Center for Global Development

CGD CASE STUDY
NOVEMBER 2021

The Journey to Universal Health Coverage

How Kenya Managed the Inclusion of Disease Programmes in its Health Benefits Package

Y-Ling Chi
Lydia Regan

CONTENTS

INTRODUCTION

Since 2018, the Government of Kenya has worked on a series of policies and pilots to support the implementation of Universal Health Coverage (UHC) by 2022. UHC ensures that all individuals and communities receive the health services they need without suffering financial hardship (WHO 2021). UHC is part of President Kenyatta's big four priority agenda to support the development of capacity and resources in the healthcare sector (Republic of Kenya 2017).

As part of this effort, a harmonised health benefit package (HBP), which includes both curative and preventative services delivered across all levels of care, was finalised in 2020. The content of the harmonised HBP is central to all aspects of the UHC policy from resource mobilisation (what is included and excluded will define what it will cost to deliver UHC) to implementation (planning of human resource, linking to clinical guidelines). Bredenkamp et al. (2015) has found that developing a HBP that is responsive to countries health challenges as well as financially sustainable is one of the biggest challenges in achieving UHC. A number of resources have been produced to support countries towards defining their own HBPs, including the guidance from the WHO (WHO 2014) and *What's In, What's Out: Designing Benefits for Universal Health Coverage* (Glassman, Giedion, and Smith 2017).

However, despite the relevance of the topic to all LMICs seeking to achieve UHC, our previous review (Regan et al. 2021) has highlighted a gap in the literature on how countries manage the inclusion of disease programmes in the HBP, especially when countries significantly rely on health funding from external partners, such as in Kenya. In 2018, external expenditure represented 15.5 percent of total current expenditure in the country (Table 1). The reliance on external partners is acute in some programmes: for every dollar spent by the Kenyan government on immunisations, TB, and HIV, donors spend 3.3, 2.8, and 1.7 additional dollars respectively (McDade et al. 2021). There are compelling arguments on both sides as to whether to include such programmes in UHC.

In this resource, we look at the inclusion of vertical programmes in the harmonized package in Kenya. Using the lens of the local policy context, we address the following key questions:

1. **How was the HBP developed and how were entitlements prioritised?**
2. **What was the initial decision to exclude or include disease programmes into the HBP?**
3. **What enablers were important in shaping those policy-decisions? Going forward, what are some of the anticipated challenges beyond the listing of entitlements?**

We build on a desk review of the literature, as well as seven structured interviews with stakeholders who actively took part in the definition process of the harmonized HBP, both working in national health institutions or as external partners (see Annex 1 for a description of our interviewee sample). We use inductive coding methods to analyse the interviews. Our research methods are described in Annex 2.

KENYA'S UHC POLICY AND HBP DEVELOPMENT

Existing HBPs prior to the harmonized package

Kenya's attempts to implement UHC dates back at least two decades. The first plan was drawn in the early 2000s, when the government considered mandatory health insurance with a package of care defined in 2004, but it was never adopted (Künzler 2016). In 2010, the Constitution outlined health as a basic human right and provided an overarching legal framework for a rights-based approach to health (Republic of Kenya 2010). The 2014–2017 Kenya Health Sector Strategic and Investment Plan (KHSSP) outlined the Kenya Essential Health Package (KEPH) as an 'obligation of the health sector towards realization of the constitutional right to health' (Ministry of Health 2021). The KEPH is organised around different policy objectives or disease programme areas; *e.g.*, accelerate the reduction of the burden of communicable conditions or reduce the burden of violence and injury (Wright 2015). Using KEPH as a foundation, various additional packages have been developed in the country including the following packages delivered under National Hospital Insurance Fund (NHIF): (i) SUPA Cover, (ii) Health Insurance Subsidy for the Poor (HISP) (ISSA 2014), a scheme which seeks to cover Kenya's 9 million indigents (Oraro-Lawrence and Wyss 2020) using the same HBP as SUPA cover, and (iii) Linda Mama, a programme to provide free maternal services. The NHIF also runs the Civil servant's scheme and EduAfya, which provides medical insurance cover for civil servants and public secondary school student during the duration of study (NHIF 2021). NHIF was initially set up as a department of the Ministry of Health and subsequentially became a State Corporation (The Republic of Kenya 1998; NHIF 2021a)

BOX 1. SUPA COVER SUMMARY

- Coverage rate in Kenya: 15.8 percent as of 2018 (80 percent of the total population with any form of health insurance) (Mbau et al. 2020)
- Revenue collection: payroll deductions for formal sector employees (mandatory health insurance), voluntary insurance (Kshs. 500 per month for principal members and beneficiaries), government contributions to cover indigents under the HISP
- HBP entitlements: outpatient services, inpatient services, maternal care, reproductive health services, renal dialysis, overseas treatment for specialised surgeries, rehabilitation for drugs and substance abuse, all surgical procedures including transplants, emergency road evacuation services radiology imaging services, cancer treatment (NHIF 2021b).

In addition to the packages ran by NHIF, many programmatic disease programmes also developed their own HBP; *e.g.*, HIV, malaria, tuberculosis (TB). These programmatic areas receive substantial external funding and their corresponding HBPs are often developed in collaboration with development partners, although often with national leadership.

Finally, as the country is very heavily decentralised (two-thirds of funding are programmed and disbursed at the county level), there has been notable progress on UHC at the subnational level. For instance, in 2016, Makueni county launched a health financing scheme, Makueni Care, which provides free access to a package of services in public hospitals (ThinkWell 2019).

Developing the first HBP draft (UHC-EBP) in 2018–2020

UHC has long been a priority for Kenya, but at the end of 2017 that UHC became especially highlighted on the national policy agenda with the newly elected president Kenyatta's campaign on the platform of the "Big Four" to accelerate socio-economic growth towards the country's 2030 vision (Republic of Kenya 2017). The most recent Kenya Health Strategy Plan (2018–2023) also highlights that the "overarching focus of the Strategic Plan is the Government's target of achieving UHC" (Republic of Kenya 2018a).

