

WHAT'S LEFT TO DO AFTER PROJECT?

MINISTRY OF HEALTH

- * Strengthening the HCF Secretariat
- * Implementation of the Strategic Plan
 - . Institutionalizing strategic planning in MOH
 - . Develop and implementation plans for improved efficiency in allocation of MOH resources
 - . Expansion of private sector in health service delivery
 - . Strengthen role of social financing
 - . Enhancing public policy role of MOH
- * Block payment scheme for reimbursing GOK facilities
- * Monitoring and evaluation - sustaining the system
- * Supervision of the DHMBs and overseeing their operations
- * Consolidation of collection and expenditure system
- * Increase revenue to full potential
 - . NHIF block payment system
 - . reduce exemptions
 - . improve collections efficiency
 - . refine fee levels
- * Refining public and private fee structure
- * Improve the use of cost sharing revenue
- * Strengthen MOH's audit functions
- * Increasing Treasury allocations to MOH in general and for P/PHC in particular
- * Rationalize health facility planning
- * Implementing staffing norms
- * Implementing clinical guidelines

NATIONAL HOSPITAL INSURANCE FUND

- * Claims streamlining
- * Computerization of claims processing
- * Block payment system implementation
- * Insurance management support

MINISTRY OF HEALTH

OFFICIAL FILE

Telegrams: "MINHEALTH", Nairobi
Telephone: Nairobi 717077
When replying please quote



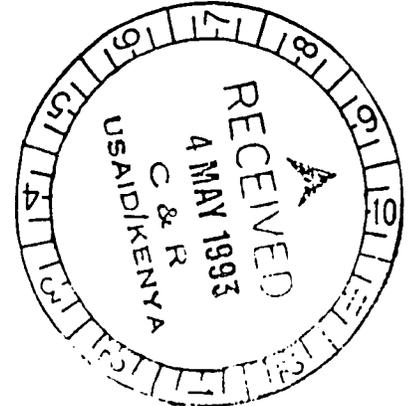
OFFICE OF THE PERMANENT SECRETARY
AFYA HOUSE
CATHEDRAL ROAD
P.O. Box 30016
NAIROBI

REF No. B/13/1/18A Vol.V/32 and

20th April, 19 93

Mr. Gary W. Newton
Chief Population and Health
USAID
P.O. Box 30261
NAIROBI

ACTION COPY
Action taken. added to
HC F Program
No action necessary.....
GA 5/2/93
(Initials) (Date)



Dear Mr. Newton,

RE: EXTENSION OF KENYA HEALTH CARE FINANCING PROGRAMME

As a supplement to my referenced letter requesting an extension of the Technical Assistance aspect of the Kenya Health Care Financing Program, attached thereto, and in follow-up to our February 16th meeting, I would like to request your consideration of the following additional matters:-

1. Extension of the dates for satisfaction of conditions Precedent and the Terminal Date for Requests for Disbursement under the Program Grant Agreement for twelve months to enable full compliance with the terms of that agreement.
2. The pressures of our rapidly increasing population on the health care financing system are such that the extension of the technical assistance project should include an increased focus on obtaining financing for family planning through user fees and insurance reimbursements.
3. Similarly, the present and projected financial impact of the HIV/AIDS epidemic on the health system are such that the extension should examine the cost implications of courses of action in HIV/AIDS prevention and control and advocate for increased financial resources through users fees and insurance reimbursements to deal with the problem.

As decided the February 16th meeting, because of the priority needs and limited funding, overall emphasis for the extension should concentrate on strengthening the capacity of the Health Care Financing Secretariat to implement cost sharing, improving the operational capacity of the NHIF, and increasing overall resources for primary and preventive health care which encompasses HIV/AIDS prevention and control and family planning.

DATE REC'D	5-4
REPLY DUE	5-12
ACTION OFF	P.H
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REDSO	
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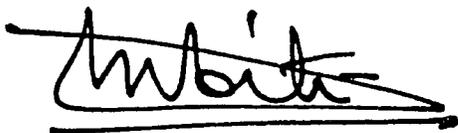
Mr. Gary W. Newton

- 2 -

20th April, 1993

Thank you for your consideration of this request. I look forward to a positive response.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Mbiti', is written over a horizontal line. The signature is stylized and cursive.

DANIEL M. MBITI
PERMANENT SECRETARY

4

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: **A** (A = Add, C = Change, D = Delete)
Amendment Number: **84277**
Two

DOCUMENT CODE: **3**

2. COUNTRY/ENTITY: **Kenya**

3. PROJECT NUMBER: **615-0245**

4. BUREAU/OFFICE: **Africa** [06] **Kenya Health Care Financing Prog.**

5. PROJECT TITLE (maximum 40 characters)

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY **08 31 95**

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY **89** B. Quarter **4** C. Final FY **94**

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	4500	1400	5900	5600	1700	7300
(Grant)	(4500)	()	(5900)	(5600)	()	(7300)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country		1965	1965		2400	2400
Other Donor(s)						
TOTALS	4500	3365	7865	5600	4100	9700

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1)	DFA			5900		1400		7300	
(2)									
(3)									
(4)									
TOTALS				5900		1400		7300	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To provide sustained, increased financial resources for the delivery of efficient quality care in both curative and preventive services.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a page PP Amendment.)

To provide additional AID financing for Project totalling U.S. \$1,400,000 and extend the PACD to August 31, 1995. Methods of implementation and financing have been approved by the Mission Controller.

17. APPROVED BY: **J. R. Westley**, USAID/Kenya Director

Signature: *J. R. Westley*

Title: **J. R. Westley**
USAID/Kenya Director

Date Signed: MM DD YY **10/13/93**

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

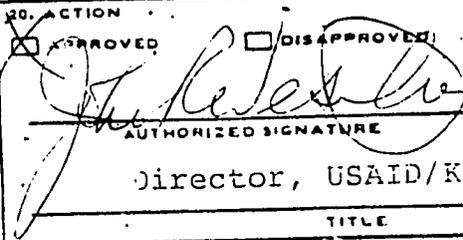
MM DD YY

AID 1120-1 10-661	DEPARTMENT OF STATE AGENCY FOR INTERNATIONAL DEVELOPMENT	1. PAAD NO. 615-0245 (Amendment Number One)	
		2. COUNTRY Kenya	
		3. CATEGORY Cash Transfer	
		4. DATE May, 93	
5. TO:	J.W. Westley, Director	6. OYB CHANGE NO. N/A	
7. FROM:	Steffi Meyer Office of Projects	8. OYB INCREASE N/A	
9. APPROVAL REQUESTED FOR COMMITMENT OF:		TO BE TAKEN FROM N/A	
10. APPROPRIATION - ALLOTMENT			
11. TYPE FUNDING <input type="checkbox"/> LOAN <input type="checkbox"/> GRANT	12. LOCAL CURRENCY ARRANGEMENT <input type="checkbox"/> INFORMAL <input type="checkbox"/> FORMAL <input type="checkbox"/> NONE	13. ESTIMATED DELIVERY PERIOD 3/89 - 8/94	14. THE ACTION ELIGIBILITY DATE
15. COMMODITIES FINANCED N/A			

16. PERMITTED SOURCE	17. ESTIMATED SOURCE
U.S. only: FY 89 LOP	U.S.: FY 89 LOP
Limited F.W.:	Industrialized Countries:
Free World:	Local:
Cash: 9.7	Other: 9.7

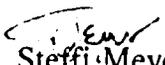
18. SUMMARY DESCRIPTION

The purpose of this Program Assistance approval document is to provide for a one year no-cost extension of the Kenya Health Care Financing (KHCF) Non Project Assistance Program (NPA) from August 31, 1993 to August 31, 1994. Other provisions of the original PAAD remain the same.

19. CLEARANCES	DATE	20. ACTION
PROG: KIOH	7/28/93	<input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED
PH: (Newton)	6/8/93	 AUTHORIZED SIGNATURE Director, USAID/Kenya TITLE
COM: CAGARS	7/14/93	
FLA: AVance	6/24/93	
D/DIR: RSimmons		
		DATE 5/13/93

CLASSIFICATION:

ACTION MEMORANDUM FOR THE DIRECTOR, USAID/KENYA

FROM:  Steffi Meyer, Chief, Office of Projects

SUBJECT: Kenya Health Care Financing (KHCF) Program (615-0245) - Amendment of Project and Program Components

DATE:

ACTION: Your approval is requested for (1) the attached PP/PAAD Supplement for the subject program; (2) the attached Project Authorization Amendment Number Two, to increase total planned life-of-project (LOP) funding for the Project component from \$5,900,000 to \$7,300,000 and extend the Project Activity Completion Date (PACD) from December 31, 1993 to August 31, 1995; and (3) the attached PAAD Facesheet Amendment Number One, to extend the Non-Project Assistance Program component from August 31, 1993 to August 31, 1994.

BACKGROUND: In August 1989, the Kenya Health Care Financing (KHCF) program was authorized for a four year LOP, with the objective of increasing the amount and reliability of the financing available to the health care sector, particularly in the areas of preventive and primary care, through cost-sharing in the form of user fees and insurance reimbursements. Total financing of U.S. \$15,000,000 was obligated in African Economic Policy Reform Program (AEPRP) funds: \$9,700,000 for nonproject sector assistance (the Program component), and \$5,300,000 for technical assistance, training and limited commodities to support the program policy reform agenda (the Project component). In June 1992, the PACD for the Project component was extended to December 31, 1993, and \$600,000 was added, bringing the total funds for the Project component to \$5,900,000.

On the whole, the program has enjoyed considerable success, with user fees and insurance reimbursement increasingly recognized as central components of health care financing in Kenya, and with wider acknowledgement of the importance of preventive and primary health care. However, due to: 1) the depth and complexity of the reforms; 2) the demands of the growing HIV/AIDS epidemic, increasing population, and rising expectations on the financial resources available for health care; and 3) Kenya's currently declining economic performance, additional time is required to carry the program to maturity and put the reforms on a self-sustaining basis, as well as to investigate the feasibility of National Hospital Insurance Fund (NHIF) financing and cost-sharing support for clinical family planning and HIV/AIDS prevention and control activities. These recommendations are supported by the May 1992 mid-term program evaluation.

DISCUSSION: The Goal and Purpose of the overall program will remain unchanged during the extension: to increase the financial sustainability of curative and preventive health services. The program contributes to USAID's goals of sustained and broad based economic growth. The program will contribute directly to the sub-goal of reducing fertility and population growth because of the added resources available for primary and preventive health services, including family planning. It will also contribute to the Mission's HIV/AIDS prevention and control efforts.

The extension will finance technical assistance in the form of: long term advisors; short-term TA; in-country training; and logistic support for the Secretariat, which administers the program for the MOH. While many of these activities are continuations of those carried out under the original Project component or its initial extension, others, such as those dealing with cost-sharing for family planning or with HIV/AIDS prevention and control, are a further refinement of efforts to increase resources in primary and preventive health services. The continued presence of the TA team under the extension will serve as a useful source of assistance to the Health Care Financing Secretariat in monitoring and reviewing local currency project expenditures under the remaining tranche disbursements.

