Objectives
A cross-programmatic efficiency analysis was conducted in Kenya to identify and analyse critical areas of functional overlap, misalignment or duplication across the country’s Tuberculosis (TB), HIV/AIDS, malaria, Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH), and Immunization programmes, and with the overall health system to inform plans to make the health system more efficient and sustainable as Kenya progresses on UHC and on the path to transition from external assistance.

The cross-programmatic efficiency analysis took place between August to December 2020. This policy brief is written based on that analysis, with recognition that changes in the health system will have taken place since the study was conducted.

Kenyan Context
Kenya renewed its commitment to moving towards universal health coverage (UHC) following the Government’s Big 4 Agenda (2018-2022) that identified UHC as one of the top priorities. As donors transition away from providing direct support to the country’s health sector, the government is expected to take on an increased responsibility for its funding and related essential services. This process will have implications on the progressive realization of UHC. From 2009/10-2018/19, there was a reduction in external health assistance as a share of total health expenditure by almost 50% (from about 35% to 18%)\(^1\). In addition, the devolution of most responsibility for resource allocation to 47 elected county governments that began in 2013 raises challenges for the alignment of actual government health spending with national policy directions. Given these realities, a cross-programmatic efficiency analysis was conducted in 2020 to identify inefficiencies that may constrain the governments’ ability to sustain or improve the coverage of priority health services moving forward.

Key Findings
The six key cross-programmatic inefficiencies identified, their implications and potential intervention to mitigate each are discussed below.

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1. Existence of multiple funding streams that are not well-aligned at the implementation level

There are multiple financing sources for the five programmes analysed. These vary by source and include development partner, private sector firms, government and individuals through out-of-pocket payment (OOP). Among the development partners, a significant proportion of the resources is still “off-budget” and channelled through various implementing partners. Additionally, the financial cycles of some of the development partners differ from that of government, which leads to misalignment in planning and implementation. The management of these funds is sometimes at the programme level, and limited pooling mechanisms exist, including with the National Hospital Insurance Fund (NHIF). The multiple streams of funding and management of funds has also led to different types of provider payment methods that are not aligned with one another. Under devolution, there are three main funding flows; the first being county governments, who are the main purchasers of health services. The Treasury provides budgets from general tax revenue to the national and county governments, who then act as purchasing organizations. Next is the NHIF, where they administer the purchasing system for those with coverage for certain services (such as for Linda Mama, the government’s free maternity programme) and channels the resources to service providers. And finally, implementing partners are also responsible for direct purchase and implementation of activities including contracting of the health workforce for programmes such as HIV and Immunization.

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<th>IMPLICATIONS</th>
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<td>· Fragmented implementation of policy vision, which complicates operations</td>
<td>· Use the current existing public financial management arrangements to harmonize and align use of health funds at the national and county levels (such as effective use of conditional grants)</td>
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<td>· Service delivery quality is affected due to delays in flow of funds to health facilities</td>
<td>· Ensure alignment of incentives and harmonize implementation support (such as audit and monitoring functions across health sector conditional grants from the national government to the counties)</td>
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<td>· Different signals and incentives to health providers</td>
<td>· Implementation of alignment principles for enhancing donor effectiveness through “One Policy, One Strategy and One M&amp;E Plan” principle through Joint Annual Work Plans processes</td>
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<td>· Duplications in the management of funds</td>
<td>· Improve public financial management capacities at county level</td>
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<td>· Allocation and use of resources are not results/performance-driven and are not allocated equitably to minimize waste</td>
<td>· Shift towards more strategic purchasing linked to health outputs/outcomes from health service delivery level</td>
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<td>· Limited accountability mechanisms</td>
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2. Multiple duplicative and fragmented data systems that compromise data quality and limits its use in making service delivery decisions

Parallel data and information systems exist for the programmes analysed. For instance, although the Ministry of Health has intentions to standardize electronic medical record systems (EMR) the study found more than 17 EMR systems in hospitals in the three counties studied (Kisumu, Kajiado and Mombasa). These systems differ in their objectives and functionality (such as capacity for basic demographic and clinical health information or order entry and prescribing), with no ability to share patient information across systems. These systems are also not interoperable with other information systems such as commodities, laboratories and health facility infrastructure. There was limited or inconsistent use of the resulting data for decision making although more use was observed among development partners. The information and data gathered was found to be primarily used for morbidity and mortality monitoring and reporting and not necessarily providing an input into service delivery decisions.
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<td>Lack of sharing and aggregation of data across system leads to different data sets and an incomplete picture of population health</td>
<td>Adopt and scale-up the Kenya digital health platform that will provide for all health care settings in Kenya and, facilitate interoperability with other systems within the Health Information System (HIS) eHealth architecture</td>
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<td>High administrative costs and heavy burden placed on staff to report through various systems (both paper- and digitally-based)</td>
<td>Strengthen Kenya Health and Research Observatory (KHRO) to present all the data required for decision making at national and county level</td>
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<td>Duplication of patient data due to lack of coordination between treatment and referral facilities</td>
<td>Strengthen use of the national data quality audits (DQA) protocol and Routine Data Quality Assessment (RDQA) tool</td>
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<td>Capacity building and/or re-orientation of the health workers on use of data for evidence-based decision-making and, contracting data clerks for the Health Records Information Systems at the service delivery points with clear targets</td>
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3. **Ineffective coordination between the vertical programmes and with the county governments leads to missed opportunities**