One of the first tasks initiated as part of the UHC planning was to develop a HBP (referred to as the Kenya Universal Health Coverage Essential Benefit Package or UHC-EBP). To this end, the UHC Health Benefits Package Advisory Panel was formed by the Cabinet Secretary through a notice published in the Kenya Gazette on June 8th 2018, (Republic of Kenya 2018b). The mandate of the HBP Advisory Panel was to design "an affordable, responsive health benefit package." The panel was formed of 17 appointed stakeholders representing all parts of the health sector in the country (academia, NHIF, national government, county government and council, National Treasury and civil society), appointed for two years. It is worth noting that the mandate of the panel was to produce a first version of a fully costed HBP within months of its convening.

First, the panel used a framework for priority setting criteria proposed by Tromp and Baltussen (2012) to select appraisal criteria to prioritise interventions in the UHC-EBP. The criteria selected were as followed (by order of priority or 'weight'): (i) effectiveness and safety, (ii) service, health products & technology requirements, (iii) equity, (iv) catastrophic health expenditure, (v) health workforce requirements, (vi) burden of disease, (vii) affordability, (viii) cost effectiveness, (ix) severity of disease and (x) congruence with existing priorities (UHC Health Benefits Package Advisory Panel 2018). In addition, some guiding principles were also adopted by the panel, including (i) the need for explicitness of services (and linking to national protocols and clinical guidelines), (ii) prioritisation of primary health care (PHC) led services, and (iii) strengthening of existing structures and capacities (including other existing HBPs such as the Kenya Essential Package for health, NHIF's SUPA Cover or county level initiatives such as Makueni care) (UHC Health Benefits Package Advisory Panel 2018). The development of UHC-EBP was carried out alongside costing of the portfolio of services to estimate the total resource requirements, as well as the incremental costs of delivering the package. These estimates were further used to estimate the budget impact of the pilots and plan the resource requirements for the expected UHC programme.

In August 2019, a first version of UHC-EBP was approved through appraisal and deliberation of the UHC HBP advisory panel. The first draft of UHC-EBP was organised into two broad categories of services: (i) public and community health services (e.g., health promotion) and (ii) facility-based services, divided into the following clinical areas: reproductive, maternal, newborn, child and adolescent services, management of non-communicable diseases, mental health services. Each clinical areas is linked to "a clinical protocol, guidelines and in some cases a policy that describes what the beneficiary is entitled (service entitlement, and conversely, what the provided is required to

deliver (service requirement)" (UHC Health Benefits Package Advisory Panel 2018). The UHC-EBC is also linked to the Kenya Essential Medicines List (2016), the Kenya Essential Medical Supplies List (2016) and the World Health Organization Model List of In Vitro Diagnostics (2018).

For 18 months, the delivery of the UHC-EBP was piloted in four counties to assess the fitness for purpose of the UHC-HBP and the accompanying planned implementation strategy.

Towards the harmonized HBP

Following the definition of UHC-EBP, a decision was taken to further refine the package by developing a harmonized package that combines existing HBPs developed through previous policies: the KEPH, Makueni Care, NHIF Supa Cover, UHC-EBP and the Kenya essential medicines list (2019 revision). The package was prioritised from these existing packages, using the following criteria: equity, disease burden, quality of care and vulnerability to catastrophic health spending. The new harmonized package is organised similarly to the UHC-EBP package, along (i) curative health services (facility based) and (ii) public health, preventive and promotive health services (community based). As of 2021, the harmonized package is viewed as the HBP for the delivery of Kenya's UHC policy.

BOX 2. PROPERTIES OF THE HARMONIZED PACKAGE

- To progressively expand health insurance coverage among Kenyans, in particular among the poor and vulnerable groups
- To progressively expand the UHC scheme benefit package
- To progressively enhance financial risk protection, in particular among the poor and vulnerable groups
- To progressively improve the quality of health services for better health outcomes.

Source: Ministry of Health (2021)

Implementation of the harmonized package

The NHIF and the Kenya Medical Supplies Authorities (KEMSA) are the vehicles for implementing the UHC policy.

During the pilot phase for the UHC-EBP, funding was provided through input financing to cover different categories of expenditure*; e.g.,* human resources, commodities, equipment and expansion of health infrastructure (Interviewee A). Going forward, funding for the harmonized package delivery is anticipated to come from different sources, for different types of services. First, the NHIF is to reimburse curative and rehabilitative services provided in all contracted health facilities and hospitals; except for HIV, Tuberculosis, Malaria treatments (including opportunistic infections in the case of HIV) and vaccines, which will receive input financing from the Ministry of Health (Ministry of Health 2021).

The Ministry of Health and the county governments are then seen to be responsible for the provision of public and community services. However, we have no confirmation that those plans have been enacted. Interviewee A also mentioned the creation of a UHC fund, which would pool resources from different sources including national and county governments, NHIF and partners, although those plans appear to have been disrupted by the COVID pandemic according to stakeholder interviews. In addition, at the time of writing, a draft of the law mandating health insurance to all Kenya is being discussed in parliament (Interviewee B).

INCLUSION OF VERTICAL PROGRAMMES IN THE HARMONIZED PACKAGE

External support in the health sector

In 2018, external expenditure represented 15.5 percent of total current health expenditure in Kenya. Given its income status (Kenya graduated to lower-middle-income status in 2014 using World Bank classification), transition features high in the policy priorities (see health financing summary indicators in Table 1).

