



Centre for Health Solutions - Kenya

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MINISTRY OF HEALTH CHS ANNUAL STAKEHOLDERS MEETING



THEME:

STRATEGIC INFORMATION FOR HEALTH SYSTEMS STRENGTHENING

THE GREEN HILLS HOTEL, NYERI



NOVEMBER 20 – 21, 2014



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Introduction

The health system has traditionally collected large amounts of data and information. However, this data is often stored in databases, locked away and not used to inform decision-making or to improve care.

A decline in international funding and the shift to local funding mechanisms for health has been accompanied by an increased demand for accountability through the demonstration of impact of the use of existing funded health interventions across the country.

As many donors and governments apply results based-financing mechanisms, this continues to create even more demand for timely and reliable data for decision making through statistics to accurately track progress and performance as well as to evaluate impact at both national and county levels. Decisions on health including on resource allocation at either the facility, county or national level, cannot be made without information.

However, there still exist major gaps in data quality and availability. Many in the health workforce face challenges in producing quality data to inform regular tracking of progress in the implementation of health interventions and towards strengthening health systems.

In instances where data is collected, the risk of not being fully utilised to influence policy, to improve service delivery or inform future plans is often quite high.

Keeping in line with its commitment to health systems strengthening, Centre for Health Solutions – Kenya (CHS) continually seeks to enhance the sustainability of its health development interventions through partnerships and building the capacity of health care workers and their managers to effectively manage and use health information.

The need for good quality and reliable data, the use of data for decision-making and interventions to improve the use of data to strengthen health systems, was the overarching message at this year's Annual Stakeholders Forum held under the theme **'Strategic Information for Health Systems Strengthening.'**

The 2014 Stakeholders Meeting brought together CHS staff, health care workers, managers and some county health leaders drawn from five CHS supported counties in Central Kenya: Laikipia, Nyandarua, Murang'a, Kiambu and Nyeri. Representatives of development partners working in the region were also present.

CHS Updates

Through the US Centers for Disease Control and Prevention (CDC) funded TEGEMEZA project that supports the delivery of HIV care and treatment services across 191 health facilities in Central Kenya, CHS has managed to consistently improve service delivery outcomes in the region.

Working in partnership and close collaboration with the five counties, some of the notable achievements over the last three years of the project have been:

- Reduced rate of transmission of HIV from mother to child at 6 weeks from 12% in 2011 to 3% in 2014
- Training of over 2,000 health care workers to support the delivery of HIV services
- Decentralisation of HIV services to 190 health facilities including services previously offered in a few care and treatment centres, including HIV Testing and Counselling (HTC) and Prevention of Mother to Child Transmission of HIV (PMTCT) services
- Support to over 150 people living with HIV as peer educators to support peer client retention
- 26,454 patients currently on Anti-Retroviral Therapy (ART)
- Over Kshs 400,000,000 disbursed to sub recipients to support the delivery of HIV care and treatment services – previously health facilities and now directly to the counties
- Renovations worth Kshs 56,000,000 for 13 health facilities in the region

- Over 640,000 people tested for HIV at CHS supported facilities
- Almost 2,000 people living with HIV put on Isoniazid Preventive Therapy (IPT) to prevent TB
- Over 11,000 patients newly initiated on ART including 1,300 children

CHS continues to support continuous capacity building of health care workers to deliver quality services through the implementation of the Residential Mentorship program run at Muranga District Hospital. The innovative use of E-learning has seen CHS support facility staff to participate in distance learning courses on Clinical Management of HIV and on Leadership and Management in Health offered by the University of Washington.

These successes would not have been possible without the support of health managers at various levels and the health care workers tirelessly working across all CHS supported facilities. Their effort is highly appreciated.

Even in light of the tremendous achievements thus far, there is still need to use this information to fill the identified gaps and ensure 100% coverage of services to those in need. CHS looks forward to continued integration of services; scale up of innovative practices, engagement with the national and county governments, greater ownership of HIV services by counties and continued strengthening of the quality of health services through the use of data.



Key Note Address:



Dr. Gichuiya M'Riara
County Health Director, Nyeri County

Despite all that has been achieved in the fight against HIV/AIDS, it still remains as dangerous as before; it is still a disease that kills. All resources available should continue to be deployed to fight the disease at all costs.

According to the 2011 document on the Joint United Nations Program on HIV/AIDS (UNAIDS) titled 'AIDS at 30, Nations At Crossroads,' UN Secretary General Ban Ki Moon cites that the number of people becoming infected and dying is decreasing but the international resources needed to sustain this progress have declined for the first time in 10 years despite tremendous unmet needs.