The assessment revealed challenges in coordination. Development partner supported programmes operate independently at the implementation level even in areas when synergy and complementarity can be obtained. There were uncoordinated and ad hoc supportive supervision visits across different programmes, as seen in Figure 1, that rarely responded to the needs of the service delivery and health workers and were not systematically documented. Often times, the national programmes would go directly to the health facility and communities bypassing the county. Lack of ineffective coordination in the actual implementation of service delivery also limits the programmes coverage.
FIGURE 1: ILLUSTRATIVE SUPPORTIVE SUPERVISION VISITS TO A MODEL HEALTH CENTRE JULY – DECEMBER 2018

Supervisor Category | Supervision Areas | Supervision Team
--- | --- | ---
MMC | NASCOP – M&E, CBO; SD-CASCO
National Nutrition | Sub County: Nutrition, HRIO, KANCO
National CCC/TB | Sub County: MOH, HIV Comm, TLC, County HRIO, IP, PH
National FP/RH | Sub County: Pharmacist, RH Coordinator, PHN, HRIO IP
County PMTCT | Sub County: SCO, CCO, NASCOP
County HIV/TB (Peer SS) | Sub County: MCH, Pharm, Pharmacist, FP
County Immunization GPI | Sub County: PHN, HRIO, RH Coordinator, MLC
Sub County TB/DGA | NLTB
Sub County PSBI/IMCI | Sub County: CO, County
Sub County PMTCT | SC: Pharm, MLS, CO, HRIO, IP

IMPLICATIONS

• Ad hoc and unplanned supervisory visits create unnecessary workload on health facilities
• Costly and inefficient visits when supervisory visit does not cover all service delivery areas

POLICY OPTIONS

• Align development partner Supportive Supervision framework to fit county specific needs. National and county governments should develop a harmonized supervision framework that aligns activities of Ministry of Health programmes and departments and development partners
• Strengthen the capacity of the County Health Departments (CHD) supportive supervision systems personnel on operational guidelines and use of tools
• Consolidate county supportive supervision data, findings and recommendations to inform performance improvement across the counties

4. Fragmented supply chain leading to unnecessary costs and complexities across the health system

Uncoordinated and fragmented procurement mechanisms exist across the programmes, largely due to all of the different funding streams. While the Kenya Medical Supply Agency (KEMSA) remains the only state corporation mandated to procure, store and distribute medical supplies for public health programmes on behalf of the government, it is not able to honour all requests. Additionally, there are parallel supply chain systems across the health programmes analysed. Sometimes the purchasing of a necessary devise is not coordinated with the procurement of services to maintain the devise. There is also a lack of clear policy for commodity redistribution or an awareness of its existence.
### 5. Programme-based human resources for health management leads to duplicative roles, sub-optimal staff performance and utilization, and over reliance on contracted staff

The human resources for health (HRH) in these five programmes were found to do similar work, yet they had different terms of service. Some can be contracted by the donor, others by the local government and some at the national level. Furthermore, key programme staff can sometimes only be deployed in areas restricted to their operations, while there is more flexibility for government staff.

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<td>• Uncoordinated recruitment and deployment of staff by partners to support disease control efforts</td>
<td>• Government and development partners need to regularly and jointly develop HRH needs and jointly recruit the staff based on needs</td>
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<td>• Some partner recruited staff are not recognized in the government scheme of service, making their transition to the civil service a challenge</td>
<td>• Implement workplace capacity building initiatives guided by county-based Training Needs Assessments to keep staff within their workstations</td>
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<td>• Donors support counties’ HRH interventions in an uncoordinated way, such as trainings in the same region, leading to high absenteeism and repeated/duplicative trainings targeting similar capacities</td>
<td>• Transition planning for recruited HRH as part of recruitment that is guided by long term staffing needs</td>
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<td>• Dependence on contracted staff for programme implementation, especially for staff in the HIV and TB programmes (threat to integration &amp; sustainability)</td>
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### 6. Disjointed service delivery, which leads to missed opportunities for access

Disjointed service delivery leads to poor health seeking behaviours, a lack of gatekeeping and referral system and inability to foster complementarity across the health sector. These duplications and overlaps of services adversely affect hospital operations.
**IMPLICATIONS**
- Missed opportunities to align services leads to adverse health outcomes and increased loss to follow-up
- Lower quality care at higher level facilities due to overcrowding and lack of staff due to lack of gatekeeping and referral system
- Difficult to allocate resources and plan infrastructure

**POLICY OPTIONS**
- Initiate discussions at national and county level on how to integrate health programme interventions into government programming
- Strengthen the primary health care system to ensure there are necessary linkages across the health system so that patients follow the prescribed pathway
- Strengthen county health department’s capacities to develop, implement and monitor performance

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**FIGURE 2: PATHWAY FOR HIV+ MOTHER**

**Way Forward**

Based on the cross programmatic efficiency analysis, this policy brief provides policy options that the government of Kenya could consider to address the identified system misalignments and duplications so as to make the health system more efficient in achieving objectives. These actions will be necessary in achieving sustainable scale-up as the country looks towards transition.

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This policy brief was based on a report authored by Wasunna Owino, with support from Brendan Kwesiga, Estella Waiguru, and Isabella Maina. It was prepared by Brendan Kwesiga and Alexandra Earle.

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