Kenya
Strategic purchasing strategies and emerging results
ABOUT KENYA

- While Kenya achieved lower-middle income status in 2014, 37% of Kenyans are estimated to live below the poverty line.
- Government’s share of current health spending is higher than average for sub-Saharan Africa, while out-of-pocket (OOP) spending as a share of total health spending is lower.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value (2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (million)</td>
<td>52.6</td>
</tr>
<tr>
<td>Population growth (annual %)</td>
<td>2.3</td>
</tr>
<tr>
<td>Urban/rural divide (% of population)</td>
<td>27.5/72.5</td>
</tr>
<tr>
<td>Population ages 0-14 (% of total population)</td>
<td>39.2</td>
</tr>
<tr>
<td>Population ages 15-64 (% of total population)</td>
<td>58.4</td>
</tr>
<tr>
<td>Population ages 65 and above (% of total population)</td>
<td>2.4</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>66.3 (2018)</td>
</tr>
<tr>
<td>GDP growth (annual %)</td>
<td>5.4</td>
</tr>
<tr>
<td>GDP per capita, PPP (current international $)</td>
<td>4,509.3</td>
</tr>
<tr>
<td>Poverty headcount ratio at $1.90 a day (% of population)</td>
<td>36.8 (2015)</td>
</tr>
</tbody>
</table>

Source: World Bank 2020
FP CONTEXT: EXTREME SUB-NATIONAL VARIATION IN CONTRACEPTIVE PREVALENCE

- The modern contraceptive prevalence rate (mCPR) in Kenya has been steadily increasing and was almost double the average for Africa in 2020.
- The national average however masks very large disparities between counties.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Kenya</th>
<th>Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>mCPR (all women)</td>
<td>42.5%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Unmet need (married/in union)</td>
<td>18.6%</td>
<td>24.5%</td>
</tr>
<tr>
<td>% of women whose demand is satisfied with a modern method of contraception (married/in union)</td>
<td>75.6%</td>
<td>55.7%</td>
</tr>
</tbody>
</table>

Source: Track20

Trends in contraceptive use:
Percentage of married women currently using a contraceptive method

Source: Kenya DHS 2014
FP CONTEXT: PUBLIC FACILITIES ARE THE MAIN SOURCE FOR FP SERVICES

- Kenya has a relatively balanced method mix; % of women using long-acting and short-term methods in Kenya (24%, 70%) is comparable with neighboring Uganda (21%, 72%) and Tanzania (23%, 68%).
- The top 3 methods are injectables, implants, and pills.
- Government health facilities account for over 60% of users of injectables, implants, IUD, and sterilization; private providers (e.g., pharmacies, shops) are the main source for pills.

Source: Kenya DHS 2014
MNCH CONTEXT: STAGNANT MATERNAL MORTALITY RATE DESPITE INCREASING COVERAGE OF MNCH INDICATORS

- Kenya did not reach its MDG target for maternal mortality rate (MMR); the MMR was 362 deaths by 100,000 live births in 2014 compared to a target of 147 by 2015.
- This is despite coverage of most MNCH indicators having improved over time.
- Improving maternal health is a key priority for the Government of Kenya, as evidenced by the Free Maternity Program and the First Lady’s Beyond Zero Campaign.

### Trends in maternal health care

<table>
<thead>
<tr>
<th>Service</th>
<th>2003 KDHS</th>
<th>2009-09 KDHS</th>
<th>2014 KDHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4+ ANC visits</td>
<td>52%</td>
<td>58%</td>
<td>58%</td>
</tr>
<tr>
<td>Antenatal care by skilled provider during pregnancy</td>
<td>47%</td>
<td>53%</td>
<td>58%</td>
</tr>
<tr>
<td>Delivery in a health facility</td>
<td>40%</td>
<td>43%</td>
<td>49%</td>
</tr>
<tr>
<td>Delivery assistance by skilled provider</td>
<td>42%</td>
<td>44%</td>
<td>49%</td>
</tr>
<tr>
<td>Postnatal check-up in the two days after birth</td>
<td>47%</td>
<td>42%</td>
<td>53%</td>
</tr>
</tbody>
</table>

NHIF Linda Mama registration, hospital and benefits
MNCH CONTEXT: FOCUS NEEDED ON INEQUITIES AND QUALITY OF CARE

- There is considerable variation in MNCH service coverage between wealth quintiles, counties, and urban versus rural areas.

