



In Search of Better Health

A situation analysis of population needs for Universal Health Coverage (UHC) in Isiolo County

OUTLINE OF UHC STUDY KEY FINDINGS

1. UHC IMPLEMENTATION PLANNING PROCESS

- a) **Involvement of key stakeholders in Planning process**
 - i) County Governments stakeholders
 - ii) Political class at county assembly level
 - iii) Facility level / service providers
 - iv) Community health volunteers
- b) **Community Sensitization on UHC**
- c) **UHC Registration Process**

2. PERCEPTIONS ON UHC: BENEFITS AND OPPORTUNITIES FOR IMPROVEMENT

- a) **Financial protection/** Affordability of services
- b) **Equity/** Accessibility of services
- c) **Quality /** Acceptability of services

3. OTHER KEY CONSIDERATIONS IN UHC IMPLEMENTATION

- a) Costing of UHC to inform future implementation and rollout
- b) Sustainability
 - *NHIF versus UHC*
- c) Accountability
- d) Technology for data capture
- e) Health Literacy
- f) Contextual considerations
- g) Role of PPP
- h) Role of multi stakeholder approach

Context

Kenya rolled out Universal Health Coverage in December 2018 as a pilot in four counties as a deliberate effort to ensuring populations receive health services and quality services free of charge to cushion the poor, the most marginalized and vulnerable populations who have had to bear the heavy brunt of the effect of diseases resulting in high prevalence, morbidity and mortality rates. The main objective of this research was to explore population-driven health needs to inform decision makers regarding provision of a high quality and appropriate healthcare package for the population for an effective UHC program in the four pilot counties of Isiolo, Kisumu, Machakos, and Nyeri that the Government of Kenya had selected based on their unique health burden representation.

This study brief presents the key findings on UHC implementation process, the perceptions on UHC in regard to financial protection, accessibility of services, availability of services and quality of services, drawing on perceived benefits and opportunities for improvement, as well as other key considerations for important for future UHC implementation in Isiolo county.

Methodology

This study used an exploratory qualitative study design method to collect information on population-driven needs for an effective UHC program in Isiolo County targeting different key informants and population groups.

Additionally, facilitators, barriers, current and future feasible strategies and priority setting mechanisms were comprehensively explored through focus group discussions with community members, CHVs and MCAs as well as in-depth interviews with health service providers, partners, policy makers and CHMTs. The data was transcribed verbatim and translated into English.

Occurring themes and subthemes were then identified and developed from the data to describe the perceptions, expectations, shortcomings and opportunities for UHC. Scientific and ethical approval was sought from relevant institutions, county health directors and study participants.

KEY FINDINGS

1. UHC IMPLEMENTATION PLANNING PROCESS

1.1: Involvement of key stakeholders in Planning process

1.1.1: County Government stakeholders

County stakeholders acknowledged their involvement at national level technical teams to facilitate and ensure UHC implementation structures were put in place in preparation for the rollout. Supportive structures and infrastructure within which the UHC program and its package of services was to be anchored, were provided and monitored effectively.

1.1.2: Political class at county assembly level

While health committees initiate, enact and oversight implementation of key policies towards enhancing health service, majority noted with concern that they were not involved at all the stages of planning towards UHC implementation.

○ Gaps in involvement of key stakeholders in UHC planning:

- The political class at county assemble level felt they were left out of the process
- Service providers felt they were not adequately involved and prepared,
- CHVs were involved in community sensitization and registration only

1.1.3: Facility level / service providers

Health providers were involved mainly in management meetings within facilities including to discuss financial matters and budgeting as described below. Some

providers felt that sensitization was not adequately done in regard to preparing service providers for rollout and implementation of UHC where many felt that they were caught unawares and felt ambushed.

1.1.4: Community health volunteers

Training and sensitization of CHVs to support community sensitization on UHC and registration the members was done, with the implementing partner playing a crucial role in recruiting and training CHVs mainly on registration of beneficiaries. CHVs were also sensitized on key messages on UHC to pass to the community.

1.2: Community Sensitization on UHC

While community acknowledged that they received information on UHC through a number of channels including mass media – radio, television and from the UHC publicity relayed health facilities, gaps in community sensitization were highlighted by a number of respondents. There was a feeling that sensitization was not sufficiently done to reach out to all, and which may impact negatively on the success and eventual uptake of UHC. For instance, the elderly population mentioned that they were not adequately sensitized hence they did not know much about UHC. There was a feeling also by the implementing partner supporting UHC registration that the hard to reach places were not well covered in terms of sensitizing the community of UHC, and

thus a missed opportunity. Misinformation and Misconceptions on UHC was a key gap highlighted in regard in the sensitization process, where there was a mix-up between NHIF and UHC, and other community members doubting the “free” services.

