



**KENYA HEALTH SECTOR WIDE APPROACH: ROLE OF CIVIL SOCIETY
ORGANIZATIONS IN THE CONTEXT OF PUBLIC PRIVATE PARTNERSHIPS**

STATUS AND VISION FOR ENGAGEMENT
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Abbreviations

AOP	Annual Operational Plan
CHAK	Christian Health Association of Kenya
COC	Code of Conduct
CSO	Civil Society Organisation
DHSF	District Health Stakeholders Forum
DP	Development Partner
DSHF	District Stakeholders Forum
FBO	Faith-Based Organisation
GOK	Government of Kenya
HENNET	Health NGOs Network
HSCC	Health sector Coordinating Committee
JPWF	Joint Programme of Work & Funding
JRM	Joint Review Mission
KEC-CS	Kenya Episcopal Conference Catholic Secretariat
KEPH	Kenya Essential Package for Health
KEPI	Kenya Expanded Programme of Immunization
MTEF	Mid Term Expenditure Framework
PFP	Private for Profit
PPP	Public Private Partnership
O&M	Operations and Management

1. Introduction

The Kenya Health Policy Framework, 1994, recognizes the need for promoting a strong health sector where the private sector is given greater responsibility for healthcare delivery while the public sector concentrates its efforts on delivering 'public goods' in health. The successive National Health Sector Strategic Plans underpin future delivery of healthcare on this principle of promoting the non-Government (non-GoK) sub-sector by providing an enabling environment. The health Sector-Wide Approach is an emerging force driving the stakeholders together to forge a common vision in healthcare development in the country among key MOH stakeholders. The National Health Strategic Plan II (NHSSP II) provides the means to plan together, implement together, monitor and evaluate jointly through the following instruments for realizing SWApS in Kenya.

- (a) The Joint Program of Work and Financing (JPWF)
- (b) The Code of Conduct (COC)
- (c) The Annual Operations Planning Process (AOP)
- (d) Joint Monitoring and Review (JMR)

In addition, the NHSSP II identifies the following actions to strengthen partnerships with the private sector:

- Engage in joint planning
- Establish collaborative regulation and develop joint explicit rules
- Encourage informal relationships
- Share resources, share information, and share technology
- Reinforce quality in both public and private sectors
- Develop common planning tools to discourage segmentation, avail incentives to the private sector to promote comprehensive care and subsidize community insurance for the poor
- Involve the PFP in vertical programs e.g. Tuberculosis control and EPI
- Public sector outsource and contracting-out non essential health services

The process of the Medium Term Economic Framework (MTEF) is one other national instrument, which once it becomes all encompassing will be the principal tool for mainstreaming the SWApS in Kenya.

The role of the CSOs is further recognized in the MDGs, the Economic Recovery paper and the Vision 2030 strategy. In support of these intentions, there is policy dialogue between FBOs and MoH at one level, and at another level policy dialogue and engagement between non-Governmental actors in the health sector (FBO included) and the MoH. The direct FBO/MoH engagement is under the FBO/MoH Technical Group. HENNET represents the NGOs in discussions with the MoH through the Health Sector Coordinating Committee (HSCC) of MoH and other MOH forums. The Private for Profit (PFP) have also entered the health sector equation. At some districts, there is integration of the non-GoK health providers within the District Health Sector Forum (DHSF). The same is envisaged at provincial and community level. However, most of these forums are patchy and not well defined.