- Increasing coverage but stagnant MMR also points to the need for a focus on quality, especially in public facilities that account for 75% of facility births nationally.

Source: Kenya DHS 2014
THE HISTORY OF HEALTH FINANCING REFORMS IN KENYA

1960s
- Kenya sets up a centralized national health service
- No user fees
- NHIF established to provide inpatient cover to formal sector employees

1988
- User fees reintroduced in all public facilities

1990s
- User fee exemptions and waivers introduced
- No reimbursements for facilities, so adherence was low

1998
- NHIF becomes mandatory for everyone in theory; but in practice, informal sector households can opt-in

2004
- 10/20 Policy introduced, capping fees to 10 and 20 shillings at public dispensaries and health centers
- Still no reimbursement

2009
- Health Sector Support Fund (HSSF) mechanism set up with donor support to compensate public facilities for user fees forgone

2013
- Devolution commences
- Free maternity services (FMS) and user fee removal at primary care facilities launched; counties given conditional grants

2015
- NHIF expands benefit package to include outpatient services; launches Health Insurance Subsidy Program

2017
- MOH gives NHIF responsibility to operate FMS, now called Linda Mama

2018
- Afya Care UHC program launched in 4 counties; user fees abolished at level 4 and 5 public hospitals, and counties receive additional resources from the National Government

2020
- Scale up of Afya Care UHC program, which is extending NHIF coverage to 1 million poor households
# Purchasing Landscape in Kenya: Fragmented Roles

Kenya embarked on a process of devolution in 2013, transferring planning, budgeting, and management responsibilities for a range of services including health to 47 newly created counties.

As a result, the country now has 49 public purchasers of health services: the national Ministry of Health, 47 county departments of health, and the National Hospital Insurance Fund (NHIF).

<table>
<thead>
<tr>
<th>National Ministry of Health</th>
<th>47 County Departments of Health</th>
<th>The National Hospital Insurance Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Oversees tertiary hospitals</td>
<td>• Responsible for all primary and secondary care</td>
<td>• Operates a range of insurance schemes (~20% of the population covered)</td>
</tr>
<tr>
<td>• Transfers funds to counties to finance health service delivery</td>
<td>• Pays for salaries, commodities, and other operating costs for public providers through input-based financing</td>
<td>• Covers inpatient and outpatient services</td>
</tr>
<tr>
<td>• Provides performance-based financing to counties under the GFF-funded Transforming Health Systems for Universal Care project (THS-UCP)</td>
<td>• As per public financial management laws, can allow public facilities to retain and spend funds they collect</td>
<td>• Manages the Linda Mama free maternity scheme</td>
</tr>
<tr>
<td>• Finances the Linda Mama free maternity scheme implemented by NHIF, as well as the UHC Afya Care pilot</td>
<td></td>
<td>• Contracts both public and private providers for all schemes</td>
</tr>
</tbody>
</table>

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As a result, the country now has 49 public purchasers of health services: the national Ministry of Health, 47 county departments of health, and the National Hospital Insurance Fund (NHIF).
**KEY CONSIDERATIONS THAT HAVE INFORMED THE EVOLUTION OF OUR STRATEGIES**