- Information on UHC was relayed through several media
- Gaps in community sensitization:
- Sensitization was inadequate
- Misconceptions and miscommunication about UHC noted

1.3: UHC Registration Process

UHC registration was seen as a key component of preparing the community members to receive health care services. Gaps highlighted by community member include lack/missing ID Cards, birth certificates may have led to some people being left out of the registration process. Others noted delays in getting registration cards, throwing confusion to registered members of the community who had not felt the benefits because they lacked cards. Limited time allocated for registration process was also noted as a challenges, meaning that the target would not be achieved within the allocated time. Arising from this concern, there were suggestions of the UHC registration process being made continuous to cater for natural attrition and additions through deaths and births. The implementing partner agreed that the suggestion on process being continuous was valid and would also facilitate timely updating of registration data.

- Gaps in UHC registration process: short period allocated for registration, community lacking the necessary documents for registration and delays in getting the UHC registration card

2.0: PERCEPTIONS ON UHC: BENEFITS AND OPPORTUNITIES FOR IMPROVEMENT

2.1: Financial protection/ Affordability of services

UHC has removed cost barrier: There was general consensus that UHC has removed the cost barrier and this is line with the goals of UHC, defined as all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them. Most of the respondents supported the idea that there is chance with that most patients will get all the services they require without any costs. Women appreciated that with free UHC they are able to access treatment especially for their children.

Community health volunteers related

UHC to having removed the financial hardships or

- UHC was widely viewed positively in terms of having removed cost barrier and that perceived to contribute to economic wellbeing,
- Gaps in financial protection: the risk of indirect costs as a result of facilities being far, attracting high transport cost to community

catastrophic expenditures that communities usually faced in the past, *and gave testimony* on cases of patients who are detained in hospital because they cannot pay for their health bills being allowed to go home.

UHC had brought about economic and wellbeing implications: Benefits of UHC through provision of equitable and affordable health care will indirectly boost the capacity of communities to be productive and contribute effectively to the growth of the economy. That unlike before the UHC when a person with only cow would sell that cow to pay for treatment, that was a case for the past and will thus improve the economy and well-being of most community members.

2.2: Equity/ Accessibility of services

Opportunity for Outreaches: In Isiolo County, community outreaches have been a part of county efforts to ensure various services are given to members. This is through mobile outreaches through support of different partners and beyond zero initiative to ensure that integrated services are provided to communities especially the hard to reach, a common feature in the county. And with that the county has come up and is setting up facilities and once they are open the access to health care will improve greatly. In order for

- UHC was perceived to be generally beneficial to all irrespective of class, contributing to equality.
- UHC availed the opportunity for outreach in that services are closer to the community.
- UHC had the opportunity to leverage on community structures such as CHVs for sustainability.
- **Gaps in the equity aspect of UHC:** Geographical access, road infrastructure, distance and opening hours a challenge to UHC needs to be addressed.
- Need to address to address training, tools and incentives for CHVs

continuity in providing health services considering the context in which communities live, health providers felt that outreach services to communities living in hard to reach areas are an essential facilitator of UHC implementation especially in promotive and preventive health services

participants noted.

UHC brought equality: Majority of respondents point out to the well-known fact that health as a human right should not be a privilege to a few but a right to all.

Opportunity to Leveraging on Existing community structures for sustainability: CHVs role in UHC success appreciated by implementing partner but also noted that CHVs need empowerment through making them a part of the UHC service provision strategy.

Geographical access, road infrastructure, distance and opening hours a challenge to UHC: Geographical reach through road networks is one of the major pillars of access to health care, therefore, availability of health facilities that are not accessible due to poor road network create a negative impact on UHC success. Road infrastructure and distance to facilities plays a role in accessing. This has an implication

on the indirect cost associated with health service provision is expressed the following responses from many participants. UHC created the expectation that the community can access health services in all levels of facilities throughout. However, that is not the case especially for dispensaries which are designed to work 8 hours a day, 5 days a week. And this is a likely reason for the influx of patients in the higher-level facilities that operate 24 hours as expressed by CHVs.

2.3: Quality / Acceptability of services

UHC had increased demand for health services

Removing cost as a barrier increases demand for health services. This was clearly echoed by various respondents who testified on the upsurge in number of patients seeking care following UHC *with up to 80% as testified by* Health service provider.

UHC had contributed to decongesting referral facilities

One of the challenges in the health care system in Kenya is poor adherence to the referral system and lack of confidence in lower level facilities. There is already consensus that minor ailments can be handled at lower level facilities and thus decongest the referral facilities;

Gaps in Quality:

Increased Workload: UHC had led to increase in patients and if the patient-doctor ratio is not addressed, it might compromise quality of service;

Shortage of health workers: The increased workload due to “free” access to services was impacted negatively on already constrained healthcare workforce;

Burn Out: High demand for health services against a shortfall of healthcare providers results in healthcare worker burnout;

Commodity shortage & stock outs

Some hard to reach areas had not received adequate supply of drugs; In some situations where no drugs available potential challenge to out of pocket expenditure, thus creating a threat to the UHC; Potential for commodity shortages could in the long run create mistrust if the patients come for services and do not receive the required treatment due to shortages.