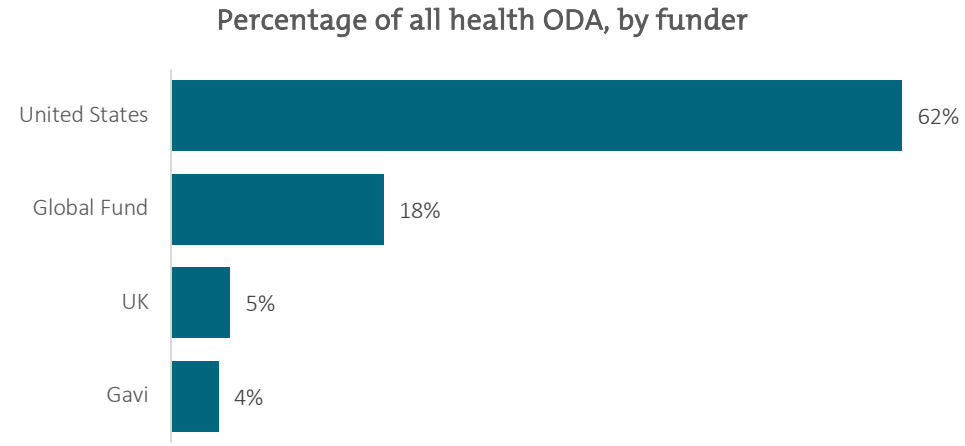
Table 1. Summary health financing indicators

GDP per capita (current US$) 2019	1,816.56
Current health expenditure (% of GDP) 2018	5.16%
Total private expenditure on health as a share of total health expenditure (% current health expenditure)	42.4%
out of pocket (% current health expenditure)	23.62%
Domestic general government health expenditure (% of current health expenditure)	42.14%
External expenditure (% of current health expenditure) 2018	15.5%
Transitioning away from aid relevance	HIGH—Near transition, remains donor dependent, particularly for HIV (McDade et al. 2021)

Source: WHO Databank, WHO GHED, Kenya National health accounts 2015/2016

In 2017, four donors made up nearly 90 percent of all health ODA in Kenya, as shown below (McDade et al. 2021).

Figure 1. Health ODA in Kenya, four major contributors



Source: McDade et al. 2021

The support from the four donors is concentrated in a handful of vertical programmes and is acute in the funding of commodities within those programmes. Kenya's roadmap for transition[1] analyses the financing of main programmes showing that for the programmes for routine immunization, family planning, tuberculosis, HIV/AIDS, Malaria and Nutrition, domestic funds make between about 7–23 percent of the total programme financing. The reliance on external funds seems to be the highest for commodities procured through the malaria programmes: 97 percent is funded by partners (53 percent by USAID-PMI, 44 percent by the Global Fund, and 3 percent by domestic sources) (Ministry of Health 2020).

Programmes supported by donors represent a large share of the disease burden. For instance, HIV/AIDS is still the highest cause of death in 2019, although the burden of disease has reduced significantly in the last decade (-41.5 percent between 2009–2019) (Vos et al. 2020). Currently, the country counts one million people living with HIV in the country, of which 32 percent are still not accessing antiretroviral therapy (ART) (The Global Fund 2017). Malaria burden increased 35 percent between the same period, and now accounts for almost half of the morbidity burden in the country and ranks as the third highest cause of death (Vos et al. 2020). As highlighted by Interviewee G "still, the three diseases form the highest burden."

The Kenya Health Sector Strategic Plan (Republic of Kenya 2018a) highlights other areas where the country has not progressed in recent years: for example, the proportion of deliveries attended by a skilled health worker has remained constant between 2013/14 and 2016/17, and the proportion of women receiving four antenatal care visits has decreased from 50 percent to 40 percent over the same time period. Full immunisation of children also experienced a drop from 90 percent to just below 80 percent. The proportion of women (of reproductive age) receiving family planning support also decreased from 60 percent to 48 percent. Maternal mortality, infant mortality and under-fives mortality are considered below target. The current Maternal Mortality Ratio (MMR) of 362 maternal deaths per 100,000 live births, and the still birth rate of 23 deaths per 1000 live births is far below the

[1] Currently in draft form, not public

target of 147 maternal mortality per 100,000 live births and 12 stillbirths per 1000 live births respectively (Lang'at, Mwanri, and Temmerman 2019). Progress in the country has also been uneven between populations and counties: this inequality in access and outcomes is one of the main motivations driving the UHC policy.

Partners engagement in the harmonized package discussions

The first iteration of the UHC-EBP was developed within 60 days of appointing the HBP Advisory Panel (between June and August 2018), building on a series of analytics and meetings organised for appraisal and deliberation (UHC Health Benefits Package Advisory Panel 2018). While partners (especially those providing technical assistance and supporting evidence generation) were consulted in the process, the HBP Advisory Panel meetings were conducted behind closed doors to ensure independence of their work. It is also worth noting that the HBP Advisory Panel composition consisted only of Kenyan nationals: no external partners were invited to take part. However, broader consultations were organised once the first draft of UHC-EBP was finalised. As well as external partners, ministries (including Treasury), the Council of Governors, the Health NGOs Network, faith-based organisations and the private sector were convened to review and provide comments on the draft. Interviewee D highlighted the importance of those consultations, while acknowledging that UHC "should be a nationally led agenda, by the current government."

To support consultations and implementation, the Cabinet Secretary for Health also developed a coordination mechanism with all stakeholders (including partners) comprising of a UHC Oversight committee, UHC inter-agency steering committee and technical sub-committees (Ministry of Health 2018). In addition, external partners also used an existing mechanism, the Development Partners in Health Kenya, to meet and discuss matters pertaining to UHC (Interviewee D). Interviewee D describes "this forum brings together all partners including multilateral partners (WHO, WB, UNAIDS, UNDP, other UN agencies, etc.), bilateral partners (JICA, USAID, CDC, PEPFAR, France, Denmark, GIZ, etc.) and others (BMGF, CHAI, CIFF, GAVI, GFF, Global Fund, etc.) are represented. The group meets every 2 months." Interviewee G highlighted that they participated in consultative meetings through this forum, and provided input on the HBP, UHC implementation strategy and roadmap for the country.