The extension of the Program component will allow for: 1) the realization of the potential benefits of cost-sharing and shifts in emphasis from curative to primary and preventive health care; and 2) institutionalization of the Secretariat by ensuring that a) full staffing is in place, b) there is support for the elevation of the Secretariat within the MOH structure, and c) a funded MOH budget-line for the Secretariat is established.

The Project component is being amended to add \$1,400,000 (\$700,000 in FY 1993 and \$700,000 in FY 1994), which will bring the Project component LOP funding to \$7,300,000, and to extend the Project PACD from December 31, 1993 to August 31, 1995. The increased funding will be obligated through Project Grant Agreement Amendment Number Two. Host country contributions to the Project component will increase by the local currency equivalent of \$468,000, for a new total contribution of \$2,433,000 or 25 percent of the Project component funding.

The Program component is being extended at no cost from August 31, 1993 to August 31, 1994 by Amendment Number One to the PAAD Facesheet. The Program component extension will be communicated to the Ministry of Health through a Program Implementation Letter (PIL).

ANALYSES AND OTHER REQUIREMENTS: Analyses in the original PP and PAAD remain valid and have not been altered by this PP supplement. Similarly, the methods of financing and implementation remain unchanged. The supplemental funding for the

Project component will be obligated under a Project Grant Agreement Amendment with the GOK and will be used to directly finance the A.I.D. direct contract with the institutional contractor.

CONDITIONS AND COVENANTS: There are no additional conditions or covenants.

WAIVERS: None.

RESPONSIBLE AID OFFICER: The officer responsible for the Program will be Mr. Gary W. Newton, Chief of the Office of Population and Health. Primary program monitoring functions will be carried out by an A.I.D. personal services contractor, Ms. Kathryn A. Colson.

PROJECT REVIEW COMMITTEE ACTION: The Project Review Committee (PRC) reviewed the PP/PAAD Supplement on April 1, 1993 and recommended its approval. The PP/PAAD supplement incorporates all of the recommendations of the PRC. (See the attached draft PRC Results Memo for full details.) In brief, the PRC requested the following:

1) Further information and clarification on:

- the PP/PAAD Supplement on the status of the tranche disbursement (how much and for what purpose)
- Congress' hold on quick disbursement funds
- the status of reconciliation of the audit
- the relationship between Project and Program components

2) Clarification that KHCF Project staff and Secretariat personnel are in place to ensure that technical skill transfer occurs as a key ongoing activity. In addition, the Supplement should focus more on expanding the skills transfer to Kenyan counterparts as an important aspect of future sustainability of cost-sharing in the health sector.

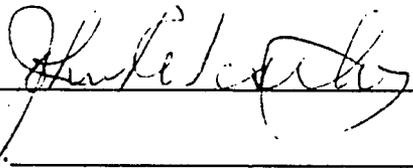
3) New HIV/AIDS-related activities under the Supplement should focus largely on the National Hospital Insurance Fund (NHIF); and

4) Clarification regarding items raised in the Issues Memo in the PP/PAAD Supplement. (For details, see attached Issues/Outcome Memo.)

NOTIFICATION TO CONGRESS: A Technical Notification for the Project for \$700,000 in increased LOP funds will be submitted in FY 1993. Another Technical Notification for the additional \$700,000 in increased LOP funds will be submitted in FY 1994 if Kenya's obligations still require notification to Congress.

AUTHORITY: Under Sections 4A(2) and (3) of Africa Bureau Delegation of Authority No. 55 (revised), you have the authority to amend Project Authorizations executed by any A.I.D. official unless it: (1) results in life-of-project funding of more than \$30 million; (2) results in a new life of project of more than ten years; (3) presents significant policy issues or deviates from the original project purpose; or (4) requires issuance of waivers that are beyond your authority. None of the above considerations represent limitations to your authority in this instance.

RECOMMENDATION: That you sign the attached: 1) Project Data Facesheet, thereby approving the PP/PAAD Supplement; 2) the Project Authorization Amendment Number Two, thereby approving an increase in Project component LOP funding of \$1,400,000, for a new LOP total of \$7,300,000, and an extension of the PACD to August 31, 1995; and 3) PAAD Facesheet Amendment Number One, thereby approving an extension to the terminal date for submission of requests for disbursement from August 31, 1993 to August 31, 1994, only upon receipt of the official budget allowance.

Approved: 
Disapproved: _____
Date: 4/13/93

- Attachments:
1. Project Authorization Amendment No. 2
 2. PAAD Facesheet Amendment No. 1
 3. Project Grant Agreement Amendment No. 2
 4. PP/PAAD Supplement
 5. Issues Paper, dated April 1, 1993
 6. PRC Results Memo (draft)

Drafted:PRJ:SMeyer:4/1/93
Clearances:PH:GNewton(draft)
 RLA:AVance(draft)
 PROG:KToh 
 CONT:CAdams(draft)
 D/DIR:RSimmons 
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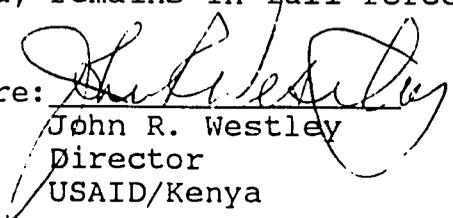
PROJECT AUTHORIZATION: AMENDMENT NO. TWO

NAME OF COUNTRY: Kenya
NAME OF PROJECT: Health Care Financing Program -
Technical Assistance Project
PROJECT NUMBER: 615-0245

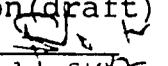
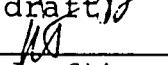
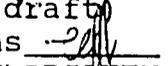
1. **Background.** Pursuant to Title II of the Foreign Operations, Export Financing, and Related Programs Appropriation Act of 1989, and the Foreign Assistance Act of 1961, as amended, the Kenya Health Care Financing Program - Technical Assistance Project was originally authorized on August 23, 1989 at a total planned level of financing of Five Million Three Hundred Thousand United States Dollars (\$5,300,000) in grant funds over a four (4) year period from the date of original authorization. On June 23, 1992, the Project Agreement was amended to increase the total planned level of financing by Six Hundred Thousand United States Dollars (\$600,000) for a total of Five Million Nine Hundred Thousand United States Dollars (\$5,900,000) and to extend the Project Assistance Completion Date to December 31, 1993.

2. **Amendment.** Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize an additional One Million Four Hundred Thousand United States Dollars (\$1,400,000) in Development Fund for Africa (DFA) grant financing for said Project for a revised total financing level for the Project of not to exceed Seven Million Three Hundred Thousand United States Dollars (\$7,300,000) in planned obligations, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to finance the foreign exchange and local currency costs of the Project. The Project Activity Completion Date is also hereby extended from December 31, 1993 to August 31, 1995.

3. **Status of Original Authorization.** Except for the foregoing, the original Authorization, as amended, remains in full force and effect.

Signature: 
John R. Westley
Director
USAID/Kenya

Date: 4/17/93

Clearances: O/PH: GWNewton (draft)
PROJ: SMeyer 
RLA: AVance (draft) 
PROG: KToh 
CONT: CAdams (draft)
D/DIR: RSimmons 
Doc: U:\...\USAID.PHD\HCF\PRJAUTH

**EXTENSION
of
KENYA HEALTH CARE FINANCING PROGRAM
and
TECHNICAL ASSISTANCE PROJECT**

T A B L E O F C O N T E N T S

<u>Section</u>	<u>Page</u>
I. INTRODUCTION	1
II. BACKGROUND	1
A. Overview	1
B. USAID/Kenya Health Care Financing Program	3
C. Other Donors	4
III. PROGRESS TO DATE AND STATUS OF IMPLEMENTATION	5
A. Program Component (NPA)	5
1. Objectives	5
2. Background	6
a. Ministry of Health	8
b. Kenyatta National Hospital	10
c. National Hospital Insurance Fund	10
3. Present Status of Program	11
B. TA Project Component	12
1. Objectives	12
2. Background	13
a. Ministry of Health	14
b. Kenyatta National Hospital	15
c. National Hospital Insurance Fund	16
IV. RATIONALE FOR PROGRAM EXTENSION	17
V. ACTIVITIES DURING EXTENSION PERIOD	19
A. Program Goal and Purpose	19
B. Activities Under TA Project Component	20
1. Long-Term Technical Advisors	21
2. Short-Term Technical Assistance	21
3. Training	22
4. Other TA Team and HCF Secretariat Costs	22
5. USAID Project Management	22
6. PP Extension Approval Authority	23
VJ. REVISED FINANCIAL PLAN	23
VII. EVALUATION, MONITORING AND AUDIT	27
VIII. REVISED IMPLEMENTATION PLAN	28
<u>ANNEXES</u>	
A. Long-Term Technical Assistance Scopes of Work	
B. Short-Term Technical Assistance Illustrative List	
C. Logframe	
D. GOK Letters Requesting Extension	
i.	

EXTENSION
of
KENYA HEALTH CARE FINANCING PROGRAM
and
TECHNICAL ASSISTANCE PROJECT

L I S T O F A C R O N Y M S

<u>Name</u>	<u>Acronym</u>
Acquired Immune Deficiency Syndrome	AIDS
AIDS Control And Prevention Project	AIDSCAP
Condition Precedent	CP
Directorate of Personnel Management	DPM
District Health Management Board	DHMB
District Health Management Team	DHMT
District Hospital	DH
Family Health International	FHI
Family Planning	FP
Government of Kenya	GOK
Gross Domestic Product	GDP
Headquarters	HQ
Hospital Executive Expenditure Committee	HEEC
Human Immunodeficiency Virus	HIV
Health Center	HC
Inspector General	IG
Kenya Health Care Financing Program	KHCF
Kenyan Shilling	KSh.
Kenyatta National Hospital	KNH
Ministry of Finance	MOF
Ministry of Health	MOH
Ministry of Local Government	MLG
Nairobi City Council	NCC
National AIDS Control Programme	NACP
National Hospital Insurance Fund	NHIF
Non-Federal Audit	NFA
Non-Project Assistance	NPA
Office of Population and Health	O/PH
Overseas Development Administration	ODA
Personal Services Contract	PSC
Project Assistance Completion Date	PACD
Project Implementation Letter	PIL
Project Implementation Review	PIR
Program Assistance Approval Document	PAAD
Project Paper	PP
Preventive and Primary Health Care	P/PHC
Provincial General Hospital	PGH
Sexually Transmitted Disease	STD
Technical Advisor for AIDS and Child Survival	TAACS
Technical Assistance	TA
United States Agency for International Development	USAID

**KENYA HEALTH CARE FINANCING PROGRAM
(615-0245)**

I. INTRODUCTION:

This Project Paper/PAAD Supplement provides the rationale for authorization of:

a 20-month extension of the PACD for Project Assistance: **from** December 31, 1993 to August 31, 1995; and

a one-year no-cost extension of the Kenya Health Care Financing (KHCF) Non-Project Assistance (NPA) Program from August 31, 1993 to August 31, 1994.