<table>
<thead>
<tr>
<th>#1</th>
<th>#2</th>
<th>#3</th>
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<tbody>
<tr>
<td>Many partners working (or attempting to) on NHIF reforms.</td>
<td>Counties are the main purchasers of PHC, FP and MNCH services</td>
<td>Counties influence facility incentives and capacity to participate in Linda Mama, a universal entitlement program for MNCH</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>#4</th>
<th>#5</th>
<th>#6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Although MNCH service coverage has been increasing overtime, MMR is stagnating.</td>
<td>Counties receive the bulk of GFF funds for improving RMNCAH</td>
<td>Afya Care pilot channeled more resources to county governments; during scale-up it transformed to an insurance subsidy</td>
</tr>
</tbody>
</table>
Support strategic purchasing for PHC at the county-level, with a focus on Linda Mama
- Program officers in Isiolo, Kilifi, and Makueni are supporting county governments to enable public facilities to participate in the Linda Mama free maternity scheme, channel more funds to health facilities, and enhance facility autonomy in the public sector
- Learning partner KEMRI Wellcome Trust is undertaking a multi-phase process evaluation of Linda Mama (first phase completed in 2019)

Leverage purchasing to promote quality standards
- Team is analyzing quality infrastructure in Kenya and touchpoints with county-level purchasing. Program officers will then engage with county officials to design reforms that link facility payments to quality metrics
- Working with Jacaranda to explore how the purchasing lever can be used to promote service delivery redesign (SDR) to improve maternal and neonatal health outcomes in Kakamega county

Support use of THS-UCP/GFF funds for strategic purchasing of FP and MNCH services
- M&E expert embedded at the Council of Governors assisted GFF the program management team to track program performance and capture best practices
- Program officers are supporting Isiolo, Kilifi, and Makueni counties to improve use of GFF funds through strategic purchasing

Inform national policy dialogue on strategic purchasing
- Team is supporting MOH design and implement UHC plans, drawing insights from county experience
- Program officers working with Isiolo, Kilifi, and Makueni counties to roll out UHC program, and document experiences in real-time
COUNTY HEALTH FINANCING
FINDINGS FROM A RAPID SITUATION ANALYSIS OF COUNTY PURCHASING

In 2019, ThinkWell conducted a landscaping study to understand purchasing policies and practices at county level. We synthesized information from a detailed desk review of existing literature and interviews with key stakeholders about the following topics:
1. County governments as purchasers of health services
2. The flow of funds to public facilities at county level
3. Opportunities to strengthen county government purchasing policies and practices

- Bulk of county health spending is financed from the block grant from the national government
- Counties generate a modest amount of own-source revenue; user fees from facilities are an important source
- All national government financing and on-budget donor funding for health are structured as conditional grants. This mechanism faces challenges:
  - Allocation formulas are not well documented and are typically not linked to county performance
  - Monitoring of conditions by the national government is weak
  - Only a few require funds to flow to health facilities

County revenue

Source: Controller of Budgets, County Governments Annual Budget Implementation Review Report, FY2018-19
Counties have limited but important opportunities to link facility payments to performance

- Salaries, drugs, and facility maintenance costs account for the bulk of the county health budget (75.8%, 6.9%, and 9.7%, respectively), which the county pays directly.

- The conditional grants they receive (user fee forgone, THS-UCP, etc.) offer an opportunity to link facility payments to performance.

- ThinkWell’s program officers are supporting counties to channel more funds to health facilities and explore ways to link them to performance.

Source: MoH, National and County Health Budget Analysis FY 2018/19
Our learning partner, KEMRI WT conducted a study in 2019 to track the flow of resources to public health facilities, and to document public financial management practices at the county level.

Facility collections are an important source of local revenue for county governments.

Hospitals in most counties are required to remit funds they collect from user fees and NHIF reimbursements to the county government.

Makueni is an important exception; hospitals can retain NHIF payments and county reimburses them for user fees under Makueni Care.

Level 2 and 3 facilities receive funds from NHIF (e.g., under Linda Mama) and from the county government (funded by DANIDA and user fee conditional grant) and can retain and spend them.

ThinkWell program officers are working with county governments to operationalize national guidelines to increase facility autonomy, and support health centers to submit NHIF claims.

