



*The*  
**Kenya Health**  
**Public Private Collaboration**  
**Strategy (2020)**



MINISTRY OF HEALTH

Promoting effective and Ethical Collaboration





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# || The Kenya Health Public Private || Collaboration Strategy, 2020

Published by:  
Ministry of Health  
Afya House Cathedral Road  
PO Box 30016 Nairobi 00100  
<http://www.health.go.ke>

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## FOREWORD



**SEN. MUTAHI KAGWE,  
EGH (CS)**

**T**o accelerate achievement of the Third Medium Plan under the Kenya Vision 2030, His Excellency President Uhuru Kenyatta led the government to conceptualize the Big Four Agenda, a development priority list that covers food security, manufacturing, affordable housing and affordable healthcare for all. To achieve affordable healthcare, the Universal Health Coverage (UHC) goal was adopted in order to expand access to quality healthcare minus financial barriers. This would be achieved through stronger collaboration between government, development partners, private sector and communities.

It is for this reason that the Ministry of Health (MOH) initiated the process of developing the Kenya Health Public Private Collaboration Strategy. The Strategy's objectives include identifying priority areas for collaboration and investment, highlighting principles to guide engagement, establishing management systems and processes, and mapping the institutional ecosystem for effective and ethical collaborations. This Strategy is a product of extensive consultation from the county to the national level. It defines the vision, mission, principles and objectives around which collaborations should anchor.

The Strategy summarizes the legislation that guides collaborations. It examines the public private partnership laws in light of the aspirations of the health sector as spelt out in the Kenya Constitution (2010), Vision 2030, Health Act of 2017 and the Kenya Health Policy (2014-2030). Importantly, the Strategy recognizes the unique nature of the healthcare sector. Knowing that PPPs have historically focused more on infrastructure projects, the Strategy tries to elaborate alternative forms of collaboration, including low-value service level arrangements. It is for this reason that the document was called the 'Public Private Collaboration Strategy', rather than 'Public Private Partnership Strategy'.

The Ministry recognizes the progress made in improving public private engagement at different levels. The county, ministerial and presidential health forums have already created a culture of open, deliberate and continuous engagement. At the same time, the Kenya Healthcare Federation has helped in unifying the private sector for more effective engagement. These mechanisms will continue to play an essential role as we embark on the journey of implementing the Strategy.

I believe that this Strategy, with its accompanying Resource Guide and Toolbox, will guide us towards more effective and ethical collaborations for universal health coverage.

**Sen Mutahi Kagwe, E.G.H**  
Cabinet Secretary, Ministry of Health

## FOREWORD



**H.E DR. MOHAMED KUTI,  
E.G.H**

**D**evolution of health services has already had a significant impact across the country. Healthcare facilities have expanded in number and scope of services, and communities have become increasingly involved in helping to shape local priorities. However, county-level collaboration with non-state actors remains an area of weakness for most counties. This weakness in collaboration has partly been as a result of the absence of a comprehensive framework to guide cooperation in planning, service delivery and investment. For that reason, the County Governments welcome the Kenya Health Public Private Collaboration Strategy document.

The six strategic objectives defined in the document are specific enough to guide County Governments on important areas of focus but sufficiently broad and flexible to allow counties enough freedom to adapt and innovate towards meeting their needs. Counties have the freedom to identify and prioritize focus areas, develop appropriate projects, engage in appropriate procurement processes to engage the most suitable partner(s) and develop monitoring and evaluation matrices that fit the projects' purposes.

The ecosystem approach emphasized in the Strategy document underlies new thinking around partnerships. Counties are recognizing the importance of having mechanisms in place that allow continuous and deliberate engagement across different stakeholders and activities. We appreciate that partnerships work best when a wide range of actors are involved throughout, starting at the planning stage. On the other hand, there is a need to emphasize the importance of promoting collaboration with non-state actors who have good business ethics and integrity and encourage open and transparent engagement. These are fundamental if collaborations are to deliver value for our people.

The development of the Kenya Health Public Private Collaboration Strategy was a collaborative process between the two levels of government, private sector and development partners. County involvement was strong and consistent, both at the Council of Governors level and at the County Executive Committee level. We thank the leadership at the Ministry of Health for ensuring wide stakeholder involvement. Special thanks go to the health leadership of Makueni County, Isiolo County, Homa Bay County and Kirinyaga County for representing counties in the development process. Finally, we thank the SDG Partnership Platform and the World Bank Group for technical and material support.

We hope that all counties embrace the Strategy and use it to guide the establishment and management of public private collaborations for the betterment of Kenyan communities.