The 2011 General Assembly High Level Meeting on AIDS offered an opportunity to formulate plans for a future of zero new HIV infection, zero discrimination and zero AIDS related deaths.

According to the Kenya AIDS Indicator Survey 2012 (KAIS 2012), HIV prevalence in Kenya was reported at 5.6% in the 15-64 years age group, while 1.2 million Kenyans were found to be living with HIV. HIV prevalence for the Central Region was at 3.8%, with 105,000 people living with HIV. Statistics show that through prevalence levels may vary, there is no region in the country that is spared from HIV.

These grim statistics indicate that the fight on HIV/AIDS is far from being won and we cannot afford to lose momentum. There is still a long way to go to prevent new HIV infections and discrimination as well as scale up treatment, care and support.

Fifty-six per cent of low-income countries have 70% of their HIV/AIDS programs run by development partners; the health workforce cannot ignore the need to take leadership and investment in health programs. Investment in health must be a priority as investment in health is investment in wealth.

What percentages of county budgets are set aside for health and for social determinants of health?

While the development and implementation of initiatives that affect the social determinants of health might not be seen as a responsibility of the health system, working in partnership with other policy sectors will go a long way to support policies and strategies that will mitigate any negative impact on the health status of the population.

Health service providers must insist that health investment becomes a priority. This would mean going beyond developing health strategic and investment plans on paper to fully implementing actions and using the results and facts to advocate for more resources.

The entry of CHS into the Central Region was a turning point in the fight against HIV/AIDS. CHS has done much to support the efforts of the Ministry of Health in the region, and these efforts, and those of other partners in the fight against HIV/AIDS are highly appreciated. However, the efforts of CHS and other partners cannot replace the central role the national government of Kenya and the county governments have to play in the fight against HIV/AIDS.

According to UNAIDS, in 2009, public and private domestic resources accounted for 52% of total spending on HIV programs in low and middle-income countries but many low income countries remain heavily dependant on external financing. In 56 of these countries, international donors supply at least 70% of HIV/AIDS resources. County governments must realise that HIV/AIDS spending is a cost-effective investment returning health and economic dividends for future generations.

Investing in programs on prevention, treatment, support and care in the fight against HIV/AIDS is not an exercise in futility. This will be the only way to realise Kenya's Vision 2030, through a healthy nation.

Building on timely evidence of national epidemics and responses, stronger national planning processes are needed to improve the efficiency and impact of limited funding. There is need to invest in the knowledge gained in implementation, and learn to practice and implement the lessons learnt in technical training to curb the spread of HIV/AIDS. Leveraging on links with professional bodies and associations (e.g. Nursing Council of Kenya) to lobby for the best interest of Kenya's population should also be a priority.

To enable stakeholders, service providers, planners, county and national governments manage the HIV/AIDS pandemic effectively; there is need for a robust health information system that will provide strategic information for health systems strengthening.

However, information alone cannot make things happen. It has to be collected in a scientifically sound manner, analysed, consumed at the level of collection, acted upon by various levels of policy and implemented effectively and efficiently. It is time to move with speed and act on the information that we continue to collect from implementation of health programs to modify our approach in combating HIV/AIDS and other public health needs.

Measuring Health System Performance



In the constantly changing health development arena, the performance of health systems continues to be a major concern for policy and decision makers.

As Kenya gears up to fulfil its commitment to universal health care for all its citizens, the ability to measure the performance of the health system in the delivery of quality health services to individuals and populations is critical.

Regardless of the size of the facility, health strategy and service delivery plans by health providers share common goals: to improve the health of local communities through health promotion and disease prevention; and to improve health system performance in regards to the accessibility of primary health care services, as well as the quality, safety and effectiveness of health services.

With that in mind, the public health sector should not be left behind in ensuring value for money invested in the health system and in providing the best possible quality of health services. This can only be achieved by applying systematic performance measurement systems that will go a long way in building grounds for more investment in health by policy and other decision makers.

Increased demand for improved efficiencies as well as improved quality of care and patient outcomes can only be met by regular measurement of performance. By conducting regular assessment of health system services, health care providers can ensure that service expectations are met and if these are not being met, allow for improvement actions.

Measurement categories for the health system include structural measurements that look at the adequacy of the environment in which patient care is provided; process measurements that address how patient care and care support functions perform; and outcome measurements that look at the results of patient care and care support functions.

The **Balanced Scorecard**, a strategic performance management tool commonly used to measure industry performance, displays system-level performance measures along four strategic categories that include: the customer, internal business process, learning and growth, as well as financials. Though its uptake within the

health sector has been relatively slow, when applied across all arms of the health system, the balanced scorecard approach can effectively address health system performance measurement and reporting.