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**Sources of financing for facility operating budget (MoH, PETS 2012)**

- **Before devolution**
  - Dispensaries: 31% Constituency Development Funds, 53% Donors, 5% NHIF, 14% HSSF, 70% HMSC

- **After devolution**
  - Dispensaries: 31% Constituency Development Funds, 53% Donors, 5% NHIF, 14% HSSF, 70% HMSC

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IMPLEMENTATION OF LINDA MAMA: BENEFITS COVERED
FINDINGS FROM A PROCESS EVALUATION CONDUCTED BY KEMRI WT IN 2019

KEMRI WT collected information from 5 counties as part of a process evaluation of the Linda Mama free maternity scheme in 2019.

The benefit package

The scheme is meant to cover delivery, ANC (4 visits), PNC (4 visits), ambulance services for emergency referrals, and care for the newborn (within one year of program coverage).

<table>
<thead>
<tr>
<th>Facility type</th>
<th>Normal</th>
<th>Caesarian</th>
<th>ANC</th>
<th>PNC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Level 2 &amp; 3</td>
<td>2,500</td>
<td>--</td>
<td>1st visit: 600; Rest: 300 per visit</td>
<td>200 per visit</td>
</tr>
<tr>
<td>Public Level 4 &amp; 5</td>
<td>5,000</td>
<td>5,000</td>
<td>1st visit: 1000; Rest: 300 per visit</td>
<td></td>
</tr>
<tr>
<td>Public Level 6</td>
<td>17,000</td>
<td>17,000</td>
<td>1st visit: 1000; Rest: 500 per visit</td>
<td></td>
</tr>
<tr>
<td>Private Level 2 &amp; 3</td>
<td>3,500</td>
<td>--</td>
<td>1st visit: 1000; Rest: 500 per visit</td>
<td></td>
</tr>
<tr>
<td>Private Level 4 -6</td>
<td>6,000</td>
<td>17,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Gaps in the benefit package

Does not include ultrasounds for the mother or post abortion care. No reimbursement rates set for ambulance services or newborn care (beyond routine PNC).

Gaps in benefit package fidelity

Some services that should be covered are not (newborn care in 3 of 5 counties, post-partum FP, up to 4 PNC visits) due to poor understanding of the package and how the rates are structured.
IMPLEMENTATION OF LINDA MAMA: PAYMENTS TO FACILITIES
FINDINGS FROM A PROCESS EVALUATION CONDUCTED BY KEMRI WT

Claims submission
Facilities reported facing a range of challenges in all 5 counties: inadequate training, insufficient staff, no access to photocopiers. These are particularly acute for primary care facilities.

Payment by NHIF
NHIF reimbursement is slow and unpredictable.

Where public hospitals have to remit funds to the county government (e.g., Nandi, Kilifi, and Isiolo), they have limited motivation to submit all claims or track payments.
In 2019 and 2020, ThinkWell supported Makueni to assess the implementation of Linda Mama.

Though majority of health facilities empaneled for Linda Mama were PHC facilities, hospitals were responsible for around 90% of the total value of claims.

Forty PHC facilities surveyed in 2020 lost ~Ksh 8 million by not submitting claims.

Facility empanelment (NHIF Local Branch Makueni 2019)

Estimated loss of revenue due to PHC facilities not claiming, FY 2019/20 (CDOH Makueni 2020)
SUPPORTING PUBLIC FACILITIES TO CLAIM REIMBURSEMENTS
RESULTS FROM THINKWELL’S SUPPORT TO MAKUENI COUNTY

- With support from ThinkWell, CDOH started tracking Linda Mama claims and payments by public facilities in mid-2019, which has resulted in a significant uptick in claims and payment (see more info [here](#)).
- Ongoing work to improve ability of PHC centers to submit claims.