Coverage of vertical programmes in the harmonized package

We reviewed the entitlements listed in the harmonized package, which are classified in three different categories: green signals a high level of inclusion (across the entire continuum of care), orange a medium level of inclusion (not comprehensive) and red a low level of inclusion (none or a handful of services only). We find a high level of coverage of services for HIV, Malaria, TB, MCH and Immunisation, including entitlements across the entire care pathway, from prevention to curative services. In the case of immunisation, the inclusions were marked as green as they cover a wide range of vaccines, including those recommended under the Disease Control Priorities 3 package of cost-effective interventions (Watkins et al. 2018)[2]. The inclusion is only marked in orange for family planning because there is no explicit mention of any barrier method provided through the HBP.

[2] We used DCP3's package of cost-effective interventions to focus the mapping on a set of vaccine interventions that are considered widely as essential services.

Table 2. Summary of inclusion of services along six disease programmatic areas[3]

Family planning		Provision of family planning services e.g., commodities (injectables, pills, IUCD, implants), sterilization	
HIV		• HIV/AIDS antiretroviral treatment and opportunistic infections treatment as this is provided for by the HIV program. Other outpatient and inpatient services are included. • Health promotion on prevention of communicable conditions • Sensitization of the community on safe sex practices • HIV test • Management in children	Not specified: laboratory services other than HIV test
Immunisation		Aligned with the Kenya Expanded Programme on Immunization, includes: OPV, Pentavalent, Rotavirus, PCV 10, Measles and Other vaccinations (namely yellow fever, HPV vaccination, Tetanus, Rabies)	
Malaria		Anti-malaria treatment as this is provided for by the malaria program. Other outpatient and inpatient services are included.	Not specified: public health interventions, prevention, laboratory services, second line treatments
MCH		Maternal health: • Maternal Health Services • Maternal Nutrition • Preconception care • Focused antenatal care • Screening for reproductive health risks • Management of pregnancy complications • Management of abnormal pregnancies • Management of labour and delivery • Postnatal care and Maternal complications in the postpartum period e.g., postpartum haemorrhage, hypertensive disorders, puerperal sepsis Child health: Management of common conditions in children e.g., diarrhoea, malaria, acute malnutrition, meningitis, upper and lower respiratory tract infections, ENT, skin, haematological, CNS, mental health and cardiovascular conditions. Deworming and Micronutrient supplementation (e.g., vitamin A, IFA). Managing children with special needs e.g., autism, abuse, neglect, disability	Has a 'negative list', e.g., modes of delivery reviewed for multiple deliveries
TB		Anti-tuberculosis treatment as this is provided for by the TB program. Other outpatient and inpatient services are included. Management in children.	Not specified details: prevention, laboratory services, second line treatments

Source: Ministry of Health (2021)

[3] *NB: text in the table is lifted directly from Ministry of Health (2021)*

Please note that the above is a summary of the entitlements listed under the harmonized package. We acknowledge that the listing of an intervention does not necessarily mean that it is accessible to each patient or even funded by the UHC policy. Glassman et al. (2016) distinguishes entitlements *de jure* from *the facto* (*i.e.,* that 'patients actual receives')—our review is not able to cover the latter.

DISCUSSION

This review of entitlements shows the Kenya harmonized HBP includes several interventions and services covered in disease programmes that are heavily supported by external partners. As we highlight in a previous review, there is no clear pattern of inclusion in the 26 HBPs found in LMICs (Regan et al., 2021).

This discussion section builds on a desk review of the literature and stakeholder interviews to review the enablers and challenges (with regards to program inclusion), which we summarise in the table below.

Enablers	Challenges
Positive views across all interviews about integration	Confusion over overlapping entitlements between current vertical programmes and the HBP
Readiness from external partners to support the delivery of some aspects of the HBP	Tight budget envelope
'Progressive realisation' view of UHC	Disbursement modality from donors (off-budget)
Functioning pre-existing stakeholder consultation mechanisms	Political economy of existing institutional structures associated with vertical programmes
Strong political commitment to covering selected programmatic areas	Concern over losing expertise and reducing quality of care
No strong sense of urgency on transition from aid	Design of HBP that may be inadequate to serve targeted vulnerable populations or deliver community public health interventions
	Emerging challenges due to COVID-19

Enablers for entitlements inclusion

Almost all interviewees agreed that the integration of the entitlements was a positive outcome of the harmonized package discussion. Interviewee A noted that "UHC is like an orchestra band. We need to integrate those services. […] This will allow an effective and efficient utilization of resources." Kenya is gradually building towards an integrated system, and many building blocks are already in place, in the words of one interviewee [G]: "…when we talk of integration of human resource per say we don't have a staff who have been employed to treat one disease. So, we can consider that as already integration as happened in that area. We've started integrating and ensuring that the health information systems are communicating to each other, and we don't have silos." The same interviewee stated that in terms of moving towards a fully integrated system "In a scale of one to ten, we are at a

five." Similarly, Interviewee F points to existing overlaps in human resource use in practice, between programmes: "Nurses that provide HIV services will do malaria." Interviewee B also pointed to the potential gains from a full integration, from the perspective of efficiency: "Look at purchasing of commodities. You can imagine each of those has administrative costs. If you say TB, Malaria [...] there will be more efficiency if we just harmonize that." Another perceived area of efficiency gain from integration is the building of infrastructures that can be repurposed for different diseases, such as laboratory services for the three communicable diseases. Interviewee G highlights that "for example, GeneXpert is also assisting in laboratory diagnosis. We can ensure analysis of other ailments and also the staff who have been engaged. It doesn't need to be used for TB only."