Since 1989, USAID/Kenya has been working with the Ministry of Health (MOH); the Kenyatta National Hospital (KNH); and the National Hospital Insurance Fund (NHIF); on the U.S. \$15 million Kenya Health Care Financing (KHCF) Program. This program was designed to develop cost-sharing programs of user fees (with a waiver system to protect the poor) and insurance reimbursements to improve the quality and availability of health care despite the budgetary stringencies of the GOK, and to increase emphasis on Preventive and Primary Health Care (P/PHC). The program has a Non-Project Assistance (NPA) Component, providing funding in support of policy reforms, and a Project Assistance (PA) component with technical assistance and training, providing assistance to the MOH, KNH, and NHIF in implementing the reform proposals as well as in overall institutional development.

The program has enjoyed considerable success in the areas of both policy dialogue and institutional development. User fees and insurance reimbursement have become important aspects of health care financing in Kenya. The importance of P/PHC is more widely recognized, and the TA Team has done extremely well in working with and training their counterparts. However, due to the complexity of the policy reforms and institutional development requirements, additional time is needed to carry the program to maturity and put reforms and institutions on a self-sustaining basis. Additional time is also needed to address more fully the financing needs of Family Planning (FP) and HIV/AIDS prevention and control.

II. BACKGROUND:

A. Overview:

Kenya is faced with a crisis in the financing of health care services. The demands of the rapidly growing HIV/AIDS epidemic and increasing population on financial resources, along with rising expectations for health care, are enormous.

The crisis in health care financing is exacerbated by Kenya's declining economic performance. GDP growth has been negative. The money supply and inflation have risen by 34 percent and 40 percent respectively in recent months. The Kenyan Shilling has been devalued. The GOK has introduced tight budgetary stringencies, including a freeze on non-wage recurrent expenditures, that have had severe adverse effects on health and other sectors of the economy. Donor aid levels have decreased because of Kenya's unsatisfactory performance on economic and political reforms. The situation has deteriorated to the point where many of the country's hospitals have indicated that only their cost-sharing income permits them to continue operating effectively.

The economic situation calls for intensified efforts to further develop the health care institutions' capacity to collect, record, plan and use cost-sharing revenue and increase cost-sharing and insurance reimbursement revenue for both curative and preventive/primary health care. Analysis of the health situation shows that:

According to a recent Kenya National AIDS Control Programme (NACP) report, HIV-positive patients now occupy between 20 and 30 percent of hospital beds, and tend to remain longer than other patients. A national HIV seroprevalence level of 5.6 percent suggests that the situation will deteriorate before it improves. According to the 1992 report, "An Assessment of the Economic Impact of AIDS in Kenya," the direct cost of treating AIDS patients in 1991 alone has been estimated to be between 236 and 832 million Shillings. Such expenditures will continue to consume a large portion of MOH annual expenditures. New cases of active AIDS are expected to reach up to six times current levels by the year 2000.

Although Kenya's population growth has decreased from 4 percent per annum to 3.5 percent, the figure is still alarmingly high, and results in an increased demand for future health care, and other social services.

Finally, with improved educational levels and the increased sophistication of the Kenyan population, the realization is growing that ill health is a condition that can often be avoided or ameliorated by appropriate

health care interventions--and that there exists a basic human right to such interventions.

Thus, the increased demands for health care that have severely stressed an already overburdened system, both institutionally and financially, are destined to stress that system even further in the near future.

B. The USAID/Kenya Health Care Financing Program:

The Kenya Health Care Financing Program was authorized and obligated in August 1989 for a four-year period with \$15 million in financing provided under the A.I.D. African Economic Policy Reform Program--\$9.7 million for the NPA Component, and \$5.3 million for the PA Component.

The purpose of the Program is to provide a sustainable level of increased financial resources for the delivery of efficient quality care in public sector primary/preventive as well as curative health services in Kenya through policy reform and funding under the NPA Component and technical assistance and training under the PA Component. Specifically, the KHCF Program was designed to result in:

1. Reallocation of financial resources in favor of preventive/primary health services;
2. Increased financial resources made available to the overall health sector through cost-sharing (user fees and insurance claims) and improved efficiency of operation to permit reallocations to be made without detriment to the level of curative services;
3. Strengthened health care institutions with the capacity to obtain and utilize available resources more efficiently and effectively.

An extension of the timeframe of the program in both its NPA and PA components is required to permit full achievement of these objectives. There has been one prior PA extension of four months duration, to provide O/PH with the additional time and resources required to close out the TA contract.

The primary GOK implementing agencies for this program are the MOH (the lead agency), KNH, a State Corporation accountable to the MOH, and the National Hospital Insurance Fund, a semi-

governmental body which is jointly accountable to the MOH and the Ministry of Finance (MOF).

C. Other Donors:

From the beginning of the design activities five years ago, the GOK, USAID and other donors have recognized the KHCF Program/Project as part of a larger 10-15 year health financing reform effort. USAID/Kenya has been the lead donor in health care financing reform over the first four years. The World Bank is currently funding, under its Health Rehabilitation Project, 6 - 8 studies to assess other potential areas of health financing reforms for a larger health sector investment program. Disbursement of funds under the World Bank Kenya Health Rehabilitation Project, which was signed in December 1991, is affected only by CPs related to cost-sharing, rather than CPs tied to broader macroeconomic performance. In addition to World Bank assistance, the British Overseas Development Administration (ODA) is considering a range of activities in the Health Sector.

Partial funding for the KHCF Secretariat has been budgeted from the World Bank-funded Health Rehabilitation Project at a level of \$422,000 for a two year period: FY 93 and 94. These funds are available to the MOH on a reimbursement basis. However, because the GOK and MOH have been suffering from cash flow problems, the funds have been difficult to access. Despite difficulty in accessing World Bank funds, GOK support for Health Care Financing continues in the form of salaries for Secretariat professional and support staff and office space. The USAID project extension will provide limited assistance to the Secretariat for such items as per diem and travel.

The Health Care Financing Strategy supported by KHCF Project funding, as well as the institutional development of the health sector agencies, will also form part of the basis for the sector investment program designed to complement USAID efforts. This proposed World Bank-supported Health sector investment program may begin as early as 1995/96, and will serve to support, continue and expand reform efforts initiated under the USAID program. To coordinate these efforts, USAID/Kenya chairs the quarterly KHCF Donor Committee meetings attended by the bilateral and multilateral donors.

III. PROGRESS TO DATE AND STATUS OF IMPLEMENTATION:

A. Program Component (NPA):

1. Objectives:

Under the NPA policy reform component (PACD: August 31, 1993), U.S.\$ 9.7 million in policy-based, dollar resource transfers was authorized to be made available as cash disbursements to the GOK, conditioned on achievement of agreed-upon benchmarks relating to the establishment and implementation of appropriate policies on health financing.

Key policy reforms proposed under the program and the degree of compliance to date are summarized below:

- a. Establishment and implementation of a clear GOK policy with respect to cost-sharing (user fees and insurance reforms) in public sector health facilities, including KNH (a State Corporation).

The GOK established and began to implement appropriate policies on cost sharing. They temporarily faltered on implementation but, when the adverse effects of that vacillation became clear, substantial compliance was re-instituted.

- b. Establishment of policies permitting at least 50 percent of the revenue generated through cost sharing to be retained by the public sector health provider facilities generating that revenue, with the balance to be used by the MOH to increase the funds made available for primary and preventive services.

The GOK has complied with this condition in that 75% of the revenue earned is retained by the facility generating the revenue.

- c. Reforms in the NHIF to introduce progressive premium rates, to introduce more realistic employee contributions and to increase reimbursement levels to registered health care providers to bring them in line with actual costs.

Substantial reforms of NHIF policies have taken place, but the institution itself remains in need of strengthening.

d. Agreement with the GOK on a mechanism and timetable for increasing the level of non-donor financing, both in absolute and percentage terms, for preventive and primary health care services within the MOH's recurrent budget.

GOK moves toward supporting P/PHC have been substantial, but are inhibited by severe budgetary stringencies, coupled with a bias on the part of many physicians toward curative care.

e. Administrative reforms in all three institutions to make possible the efficient execution of the desired policies.

An excellent foundation has been laid for administrative reform and considerable progress has already taken place, but a great deal remains to be done to ensure efficient execution of agreed-on policies.

It is clear that there has been considerable progress in establishing and implementing these reforms, but substantial shortfalls remain, which will be dealt with during the period of the extension.

2. Background:

In the last three years, through the combination of policy dialogue, technical assistance and training, Kenya has initiated a program of health care financing reform based on cost-sharing through user fees and social health insurance. As concluded in the mid-term evaluation report, this health care financing program is one of the most successful in Sub-Saharan Africa. The cost-sharing revenues are devoted to patient-related care: 75 percent is used in the facility where it is earned; and 25 percent is used for district-level primary/preventive health care activities, including family planning and HIV/AIDS services. A waiver system and free dispensary-level care ensures access to health services for the poor. Further, insurance contributions are now progressive and more equitable, while NHIF insurance reimbursements have increased to both public and, to an even greater degree, non-governmental (NGO and for-profit) hospitals.

The following chronology reveals that, while the GOK has adjusted a few specific fees, overall commitment for cost-sharing has remained strong, particularly within the Ministries of Finance

and Health. In addition, all major political parties have endorsed the principle of cost-sharing for health services.

In August 1989, the GOK complied with the most critical condition of the KHCF Program when the Cabinet approved a Cost-Sharing Cabinet Paper, which introduced graduated fees for inpatient and outpatient services in GOK hospitals. However, in 1990, a number of modifications were made in the previously approved fee schedules: maternity fees were reduced; civil servants were exempted from paying fees; outpatient medical consultation fees were dropped. Outpatient fees for lab, x-ray, dental, and physical therapy services, however, were retained. The reductions, especially elimination of the outpatient consultation fee, resulted in a drop of revenue versus original projections of over 50 percent.

Subsequently, in an effort to regain a portion of the lost revenue and rationalize primary, secondary and tertiary outpatient services through graduated fees, Cabinet papers were approved for the reintroduction of most outpatient fees. Accordingly, these fees were re-introduced at KNH in April 1992, at Provincial General Hospitals (PGHs) in July 1992, and at District Hospitals (DHs) in January 1993. Reintroduction of fees at health centers (HCs) is planned for July 1993. Outpatient treatment fees are widely accepted by the public since fees are only imposed when drugs and medical supplies are available to patients at health facilities.

The other source of cost-sharing revenue is reimbursement by NHIF for in-patient hospital services to NHIF members. During the period of reduced user fees, KNH and the PGHs increased revenue from NHIF claims. As a result, KNH was able to generate net revenues at approximately the same level as before, and the PGHs did at least as well. Combined fees and reimbursements represent more than 10 percent of KNH's monthly budget and 20 percent of its non-wage recurrent budget. However, KNH obtains only 30 percent of the revenue possible if all payments owed for NHIF-insured patient services were collected.

Cost-sharing revenues currently equal 30 to 70 percent of PGHs non-wage recurrent cost budgets, and over 70 percent of the cost-sharing revenue comes from NHIF claims.

The chart on the following page shows the total revenue earned at PGHs from December 1989, at the start of cost-sharing, to September 1992. Revenue decreased in 1990 after outpatient fees were dropped, but increased in late 1991 and 1992 as a result of intensified efforts to claim for NHIF reimbursement, improved systems of collection, and resumption of outpatient fees. That trend continues.