Customer measures include, but are not limited to, the percentage of patients expressing satisfaction with services provided, those that would recommend the facility and its services, the number of service complaints or the percentage of patients reporting their pain or ailment as adequately controlled.

Internal business process measures may include the average patient length of stay, percentage of patients readmitted for the same or similar conditions, the rate of dispensed medication errors, the percentage of emergency patients seen within 15 minutes of arrival or the number of employee occupational injuries.

Learning and growth measures may include the number of new services offered at health facilities, the number of new research projects undertaken, the number or percentage of staff attending at least one formal training session, introduction of innovative information technologies and employee turnover/retention rates.

Financial measures should not be left to Finance Units only. Measurements include knowing the average cost of treating a patient for a specific condition, growth in revenue for facilities that charge clients and when to waive patient costs, among others.

Some facilities across the CHS supported counties in Central Kenya have applied the balanced scorecard to measure performance. Highlights on performance and required actions to improve data quality as presented by the counties included:

- Evidence that many health facilities had few indicators that could be used to measure client satisfaction
- Information collected shows that there is need to step up CMEs and mentorship to enhance data quality
- The need to invest in ICT so as to improve the efficiency of service delivery and timely data entry
- The need for prompt analysis of data to ensure timely interventions
- Regular data review meetings at different levels and the provision of required data collection materials to standardise and improve data quality
- Data verification and cleaning before posting onto the information system
- The importance of formation of data review teams at the facility level and enhancing of QI teams
- Cascade DHIS2 use to lower level facilities i.e. Level One and Two through training staff across these facilities

The Balanced Scorecard, is a strategic performance management tool commonly used to measure industry performance along four strategic categories

Implementation Of Revised National Art Guidelines - Impact On Counties

The recent revisions to the national anti-retroviral therapy (ART) guidelines offer opportunities to turn the tide in the fight against HIV/AIDS in the country. With guidance that now expands the ART eligibility criteria, this will mean that more patients will now be placed on ART; thereby reducing HIV related morbidity and mortality.

The revised guidelines place increased emphasis on provider initiated testing and counselling (PITC) for all accessing health care services, testing among children of people living with HIV (PLHIV) and sexual partners of PLHIV.

The recommendation to use Isoniazid Preventive Therapy (IPT) for all PLHIV and the GeneXpert test as the primary diagnostic test for TB in PLHIV will result in early and more accurate diagnosis of TB including drug resistant TB and a consequent reduction in TB incidence and related mortality. Superior viral load monitoring in HIV treatment will lead to earlier detection of treatment failure, resulting in reduced morbidity and mortality. If these projected gains are to be realised, it cannot be business as usual and county governments need to make a significant investment in the implementation of the revised guidelines.

Counties will be required to expand activities that support the identification of HIV+ persons as well as expand the provision of ART services. Some critical components of HIV treatment

like toxicity monitoring are no longer supported through donor funding and there is need for county governments to make an investment in this area so as not to lose the gains made in the fight against HIV.

The time is right for county governments to consider making HIV care an essential service. This will require investment in human resources to support the expansion of HIV Testing and Counselling (HTC) services, ART and PMTCT. County governments will also need to set aside resources to enhance the capacity of these staff to adequately carry out the expanded services through on-the-job training and mentorship.

Investment in adequate monitoring and evaluation (M&E) systems including Electronic Medical Records (EMRs) as well as data quality assurance (DQA) mechanisms, and support supervision, among others cannot be ignored. This is even more critical in light of the increasing requirements from policy/decision makers and funding agencies for information on health system outcomes that will inform future investment in health.

Working Together To Reduce Kenya's TB Burden



With funding from USAID, CHS supports the National Tuberculosis, Leprosy and Lung Disease Unit (NTLD-Unit) to provide reliable leadership and coordination of TB services in Kenya.

Launched on World TB Day 2014, the Tuberculosis Accelerated Response and Care (TB ARC) activity seeks to foster country ownership of TB control efforts, by investing for impact through multi-sectoral involvement while building on existing systems.

In efforts to support sustainability of TB control gains, CHS through TB ARC supports Kenya's STOP TB Partnership Secretariat to mobilise

a voluntary massive movement of organisations committed to the fight against TB in order to bolster actions and leverage resources for the elimination of TB in Kenya.

The Partnership seeks to grow its membership with like-minded organisations seeking to engage policy makers to support TB care and control at national and county levels as well as the corporate/private sector. This will be done through professional bodies, private health service providers, business owners/coalitions, unions, civil society organisations, research and academic institutions and the media among other non-health actors.