One of the common messages conveyed by five of our interviewees working both at the national and global level was that the current UHC policies and the development of the harmonized package was considered the first step of Kenya's long journey towards UHC**. The progressive realisation argument was put forward for explaining why some of the services were included in the list but provided concurrently through other vertical programmes and not accounted for in tariffs or costing** (see challenges for discussion of this issue). Interviewee G noted "this is not a process that will take off immediately. We see it as a gradual process, even in terms of the benefits package development." Interviewee B also raised that the harmonized package "has been limited in terms of evidence generation, including health technology assessment. What we are envisaging is that we implement the harmonized benefits package, we will closely monitor the utilisation and use of resources, but also do costing of health services to better inform the tariffs and provider payment rates. [...] so yes, the benefit package is progressive, we envision a revision every two years." This 'progressive' approach to UHC was put forward also in policy documents (e.g., in the case of inclusion of the free maternity services programme Linda Mama) (Ministry of Health 2021).

Some development partners also appear to be contributing to the delivery of the services listed under harmonized package (and within the remit of their programmatic activities), through funding some categories of expenses, such as commodities. Interviewee D, who works as a partner, notes "we fund aspects of the harmonised HBP that fit in the UHC plan, mainly health products." Interviewee G also provides examples of funding of cross cutting activities to support UHC by partners, such as "health system strengthening and their community systems, general forecast to procurement, supply and management, [...] and health information systems."

Relating to the above point, one facilitator for inclusion of the vertical programme seems to be the belief that **transition will not occur in the medium term**, allowing the country to adjust its strategy for financing the package in the years to come. Both the UHC-EBP and harmonized package report highlight that while management of major infectious diseases services are listed, they are not subject to any payment to providers because those are taken care of by other funding sources. Interviewee B highlighted the planning of transition and current work on the drafting of a Transition Roadmap at the time of the interview. The roadmap highlights the reliance on external sources, including for the procurement of essential health commodities and an accelerating timeline for transition, partly due to shrinking global fiscal space and COVID. However, throughout the interviews, the topic of transition was not considered an immediate priority. Interviewee C highlighted "Despite the gaps that we have in funding, we still have one of the better funded disease programmes [...] the funding has remained more or less constant, and they are shown to be more or less constant moving forward so we are not feeling it [transition] yet. [...] the challenge has been in getting more funding." The lack of clear communication about set timelines may be contributing to this feeling. Interviewee E explains:

"countries begin the process of transition once they reach the lower LMIC, upper LMIC income classification. Kenya as a low-income, lower-middle-income country, is currently assessed against co-financing requirements to increase progressive government expenditure on health and progressive absorption of key program costs. […] Kenya does not have a timeline but there is an expectation that they need to increase their government expenditure."

As discussed earlier, the harmonized HBP built on many existing HBPs running in the country and there was a **strong political commitment from the outset of using the package to consolidate those HBPs into a single effort**. The presence of existing packages for different disease programmatic areas, as well as different populations groups (e.g., indigents, elderly, school age children) was both perceived as an enabler and a challenge by some of our interviewees. Interviewee A noted "some packages like the Linda Mama were non-negotiable": they were not even discussed in their content, but automatically transferred to the harmonized HBP in their entirety.

Another enabling factor seems to be the **existing structures within the health sector to consult and engage different actors of the sector at the sub-national, national and global level**. Interviewee B noted "Luckily for Kenya we already have structures for consultation with all our stakeholders for whatever agenda we have at hand." Two of our interviewees working in partner organisations (Interviewee D and Interviewee F) highlighted that their teams had been given the possibility to discuss, review and comment on the UHC work extensively, including formally through some of the structures set up by the Ministry of Health such as the UHC inter-agency steering committee.

Challenges of inclusion going forward

It is not clear how the inclusion of entitlements affects either their funding or delivery in practice, especially when those are covered by other disease programmes and HBPs. For instance, the harmonized package lists services offered to expectants mothers (pre, during and post maternity), but those services are also provided under the Linda Mama scheme. The harmonized HBP notes that "Linda Mama continues to be offered as has been ongoing concurrently with the UHC health benefits Maternity package subject to inclusion progressively" and that the pros and cons should be reviewed prior to a decision (Ministry of Health 2021). This situation is common to all six programmatic areas included in this review. For instance, the UHC-EBP final report notes that the management of HIV/AIDS, Malaria and TB is covered by the new package, but that 'other costs (*e.g.,* medications) [are] catered for by donors and GoK [Government of Kenya]'. It is worth noting that Interviewee F mentioned that while the initial version of the UHC-EBP was fully costed, this costing estimates (which were subsequently used to estimate resource requirements) did not include any of the services in the three disease programmatic areas heavily supported by donors (HIV/AIDS, Malaria and TB).

The tight budget envelope allocated to delivering the harmonized plan is one obvious challenge for inclusion of the vertical programmes. Interviewee F noted that the inclusion of vertical programmes and requiring the government to pay for it would "blow the budget […]. It would mean perhaps tripling or quadrupling the budget allocated by the Ministry of Health. And there is not enough money. That is the reality. If you say to bring in HIV, Malaria, TB into this and this means you need to pay for it, it's off the table. […] this discussion ends very, very quickly with the Ministers of Finance. A more nuanced discussion is needed around the cost of the package and how this will be financed by domestic resources and donors with an increased transition over time to government financing." Interviewee B highlighted that current on-going work to is to "look at how we can mobilize

more of domestic resources" to support implementation going forward. As previously noted, a health sector transition roadmap is currently underway to prepare for transition and support UHC (Ministry of Health 2020).

