and capture learnings for the future. We offer the following reflections and recommendations in that spirit.

### Sustainability of funding for health

**The THS-UCP has led counties to invest more in the health sector, but the funding levels are not assured beyond the life of the project.** Counties are required to increase their budget allocation for health in order to meet the minimum eligibility criteria for THS-UCP. Hence, significant gains have

been made in terms of resource mobilization for health. It is now critical that mechanisms are put in place to safeguard financing for health. The scale up of Afya Care (UHC program pilot<sup>17</sup>) provides an opportunity for the National Government to build similar conditions around a minimum allocation for the health sector.

### Transparency in fund allocation and disbursement THS-UCP has yielded important lessons about how Kenya’s system of intergovernmental fiscal transfers can be strengthened.

Counties often express the view that the penalties for not meeting the THS-UCP eligibility conditions and performance criteria were not clearly stated in the various THS-UC project documents, despite being outlined in the county intergovernmental partnership agreements. In addition, adjustments to the county eligibility conditions, allocation formula, and disbursement conditions for THS-UCP funds have not always been clearly understood, hence counties perceive them as being unfair. There is a need to constantly communicate these details in simple language to non-finance staff. Also, project financial records seem to vary across sources and implementation levels, and it is necessary to communicate what happens to undisbursed county allocations. Strengthening transparency around transfers and communication with counties will go a long way in building confidence across stakeholders.

### Encouraging strategic purchasing at the county-level

**While THS-UCP links county allocations to performance, most counties are currently not cascading that performance orientation to health providers.** As per the project design, counties have the choice to transfer some THS-UCP funds to health facilities to enable improved service delivery, but most are not exercising this option. Instead, they are spending the funds directly to undertake a range of activities to improve RMNCAH service delivery. Many of these activities are undoubtedly important. However, ensuring some of the funds flow to frontline service providers, ideally in ways that are linked to their performance, would make county governments more strategic purchasers of

<sup>17</sup> The Government of Kenya is building on a 2019 UHC program piloted in four counties to give all persons

living in Kenya access to essential health services without suffering from financial hardship.

health services and enhance the quality of service delivery in the public sector. Greater information sharing and advocacy for this approach by PMT and other stakeholders will encourage counties to explore such options.

### Monitoring performance

**Reliance on DHIS2 data for performance measurement means the intrinsic weaknesses of the DHIS2 affects the quality of data used for resource allocation to counties.** Therefore, each county needs to invest in improving its own data quality. THS-UCP has trained county staff on DHIS2 through the annual county data verification.

### Technical support to county governments

**In addition to financing, counties need more direct technical support, capacity building, and mentoring.** The COG-based staff have been providing technical support to counties, which has expanded beyond tracking fund flows to include support for planning, project implementation, and M&E. However, counties need a lot more support such as the one provided by the RMNCAH Multi-Donor Trust Fund to provide technical assistance in supply chain management, planning, budgeting, monitoring and reporting, and M&E in 27 of the 47 counties. These areas have taken on added significance given the imminent scale up of Afya Care that will channel additional resources for healthcare delivery to the counties.

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For more information, please visit our website at <https://thinkwell.global/projects/sp4phc/>. For questions, please write to us at [sp4phc@thinkwell.global](mailto:sp4phc@thinkwell.global).

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## ANNEX 1. THS-UCP ALLOCATION, DISBURSEMENT, AND EXPENDITURE IN SP4PHC PROJECT COUNTIES (KES)

	ANNUAL BUDGET LEGISLATION	ESTIMATES FROM THE CONTROLLER OF BUDGETS		ESTIMATES FROM THS-UCP ACCOUNTS		
	THS-UCP allocation <sup>1</sup>	THS-UCP allocation <sup>2</sup>	THS-UCP cumulative disbursements <sup>2</sup>	THS-UCP allocation <sup>3</sup>	THS-UCP disbursements <sup>3</sup>	THS-UCP expenditure <sup>3</sup>
<i>Isiolo</i>						
FY 2017/18	45,533,008	20,696,822	20,696,822	20,696,822	20,696,822	8,538,430
FY 2018/19	66,229,830	66,229,830	40,147,057	47,797,505	35,293,333	37,949,600
FY 2019/20	64,370,437	64,373,437	64,373,437	53,033,354	53,033,354	57,619,619
<i>Kilifi</i>						
FY 2017/18	93,668,256	93,668,256	42,576,480	42,576,480	42,576,480	42,027,517
FY 2018/19	100,000,000	101,527,335	81,946,533	100,000,000	81,946,555	64,468,862
FY 2019/20	129,114,721	137,494,851	118,565,287	129,114,721	118,565,287	122,087,880
<i>Makueni</i>						
FY 2017/18	71,695,469	71,695,469	32,588,849	32,588,849	32,558,849	10,043,451
FY 2018/19	100,000,000	100,000,000	51,160,924	69,810,893	51,160,924	55,850,367
FY 2019/20	89,179,782	89,179,782	84,293,539	84,095,943	84,293,538	47,458,902

Notes:

<sup>1</sup> As presented in the County Allocation of Revenue Acts 2017-2019

<sup>2</sup> As presented in the Annual County Governments Budget Implementation Review Reports for FY 2017/18 – FY 2019/20

<sup>3</sup> Data obtained in September 2020 from the THS-UCP accounts

Source: MOH 2017; 2018; 2019b; Office of the Controller of Budget 2018; 2019; 2020; Council of Governors 2020