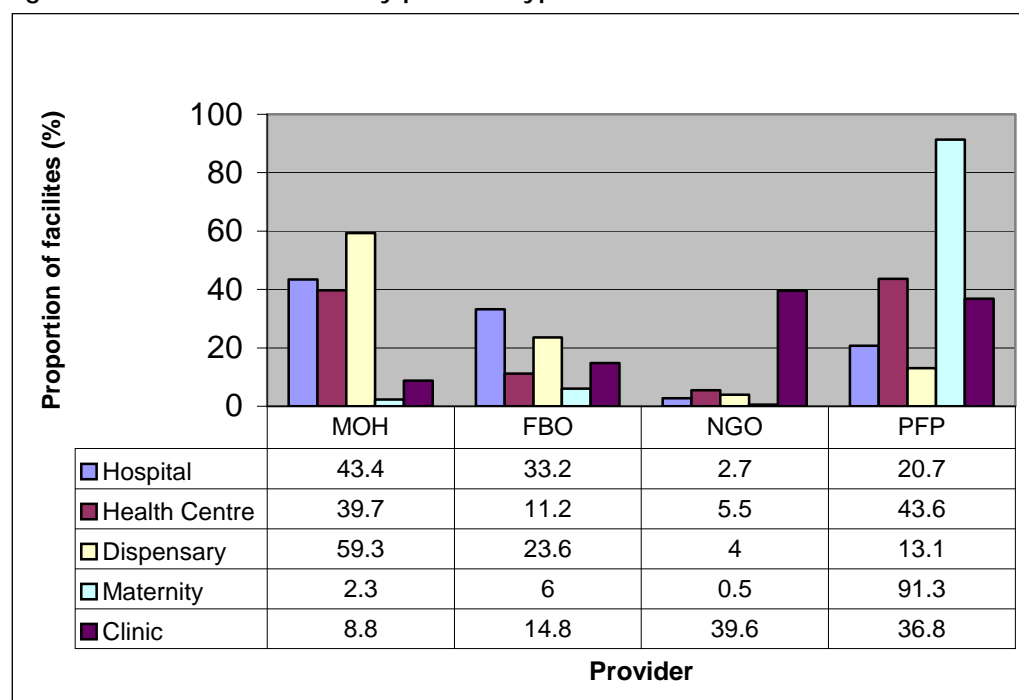
Based on the above highlights, this brief paper will address two key issues:

1. What is the status of the Civil Society Organizations contribution and participation in the SWAp process in Kenya?
2. How should this contribution and participation evolve to formalized CSOs engagement in the broad agenda of Public Private Partnerships?

2.0 CSOs and Healthcare Delivery in Kenya

In Kenya the CSOs and Private for Profit are responsible for a large proportion of the health infrastructure (Figure 1). More importantly the health infrastructure particularly of the FBOs and other private-not-for profit benefits mainly the rural communities, vulnerable populations and the hard-to-reach areas.

Figure 1 Healthcare services by provider type



Source: KSPA 2004

In 2004, the private sector was instrumental in providing some of the basic health and essential healthcare services to the people of Kenya as shown in table 1 and 2.

Table 1 Proportion (%) of facilities providing ANC, PNC and TT vaccine by provider

	ANC	PNC	TT Vaccine	ANC, PNC and TT vaccine
Government	81	40	86	38
NGO	88	74	69	74
Private for Profit	59	23	86	22
FBOs	87	24	88	24

Source KSPA, 2004

Table 2 Proportion (%) of facilities providing HIV/AIDS services

	Care and support	Home based care	ART	Staff have access to PEP
Government	64	17	5	7
NGO	85	25	20	19
Private for Profit	84	15	15	11
FBOs	68	23	6	6

KSPA, 2004

Evidently the private health sector (NGOs, FBOs and PFP) has not only invested heavily in the health infrastructure but is contributes greatly towards equity and improved access to the healthcare and closer to the populations.

NGOs also enjoy comparative advantage in longstanding experience in Community Based Health Care Services, advocacy and championing health rights, resource mobilization as well mobilizing communities to engage in the planning, utilization and monitoring of health services at community level. Hence, the non-government health providers are an asset in the realization of the goals and objectives not only of the NHSSP II but specifically of the community health strategy.

3.0 CSO's Challenges in the Health SWAp and action required to address them.

Although the MOH and other stakeholders are striving to support and collaborate with non-governmental health sector in the SWAp context, big gaps still exist in meetings these challenges as indicated in table 3.