Interviewee C also points to the **challenges posed by the disbursement modality (typically off-budget) used by some donors, which limits the visibility on how the funds are used and their alignments with country national plans and investments**. According to our interviews, those off-budget funding contribute to the black box of 'costing estimates' for some services under those programmatic areas. This interviewee pointed out "if USAID pulls back $1 million hypothetically, we cannot go to the Ministry and ask them to reallocate $1 million for when they pulled out. [….] you may not find the government really willing to bridge that gap very rapidly […] I think for there to be a successful integration, this also has to come from donors." They also highlight that "governments feel donor run programs are not very efficient. They're overfunded, the unit costs for, for example, of treating one malaria case under donor funding is higher than would be if it was government funding, so it becomes difficult to sell that idea of, you can replace coin for coin or dollar for dollar what the donor has stopped funding."

Another challenge brought forward by almost all respondents was the **existing strong institutional structures supporting the delivery of the disease programmatic areas, which would appear to make it complicated at the government level**. As interviewee A puts it, "the challenge is that everyone wants a disease programme. Every programme wants their own budget." Interviewee F "look at how HIV is organised within the government. It is not driven out of the Ministry of Health. It is not integrated at the country level […] To achieve UHC the structural arrangements of vertical programs will need to be changed so they are fully integrated into the Ministry of Health." Interviewee C goes further "We are well funded so there is normally not a very high level of prioritization for our programme compared to others at the Ministry." Because disease programmatic areas are organised in silos (both in terms of their programming, operations and funding), it has been difficult to push for their full integration beyond just the entitlements. This challenge has also been highlighted in the health transition roadmap draft, which proposes the creation of a National Coordinating Authority to consolidate and coordinate the Tuberculosis, Malaria, HIV/AIDS, community and family planning programmes (Ministry of Health 2020). A related issue is the challenges of stakeholder management. Interviewee G stated "In the consultative meetings each particular key stakeholder will want to ensure that you know their interests are taken care of. So, one of the challenges is consensus building." To solve this issue, they describe "the most important is first of all trying to explain the task before you know the key stakeholders and engaging the stakeholders in the prioritization and agreeing based on merit the key issues to be collected and for consideration (…) a well guided criteria to justify the prioritisation greatly assists in prioritisation."

Another common thread highlighted by several respondents is the **fear of losing the expertise, staff and quality of care that may come with a full integration of the disease programmatic areas into UHC**. This concern has been raised for both programmes supported by external partners and programmes delivered by the NHIF. Interviewee A raised about Linda Mama "during the pilot, they consulted the counties, and the conclusion is that it should be operating as a duplicate, also because they were worried it would collapse if it was integrated in the package." Interviewee B separately also highlights about the same programme "now the problem of consolidating right now is that our insurance coverage is still quite low, we risk denying [expectant mothers] the service they need." Interviewee F highlights about the HIV programme "there is above site activities. There is training,

capacity building, management, information systems. […] the minute you integrate into primary health care system, all this oversight, all this insistence on high quality of care and effective care will go away. We will go down to the mean […] in terms of quality, in terms of effectiveness, in terms of responsiveness." However, the same interviewee also acknowledges that "It is not clear that the level of supervision and management done by the donors is really essential to ensure quality of services. A discussion will need to take place with the government on which of these functions are absolutely needed and how it will be funded and managed." Interviewee C noted about yet another programme: "these programmes have very well set out structures. Good M&E structures, commodities, capacity of health care workers, advocacy and communication. This emphasis [exists] because it is a vertical programme. And the dilemma would be then when we integrate, do we scale down? Do we make them like any other programme? Do you disable […], loose the progress on all those activities?"

Interviewee A also relatedly points to worries about the **design of the package**. "The package is not explicit enough to say what they are going to purchase; this is the weakest point. The donors are still going to purchase the commodities, but the government has not been putting money to it." Interviewee C also highlights that some of the activities under the programmatic area they oversee don't seem to fit neatly into an HBP. They state "The challenge I have […]. You know the case management is quite easy to include this, but including vector control, malaria prevention activities, within the harmonized benefits package for me poses a challenge because these are services that cover […] the community level." According to the interviewee, for instance, bed nets, prevention among pregnant mothers or indoor spraying to prevent transmission of malaria needs to be distributed with prioritising certain geographic areas, and not be universal. Those prevention activities account for a large share of funding in the malaria programme, "I think between 60–70 percent. And these are not implemented uniformly across the country. This service is [most impactful] where we have malaria, endemic regions, epidemic prone regions" (Interviewee C). This also may be a concern for interventions that are targeting specific key populations (e.g., in the case of HIV, Tuberculosis or family planning), which are typically provided through NGOs.

Finally, as is the scenario in many countries, **the COVID-19 pandemic has halted progress towards other health care policy goals, such as the achievement of UHC**. In Kenya, interviewee A states: "The UHC policy has been signed, but the funding has now been diverted to do only COVID." The COVID-19 pandemic has not only thrown up additional challenges, through diversion of resources and other capacity constraints, but has shown the importance of a coordinated approach to health care in Kenya. The pandemic has changed the perception of vertical programmes, as one interviewee G points out: "Now we have COVID-19 we cannot seem to be vertical dealing with one disease (…) we would be spreading the bullets and the impact we want to achieve, meaning it will be not possible."

CONCLUSION

This present study provides detailed information about Kenya's journey towards UHC, prioritisation of the harmonized package of care, focussing on the inclusion of vertical programmes to the HBP's entitlements. This is, to our knowledge, the first case study addressing those questions in Kenya and in other LMICs.

Although all efforts were made to have interview a number of relevant stakeholders, it was not possible to interview a representative sample, and to capture all perspectives, within the time allocated to this project. It is worth noting that we tried to include a plurality of views from government officials as well as development partners in our interview sample. Moreover, we rely on interviews for the discussion part, which may be prone to biases (e.g., if interviewees did not feel they could speak freely or biases on the part of the research team on the interpretation of the transcripts). As a result, this present case study should be seen as preliminary work and our findings should be interpreted in the context of this limitation.

