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DELIVERY NOTE

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Strengthening Health Systems Management under Decentralization in Kenya

Overview

JICA's technical cooperation project in Kenya, "Strengthening Management for Health in Nyanza Province" (hereafter, the Project), ran from July 2009 to June 2013. Provincial and district health management teams were seen by JICA as the key to a strong health system that would improve the quality of health services for Kenyans. This delivery note explores how the Project developed the capacities of those teams. This note also illustrates challenges the Project faced and how they were addressed and analyzes key factors contributing to the Project's success.

The health management teams' capacities that were developed by the Project have been sustained despite the drastic changes in Kenya's administrative structure that occurred immediately after completion of the project. The administrative structure in Kenya was centralized when the four-year project started. However, full-scale movement toward devolution occurred during the project, and a county system was introduced in July 2013. As a result, Nyanza province was restructured into six counties. Nonetheless, many former health management team members who were posted in Nyanza province and its districts adapted to the new teams formed under the devolved system and continued to improve the working environment and the delivery of quality health services.

PROJECT DATA

SECTOR:
Health

DEVELOPMENT CHALLENGES:
Delivering, in a timely manner, adequate health services to those who need them the most in Nyanza province in Kenya

DELIVERY CHALLENGES:
Lack of stakeholder commitment, poor coordination, and an incomplete project design

COUNTRY:
Kenya

REGION:
Sub-Saharan Africa

PROJECT DURATION:
July 2009–June 2013

PROJECT TOTAL COST:
398 million yen

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For more information on this project, see https://www.jica.go.jp/english/our_work/evaluation/process.html.

Key Contextual Conditions

In the mid-1990s, three things—a lack of skilled and knowledgeable health care providers, the deterioration of infrastructure, and inefficient procurement of medical equipment and medicines—led to a worsening of Kenyan health indicators. Patients' trust in health care services was low, which in turn had a negative effect on health providers' commitment to and motivation in their roles. Health management teams evaluated health care providers quarterly using the national supervision checklist, in accordance with Ministry of Health guidelines. However, according to the JICA project team, the evaluation method and tool did not meet actual needs on the ground. They were not geared toward problem solving; rather, they represented a routine input to a top-down and highly centralized system that would then identify gaps between the checklist's instructions and the work that health care providers had performed.

Improving the health management system required new leadership with a team-building perspective and the management capacity to appropriately allocate resources to provide high-quality health services to those who need them the most. The project team's concern was intensified by the impending decentralization stipulated in the new constitution of 2010.

The Second National Health Sector Strategic Plan of Kenya (2005–2012: NHSSP II) promoted the decentralization process and encouraged provincial and district health management teams to take new responsibilities for preparing annual health plans by identifying problems and solutions, setting objectives, and prioritizing their activities to achieve those objectives. The stategic plan thus expected the health management teams to manage the cycle of the health plans: planning, implementation, and monitoring & evaluation. Also, the strategic plan expanded the district health offices'

duties to include budgeting, procurement of medical supplies, and management of health information. This change required district- and facility-level members (such as medical officers, public health nurses, and health records and information officers) to develop their capacities for financial management and required provincial and district health management teams to improve their capacities to supervise health service providers at the health facilities within their jurisdictions.

Development Challenge

In Kenya, important health indicators showed some improvement from 1960 to 1990. The infant mortality rate fell from 122 per thousand live births in 1960 to 63 per thousand live births in 1990, and the under-five mortality rate dropped to 97 per thousand in 1990 from 204 per thousand in 1960. However, the infant mortality rate rose to 77 per thousand live births in the five-year period preceding the 2003 Kenya Demographic and Health Survey (KDHS). The under-five mortality rate also increased to 115 per thousand for that same five-year period (CBS, MOH, and ORC Macro 2004).

At these indicators, Nyanza province fared worst in the country, despite ongoing support from a number of development partners. Nyanza's infant mortality rate and under-five mortality rate for the five-year period preceding the 2003 KDHS were 133 and 206, respectively, per thousand live births. Additionally, before the 2003 KDHS, the percentage of children age 12–23 months who received the standard childhood vaccines was 37.6 percent, compared with a 56.8 percent national average (CBS, MOH, and ORC Macro 2004). The prevalence of HIV/AIDS (among those aged 15–49 years) in Nyanza province was 14.9 percent, compared with a national average of 7.4 percent (NASCOP 2007). To improve these indicators, it was necessary to deliver adequate health services to those who needed them in a timely manner, which required a properly managed health system.