Table 3 Important challenges to NGO, FBO and PHP healthcare delivery

Support issue	Current status	Gaps	Action required
Coordination	<ul style="list-style-type: none"> ▪ MOH/FBOs- Task Working Group in place ▪ HENNET included in national policy dialogue bodies ▪ HENNET has signed COC ▪ PFP network organizations formed – KEPSA and PHA ▪ District Health Forum includes NGOs and FBO representatives 	<ul style="list-style-type: none"> ▪ Structures not formalized ▪ No focal point /home for NGO/FBOs/PFP at MoH ▪ Instruments for coordination not available 	<ul style="list-style-type: none"> ▪ Appoint focal point for PPP in MoH ▪ Support institutional capacity development for NGO and FBO secretariats ▪ Support development of contractual documents ▪ Conduct mapping of NGOs ▪ Constitute inclusive community level teams / groups /committees
Implementation of KEPH	<ul style="list-style-type: none"> ▪ KEPH documents, NHSSSP and JPW disseminated ▪ Community strategy disseminated but not adequately discussed ▪ Weak capacities of FBOs especially human resource, commodities and management ▪ Declining allocations for maintenance and replacement ▪ NGOs /FBOs not directly linked to resources for KEPH delivery ▪ MoH has allocated some health personnel to FBOs and provides some 	<ul style="list-style-type: none"> ▪ CSO/FBOs not part of FIF and not yet receiving grants ▪ MoH support not formalized or modalities defined ▪ NGO/FBOs contributions to KEPH not captured at District or community level ▪ Personnel matters not harmonized ▪ Shortage of personnel 	<ul style="list-style-type: none"> ▪ Develop harmonized options for financial /resource allocation and disbursement to the FBOs and NGOs ▪ Support NGOs that meet minimum criteria by allocating resources ▪ Support NGOs to develop and test models ▪ Support Health Research policy implementation ▪ Install coordinating bodies for integrating and joint monitoring of KEPH implementation ▪ Provide Technical assistance to FBOs

Support issue	Current status	Gaps	Action required
	commodities		
Planning and management	<ul style="list-style-type: none"> • NGOs and FBOs not involved in joint planning • Mistrust 	<ul style="list-style-type: none"> • Input of non-public sector not reflected in plans 	<ul style="list-style-type: none"> • Strengthen planning process /institutions
Funding and financial management	<ul style="list-style-type: none"> • No grants to the non-public sector • Commodities for public goods given to the non-public sector 	<ul style="list-style-type: none"> • FBOs in dire straights • No formal process for providing resources and accounting 	<ul style="list-style-type: none"> • Develop effective financing mechanisms • Allocate resources to non-public sector
Evidence based planning	<ul style="list-style-type: none"> • NGOs and FBOs have capacity to generate evidence for decision making through testing models 	<ul style="list-style-type: none"> • Resources not assured • Weak mechanisms for sharing data 	<ul style="list-style-type: none"> • Allocate resources to the non-public and public sector for research and testing models • Provide resources for dissemination and PPP

Source: JDM Report, 2007¹

The above challenges fall into the following broad categories.

- ***Institutional:*** Strong organizational arrangements that would promote the participation of the non-state sector in health policy development and managing the healthcare systems
- ***Resources:*** Sufficient resources through equitable allocation mechanisms and resource flow channels for the non state sector.
- ***Acceptance:*** Recognition of the inputs from the non-state providers at all levels of the healthcare system

4.0 Gaps in Budget and financial flow mechanisms

During the recently concluded Joint Design Mission the existing global goodwill existing in the country led to a clear statement on approaches to mainstreaming Public private partnerships in Kenya and the supportive financial flow mechanisms. The overall goal of these interventions is to realize a strong SWAp in Kenya's health sector. The PPP budget and gaps until the end of the NHSP II are shown in table 4 while the proposed financial flow channels are shown in Figure 2.