Further assistance, in collaboration with the Ministry of Local Government (MLG), is needed to ensure that the same cost-sharing principles are also implemented by major Municipal Councils, primarily Nairobi City Council (NCC). Since the MLG is a signatory to the Cost-Sharing Cabinet Paper and the MOH is legally responsible for supervising municipal health services, their collaboration is expected. While some problems exist regarding the introduction of cost-sharing measures within NCC and other municipalities, they should be minimized, due to improved collaboration between the MOH and MLG. Project assistance to municipalities will consist primarily of conducting training workshops for cost-sharing and providing cost-sharing manuals already developed.

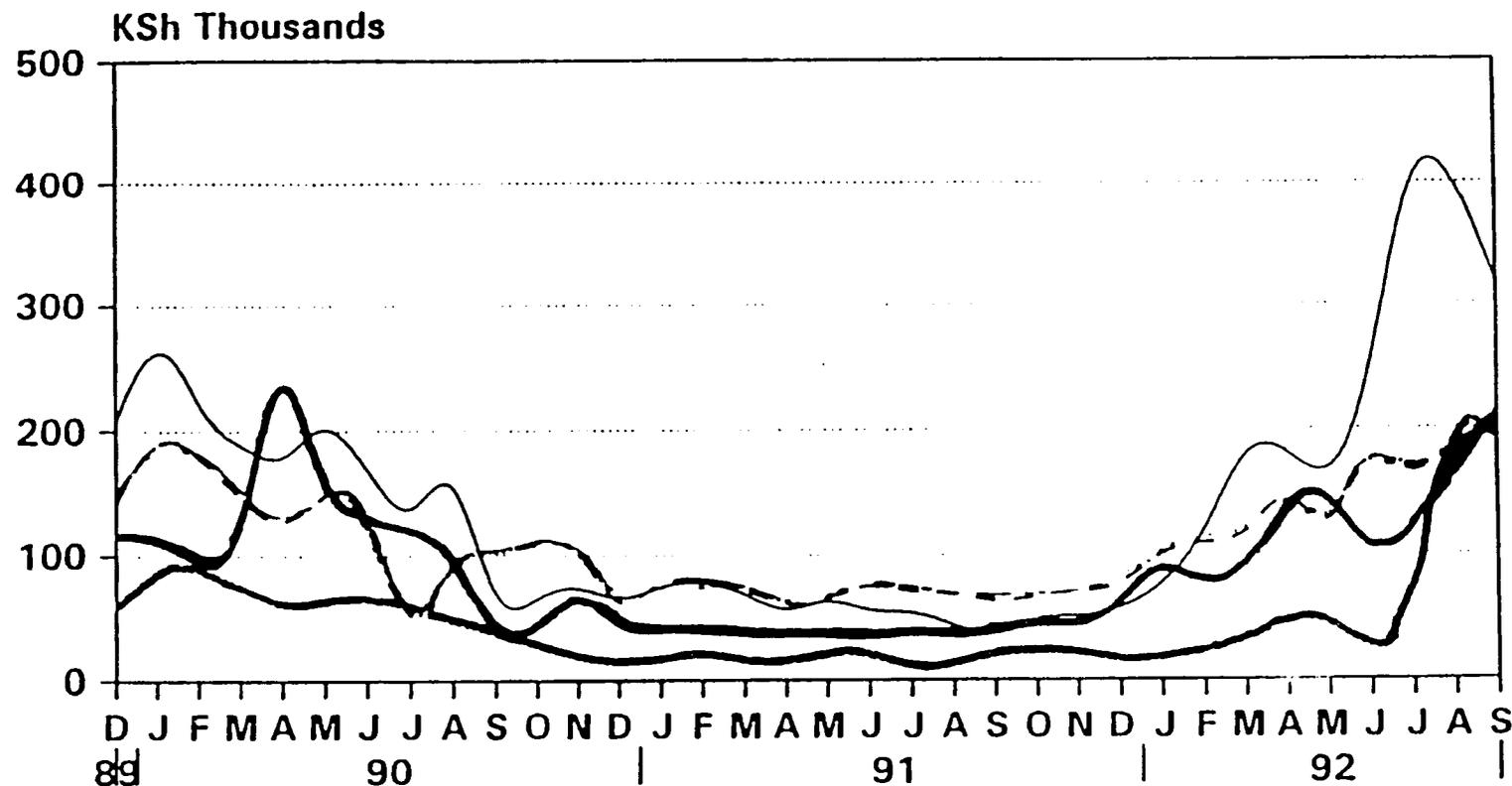
Senior KNH and PGH management report that, given current GOK cash flow problems, they would not be operating without cost-sharing revenues.

Nevertheless, despite the successes of the KHCF Program to date in both policy reform and institutional development, the full potential benefits of cost-sharing and a shift in emphasis from curative to preventive and primary care, as required to meet the Conditions Precedent (CPs) to disbursement of further Program tranches, are not yet fully institutionalized. There are several reasons for this shortfall, corresponding to the institutions involved:

a. Ministry of Health (MOH):

Because of MOH delays in fully staffing and supporting the KHCF Secretariat, MOH capacity to implement cost-sharing and meet CPs required more time to develop than originally anticipated. The Secretariat was further weakened by the lack of a budget-line within MOH to support its operating costs and by a relatively low position in the MOH organizational structure.

PGH Total FIF Fee Revenue December, 1989 to September, 1992



	EMBU		GARISSA		KISUMU		MACHAKOS
<i>Current total potential</i>	KSh 0.6 mill.	<i>Current total potential</i>	KSh 0.3 mill.	<i>Current total potential</i>	KSh 1.1 mill.	<i>Current total potential</i>	KSh 1.0 mill.
<i>Current NMF Potential</i>	KSh 0.4 mill.	<i>Current NMF Potential</i>	KSh 0.2 mill.	<i>Current NMF Potential</i>	KSh 0.8 mill.	<i>Current NMF Potential</i>	KSh 0.8 mill.

File: revsum2.cht

Assumptions for potential: Exempts 40%, Waivers 5%, Efficiency 100%, Fee levels Sep 92.

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To address these weaknesses, the MOH has increased the number of professional Secretariat staff from 2 to 6 and provided office space and salaries for Secretariat personnel. Increased support for the Secretariat and its role in the health care sector has been evidenced in the MOH reorganization currently under way which provides for direct MOH funding for the recently gazetted District Health Management Boards (DHMBs).

The NPA Component of the KHCF program will continue to be utilized to ensure that the Secretariat is fully institutionalized by requiring as Conditions Precedent to Tranche Three disbursement that the full staff are in place; the Secretariat obtains a funded budget-line in the MOH recurrent budget; and the Secretariat has been elevated to a higher position within the MOH organizational structure. These refinements of the existing CP regarding the institutionalization of the Secretariat have been agreed to by the MOH, and will be addressed in Project Implementation Letters (PILs).

b. Kenyatta National Hospital (KNH):

During the last two years, KNH has upgraded, recruited and retained senior-level management and accounting personnel as steps toward meeting its KHCF CPs, and as further required under the World Bank's Health Rehabilitation Project. KNH staff have been designated to identify patients who are NHIF contributors to facilitate the preparation of NHIF claims for their inpatient treatment. As a result, KNH has increased its capacity to administer its cost-sharing program and improve operational efficiencies.

Other improvements in KNH include the addition of full-time staff assigned to implementing, monitoring, and evaluating cost-sharing, and improved training of staff and development of in-house training capabilities.

Under the KHCF Program Extension, CPs to disbursement of the remaining tranches will continue to be used to ensure that reforms are fully institutionalized and cost-sharing and P/PHC retain their place in KNH operations.

c. National Hospital Insurance Fund (NHIF):

Establishment of NHIF as a state corporation was one of the CPs for Tranche One disbursement, and a bill to do so was proposed.

Subsequently, USAID amended the requirement to make it a Tranche Two CP. However, the MOH indicated that the idea of making NHIF a state corporation needs further study, since current GOK policy is to reduce rather than increase the number of state corporations. USAID is presently considering the implications for NHIF institutional development of this change of course.

Raising health care revenue levels to their full potential, as required under the KHC Program, will involve significant streamlining of the NHIF claims system. However, the MOH has expressed concern about NHIF capacity to carry out such streamlining or to manage claims reimbursement effectively without direct MOH oversight.

In order to study these issues further, MOH requested and obtained USAID financing for three studies of NHIF: structural options; cash position analysis; and a consumer/employer/provider perceptions study. Based on the results of these studies, recommendations will be reviewed by senior GOK and MOH policy makers on the future structure of NHIF and measures to ensure its operational efficiency. At the same time, a decision is expected regarding State Corporation status for NHIF. As a follow-up to the studies, and to help in the determination of future USAID/Kenya dealings with NHIF, a full-time insurance management specialist will be provided under the extension to assist the MOH evaluate and implement recommendations for restructuring and improving NHIF managerial and financial operations.

3. Present Status of Program:

To date, all three agencies have met their conditions precedent for the first tranche of funding and \$ 4.6 million has been disbursed.

However, disbursement of the second round of tranches has been delayed due to three factors. First, second tranche disbursement, like other USAID quick-disbursing programs, has been delayed due to AID/W and U.S. Congressional concerns about Kenya's overall economic and political reform process. USAID/Kenya will seek approval from AID/W to disburse Tranche Two funds based on humanitarian grounds, given that most of these funds will be used for patient care.

Second, audit recommendations in the Non-Federal Audit (NFA) draft report: "Agency Contractual Audit of the Kenya Health Care Financing Project" must be cleared for KNH and MOH before tranche

disbursement can be made. O/PH will work closely with both KNH and MOH to reconcile all such recommendations before proceeding with request for Tranche Two disbursement.

Third, the MOH has failed to document two of the remaining fourteen CPs for Tranche Two, but such documentation is expected before the end of June 1993. Therefore, Tranche Two disbursement is expected and will, in part, support the operations of the Secretariat. While further delays in Tranche Two disbursement could adversely affect the Program, technical assistance provided under the extension, coupled with World Bank support, will continue to provide limited assistance to the Secretariat.

Lastly, pending submission of required documentation from NHIF and release of the NHIF organizational structure and cash flow study findings, Tranche Two disbursement to NHIF is on hold. The key role of NHIF in financing health care in Kenya and questions regarding its institutional capacity dictate that a careful review of the relative role of NHIF in the Health Care Financing Program should precede any additional disbursements under the NPA component or the provision of technical assistance under the TA contract.

Under the program amendment, USAID will extend the Terminal Date for Request for Disbursement for the Program as a whole, but will provide further clarification regarding CPs and terminal dates for submission of remaining tranche documentation in PILs.