Intervention

The JICA project team identified improved health systems management capability as one of the most essential prerequisites for improving the performance of intermediate-level provincial and district health managers and health professionals, who are employees of the local government. The Project aimed to strengthen the health system as a whole by tightening relationships between the core components of the health systems: (a) leadership and governance, (b) health human resources, (c) health finance, (d) health information, (e) service delivery, and (f) health technology (equipment and pharmaceuticals). The health managers were expected to work as "change agents" in the system; to this end, the Project focused on developing the competency for leadership (the core capacity) of health management teams and these teams' technical capacities in health systems management. The Project introduced several implementation models: (a) health systems management (HSM) implementation, (b) health promotion operation, (c) integrated supportive supervision, and (d) community health management.

Addressing Delivery Challenges

The Project identified and addressed the following delivery challenges: (a) lack of stakeholder commitment, (b) poor coordination among development partners, and (c) an incomplete project design.

Lack of stakeholder commitment. Before 2010, Kenya was a centralized state that was influenced by foreign donors, particularly in the management of its health services. The agenda for the provincial and district health management teams was set by the ministry and by donors; local teams had little flexibility or opportunity to take initiative. The resulting passive attitude contributed to lowering the commitment of health management teams to fulfilling their duties.

To help health management teams be more proactive in carrying out their responsibilities, the Project organized a half-day dialogue session for "visioning," in which provincial and district health management teams identified challenges they had faced and clarified their vision of what actions were necessary to overcome the challenges. During the training session, team-building games were also introduced. According to the project members, this visioning was crucial to their development of a "systems thinking" perspective, in which managers form an understanding of a system

by examining the links and interactions between each component of the system. This perspective helped the health management teams clarify favorable changes (for example, improvement of health service delivery) and identify steps toward those changes on their own under the new county-based governance system.

With this visioning exercise and intensive team-building training, the Project fostered an ethos of servant leadership, in which leaders share power, put the needs of others first, and help people perform to the best of their abilities.

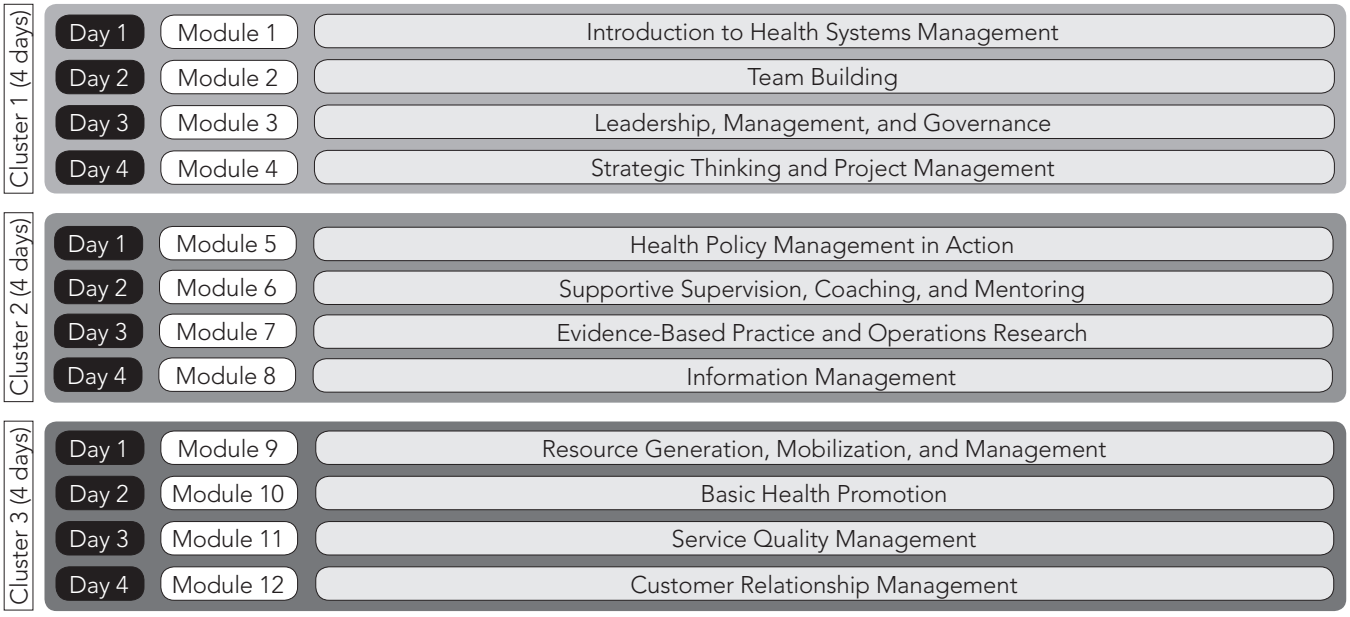
Poor coordination among development partners. From the start, the Project faced challenges in coordinating the development of its health systems management training program with the efforts of other development partners. Several training programs in the same field had been built with the support of various partners, including the Leadership Development Program supported by Management Science for Health (a nonprofit international health organization) and the Health Systems Strengthening Program supported by the World Health Organization, Danish International Development Agency, and U.K. Department for International Development. These other programs had been implemented with official approval from the Ministry of Health, which later caused confusion on the part of not only the provincial and district health management teams but also the ministry itself.