Linda Mama claims in public facilities, KSh (CDOH Makueni 2019)

![Bar chart showing claims and payments by NHIF for Linda Mama](chart.png)

- Amount paid by NHIF to facilities
- Amount processed and forwarded by NHIF branch for reimbursement
- Pending claims

Strategy 1

80,000,000

60,000,000

40,000,000

20,000,000

0

8,440,498

42,984,297

4,426,620

22,928,940

32,919,018

57,564,100

January-May 2019

June-September 2019
In partnership with Jacaranda, ThinkWell is working with the County Government of Kakamega to test service delivery re-design to improve maternal and newborn health, as proposed by the Lancet Global Health Commission on High-Quality Health Systems.

Goals of the activity are to:
- Support Kakamega County Government to have effective and sustainable purchasing arrangements and increase fiscal space to undertake SDR to improve the quality of MNCH services.
- Engage national stakeholders and other county governments.
SUPPORTING IMPLEMENTATION OF GFF-FUNDED PROGRAM

Under the GFF-funded Transforming Health Systems for Universal Care (THS-UC) program, the national government gives counties funds based on them meeting certain condition as well as performance metrics.

ThinkWell’s M&E expert supporting the program management team documented program implementation (see brief), and county-level program officers are supporting the use of funds to promote strategic purchasing (see example from Makueni).

Targeted support to counties

- Consensus that county governments need more technical assistance for implementing GFF-funded activities
- They are typically using funds to procure medical equipment and commodities, undertaking community outreach campaigns, conducting trainings, supportive supervision etc.
- Use of funds to “purchase” services from facilities is rare
- ThinkWell program officers have been supporting our target counties to explore results-based financing for public facilities, as well as contracting arrangements with private providers
- ThinkWell is also contributing to ongoing discussions about how intergovernmental transfer mechanisms -- specifically conditional grants – can be improved
**THE AFYA CARE UHC PROGRAM**

### Afya Care pilot
- In December 2018, GoK piloted the Afya Care program in 4 counties including Isiolo.
- The County Governments discontinued user fees in level 4 and 5 facilities and received additional resources from the National Government.

### Isiolo’s experience
- ThinkWell undertook a rapid review of the pilot.
- Half of the funds were received on time in the first half of 2019; the rest were delayed.
- Initial delays in receiving commodities from KEMSA, but the situation improved with time.
- Funds flowed down to health facilities, which used them to improve infrastructure for providing better services.
- Stockouts of medicines and supplies at health facilities reduced considerably during the pilot.
- The majority of Isiolo’s population was reached, granting them access to services free of charge.
- A few new staff were hired at facility level which resulted in increased workload of existing staff.
- County experienced issues around correctness of card holders’ information.
- Not all health facilities had a verification system in place.

### UHC scale up
- In late 2020, GoK announced plans to scale up the UHC program. But the design focuses on subsidizing NHIF cover for poor households, starting with 1 million households nation-wide.
- ThinkWell team is documenting the implementation of the scheme in our focus counties and using insights from that to influence national dialogue about UHC and building coherence in the purchasing landscape.
FINAL REFLECTIONS: THINKWELL’s CONTRIBUTION THROUGH SP4PHC

Strengthen county government purchasing policies and practices with a focus on FP and MNCH through direct support to 3 project counties, document best practices from other counties, and facilitating learning between counties.

Use THS-UCP experience to generate learnings about how intergovernmental transfers from the national government to counties can be linked to results.

In the content of Kenya’s UHC plans, influence national dialogue around greater coherence in the purchasing eco-system especially as it relates to improving the delivery of FP and MNCH services.
Supporting the pandemic response in Kenya

As the COVID-19 pandemic rapidly spread around the world in 2020, the SP4PHC project pivoted to incorporate activities to respond to the crisis even as it continued to work towards its original mission.

In all five project countries, ThinkWell staff responded to government requests for support and more information on our COVID-related activities and learnings can be found here.

To stay updated on all the latest insights and events from the SP4PHC team, visit our Latest News page.
Thank you

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SP4PHC is a project that ThinkWell is implementing in partnership with government agencies and local research institutions in five countries, with support from a grant from the Bill & Melinda Gates Foundation. For more information, please visit our website at https://thinkwell.global/projects/sp4phc/. For questions, please write to us at sp4phc@thinkwell.global.