B. Project Assistance (PA) Component:

1. Objectives:

Under the PA component (PACD: December 31, 1993), a total of \$5.3 million in grant financing was made available for technical assistance, training and commodities, both to support the Program's reform agenda and to develop the overall institutional capabilities of the key health sector agencies. The objectives of the Project were, and are, to support the analyses for and undertaking of policy reform initiatives and to assist in making necessary institutional changes. Key activities and accomplishments have been:

- a. Helping the three implementing institutions establish the administrative systems necessary to implement cost-sharing and related improvements in operational efficiency;

A number of important administrative reforms have taken place, but additional efforts under the extension will be required to attain adequate operational efficiency.

b. Assisting the GOK in further defining a long-term policy reform agenda in the health sector;

A National Health Care Financing Strategy has been drafted, but has not yet been adopted by the GOK. Additional needs in family planning and HIV/AIDS prevention and control will also require assistance in the formulation of sound policies.

c. Assisting the GOK in monitoring the program's impact;

Monitoring and evaluation remain weak and in need of further TA.

d. Strengthening the implementing agencies' institutional capacities.

Although substantial improvements in institutional capacities can be demonstrated, the need for further progress is clear. This requirement is complementary to the policy reforms also being supported.

2. Background:

An institutional technical assistance contract for \$4.6 million was awarded to Management Sciences for Health (MSH), with a contract completion date of October 31, 1993, two months prior to the December 31, 1993 PACD. On November 19, 1992, \$600,000 was added to the TA contract to extend the services of the long-term advisors and provide additional funding for intensified on-site training of HCF Secretariat, DHMB, DHMT, and district hospital personnel. The TA contract now totals \$5,293,000.

The TA contract provides assistance to the counterpart agencies both in implementing the KHCF Reform agenda and in increasing their own institutional capacities. The contract provides financing for short- and long-term TA, training, and limited commodities. The contractor's five long-term technical advisors have included: a health economist, a health planner/evaluation expert, a management/financial expert, a health insurance specialist, and a Chief of Party. The advisors are located in the MOH and NHIF with their counterparts. This arrangement,

coupled with the team members' proven ability to work with and train their counterparts, has facilitated the skills transfer essential in establishing long-term sustainability and developing excellent working relationships.

The mid-term evaluation of the KHCF Program and Project confirmed that the combination of non-project assistance and the project's technical assistance component have proved to be an effective means to promote and develop the GOK's capacity to review, design, monitor and implement health sector policy reforms and to develop the institutions necessary for sustainability of those reforms. The technical assistance and training inputs of the KHFC Project were found to be of high quantity and quality, timely and appropriate.

The evaluation also found that the results of the TA to strengthen cost-sharing have been most successful at the PGH level. Because of the time and effort required to refine cost-sharing systems and ensure that they were in place at the PGHs, the same systems have yet to be fully established at the DHs and HCs. As a result, the evaluation team recommended extension of the TA contract beyond the Project period and the provision of additional funds for training project-related MOH staff and monitoring the implementation and impact of cost-sharing in order to strengthen implementation at the DH and HC levels. This would enhance the institutional capacity of the MOH to implement the project after the TA contract ends. These and other recommendations of the evaluation team are reflected in the following sections for each implementing agency.

a. Ministry of Health:

The mid-term evaluation and minutes of the MOH KHCF Implementation and Advisory Committee meetings confirmed that the TA team and the KHCF Secretariat in the MOH, have attained a high degree of visibility and credibility with senior policy makers within the MOH. This has enabled the TA team and the Secretariat to present the case for and reach agreement on improving the financial and accounting systems for cost-sharing, the waiver system for low income people, and procedures for submitting NHIF claims. These systems are in place in KNH and the PGHs.

However, it has not yet been possible to bring the District Hospitals and Health Centers fully on-line. Secretariat and TA team field trip reports indicate wide variability in implementing cost-sharing systems at those levels. As a result, the MOH has

delayed introducing outpatient fees at its 384 health centers. Follow-up training for MOH staff trainers, who will train personnel at the field level, is required. This will be done through workshops coupled with on-site demonstration training at the Districts by the Secretariat and TA team to ensure that cost-sharing systems are successfully implemented.

During the initial four-month extension, the TA team refined the cost-sharing operations manual to reflect important changes: e.g., fee schedule adjustments; NHIF reimbursement processes; use of cost-sharing revenue; and roles of District Health Management Boards (DHMBs). This manual is the core tool in institutionalizing cost-sharing systems nationwide.

Through several project-assisted private sector and policy workshops, the Secretariat and TA team have developed a near-final draft of the USAID-supported Health Care Financing Strategy. The strategy outlines key future reforms and initiatives needed in social financing; resource allocation; cost-sharing; and private sector participation. Annual workplans will be developed to implement the broad policy framework. The strategy is under final review by senior MOH and GOK staff and is expected to form part of the GOK Seventh Five-year Development Plan, to be published late 1993.

The main MOH activities yet to be completed include:

a) training MOH trainers to carry out field-level training of DH staff in cost-sharing systems; b) expanding district-wide training in such systems by the MOH trainers to health center levels; c) field-testing the drug manual and final draft of clinical guidelines; d) implementing KNH/MOH in-country training for cost-sharing-related topics; e) adoption of the Health Care Financing Strategy; and f) preparing a report on the impact of cost-sharing based on the comprehensive monitoring plan.

b. Kenyatta National Hospital (KNH):

Project support to KNH is intended to improve financial and accounting systems to increase KNH ability to meet its reform goals and operate more efficiently and effectively overall. The TA team and counterparts have jointly reviewed KNH fee collection and reporting, the waiver system, and NHIF claiming procedures. Recommendations based on these reviews are currently being implemented. As a result, KNH prepared its yearly financial reports for FY 91/92 without outside assistance.

Following a review of cost-sharing studies and client and provider interviews, a revised fee schedule for KNH was recommended by the TA Contractor, accepted by the KNH Board, and implemented. The new fee schedule has been accepted by the public.

Under interim TA provided through the Project before the TA team arrived, KNH developed the basic capacity to undertake quality assessments of key departments such as casualty and x-ray. During the last year, KNH has demonstrated this capacity by completing quality assessments with action plans for the pharmacy department and sterile preparation units. KNH's acceptance of the value of such reforms can be seen in recent steps taken to assign responsibilities in these areas to appropriate staff.

Under the June 1992 KHCF amendment, funding for out-of-country training was reprogrammed to developing, testing and implementing in-country training curricula. While training-related equipment has been received and classroom arrangements completed, the subcontract for the training itself has taken longer than expected. As a result, the subcontract will need to be completed during the contract extension.

The main KNH activity yet to be completed involves in-country training at KNH and MOH in cost-sharing topics which will be among the major tasks of the TA Team and its counterparts during the extension. No further training is planned during this period.

c. National Hospital Insurance Fund (NHIF):

The TA Contractor has provided TA and training to develop an actuarial database and computerize claims processing at NHIF. The large databases for claims and providers have been completed. Clean-up of the membership database is continuing and has required more assistance because of incompleteness and errors in the manual records. Actuarial theoretical models and interim reports have already been completed with Project Assistance support. However, clean databases are required for effective computerization. Under the previous amendment, part of the funding originally intended for a large computer purchase was reallocated for this activity.

Options were identified for streamlining claims processing during a project-assisted observation tour of insurance schemes in the

USA and Canada by team members and counterparts. However, no agreement has been reached between NHIF and the TA Team on which insurance reimbursement scheme to pursue. A Scope of Work (SOW) has been prepared for testing new reimbursement strategies. This will be pursued during the 20-month extension as a major step toward strengthening the entire financial structure of the health care sector.

In addition to the assistance provided to NHIF under the TA contract, USAID/Kenya has contracted for three studies of NHIF:

The nearly completed Cash Flow Analysis study is designed to provide financial information to help assess to what degree the NHIF could increase benefit payments to GOK facilities in the short and medium terms.

The Organizational Structure study will review the NHIF's overall mandate, structure and functions, and will provide recommendations regarding the mission of the NHIF and structural and functional changes to enhance the efficiency and effectiveness in the uses of contributed revenue and improve the overall management of the NHIF.

The final study will consist of two surveys: one of NHIF members and beneficiaries; and one of employers to better understand their perceptions of the NHIF, their preferences regarding benefits, and how much they are willing to pay for such benefits. It is expected that the member/beneficiary study will be expanded to include health care providers' viewpoints.

NHIF activities yet to be completed include: 1) completion of the three studies; 2) cleaning-up of membership data base; and 3) training on actuarial reports.

IV. RATIONALE FOR PROGRAM NPA and PA COMPONENT EXTENSIONS:

Despite, or, more properly, because of, substantial progress to date, the proposed extension is urgently needed to finish the job.

The extension of time to request disbursements under the NPA Program Component is required to grant the reform process sufficient time to become fully self-sustaining. The fundamental

infrequently. The delays in making the Secretariat fully operational were of particular importance given that one of the TA team's key jobs was to assist their Kenyan counterparts in successfully implementing cost-sharing and ensuring the sustainability of project activities. Due to the additional time required to institute the cost-sharing mechanisms at the PGHs, the TA team and Secretariat were unable to extend the training or to monitor implementation of the refined system at the district and HC levels.

In addition, the absence of budget-line financing for the Secretariat and difficulty accessing the World Bank funding diminished the Secretariat's ability to function at its expected capacity. As an interim measure, the Project has funded travel and per diem for TA Team/Secretariat monitoring visits to the PGHs, and will continue to do so. In the longer term, the elevation of the Secretariat's status as a result of the NPA CP and growing GOK awareness of the Secretariat's importance, are expected to ensure adequate sustainability.

The USAID mid-term Program evaluation played a major role in the design of the extension and has clearly documented PGH progress. However, it also concluded that additional TA and time beyond the scope of the current Project budget and Contract is needed to extend these same systems to the DH and HC levels.

V. ACTIVITIES DURING EXTENSION PERIOD:

A. Program Goal and Purpose:

The purpose of the Kenya Health Care Financing Program and Project will remain unchanged during the extension--to increase the financial sustainability of Kenya's curative and preventive health services. The KHCF program contributes to USAID's goal of sustained and broad-based economic growth. The program will contribute directly to the sub-goal of reducing fertility and population growth because of the added resources made available for P/PHC services, including clinical family planning. It will also contribute to the proposed new USAID sub-goal of HIV/AIDS prevention and control.

B. Activities Under Project Component:

In keeping with the findings of the mid-term evaluation, the MOH has requested additional KHCF Project funding and an extension of the PACD for the completion of the following activities:

1. Strengthening MOH institutional capacity, with concentration on the Secretariat, to implement health care financing reforms which will ensure more sustained financial resources for both curative and primary/preventive health services (P/PHC). Key activities will include:
 - a. Increasing the collection of cost-sharing revenues from fees and NHIF claims, in order to maximize revenue while still ensuring access to care for the poor.
 - b. Improving the allocation of MOH recurrent and development budget resources to maximize the resources available for primary and preventive health services.
 - c. Building the capacity of the District Health Management Teams (DHMTs) and District Health Management Boards (DHMBs) to plan and use their 25 percent of cost sharing revenue for P/PHC services.
 - d. Working with the MLG to ensure that the cost-sharing principles, as stated in the cost-sharing cabinet paper, are implemented in those areas under its jurisdiction.
2. Improving the operational efficiency and strategic planning capacity of the NHIF and streamlining its claims system to increase eligible reimbursements to the public hospitals.
3. Increasing the focus on obtaining financing for clinical family planning activities through user fee revenue and insurance reimbursement.
4. Examining possible courses of action in HIV/AIDS prevention and control, including the development and implementation of a financing strategy, e.g., costing options for treatment of HIV/AIDS patients. Particular emphasis was placed on the potential for NHIF reimbursement of the cost of hospitalization, when such hospitalization is required.