To solve this issue, the Project coordinated with development partners such as the United Nations International Children's Emergency Fund and the U.S. Agency for International Development through information sharing, mutual observation of training, and technical support. In 2012 and afterwards, when the Ministry of Health moved to harmonize the existing programs to establish a standardized national training program, the Project proactively participated in meetings of the working group on review, revised the training curriculum, and provided suggestions based on its experiences.

Two key factors enhanced the Project's contribution to program standardization:

- The Project had engaged with the ministry to initiate the HSM training as a member of an exisiting community of practice, which consisted of key development partners; education and research institutes; nongovernmental, community-based, and faith-based organizations; and private companies. The goal of the HSM training was to strengthen both the technical capacity and the core capacity of the provincial and district health management team members at the individual level while strengthening organizational capacity at the team level (See graphic).

Health Systems Management Training Program: Outline



Source: JICA 2013.

- The former chief adviser of the Project served as a health program adviser for the Ministry of Health for the third and fourth years of the project, which made it easier for the Project to obtain timely information regarding national-level occurrences and communicate with development partners stationed in Nairobi.

As a result, the six HSM training topics developed by the Project, as previously mentioned, were incorporated into the national training program.

Incomplete project design. The original design for the intervention, which aligned with the national strategic objective of improving health indicators, focused only on development and implementation of HSM training. However, in the process of implementation, project members and key stakeholders came to a consensus that health indicators would not improve unless the trained managers properly applied their knowledge and skills in practice and service users had their trust restored in health services and gained greater access to those services. This consensus derived from exercises in the Training Management Working Group, in which provincial and district health management team members, who were the target of the training, played a core role in designing and implementing the training program with support from the community of practice.

The original implementation plan was modified in the middle of the Project when two new members joined the project team. One of these new members was assigned to improve service delivery at health facilities in the target districts through development and practice of supportive supervision, and the other was assigned to promote community health strategy through developing the capacity of community health extension workers and community health volunteers. This modification made the project's intervention more comprehensive, allowing it to address issues on both the supply and the demand sides of the health care delivery equation. The health management teams in the province and the target districts used what they learned in the HSM training to improve service delivery to community members, which raised the satisfaction of the community with the services provided by heath facilities. Also, better community health management resulting from developing the capacity of community health extension workers and community health volunteers contributed to increased referrals of community members to health facilities and enhanced monitoring of their health conditions after the referrals. This synergistic effect was thought by the project team to have contributed, in collaboration with the efforts of other development partners, to the improvement of key health indicators in Nyanza province.

Lessons Learned

This delivery note captures lessons from the Kenya context that may be useful in other projects that face similar delivery challenges.

- It is critical not only to develop the capacities of stakeholders at all levels of the governance structure (that is, province, district, and community) but also to incorporate the perspectives of both the supply side and the demand side to improve service delivery and, ultimately, health indicators.
- When a project aims to develop the capacity of intermediate-level health managers, any intervention should consider the governance system of the recipient country. In particular, if the country is a centralized state and in the initial stage of the devolution process, it is critical to empower the target group. The "visioning" exercise used by the project team, for example, can be used to build self-confidence and develop leadership skills.
- Health systems become functional through developing the capacity of their health management teams, but technical capacity alone cannot make a significant difference in performance. Leadership is key to positive change. This change is best accomplished not by a traditional authoritarian leader but by a servant leader who helps people develop and thrive.
- If a project establishes a model in target areas (such as provinces or districts) with a plan to scale up or spread its new methods to the mainstream, it is pivotal to involve core members of the national government in project activities from the beginning, as integral members of the project's implementation structure.

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