Membership benefits for joining the STOP TB Partnership include: -

- Access to reliable and up-to-date information on disease burden, country challenges, available resources, gaps and opportunities
- A pool of and access to resources - larger network of human and financial resources
- Collectiveness: planning, mobilisation and effective utilisation of resources and monitoring of achievements
- Advocacy networks/forums for policy formulation
- Recognition and opportunity to publicise their work
- Strengthening relationships and accountability of partners
- Sustained interest through roles and responsibilities ensuring ownership and active participation

Health Care And Law



Prof Kiama Wangai

Kenya's Health Policy Framework (KHPPF) governs the legal framework of the health sector in Kenya.

The Right to Health

The Bill of Rights enshrined in Chapter Four of Kenya's Constitution of 2010, provides for a wide range of rights including social and economic rights as set out in Article 43. Article 43(1) provides that: Every person has a right to (a) the highest attainable standard of health, which includes the right to health care services. Article 43(2) provides that no person shall be denied emergency medical treatment.

In light of this, it would be unconstitutional for health service providers to deny anyone emergency treatment. It is therefore the responsibility of government to avail funds for emergency treatment. This requires that leaders at national and county government level lobby for the allocation of funds for emergency treatment to ensure that this constitutional right is not infringed upon.

The Right to Life

Regardless of social class or economic power, the Right to Life, as laid out in the Constitution, is not feasible without a proper, working health system. It is therefore the responsibility of national and county governments to ensure that the health system remains effective and efficient to ensure that every Kenyan's life is preserved through access to quality health services.

Regulation of Health Care Services

Seven regulatory bodies regulate the provision of health care services in Kenya. These include Kenya Medical Practitioners and Dentistry Board (KMPDB) that is charged with the responsibility of training, registering, disciplining medical practitioners and dentists, as well as registering and regulating health care institutions.

The Clinical Officers Board is charged with the registration and training of Clinical Officers and is headed the Clinical Officers Council. The Nursing Council of Kenya (NCK) is charged with the responsibility of ensuring that nurses are trained, regulated and monitored. The Radiology Board, Physiotherapy Board, Nutrition and Dieticians Boards are the other regulatory bodies charged with the responsibility of ensuring that the relevant professionals are adequately trained, oriented and that they keep up with the relevant code of ethics.

The Public Health Act creates provision for securing and maintaining health and addresses issues like the supervision of public health activities by Public Health Technicians e.g. inspection of abattoirs and market places; control of infectious diseases like TB control, vaccinations among other issues of public health concern.

Medical Negligence

By consulting a doctor or any other health service provider, a patient establishes a 'contract' with the doctor/service provider. The basis of this 'contract' is the expectation on the part of the patient, to be treated with the reasonable skills that the provider says to have. In the event that the doctor/service provider manages the patient in ways that are not in keeping with the contract, there is a breach of contract and this is what is referred to as negligence.

Negligence may also occur if as a result of the service provided, the patient incurs costs that would have otherwise not been incurred had the service provider carried out the treatment as required. The breach of duty of care owed to a patient by the service provider that leads to the patient suffering loss (of life, limb or financial) is considered negligence. Medical practitioners and health care workers therefore need to offer the best care possible to uphold every individual's right to quality health services.

Patients' Right Charter

The patient, who is at the very heart of the health system, has a number of rights that should be honoured by all service providers within the health system.

These rights include: the right to access health care; the right to the highest attainable quality of health care products and services; the right to receive emergency treatment in any health facility; the right to choose a health service provider; the right to information; the right to refuse treatment, the right to confidentiality; the right to informed consent to treatment; and the right to information (concerning their health and health care) among other rights.

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Role Of Counties In Data Quality Assurance



Boniface Isindu, National AIDS and STI Control Program

It continues to become more evident that the continued provision of quality health care services can only be informed by what is documented. Essential services cannot happen without quality data that is used for: 1) patient decision support to inform the clinical management of clients and 2) management decision support to inform policy and other patient support systems.

In order to achieve significant results in the management and use of data, there has to be a substantive investment in the generation and management of data. Going hand-in-hand with this investment is the need to review reporting rates for timely and regular reporting towards ensuring the availability of updated data to those who require it at national and global levels.

In order to effectively use and allocate the existing meagre health resources for identified health priorities, good quality data is essential to guide the process of decision-making and prioritisation.

To strengthen programs and improve health system results, data has to be of the highest quality possible. Counties must therefore: have monitoring and evaluation capacity with clear roles and responsibilities (staff dedicated to the process of data management); invest in capacity building, mentorship, on-the-job training; be clear on data reporting requirements and utilisation; be clear on indicator descriptions, data reporting tools and systems; have a proper (logical) understanding of the entire data management process; apply data quality assurance mechanisms and control measures; ensure proper linkage to the national level reporting system (DHIS).