A formal MOH request for these supplementary activities has been received.

The MOH request is primarily directed at extending current activities to help achieve the Program objectives, but it also recognizes the importance of the additional emphasis on family planning and HIV-AIDS as major contributors to the financial burden of health care.

The extension will finance: long-term advisors; short-term TA; in-country training; and logistic support for the Secretariat. The USAID/Kenya Personal Services Contract (PSC) Project Officer will also be funded under the PA component. No major commodity purchases are planned.

Many of the activities to be funded under this extension (e.g. Monitoring and Evaluation of Cost Sharing) are continuations of those carried out under the original project. Certain others reflect a further refinement of efforts to increase resources in P/PHC services, such as the studies investigating cost-sharing for clinical family planning interventions, or HIV/AIDS prevention and control.

1. Long-Term Technical Advisors:

The amendment will fund contract extensions for two long-term advisors under the institutional TA Contract: the Chief of Party and the Planner/Evaluator will be extended through April 30, 1994 under the 6-month no-cost extension. When the \$1.4 million in additional funding becomes available, the Planner/Evaluator will be funded through June 30, 1994, and the Chief of Party to the new terminal contract date, June 30, 1995. The extension will fund a full-time health insurance management specialist for the 20-month contract extension period, with pro-ration between the no-cost extension and the \$1.4 million funded extension. The PACD for the Project component will be initially extended to June 30, 1994 under the no-cost extension, and subsequently to August 31, 1995 when additional funding becomes available, to permit completion of project activities.

2. Short-Term Technical Assistance:

Consistent with the recommendations of the mid-term evaluation, short-term TA is needed to: 1) implement cost-sharing systems at district and health center levels; 2) improve NHIF operational and financial operations, including the piloting of simplified

claims processing methods; and 3) train DHMTs and DHMBs in the use of cost-sharing revenue for P/PHC. Assistance conducting activities and investigations pertaining to family planning and HIV/AIDS will be initiated with short-term TA. Finally, through short-term TA provided by the TA Contract-funded Financial Management Expert, the TA team will also be in the position to assist the Secretariat to monitor and review local currency project expenditures.

3. Training:

As with the original project, training activities will concentrate on multiplying the efforts of the TA team by working with counterparts and training trainers to ensure project sustainability. The extension period and expected additional funds will help finance the follow-up training costs related mainly to cost-sharing systems at the DH and HC levels.

Training will focus on: collection and use of KHCF revenues; instituting/reviewing waivers and exemptions; NHIF claiming procedures; and training for DHMTs and DHMBs. All project-assisted DHMB and DHMT training will emphasize the cost-effectiveness of increasing resources for family planning and HIV/AIDS. The ongoing Deloitte & Touche subcontract to develop institutional training capacity at KNH will be completed during the extension. The last KNH masters degree level trainee in the U.S. will be returning to Kenya during the extension. No further training support to KNH is planned during the extension period.

4. Other TA Team and MOH HCF Secretariat Costs:

A limited amount of additional funds will be required to finance other direct costs, such as reproduction of materials, petrol and vehicle maintenance, travel and per diem, and office supplies, to support TA team and KHCF Secretariat operations. However, no major commodity purchases are planned. Funding for audits and evaluations will be provided from project funds.

5. USAID Project Management:

The project will be managed by USAID/Kenya's Office of Population and Health. The KHCF Project Officer will be a USAID Personal Services Contractor funded out of Project resources.

6. PP/PAAD Extension Approval Authority:

Based on the previous delegation of approval authority for the KHCF PP/PAAD, approval authority continues to rest with USAID/Kenya. There are no policy issues in the development or implementation of the project that require AID/W resolution.

VI. REVISED FINANCIAL PLAN:

A. Summary

This Project Paper Amendment will increase A.I.D.'s LOP funding by \$1.4 million from \$5.9 million to \$7.3 million. The GOK contribution is estimated to increase from \$1.96 million to \$2.43 million.

B. A.I.D. Contribution

The 20-month KHCF Project Amendment will increase A.I.D funding by U.S. \$1.4 million in grant financing to support the following project components:

1. Prime TA Contractor:

Project financing for the Prime TA contractor (TA) for the 20-month extension estimated at \$ 1.2 million, will cover costs for three long-term technical advisors and short-term technical assistance to the three GOK implementing agencies. The TA budget also includes funds to finance mainly cost-sharing systems training via the Secretariat at the district and health center levels. In addition, funds have been provided for other direct costs such as petrol and vehicle maintenance, travel and per diem, office supplies, and reproduction of materials to support both TA team and KHCF Secretariat operations.

2. Evaluation and Audit:

A non-federal audit (NFA) is currently being conducted for the first tranche disbursements to the three implementing agencies under the NPA component of the KHCF program. Additional NFAs will be conducted for the second and the third tranches. It is also anticipated that a final evaluation of the KHCF Program/Project will be financed and conducted during the early part of 1995.

3. Program Management:

A direct A.I.D. contract will finance the services of one USPSC who will serve as Project Officer. Support for the Project Officer is included in the "Evaluation and Audit" budget line item funded at a level of U.S. \$95,000.

4. Contingency:

U.S \$35,000 has been included in the budget for any contingencies.

C. GOK Contribution:

The GOK contribution to this Amendment is estimated at \$468,000 or 25 percent of the total cost of the extension. This Amendment will increase the total GOK estimated contribution from \$1,965,000 to \$2,433,000, or 25 percent of the cost of the project. The contribution will be met largely through revenues generated through cost-sharing.

Kenya Health Care Financing Project 614-0245
 Illustrative Budget for the period August 1989 to August 1995
 In US Dollars

Budget Item	Current Budget	Revisions	Revised Budget
Prime TA			
Salaries & Wages	942,084	218,714	1,160,798
Consultants	142,429	92,092	234,521
Overhead	728,935	361,281	1,090,216
Travel & Transportation	544,596	189,267	733,863
Allowances	312,843	65,915	378,758
Other Direct Costs	328,281	103,631	431,912
Equipment & Commodities	347,430	0	347,430
Participant Training	810,589	64,000	874,589
Subcontractor	1,135,813	85,100	1,220,913
Subtotal Prime TA	5,293,000	1,180,000	6,473,000
Technical Assistance	203,000	0	203,000
Training	10,000	0	10,000
Evaluation & Audit	110,000	185,000	295,000
Other Costs & Contingency	284,000	35,000	319,000
GRAND TOTAL.	5,900,000	1,400,000	7,300,000

GOK contributions 1,965,000 2,433,000
 (Met with revenues generated through cost sharing)

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37

**KHCF PROGRAM/PROJECT AMENDMENT
PROCUREMENT SOURCE/ORIGIN, IMPLEMENTATION/FINANCING PLAN (\$000)**

Item	Source/Origin				Method of Impl.	Method of fin.
	000	935	Kenya	Totals		
1. Prime TA Contractor	1,180	0	0	1,180	A.I.D. Contract	Direct pay
2. Evaluation & Audit						
- USPSC	95	0	0	95	PSC	Direct pay
- NFA	45	0	0	45	A.I.D. Contract	Direct pay
- Evaluation	45	0	0	45	A.I.D. Contract	Direct pay
3. Contingency	0	0	35	35		
TOTALS	1,365	0	35	1,400		

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VII. EVALUATION, MONITORING AND AUDIT:

The Project will continue to be monitored on an ongoing basis by USAID's Office of Population and Health. A project-funded A.I.D. PSC will serve as Project Officer. Monitoring will be carried out through semi-annual progress reports prepared by the KHCf TA team to assess progress against the jointly agreed-upon annual work plan. USAID/Kenya uses these reports as the basis for semi-annual program/project reviews with the MOH, KNH, and NHIF on progress towards achievement of Program/Project goals. USAID will continue to review quarterly financial reports of TA Contractor expenditures, and semi-annual Mission Project Implementation Reviews (PIRs) will continue to review progress against objectives and address issues that arise. In addition, periodic meetings will be held among USAID, MOH, KNH, NHIF and TA team personnel to verify the formal reports and to deal with any unanticipated situations.

An external Project-financed mid-term evaluation of the total Program, including the technical assistance Project contract was conducted in April/May 1992. A final evaluation is planned for March 1995 to determine the degree to which program objectives were met and to assess overall program impact.

Since the current TA Contractor is U.S.-based, financial audits will be the responsibility of the AID/W IG.

In accordance with the USAID/K-RIG/A/N plan, a Non-Federal Audit (NFA) of counterpart shillings from Tranche One disbursement is nearing completion. The Draft Audit Report indicates audit exceptions with both KNH and MOH first tranche expenditures. The audit recommendations are currently under discussion with the two agencies. Repeat audits will be done for the remaining tranches. Funding in the amount of \$45,000 has been included in the budget for each audit.

VIII. REVISED IMPLEMENTATION PLAN:**

ACTIONS:	DATES:
KHCF Project's Semi-annual Progress Reports submitted by Contractor to O/PH	September 30, 1993 March 31, 1994 September 30, 1994* March 31, 1995*
Cost-sharing introduced at Health Centers	July 1, 1993
Final MOH review and adoption of Health Care Financing Strategy	July/August 1993
Complete MOH submission for 2nd tranche (subtranche 2) submitted to USAID	August 1, 1993
Review Submissions for MOH 2nd tranche	August 1993
Monitoring Report on Impact of Cost Sharing Submitted	September 1, 1993
USAID/HCF TA Team/HCF Secretariat quarterly financial review of USAID-supported HCF Project expenditures	September 1993, Jan/Apr/July/Oct 94
4th Year Contractor's Work/ Implementation Plan completed	November 1, 1993
NHIF Act approved by Parliament/ Mission review of role in NHIF in HCFP	November 1993
NFAs of second tranches	January 1994
MOH terminal date for satisfaction of CPs for disbursement of subtranche 3	January 1994
Semi-annual Program/Project Reviews USAID/MOH/KNH/NHIF KHCF-TA Project	October 1993, Apr/Oct 1994* April 1995
Cost-sharing revenues attain a level equivalent to 9.4% of overall MOH non-wage recurrent expenditures budget by end of FY 1993-94	July 1, 1994

Terminal date for satisfaction of MOH/KCH CPs for meeting disbursement for final tranches	July 1994
At least 10% of KNH non-wage recurrent cost-budget financed through cost-sharing by end of GOK FY 1993-94	July 1, 1994
Review of Submissions for 3rd tranches	August 1994
Terminal Date for Requests for Program Funds Disbursements	August 31, 1994
NFAs of third tranches	December 1994
Final Evaluation	March 1995*
Final Policy Review/Review of Final Evaluation	April 1995*
Close-Out Action begun by O/PH	May 1995*
Final TA Consultant's Report	June 1, 1995*
Contract Termination Date	June 30, 1995*
(Project) PACD	August 31, 1995*

* Activities/dates marked with an asterisk [*] are conditioned upon obtaining the additional \$ 1.4 million FY 94 funds.