A handwritten signature in black ink, appearing to read 'Mohammed Kuti'. The signature is stylized and written over a faint circular watermark or background.

**H.E Dr. Mohammed Kuti, E.G.H**  
Chairman, Council of Governors Health Committee  
Governor, Isiolo County



## FOREWORD



**DR RASHID A. AMAN**  
(CAS)

**W**ith an annual funding gap of US\$ 2.5 trillion, countries globally are recognizing the futility of trying to achieve Sustainable Development Goals without effective collaborations, including partnerships between governments, private non-profit and private commercial sectors. On the other hand, such collaborations must be government-led and well-guided through Strategy to achieve meaningful impact.

The Kenya Health Public Private Collaboration Strategy provides a framework to guide public contracting authorities and private organizations wishing to collaborate towards meeting mutually beneficial goals. The framework describes how the country’s ambitious health-related goals, including Universal Health

Coverage, can be better delivered, building on the individual strengths of the respective partners. We believe that this Strategy will allow partners in the Kenyan health sector to develop innovative, cost-effective, homegrown solutions to our health systems challenges.

The Collaboration Strategy aims to inform engagement at the policy and legislation development level, financing and investment level, as well as service delivery level, ranging from innovative small-scale collaborations to capital-heavy partnerships at national and county government levels. Beyond that, the Strategy spells out the



**DR. MERCY MWANGANGI**  
(CAS)

principles which must guide collaborations, emphasizing important elements such as transparency and accountability, integrity, equity, value for money, mutual Beneficence, inclusivity, social responsiveness and demonstrated impact.

Successful implementation of this Strategy will require commitment and coordination across multiple actors at national and county levels, including both the public and private sectors. We are confident that this Strategy will inform the process of initiating, structuring and implementing effective, trustworthy and ethical collaborations in health, resulting in improved services and better health outcomes.

**Dr Rashid A Aman**  
Chief Administrative Secretary  
Ministry of Health

**Dr Mercy Mwangangi**  
Chief Administrative Secretary  
Ministry of Health



## ACKNOWLEDGEMENTS



**SUSAN N. MOCHACHE,**  
**C.B.S**

The Kenya Health Public Private Partnership Collaboration Strategy was developed through extensive engagement at different levels. The Ministry of Health established a Technical Working Group (TWG) to drive the technical processes, and a Steering Committee (SteerCo) to provide oversight. Both the TWG and SteerCo drew on a wide range of expertise from within and outside of the government. The membership for the Steering Committee and TWG included the following:

- ❖ The Ministry of Health
- ❖ The Council of Governors
- ❖ County Governments (CECs Health)
- ❖ The Kenya Healthcare Federation
- ❖ Health Professional Associations
- ❖ Semi-Autonomous Government Agencies (SAGAS)
- ❖ Development partners
- ❖ SDG Partnership Platform
- ❖ World Bank Group

Gratitude goes to Ministry of Health and the Council of Governors leadership for technical and material support, and the SDG Partnership Platform Steering Committee for useful input at various stages of the process. We thank the PPP Unit team at Treasury for valuable input and Brim Consulting for carrying out the situational analysis that contributed to the TWGs deliberations. Funding and technical support was provided by the SDG Partnership Platform and the World Bank Group.

The lead author of the document was Dr Francis Wafula on behalf of Steering Committee and Technical Working Group, guided by the Ministry of Health and Council of Governors.

A handwritten signature in black ink, appearing to read 'Susan N. Mochache'.

**Susan N. Mochache C.B.S**

Principal Secretary  
Ministry of Health



## LIST OF ACRONYMS AND ABBREVIATIONS

<b>BOO</b>	Build-Own-Operate
<b>BOOT</b>	Build-Own-Operate-Transfer
<b>BOT</b>	Build-Own-Transfer
<b>CSR</b>	Corporate Social Responsibility
<b>FBO HF</b>	Faith-Based Organization Health Facility
<b>Gov. HF</b>	Public Health Facility
<b>KAPH</b>	Kenya Association of Private Hospitals
<b>KEPI</b>	Kenya Expanded Programme of Immunization
<b>KEPH</b>	Kenya Essential Package for Health
<b>KEPSA</b>	Kenya Private Sector Alliance
<b>KHF</b>	Kenya Healthcare Federation
<b>KMA</b>	Kenya Medical Association
<b>KNH</b>	Kenyatta National Hospital
<b>KNHSSIP</b>	Kenya National Health Sector Strategic and Investment Plan
<b>MoH</b>	Ministry of Health
<b>MTRH</b>	Moi Teaching and Referral Hospital
<b>NHIF</b>	National Hospital Insurance Fund
<b>PFP HF</b>	Private for-Profit Health Facility
<b>PPD</b>	Public Private Dialogue
<b>PPADA</b>	Public Procurement and Asset Disposal Act
<b>PPP</b>	Public private partnership
<b>PPP PFF</b>	Public Private Partnership Project Facilitation Funds
<b>PSK</b>	Pharmaceutical Society of Kenya
<b>SAGA</b>	Semi-Autonomous Government Agency
<b>UHC</b>	Universal Health Coverage
<b>VGf</b>	Viability Gap Funding