Weak Laboratory Services Capacity

The number of patients seeking care in facilities in the county was noted to have increased after the introduction of UHC. However, the capacities of many laboratories were not worked out to match the influx of patients in terms of capacity, both human resource and equipment.

Gaps in quality: Capacity and emergency (critical care) services shortfalls

- On quality and acceptability of services under UHC, this was evident from the increase in demand of services.
- UHC contributed to decongesting the higher-level facilities, meaning that the community had trust in lower level facilities.
- **Gaps in quality aspects:** Health worker shortage, increased workload which could result to burnout; commodity shortage and stockouts, weak laboratory capacity and critical services shortfalls need to be addressed

Concerns over shortfalls in emergency preparedness of the facilities were observed to be potential threat to the success of UHC in Isiolo county especially, considering the vastness of the county and the distances to the health facilities.

3: OTHER KEY CONSIDERATIONS IN UHC IMPLEMENTATION

- Cost of UHC to inform future implementation and rollout is critical and recognition that UHC does not mean free coverage and decisions should be made about the services that can be guaranteed to the population initially and those to be added over time.
- Sustainability- Sustainability tries to secure present needs without compromising the future generations
- *NHIF versus UHC* –A clear pathway, on how the different insurance schemes play a role in UHC more so the National Hospital Insurance Fund, is essential.
- Accountability/ Corruption-Ensuring progressive realization of UHC involves the aspect of financial management and accountability.
- Technology for data capture is crucial at every stage
- Contextual considerations- The effectiveness of any interventions, as well as their success in reaching all relevant target populations, is highly influenced by their implementation in a given context and how it interacts with given interventions
- Private-public partnership
- Role of multi stakeholder approach

CONCLUSION

Evidently, UHC was acceptable and embraced by majority amidst except for the gaps on missed registration due to misinformation or lack of mobile phones to support the registration process. The high influx of patients in facilities was evidence to support how the population was ecstatic about the programme. Furthermore, the excitement of accessing health services without financial hardship was the game changer to both community members and healthcare providers. Availability of medicines in facilities that had never experienced such stocks was embraced with high expectations for the government to put in place mechanisms for sustainability of the UHC programme.

The barriers which by extent are opportunities, towards provision of quality health services to the general population the study established three categories of barriers. At the governance level, there were limited engagements of members of county assemblies. At health facilities service delivery level barriers included inadequate supervision, poor facility infrastructure, limited availability of equipment and supplies, and shortages of workers; at community level, weak sensitization and mobilization on UHC, and insufficient coordination with community network. At county health management level, barriers included delays in disbursement of funds to lower level health facilities and unpredictable supply and delivery of essential medical commodities and drugs in some of the facilities.

RECOMMENDATIONS

- Harmonize and strengthen referral infrastructure through investments in patient transport especially

strategic purchase of basic and advanced life support ambulances for critical care management.

- In addition, the current effort by national and county governments to continuously expanding the road infrastructure should be encouraged.
- Leveraging on community health volunteers to support UHC implementation by recruit more CHVs to reach more beneficiaries
- Build capacity of CHVs to support UHC through training and equipping CHVs to offer services to the community. In addition, there is also need to address the issue of CHVs incentives and work environment. Motivation for CHVs could take either the form on monetary and non-monetary incentives.
- There is need to rethink of innovative ways to decongest higher level facilities especially tier 5 to reverse the trend of patients bypassing lower level facilities in favor of preferred health facilities, concerted effort should be put in place, which could include adequate staffing, upgrading and expanding range of services offered at this facilities.
- A national dialogue is required to address equity issues through increasing number of facilities to reach all. Revitalize the outreach and mobile clinics.
- UHC registration should be a continuous process so as to reach more people as well updating the demographic surveillance.
- Human resource for health function should be reviewed from time to time, especially in relation to recruitment, development, training and retention of the health workforce. In addition, to address the issue of health workers' burnout, deliberate efforts to motivate and inculcate positive attitudes at the work place.
- Stepping up awareness and sensitization in the community regarding UHC aspirations. Continuous community sensitization is critical so as to create ownership and grassroots' support. The targeted messages should help clarify grey areas such as the connection between UHC and NHIF, as well as any misinformation and misconceptions.
- Using data to support UHC through addressing data capture and sharing infrastructure. The data architecture should not be burdened to the health service provider

Contributors

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