** Dates for specific NHIF benchmarks will be defined and included in the above schedule based upon the findings/recommendations of three NHIF situation analysis studies and the outcome of pending NHIF legislation.

41

Annex A: Long-Term Technical Assistance Scopes of Work

Specific Work Objectives During the Extension Period:

[These work objectives are set out for the entire 20-month period expected for the overall extension, and will be prorated between the 6-month no-cost portion and the portion to be financed with the \$1.4 million additional funding that has been proposed.]

a. Chief of Party/Health Systems Administrator:
through June 30, 1995:

- i. Serve as Chief of Party for the TA contractor for approximately 60 percent of time. Develop, reach agreement on and manage overall workplan. Ensure quality services for TA Project. Provide TA for approximately 40 percent of time to NHIF and MOH to maximize utilization of short-term TA. During the last 12 months of the project provide TA on a 50 percent basis.
- ii. Assist in strengthening MOH institutional capacity to implement health care financing reforms which will ensure more sustained financial resources for both curative and primary/preventive health service.
- iii. Monitor project-funded subcontract to create sufficient in-house training capacity at KNH, with emphasis on the training of trainers in order to permit more effective extension efforts in the district and local facilities.
- iv. Together with the HCF Secretariat and HCF Implementation Committee, ensure coordination between MOH and MLG for uniform implementation of cost-sharing systems, with special emphasis on the NCC. Arrange workshops to train NCC, at a minimum, in cost-sharing systems and planning for use of revenue.
- v. Review, assess and recommend changes in exemptions/waivers and for progressive expansion of fee structures.

- vi. Engage in policy dialogue together with USAID to increase the sustainability of the cost-sharing program and its principles.
- vii. Work with short-term technical consultant preparing feasibility study on NHIF reimbursement for clinical methods of family planning.
- viii. Assist all three implementing agencies in preparing and submitting documentation to USAID regarding attainment of conditions precedent required for tranche disbursements.
- ix. Assist USAID in leveraging future donor resources to assist with underfunded areas with a high potential for beneficial interventions.

b. Health Planner/Evaluator: through June 30, 1994:

[The Planner/Evaluator will serve the project on a full time basis for 10 of the last 12 months. Benefits will be prorated accordingly.]

- i. Program planning process in MOH for increased budget allocations to preventive/primary health care (P/PHC) and non-wage recurrent costs:

During planning of the FY 94/95 Draft Estimates and Forward Budget, the Planner/Evaluator will work closely with the MOH planners, policy makers and Treasury officials to identify possible budget shifts from curative to preventive services and to incorporate these changes into future MOH budgets. While this process has begun with the 93/94 Draft Estimates, and has garnered widespread support, more time is needed to ensure that this process is well-understood and fully utilized by MOH and MOF budget officials. With these efforts, it is expected that the process can be established as a routine part of each GOK budget cycle.

- ii. Planning and Utilization of Cost-Sharing Revenues for Facility-level P/PHC Activities:

Less than half of the 48 districts have developed cost-sharing plans for utilizing their 25 percent portion of cost-sharing revenue for primary and preventive health care.

DHMTs, DHMBs and Hospital Executive Expenditure Committees (HEECs) need to better understand how to set priorities and use available data for preparing their plans. This will become increasingly important as the health centers begin to develop their own expenditure plans. Therefore, the Planner/Evaluator, with team assistance, will work with the Secretariat to conduct a program of training trainers and will supervise the district-specific training, monitoring and supervision necessary to ensure that planning for the use of the cost-sharing revenue will be properly and thoroughly carried out and that the planning and accounting systems for the planning and expenditure of cost-sharing revenue are in place in all facilities down to the health centers. Since funds and time are insufficient to enable the team to go to each facility, selected PGH Districts will be used as locations for trainer training, so that selected district hospital, HEEC, DHMT and DHMB staff participate in the training of trainers, in addition to being trained themselves.

iii. Increased Emphasis on Appropriate Aspects of Clinical Family Planning Financing and Activities:

Work with the Health Insurance Specialist to explore the possibility of extending cost-sharing principles to the use of clinical methods of family planning (e.g. insertion of IUD or Norplant; vasectomy or tubal ligation) and advocate use of cost-sharing revenue to pay for family planning consumables such as rubber gloves and lotions (disinfectants). All project-assisted training of the DHMTs and DHMBs will emphasize the cost-effectiveness of increasing resources for family planning.

iv. Increased Emphasis on HIV/AIDS Control and Prevention:

Working in conjunction with the health insurance specialist, the USAID/AIDSCAP Project, the MOH and NHIF, the Health Planner will develop measures to assist the GOK to increase its understanding of different aspects of HIV/AIDS prevention and control. This will include such activities as refining guidelines for P/PHC plans to ensure that AIDS control and prevention are considered by the DHMTs and DHMBs for funding with cost-sharing revenue. The training of DHMTs and DHMBs will also serve to provide information on

the cost-effectiveness of increasing resources for AIDS prevention and control.

Additionally, as part of the efforts to define clinical protocols for the most commonly treated diseases, the Planner will assist in refining treatment protocols for STD/HIV/AIDS. Based on the treatment protocols, the Planner and select short-term TA will assess the resource requirements of alternative treatment options against available and proposed resources. The Health Planner will work with FHI/AIDSCAP and the NACP to define appropriate policies to increase resources for HIV/AIDS prevention and control, with emphasis on accessing NHIF reimbursements for hospitalized patients.

Given information on the costs of AIDS treatment, the Planner and the Insurance Specialist, coupled with complementary short-term TA, will determine the potential financial liability of NHIF for treating hospitalized AIDS patients. Alternative options will be developed, discussed, and decided upon for NHIF reimbursement of alternative treatment modes for AIDS patients.

On these and other policy and program issues related to the financing of HIV/AIDS prevention and control, the Planner/Evaluator will collaborate closely with the NACP, FHI/AIDSCAP, and the USAID/K O/PH Technical Advisor in AIDS and Child Survival (TAACS).

v. Monitoring and Evaluation of the Cost-sharing System:

Assist the Secretariat with implementation of a simplified monitoring plan for cost-sharing within the MOH and KNH. This includes the monitoring of revenue collection and use, NHIF claim procedures, waivers, and exemptions. By the end of the 20-month extension, the Secretariat should be able to independently implement the monitoring plan.

**c. Health Insurance Management Advisor:
December 1, 1993 through June 30, 1995:**

At least 80 percent of his/her time will be devoted to NHIF and up to 20 percent to similar issues in the private health insurance sector to provide for exchange of ideas and

experiences between public and private sectors. The Advisor will be recruited from within Kenya and will:

- i. Assist NHIF management to implement structural reforms and management improvements decided upon by MOH/GOK policy makers, including training in evaluating proposed investments of NHIF reserves.
- ii. Assist NHIF with design and implementation of a more streamlined and user-friendly reimbursement payment system.
- iii. Work with the Health Planner to oversee the feasibility studies on reimbursement of clinical methods of family planning.
- iv. Work with the Health Planner and the AIDSCAP team to assess the financial liability of NHIF for reimbursing for treatment of HIV/AIDS in-patients. Explore, define and reach agreement on reimbursement for alternative treatment of HIV/AIDS patients.
- v. Refine actuarial reporting and train both mid-level and senior NHIF management on use of reports for increasing operational efficiency and strengthening financial performance.
- vi. Assist in the review and revision of NHIF contribution levels in view of its actual and projected liabilities.
- vii. Identify and test feasibility of increasing NHIF contribution by employees and initiating employer contributions.
- viii. Study the effect of NHIF benefits as incentives to the increase in number, kind and location of new or expanded health facilities.

Annex B: Short-Term Technical Assistance Illustrative List

An illustrative listing of the major projected items of short-term TA under the 20-month extension includes:

- a. Financial/Management Expert: through June 30, 1995 - 12 person months (Kenyan):**
 - i) Financial/Accounting of Cost Sharing - 8 person months equivalent:**

Assist the Secretariat to ensure uniform implementation of the cost-sharing management systems at the 73 District and Sub-District Hospitals and 384 health centers. Assist the 45 DHMTs and DHMBs through tracking and feedback of monthly reports from HQ and provincial level workshops.

Ensure that the Secretariat can consolidate the financial monitoring system at the district, provincial and HQ levels, including reporting of utilization of cost-sharing revenue against approved expenditure plans.

Ensure that the Secretariat is fully conversant with procedures for improving NHIF claiming at District and Subdistrict hospitals.

Continue to improve fee collection at the PGHs, DHs and subdistrict hospitals through the periodic review and possible revision of fee schedules, refinement and implementation of fees for private services and tightening of collection procedures.

Assist the Secretariat to define mechanisms for increasing efficiency in fee collection, where appropriate, and submission of NHIF claims that can be tested at selected PGHs and communicated to other hospitals through circulars and workshops.

**ii) Monitor Expenditure Plans for Cost-sharing Revenue
- 2 person months equivalent:**

Assist the KHCf Secretariat with the monitoring of implementation of the facility and P/PHC plans for using cost-sharing revenue.

**iii) Assistant for TA Project Financial Accounting
Reports - 1 person month equivalent:**

Work with the Secretariat to gather and collate the financial accounting reports necessary to demonstrate project accountability. Assist the Secretariat to monitor and review local currency project expenditures.

b. Special Studies for NHIF:

In response to MOH requests, funds originally planned for software purchases for NHIF will instead be used for fund several studies of NHIF regarding: 1) a structural analysis of NHIF; 2) the institution's cash position; and 3) consumer/employer and health care provider perceptions of the Fund. Select actuarial studies will also be conducted. This TA will be rendered through short-term TA, with a long-term Health Insurance Specialist to assist in implementing changes at NHIF recommended by the above studies. Collectively, these activities will be used to improve the NHIF's operational efficiency. NHIF will have to purchase software with its own resources. The project-assistance team estimates that such software will not be needed for another 1.5 - 2 years, since NHIF has only begun to prepare for its utilization.

In the areas of membership database, clean-up of the NHIF membership databases to be used for future on-line claims processing, will be carried out with Project resources. Strict financial and time limitations to this assistance will be specified, however. The objective of this database development activity is to achieve a reasonable degree of accuracy, acknowledging that it will be impossible to attain complete accuracy in the membership database.

c. Additional short-term TA will be provided through the extension, equivalent to 17.5 person-months. Illustrative examples of the short-term TA include:

- Follow-up TA on NHIF structural changes;
- Implementing streamlined NHIF claiming processes;
- Select actuarial analyses;
- Feasibility study on NHIF reimbursement for family planning clinical services: pilot new benefit;
- Determining NHIF liability and payment options for treating HIV/AIDS patients;
- Determining feasibility of private insurance reimbursement for clinical methods of family planning and AIDS treatment;
- Identifying cost and resource incentives of NHIF reimbursement;
- Select assistance for computerization of NHIF claims processing;
- Integrated analysis of NHIF utilization data;
- Assisting mission hospitals to increase financial viability through improving cost sharing and insurance claiming;
- Increasing cross-subsidization of family planning services and HIV/AIDS prevention and control;
Assessment of changes needed in waiver, exemption and fee procedures;
- Expenditure review study;
- Update cost-sharing manual;
- KNH marketing study;
- Study on the impact of cost-sharing to precede external evaluation of the HCF Program using same methodology as in previous impact studies.