¹ The Joint Design Mission (JDM) objectives were to assess the health sector needs and priorities that will lead to the design of coordinated programmes of support for implementation of the NHSSP 11, identify options and recommend harmonized programmes of support for implementation of the JPWF and the health SWAp in Kenya that can be supported by participating DPs over the next 3-5 years, commencing in FY2007/08 (July 2007), provide an overview of expected funding to the health sector by the participating Development Partners and identify emerging priorities, review ongoing and planned interventions against those outlined in the JPWF, and highlight critical gaps that need to be addressed in designing future programmes of support to MOH to achieve NHSSPII and JPWF objectives.

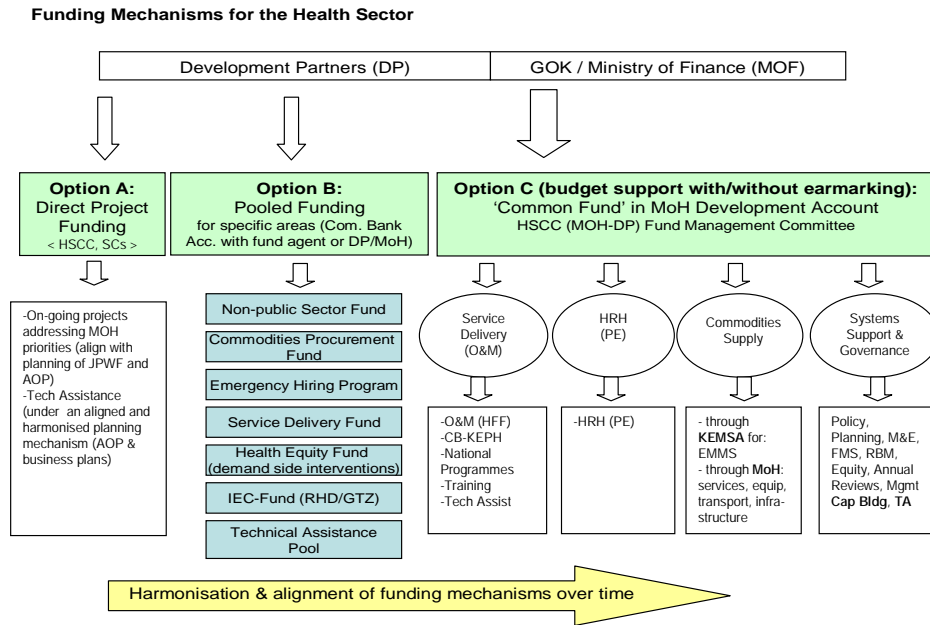
Table 4 Private Health Sector Partnership Fund 2007/2009

	Estimated cost (Million Ksh)					Committed, source and gaps			
	Pre-SWAp	2007/08	2008/09	2009/10	Total	GOK	DP	Total budget	Out-standing
Service Delivery									
Mapping of PHP	3.5	0	0	0	3.5	0	3.5	3.5	0
Cost-effectiveness analysis	3.5	0	0	0	3.5	0	3.5	3.5	0
Human resource FBOs	0	855	940	1,034	2829	173	200	373	2456
Commodities FBOs	0	828	911	1,002	2741	498	500	998	1743
O&M for FBOs	0	479	527	580	1586	0	300	300	1286
Commodities NGOs (1/2)	0	50	100	100	250	0	250	250	0
Public goods package through PFP /NGO	0	5	5	5	15	0	15	15	0
Service contract – OBA	0	50	50	50	150	0	150	150	0
Service contract - Social franchising	0	30	30	30	90	0	90	90	0
Support to NGOs for BCC advocacy	0	50	50	50	150	0	150	150	0
Social marketing	0	50	50	50	150	0	150	150	0
Systems research	0	20	20	20	60	0	60	60	0
O&M for NGOs	0	17.5	17.5	17.5	52.5	0	52.5	52.5	0
Governance								0	0
Logistics support to PPP Office in MoH	10	20	20	20	70	0	70	70	0
Support to CHAK, KEC and SupKem, and HENNET	12	10	10	10	42	0	42	42	0
Technical Assistance								0	0
Development of PPP policies	3.5	0	0	0	3.5	0	3.5	3.5	0
Facilitate bottom-up planning	0	10	10	10	30	0	30	30	0
Monitoring and evaluation	0	10	10	10	30	0	30	30	0
Clinical guidelines for community strategy	3	0	0	0	3	0	3	3	0
Package of public goods definition	3	0	0	0	3	0	3	3	0
Kshs (million)	38.5	2484.5	2750.5	2988.5	8262	671	2106	2777	5485
USD = 70 (million)	0.6	35.5	39.3	42.7	118.0	9.6	30.1	39.7	78.4