A general positive consensus for the eventual integration of vertical programmes entitlements to Kenya's HBP has been shown through both the desk review and interviews. It is clear Kenya's harmonized package is intended to be a unifying policy across different levels of care and disease control priorities, as is demonstrated by the wide range of entitlements (Table 2). Another positive lesson is Kenya's practical approach to progressive realisation of UHC; for instance, combining different sources of funding to support delivery and building positive relationships with external partners while retaining local ownership on the decisions. This step-by-step progressive approach has allowed Kenya to take a long-term view, that incorporates anticipated changes in health needs and resource availability within Kenya's health sector. It could lead, in the short run, to developing different modalities of integration, perhaps relying in a first instance on donor funding for certain categories of expenses (e.g. commodities) and on government funding for others (e.g. salary and infrastructure).

As Kenya works to fully implement the harmonized package, resolving the many challenges of such integration and addressing transition from aid will be essential. Otherwise, the country will risk piecemeal implementation, creating tensions between the UHC programmes and the delivery of those programmatic areas and of negative impacts on the provision of services for patients. If this integration of entitlements translates into integrated delivery on the ground in the future, then this experience could be insightful for other LMICs embarking on the journey to UHC.

ANNEX 1. INTERVIEWEE SELECTION PROCESS

Interviews were sought with a wide range of stakeholders, the two primary groups being external partners and government officials. We identified stakeholders based on contacts from our networks, reviews of official documents (*e.g.*, review of contributors' list).

We sought to target interviews to capture the views of officials working in the development or revision of Kenya's Health Benefit Package, head of disease programmes, and major funders. 25 invitations were sent out for consultation, resulting in 7 1-hour structured interviews completed. All interviews were conducted online over the course of the months of July and August 2021 by the two research staff (YLC and LR).

Interviewee list

	Affiliation
A	Ministry of Health government official 1
B	Ministry of Health government official 2
C	National disease programme government official 3
D	Development partner 1
E	Development partner 2
F	Academic, external partner 1
G	Consultant 1

ANNEX 2. INTERVIEW TRANSCRIPT INDUCTIVE CODING METHODOLOGY

Each interview was recorded, and a complete transcript was produced using the online meeting tool, with the exception of one interview where detailed notes were taken due to technical issues.

To analyse the information garnered through the interviews, inductive coding was used. Inductive coding allows thematic analysis of qualitative interviews, through grouping together key information into themes, and allows comparison of information provided across different respondents on common themes (and identify any source of discrepancy) (Thomas 2006).

Interviews were split between the two research staff (YLC and LR), and each staff was responsible for steps 1 to 4 described below. Once interviews were coded, an excel spreadsheet bringing together all statements and codes was generated, and pivot tables were created to summarise the categories and codes. Those pivot tables were then subsequently used to create broad themes that were used to discuss the enablers and the challenges linked to integration.

The below step-by-step methodology describes the process developed for this case study.

Step 1: Interview transcripts

1. Interview transcripts are reviewed and cleaned up (e.g., removal of any wrong text input from Microsoft teams)

2. Researchers read through all interview transcripts to get a feel for the information and make notes of initial impressions

Step 2: Coding

1. Transcripts were reread line by line

2. The researchers began coding by highlighting and labelling relevant words, phrases, sentences or sections. These included functions, activities, concepts, challenges, opinions, processes, or anything deemed relevant to objectives of the study.

    - In particular, researchers highlighted information that is repeated, surprising, interviewee explicitly stated is important, or related to information found in published literature through the desk review.

    - These codes included interviewee's summarising a topic or data, (e.g. organisations, team roles, etc), direct quotes on feelings, perspectives and descriptions of processes.

Step 3: Creating categories

1. All highlighted excerpts were brought together in an excel spreadsheet, a code per cell.

2. Categories were created by bringing several codes together. The categories used were the following: Funding, inclusion / integration, challenges, benefit package design, donor coordination, political aspects, stakeholders, transition, malaria, department / function, capacity, HIV, HSS, Family planning, communication, economy, collaboration, enabler, Covid, prioritisation, progressive / incremental, opinion, maternal child, evidence.

3. Some initial codes were dropped at this stage when deemed not as relevant.

4. Each excerpt was labelled with at least one associated category.

5. Pivot tables were created then to view the most populous categories. The pivot tables were used to review and revise categories making sure they are distinct, relevant. The categories were narrowed down to the 8 most relevant to the study objectives.

Step 4: Writing up of results

1. The categories were used to create broad themes that were used to discuss the enablers and challenges of integration of vertical programmes within HBPs.

2. The discussion section of this paper describes the researchers interpretations of these themes, including information from other literature, theories and concepts.

REFERENCES

Bredenkamp, C, T Evans, L Lagrada, J Langenbrunner, S Nachuk, and T Palu. 2015. "Emerging Challenges in Implementing Universal Health Coverage in Asia." *Social Science & Medicine (1982)* 145 (May): 243–48. https://doi.org/10.1016/J.SOCSCIMED.2015.07.025.

Glassman, Amanda, Ursula Giedion, and Peter Smith. 2017. *What's In, What's Out: Designing Benefits for Universal Health Coverage | Center for Global Development*. https://www.cgdev.org/publication/whats-in-whats-out-designing-benefits-universal-health-coverage.

ISSA. 2014. "Health Insurance Subsidy Programme for the Poor, Older Persons and Persons with Severe Disabilities | International Social Security Association (ISSA)." Health Insurance Subsidy Programme for the Poor, Older Persons and Persons with Severe Disabilities. 2014. https://ww1.issa.int/gp/162201.