## DEFINITION OF KEY TERMS ■■

**Contracting authority** A state department [ministry], agency, state corporation or county government which intends to have a function undertaken by it performed by a private party (PPP Act, Section 2)

**Public Private Collaboration in Health (H-PPC)** All arrangements and partnerships between a contracting (public) authority and a private party. These include the PPPs as defined in the PPP Act of 2013 and other forms of collaboration that do not fulfil the PPP requirements. These may include lower value partnerships, service level agreements and information exchange arrangements. The private partner receives a financial or non-financial benefit from the arrangement. Health Public Private Partnerships are one form of HPPC.

**Procurement** Regular procurement from a private party by a contracting authority under the Kenyan Public Procurement and Asset Disposal Act of 2015.

**Public Private Partnership (PPP1)** Arrangements between a contracting authority and a private party governed by the Kenya PPP Act (2013), under which a private party (usually commercial party) undertakes to **perform a public function, receives a benefit** for performing a public function. For PPPs, the benefit is usually through compensation from a public fund or user charges. PPPs involve risk-transfer from the public to the private partner.

**Risk Allocation** Refers to the process of deciding the party that should bear the cost or benefit of a change in the project's outcomes that may arise from respective risk factors. The intention is to allocate risk to the party that is best able to manage it.

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1 Legal definition in Kenya

## EXECUTIVE SUMMARY



**DR PATRICK OMWANDA AMOTH**

Provision of health services is primarily a mandate of the government. However, increased budget strain from rising disease incidence and emergence of global health security threats like Covid-19 underscore the value of cross-sectoral collaboration, which could help expand service coverage, improve efficiency and innovation, and harness additional resources. However, such collaborations require strong government leadership and guidance. It is for this reason that the Ministry of Health (MOH) initiated and led the process of developing the Kenya Health Public Private Collaboration Strategy of 2020.

The Strategy development process included detailed document reviews and consultative multi-stakeholder workshops at different stages. A technical working group (TWG) led the development process, guided by a public private collaboration expert. A three-day workshop delivered the first draft of the Strategy. This initial strategy was reviewed by a wider group of stakeholders, revised accordingly, then discussed, adjusted and adopted at a multi-stakeholder Steering Committee workshop. The final document was then subjected to internal and external validation processes.

The Strategy's Vision is 'a healthy, productive and globally competitive nation achieved through partnerships,' with the Mission being the provision of a framework that fosters transparent, informed and effective engagement between the public and private sector towards promoting access to quality and affordable healthcare. The Strategy proposes achieving these with the guidance of eight principles: Transparency and Accountability; Equity; Integrity; Value for Money; Mutual Beneficence; Inclusivity; Social Responsiveness; Sustainability and Demonstrated Impact on the Health of the Public.

The Strategy identifies six core objectives: (1) Support the creation of a policy and regulatory environment that allows effective private sector participation in meeting public health goals; (2) Leverage private sector efficiency strengths, and innovation and technological capacity to improve public health service delivery; (3) Harness private sector resources and channel them towards equitable financing of public health services; (4) Guide contracting authorities on identifying and prioritizing projects that can deliver better value through collaboration with private partners; (5) Develop mechanisms for effective information sharing to promote transparency and accountability between the public and private health sectors; and (6) Build the capacity of stakeholders to initiate and engage in public private dialogue and establish mutually beneficial collaborations for maximum impact.

A handwritten signature in black ink, appearing to read 'Patrick Omwanda Amoth'.

**Dr Patrick Omwanda Amoth**  
Ag. Director General ,Ministry of health



# CHAPTER 1:

## INTRODUCTION

### 1.1. Background

The Constitution of Kenya 2010 guarantees universal access to the highest attainable standards of the health under the Bill of Rights. The role is allocated to the Kenyan government, whose commitment is outlined in both the Vision 2030 policy blueprint and the Big Four Agenda. However, there is increased recognition that well-structured collaboration with the private sector can deliver additional value.