Source JDM, 2007

The creation of the partnership fund is seen as the interim measure for channeling DP and other resources to the CSOs and other non-state health service providers (Figure 2). A migration path is proposed towards full budgetary support as the common basket for financing the SWAp in Kenya.

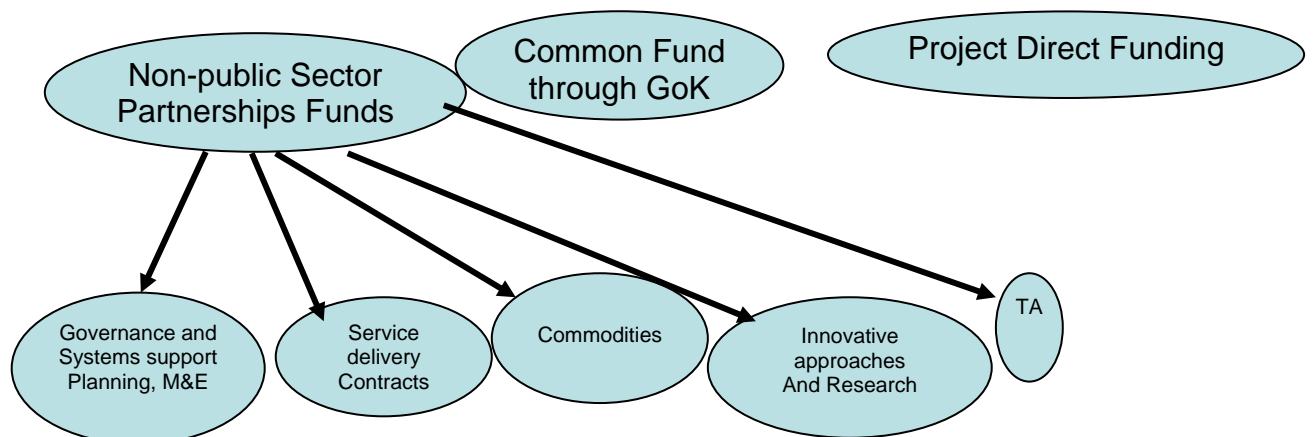
Figure 2: Funding Mechanisms



The following options are proposed for channeling financial resources (non public sector fund) to the non-public health service providers.

Figure 3: Options for flow of funds to the private sector

Funding flow to the Private Health Sector (NGOs, FBOs and PFP)



5.0 Conclusion

Kenya has made great strides towards realizing a SWAp in the health sector. More and more stakeholders are beginning to use commonly agreed planning tools and processes. More importantly key MOH stakeholders including CSOs have now signed the Code of Conduct. However more needs to be done particularly towards realizing a formalized PPP framework through formulation of a PPP policy, PPP secretariat and PPP MOH technical working group. Once in place, the PPP policy will address emerging key issues as regards meaningful participation of CSOs in the SWAp process. Key issues include resource allocation to CSOs based on comparative advantage, participation of CSOs in the coordination, technical input and actual implementation of NHSSP II components and the community health strategy. The Social health insurance has not yet full materialized. Despite these hurdles, CSOs are committed to the SWAp process; the most important bottlenecks to full participation being not well defined all inclusive governance structures especially at district level, lack of a formalized PPP framework and or policy, resource constraints and lack of mechanisms for transfer of resources from government to CSOs implementing activities within the NHSSP II .