Data quality assurance is essential as it allows for the rapid verification of the quality of data, gives room to apply corrective measures, as well as an opportunity to measure and monitor data quality progress over time.

In an effort to strengthen health information systems, all counties should invest in training of the right personnel in handling data by providing periodic mentorship, on-the-job training, and updated training in data management.

Counties must also ensure the constant and timely distribution of standardised reporting tools across the health system so that they are all providing quality and standard data.

Supportive supervision of health facility staff charged with data management is also a critical function that county governments can play in ensuring improved data quality. This should also include a review of the data already collected and raising the right questions in the event that the data speaks of a problem.

In order to effectively use and allocate the existing, meagre health resources for identified health priorities, good quality data is essential to guide the process of decision-making and prioritisation

Counties should ensure proper human resource management for the continuity of good practices. This may include retaining health care workers who have been trained in data management to ensure that the full benefit of their training is realised at the facility and health system levels. Facility level managers should involve county health management teams (CHMTs) and sub CHMTs in data quality management to ensure sustainability and continuity of data quality and improvement functions.

Institutionalisation of M&E plans for proper planning and budgetary allocations will go a long way in supporting the data quality assurance process. This will guide correct/sufficient budget allocation to facilitate the functioning of data quality assurance measures in the health system.



CHS 2014 EXCELLENCE AWARDS

Excellence in Prevention of Mother To Child Transmission Services

Kangari Health Centre, Muranga County
Nyahururu District Hospital, Laikipia County

Excellence in Pharmacy Services

Muranga District Hospital, Muranga County

Excellence in TB Services

Gatundu District Hospital, Kiambu County

Excellence in HIV Testing and Counselling Services

Kandara Health Centre, Muranga County

Excellence in Adherence, Psychosocial Support and Community (APSC) Services

Kirogo Health Centre, Muranga County
Nyeri Provincial General Hospital, Nyeri County

Excellence in Laboratory Services

Karatina District Hospital, Nyeri County

Excellence in Monitoring and Evaluation

Mweiga Health Centre, Nyeri County

Excellence in Care and Treatment Services

Githunguri Health Centre, Kiambu County



CHS 2014 EXCELLENCE AWARDS



Using Data To Influence Decision Makers

Drawing from the evidence base, national and county government leaders are expected to improve the health of their populations. However, effectively utilising data and evidence for public health decision-making remains difficult.

Studies have shown the existence of three effective levels of influence: individual, interpersonal, and collective. At each level, there are a number of mechanisms (change processes or outcomes) that may occur. These changes can only occur once a 'trigger' or 'catalyst' has been applied. When packaged in a relatable context, the data and evidence that the health system generates would be an effective trigger to influence decision makers.

At the individual level, changes occur in knowledge, attitudes, opinions, or actions as a result of information. At the interpersonal level, changes occur as a result of interactions between individuals, while the collective depicts the direct or indirect influence on the decisions and practices of governance structures or other decision makers.

It is therefore of utmost importance to understand how various types of information influence decision makers' actions for maximum effect. Different individuals/groups of decision-makers will require different platforms of engagement that may include face-to-face discussions, media (free or paid for), policy briefs, and roundtable meetings among others.

The first step in the process would be to present the arising challenge, gap or problem that will require decision maker support in a manner that is relevant to the decision-maker(s). It is paramount to establish what information is already available to them on the issue and seek to fill the information gap that may exist, in a language and manner they can understand.

This will require the use of easy to understand facts presented in practical/useable/friendly form and channels that may require repetition over time. The main purpose would be to bring the issue home by use of everyday examples that show the impact of the issue on the population.

The first step in the process would be to present the arising challenge, gap or problem that will require decision maker support in a manner that is relevant to the decision-maker(s)

ASM 2014 RESOLUTIONS

To wrap up the two-day discussions and chart the way forward, participants at the 2014 Annual Stakeholders Meeting resolved to implement and advocate for the following actions in their respective counties in the coming year:

1. Proactive use of data for decision-making and service improvement by health care workers and managers
2. County ownership and sustainability of HIV services
3. Strengthening of existing systems
4. Increased efforts to improve data quality by health care workers and managers
5. County support towards capacity building and mentorship of health care workers
6. Decentralization of sites for commodity management and distribution
7. Lobbying for increased health resources in each county
8. Procurement of TB commodities to meet respective county needs and ensure no stock-outs occur.