For this reason, governments must lead effort towards establishing frameworks to guide engagement and collaboration. This underlies the Kenyan government's initiative to develop this Strategy. The Ministry of Health (MOH) led the multi-stakeholder initiative, whose purpose was ensuring that future engagements between the public and private health sectors are well-guided towards delivering public good and doing so without compromising important values like fairness, transparency and integrity.

### 1.2. Public-private partnerships and collaborations

The definition of public private partnerships (PPPs) varies across sectors. However, certain defining features are common in most definitions:

- ❖ Duration - usually long-term arrangements of between five and 30 years;
- ❖ Risk-allocation - a clear risk-allocation process between a public entity and a private partner;
- ❖ Asset transfer – PPPs usually have some form of asset/expertise transfer from the private partner to the public entity at (or before) the end of the contract period;
- ❖ Pay for performance – PPPs usually have agreed on performance indicators against which compensation is pegged fully or in part.

However, the term 'public private partnership' has historically leaned towards infrastructure projects, as opposed to partnerships seen in social sectors such as health and education. This creates some concern whenever the term is used in reference to service-focused arrangements, a common feature of collaborations in health. While infrastructure projects tend to be capital intensive, operations, salaries and commodities consume the bulk of expenditure in health. The implication is that, unlike infrastructure projects, it is possible to have health collaborations that do not necessarily require heavy capital investment. For this reason, the technical working group (TWG) that developed the Strategy opted to call it 'the Kenya Health Public Private Collaboration Strategy', as opposed to 'the Kenya Health Public Private Partnership Strategy'. The intention was to have a framework that has relevance to both the traditional PPP-type of arrangements as well as more granular forms of collaboration commonly seen across social sectors. Box 1 highlights some of the benefits that may accrue from well-structured collaborations in health.



Equally, poorly structured engagements can result in the loss of public resources and other market failures such as the denial of essential services, loss of public confidence and worsening of health-related outcomes. Globally, lack of open and transparent engagement has caused multiple problems, including failure to deliver projects as intended, poor performance and failure to improve services, lack of stakeholder buy-in and community consultation and escalated costs (at times driving governments into financial strain). Problems of corruption and bribery have also been linked to poorly developed collaborations.

### 1.3. The Kenyan context

The Kenyan private sector represents roughly 45% of the healthcare market, although this varies by sub-market. With the emergence of global health security threats such as Covid-19, and concurrent reduction in development assistance for health, the share of private sector funding and provision of health services is expected to increase further.

The private sector is defined to include all forms of legally recognized enterprises, ranging from small establishments operated by one or two individuals to large multispecialty hospitals, diagnostic centres and the pharmaceutical industry. These may be operating for-profit or may be not-for-profit entities. The majority of Kenyan healthcare facilities are owned by the for-profit sector (Master Facility List, 2019), including all forms of providers, from small establishments operated by one or two individuals to large multispecialty hospitals and diagnostic centres. However, it is worth noting that while most healthcare facilities are small private commercial enterprises, the public sector serves larger volumes of patients, because public facilities tend to be larger in size and appeal to large sections of the communities. On the other hand, the public facilities at times provide limited care, forcing public patients to seek additional services (for instance, laboratory of diagnostic services and purchase of certain medicines) at private facilities.

#### **BOX 1: Benefits of well-structured public private collaboration**

- Can harness private sector efficiencies learned through years of operating in competitive environments and direct them towards delivering public services.
- Collaborations can harness private capital and encourage private firms to invest in projects they would have deemed unfavorable. This allows governments to free up resources for more urgent uses. Collaborations may also enable public entities to engage in projects that carry benefits over long periods of time.
- Collaborations can promote trust and accountability through objective performance assessment. Separating service delivery and monitoring functions improves objectivity. This differs from the normal short-term procurement processes where the public entity becomes both the service provider and evaluator, thus creating situations where they may not monitor themselves effectively or objectively.

- Collaborations can unlock innovative solutions and encourage ‘out-of-the-box’ thinking. Private entities may also have access to newer technologies including those under patent, which could be quickly availed for public benefit.
- By focusing on life cycle costs (costs over a long period), long term collaborations encourage better use of resources. For instance, when a private firm is contracted to construct and operate a facility, they are likely to do it in such a way that operations will be optimized in the future, allowing them to run the facility at low cost post-construction. At the end of the contract, the public entity will inherit an efficient facility, thereby enjoying residual benefits beyond the life of the contract. This kind of benefit would not be possible for a short-term procurement project, where both the government and private firm’s focus is on delivering the facility.
- Collaborations can allow public benefit from private skill and expertise without the need to invest in training and capacity building. This is particularly helpful in health and other social sectors, where prohibitive costs of developing capacity for low demand services remain a major barrier. For services that are rarely used, collaborations can provide a long-term solution to governments.