In sum, the extension provides for a total of 29.5 (12 plus 17.5) person-months of short-term TA. Approximately 20.5 person-months will be from local consultants and 9 from external consultants. This is consistent with the current project in which at least 60 percent of short-term TA is drawn from local sources.

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PROGRAM EXTENSION DESIGN SUMMARY
LOGICAL FRAMEWORK

Program Title and Number: Kenya Health Care Financing Program
(615-0245)

Life of Program: \$19,433,000 (U.S.)
Total US Funding: \$17,000,000 (U.S.)
Date Prepared: April, 1993

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Goal:</u></p> <p>(a) Improve the health status of the population, particularly women and young children, and (b) Contribute to MOH budget rationalization.</p>	<p><u>Measure of Goal Achievement</u></p> <p>(a) Infant, young child and maternal morbidity/mortality decreased. (b) MOH budget shows consistent shift to preventive/primary care and non-wage recurrent costs. (c) Guidelines for MOH budget allocation institutionalized.</p>	<p>(a) Census, Demographic and Health Survey, and MOH Health Information System. (b) MOH and MOF budget documentation.</p>	<p><u>Goal Assumptions</u></p> <p>(a) Increased availability of resources in the health sector results in increased quality of preventive/primary care services (P/PHC) which, in turn, leads to significant reductions in morbidity/mortality and fertility levels. (b) This encourages more effective and efficient use of health care services. (c) GOK commitment to budget rationalization program is sustained. (d) Health care service providers are able to handle administrative aspects of cost-sharing.</p>

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Program Purpose:</u></p> <p>To provide sustained, increased financial resources for the delivery of efficient quality care in both curative and preventive health services.</p>	<p><u>End of Project Status:</u></p> <p>(a) Reallocation of resources within the MOH budget, as evidenced by increases in expenditures from GOK FY 1989-90 through FY 93-94 for rural health services, MCH/FP, P/PHC, and Essential Drug Program.</p> <p>(b) Cost-sharing revenues attain a level equivalent to 9.4% of the MOH's overall non-wage recurrent expenditures budget by the end of GOK FY 1993-94.</p>	<p>(a) MOH budget reviews</p> <p>(b) Financial records maintained by MOH headquarters and relevant health care service facilities.</p> <p>(c) MOH annual budget and expenditure data</p> <p>(d) Final program evaluation.</p>	<p><u>Assumptions:</u></p> <p>(a) GOK will remain committed to budget rationalization.</p> <p>(b) GOK will remain committed to reallocation of resources towards primary and preventive care.</p> <p>(c) Cost sharing revenue is retained by provider facilities and used to make improvements.</p> <p>(d) This will result in public willingness to pay for health care.</p> <p>(e) The fee waiver system can provide a social safety net for the poor.</p>

51

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Outputs: <u>1. Implementation of Cost-Sharing Reforms:</u> (a) Cost-recovery and related cost-control measures contained in MOH reform plan implemented. (b) Cost-sharing measures implemented in GOK and select municipal health facilities. (c) Mechanism and timetable for increasing the level of non-donor financing for preventive and primary services established within the MOH recurrent budget. (d) District Health Management Boards strengthened. (e) District MOH administrative capabilities improved.</p>	<p><u>1. Reforms Implemented:</u> (a) <u>MOH</u> • System for allocating increased proportion of financial resources to augment budget for preventive/primary (P/PHC) services fully operational. • System for monitoring the impact of cost-sharing reforms on health services utilization in place. (b) <u>KNH</u> • Comprehensive cost-sharing program and system for managing such measures established. • At least 10% of KNH non-wage recurrent cost budget financed through cost-sharing by the end of GOK FY 1993/4.</p>	<p>(a) GOK policy documents (b) MOH central and facility level financial documents (c) MIS data and operations research (d) Records of MOH and technical assistance contractor (e) KNH and NHIF records (f) MOH budgets (g) KHCF Secretariat monitoring and evaluation.</p>	<p><u>Assumptions:</u> (a) GOK political climate favoring cost-sharing does not change. (b) MOH will allocate staff needed to lead this design effort and will endorse and act upon the agreed on policy reform measures. (c) Introduction of cost-sharing at MOH facilities will not be met with strong adverse public reaction. (d) Introduction of revised contribution structure at NHIF is accepted. (e) MOH will undertake redistribution of public resources to needy areas which do not generate sufficient revenues from cost sharing.</p>

52

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	<p>(c) <u>NHIF</u></p> <ul style="list-style-type: none"> • Public sector providers seeking and receiving reimbursement from NHIF according to revised benefit structure. • More realistic premium structure in place at NHIF (possibly including employer contributions). • NHIF Organizational goals/objectives established, revised premium/benefit structure in place, quality and cost assessment system to establish reimbursement levels in place, automation plan implemented, and actuarial database established. 		<p>(f) GOK retains commitment to reduce proportion of public subsidy to KNH.</p> <p>(g) GOK introduction of cost-sharing at MOH facilities and MOH is approved on schedule.</p> <p>(h) Willingness and ability to pay for health services adequate to recover significant portion of costs of service delivery.</p> <p>(i) Inappropriate use of hospital-based services can be significantly decreased by introducing by-pass fees/charges.</p> <p>(j) Further definition of reform agenda will leverage additional donor resources to help implement broad-based reform program in health sector.</p>

69

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	<p>(d) <u>MOH Service Facilities:</u></p> <ul style="list-style-type: none"> • Modest user fees established in all DHs and HCs on a phased time schedule with 100% of revenue retained within districts during the LOP with a portion (at least 75% at facility) of the balance of revenue used to increase primary/preventive programs budget. • System for monitoring and evaluating the impact of cost-sharing measures established, with findings being used to modify fee schedules, as appropriate. • NHIF reform program approved and implemented, including establishment of progressive premium structure and employer contributions. 		<p>(k) Other donor assistance for complementary inputs (e.g., renovations of facilities, equipment, etc.) will be made available in a timely manner.</p>

55

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>2. Implementation of Institutional Reforms:</u></p> <p>(a) KHCf Secretariat strengthened and given higher status within MOH structure, with emphasis on its monitoring and evaluation capabilities.</p> <p>(b) KNH administrative capabilities improved.</p> <p>(c) Revised organizational, premium, and claims structures for NHIF designed and implemented.</p>	<p><u>2. Enhanced Institutional Capacity</u></p> <p>(a) Plan of introducing cost-sharing at MOH through establishment of private wards, selected fees-for-service, and clinic/office space rental for consulting physicians prepared, approved, and implemented. System for revenue management, and exempting the medically indigent, established and functioning.</p> <p>(b) Plan for introducing user fees in PGH, DH's, and health centers designed and implemented by the end of CY 1994.</p> <p>(c) Management accounting and waiver systems designed and implemented in all participating facilities.</p>	<p>(a) MOH records and reports</p> <p>(b) Study reports, MOH official documents, and program monitoring reports</p> <p>(c) Study documents and records of NHIF.</p>	<p>(a) Administrators review plans, recommendations and make decisions to implement in a timely manner.</p>

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>3. <u>Particular Reforms:</u> (a) Feasibility study of NHIF reimbursement for clinical family planning (fp) services completed and decision made by MOH regarding implementation of reimbursement for clinical fp services. (b) HIV/AIDS prevention and control activities studied and costed. (c) Fee waiver system is monitored and evaluated for preservation of social net.</p>	<p>(a) Administrative procedures ensuring access for those unable to pay for services operational in MOH and all MOH service facilities engaged in cost-sharing.</p>		

56

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Inputs</p> <p>1. <u>Policy Reform Support - Dollar Disbursements</u> Upon achieving conditions precedent and subsequent establishment of local currency special account funds for disbursement to implementing institutions.</p> <p>2. <u>Technical Assistance Component;</u></p> <p>a. <u>Studies & Analyses</u> Studies and analyses, including pilot tests, to define policy and institutional reforms needed, and steps required for their implementation. Studies and analyses will be identified jointly by USAID, other donors, and GOK.</p>	<p>(1) USAID/GOK joint programming plans for Kenya Shillings equal to U.S. \$9.7 million over LOP.</p> <p>(a) Studies completed, options identified and implementation plans approved by relevant authorities.</p>	<p>(a) GOK/USAID Programming Documents. (b) GOK Auditor General audits of local currency programming.</p> <p>(a) Study reports, MOH records and statistics, and special studies. (b) Study reports, MOH records, and records of facilities affected. (c) Reports and MOH records. (d) Consultant report(s) action plan documents, contractor and MOH records.</p>	<p>(b) GOK utilizes study results in shaping and implementing policy and institutional reforms. (c) Appropriate GOK counterpart staff are available to ensure technical skill transfer.</p>

51

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Illustrative list of priority issues:</u></p> <p>(1) The respective roles of the public, private, parastatal, community and donor sectors in the provision/payment of health services;</p> <p>(2) Impact of changes in waivers/exemptions for progressive expansion of fee structure;</p> <p>(3) Impact of cost sharing on health services utilization patterns;</p> <p>(4) Role of the pricing structure and medical referral system in cost containment;</p> <p>(5) Feasibility of NHIF reimbursement for clinical family planning methods;</p>			

96

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>(6) Review/assessment of NHIF management structure with recommendations for possible reorganization;</p> <p>(7) Assessment of NHIF cash position;</p> <p>(8) Consumer/employer/health care provider perceptions of NHIF.</p> <p>b. <u>Institutional Strengthening:</u> Establish the capability to:</p> <p>(1) Conduct policy and systems analyses in the health sector and monitor/evaluate impact of policy/institutional reforms, and (2) strengthen MOH and KNH capacity to operate and manage cost-sharing system.</p>	<p>b. <u>Institutional Strengthening</u></p> <p>(1) Persons trained in health policy and systems analysis.</p> <p>(2) System established in the MOH for monitoring/evaluating reform programs.</p> <p>(3) Persons from KNH and selected provincial/district hospitals trained in financial planning and management relevant to cost-sharing.</p> <p>(4) Through long-term technical assistance contractors, capacity enhanced within the MOH to monitor and evaluate the GOK's health reform agenda and its impact.</p> <p>(5) NHIF planning unit operational.</p>	<ul style="list-style-type: none"> • USAID and contractor training records. • Contractor reports. USAID mid-term and final evaluation. 	<p>(a) GOK implementing institutions recruit and retain qualified staff to manage cost-sharing programs.</p> <p>(b) Appropriate counterpart staff are available to ensure technical skill transfer.</p> <p>(c) Institutions will meet conditions precedent.</p>

15

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>C. <u>Evaluation/Monitoring</u></p> <p><u>Resources:</u> Policy Reform Support Prime TA Contract Other TA Evaluation/Monitoring Costs Other Costs and Contingency</p> <p>* Includes training, commodities, and other TA support costs.</p>	<p>(6) HCF Secretariat fully staffed. (7) HCF Secretariat elevated to higher position within MOH and funded in recurrent budget.</p> <p>C. Mid-term and final evaluations.</p> <p>\$ 9.7 million 6.5 million .2 million .3 million <u>.3 million</u> \$17.0 million</p>		

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81