Künzler, Daniel. 2016. "The Politics of Health Care Reforms in Kenya and Their Failure." *Social Policy* 1.

Lang'at, Evaline, Lillian Mwanri, and Marleen Temmerman. 2019. "Effects of Implementing Free Maternity Service Policy in Kenya: An Interrupted Time Series Analysis." *BMC Health Services Research 2019 19:1* 19 (1): 1–10. https://doi.org/10.1186/S12913-019-4462-X.

Mbau, Rahab, Evelyn Kabia, Ayako Honda, Kara Hanson, and Edwine Barasa. 2020. "Examining Purchasing Reforms towards Universal Health Coverage by the National Hospital Insurance Fund in Kenya." *International Journal for Equity in Health 2020* 19:1 19 (1): 1–18. https://doi.org/10.1186/S12939-019-1116-X.

McDade, Kaci, Kenneth Munge, Gilbert Kokwaro, and Osondu Ogbuoji. 2021. "Reducing Kenya's Health System Dependence on Donors." Brookings, March 2, 2021. https://www.brookings.edu/blog/future-development/2021/03/02/reducing-kenyas-health-system-dependence-on-donors/.

Ministry of Health. 2018. "Health CS Calls for Partnership to Achieve UHC ." *Ministry of Health*, March 13, 2018. https://www.health.go.ke/health-cs-calls-for-partnership-to-achieve-uhc/.

———. 2020. "Kenya Health Sector Transition Roadmap in the Context of UHC Sustainability Financing DRAFT (Unpublished)."

———. 2021. "Policy Brief on Universal Health Coverage Benefits Package 2020 DRAFT (Unpublished)."

NHIF. 2021a. "National Hospital Insurance Fund Objectives." National Hospital Insurance Fund. 2021. http://www.nhif.or.ke/healthinsurance/Objectives.

———. 2021b. "NHIF SUPA Cover Products." National Hospital Insurance Fund. 2021. http://www.nhif.or.ke/healthinsurance/supacoverServices.

Oraro-Lawrence, Tessa, and Kaspar Wyss. 2020. "Policy Levers and Priority-Setting in Universal Health Coverage: A Qualitative Analysis of Healthcare Financing Agenda Setting in Kenya." *BMC Health Services Research 2020 20:1* 20 (1): 1–11. https://doi.org/10.1186/S12913-020-5041-X.

Regan, Lydia, David Wilson, Kalipso Chalkidou, and Y-Ling Chi. 2021. "The Journey to UHC: How Well Are Vertical Programmes Integrated in the Health Benefits Package? A Scoping Review." *BMJ Global Health* 6 (8): e005842. https://doi.org/10.1136/BMJGH-2021-005842.

Republic of Kenya. 2010. *Constitution of Kenya*. National Council for Law Reporting. https://www.wipo.int/edocs/lexdocs/laws/en/ke/ke019en.pdf.

———. 2017. "The Big 4 - Empowering the Nation." 2017. https://big4.delivery.go.ke/.

———. 2018a. "Kenya Health Sector Strategic Plan: Transforming Health Systems: Achieving Universal Health Coverage by 2022." Nairobi.

———. 2018b. "Kenya Gazette Notice No. 5627." Kenya Gazette. June 8, 2018. http://kenyalaw.org/kenya_gazette/gazette/volume/MTgwMw--/Vol.CXX-No.69/#GAZETTE%20NOTICE%20NO.%205627.

The Global Fund. 2017. "Kenya Essential Data Table." Kenya Coordinating Mechanism.

The Republic of Kenya. 1998. *National Hospital Insurance Fund Act*. www.kenyalaw.org.

ThinkWell. 2019. “A Review of Makueni Care.” Kenya Knowledge and Learning Brief 1. https://thinkwell.global/wp-content/uploads/2020/02/Makueni-Care-Brief-2019_10_09-Final.pdf.

Thomas, David R. 2006. “A General Inductive Approach for Analyzing Qualitative Evaluation Data.” *American Journal of Evaluation* 27 (2): 237–46. https://journals.sagepub.com/doi/abs/10.1177/1098214005283748.

UHC Health Benefits Package Advisory Panel. 2018. “Report on the UHC Essential Benefits Package.” https://centerforglobaldevelop-my.sharepoint.com/:w:/g/personal/lregan_cgdev_org/ETz3vfSjOiFPhu1MlEDPl5sBkz20Uu9IJWjaBuTqaaVj9w?rtime=LCJOwxJu2Ug.

Vos, Theo, Stephen S Lim, Cristiana Abbafati, Kaja M Abbas, Mohammad Abbasi, Mitra Abbasifard, Mohsen Abbasi-Kangevari, et al. 2020. “Global Burden of 369 Diseases and Injuries in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019.” *The Lancet* 396 (10258): 1204–22. https://doi.org/10.1016/S0140-6736(20)30925-9.

Watkins, David A, Dean T Jamison, Anne Mills, Rifat Atun, Kristen Danforth, Amanda Glassman, Susan Horton, et al. 2018. “Universal Health Coverage and Essential Packages of Care.” *Disease Control Priorities (Third Edition)* 9.

WHO. 2014. “Making Fair Choices on the Path to Universal Health Coverage.” Geneva.

——. 2021. “Universal Health Coverage (UHC).” April 1, 2021. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

Wright, Jenna. 2015. “Essential Package of Health Services Country Snapshot.” https://www.hfgproject.org/essential-package-of-health-services-country-snapshot-kenya/.

Center for Global Development

WWW.CGDEV.ORG

Y-LING CHI is a senior policy analyst at the Center for Global Development.

LYDIA REGAN is a research associate at the Center for Global Development.

Photo: U.S. Army photo by Rick Scavetta, U.S. Army Africa Public Affairs