Challenges across the Kenyan health system include low numbers of skilled staff, inadequate enforcement of standards and regulatory provisions and inadequate and dilapidated infrastructure and facilities necessary to provide needed care. In addition, excessively fragmented supply chains and low coverage of health insurance contribute to high out-of-pocket costs, denying care to poorer groups. All these are happening at a time when there are increased risks of global pandemics and a growing burden of non-communicable diseases such as diabetes, cancer and hypertension.

It is for these reasons that the government and other stakeholders in health are now, more than ever, keen on developing a framework to promote well-structured engagement and collaboration between the public and the private sectors. Public private collaborations are not a new phenomenon in Kenya. They have existed in various forms and sizes over the past decades.



# CHAPTER 2:

## SITUATION ANALYSIS

### 2.1. Introduction

A situational analysis was done to understand current realities with respect to public and private sector collaborations in Kenya. This section looks at the situation from reviewing multiple reports and interviewing stakeholders. The objective was to understand the current status and define important areas for collaboration.

The 2013-2017 Health Sector Strategic Plan defined the private sector as comprising of ‘organizations and individuals working outside the direct control of the government, including for-profit organizations (companies and individuals) and not-for-profit organizations.’ To ensure consistency in meeting the health sector goals, this Strategy document adopts a similar definition.

#### **BOX 2: Defining the private sector in Kenya**

‘The private sector comprises of organizations and individuals working outside the direct control of the government, including for-profit organizations (companies and individuals) and not-for-profit organizations. In the health sector these may include medical practitioners, diagnostic centers, ambulance providers and health institutions such as hospitals and clinics, pharmaceutical companies, healthcare insurers and community-based welfare organizations.

*Ministry of Health, Kenya*

The definition covers a wide array of actors, including medical practitioners, diagnostic centres, ambulance providers and health institutions such as hospitals and clinics, pharmaceutical companies, healthcare insurers and community-based welfare organizations.

### 2.2. Public private engagement in health

To streamline the health sector and harness private sector strengths, governments make effort to improve private sector engagement through formalized public-private dialogue (PPD) initiatives. For Kenya, an early effort to institutionalize PPD in health was demonstrated under the Public Private Partnership for Health-Kenya (PPP-HK) initiative in 2009 (1). Since then, there have been other efforts to engage the private sector. Most notably, in 2013, through the Kenyan Private Sector Alliance (KEPSA), the government and private sector formed a framework for PPD at the macro level in health (2). Presently, the private sector in health is represented under the Kenya Healthcare Federation (KHF), which serves as the health sector board for KEPSA.

The Kenya Healthcare Federation represents private organizations of varying size and mandate, ranging from large multinationals to small and medium-sized care providers. These include professional associations and societies, associations of hospitals and healthcare facilities, social franchise networks, multinational drug



companies, pharmaceutical distributors and wholesalers, original equipment manufacturers, diagnostic supplies distributors, health insurance companies, private equity firms investing in hospitals and other healthcare businesses, funders and healthcare providers.

Under KHF, public private dialogue happens regularly through the Ministerial Stakeholders Forum (MSF) and the Presidential Round Table (PRT) at national level, and the County Stakeholder Engagements (CSEs) at the sub-national level. In addition, there are ad hoc meetings with various stakeholders over a wide range of issues including bilateral engagements with different government agencies.

The engagement has contributed to a positive investment climate for healthcare in Kenya, attracting additional investment to the sector, including foreign direct investment. From an operations perspective, regular dialogue and engagement with public entities is conducted through six KHF committees, partly modelled along the World Health Organization's health systems building blocks. These are human resources for health (HRH); health governance (regulation, quality management and standards); healthcare financing; information technology in healthcare (ICT and mobile health committee); public private partnership (PPP) committee; and supply chain. The PPP committee is involved directly in policy engagement on PPP matters.

Moreover, the Government, with support of partners, has established action-oriented partnership platforms that focus on healthcare to accelerate attainment of Kenya's development priorities. In September 2017, The Government of Kenya announced at the UN General Assembly the establishment of the SDG Partnership Platform. The Platform has since become a flagship programme under Kenya's official UN Development Assistance Framework 2018-2022 with the Government of Kenya and received global recognition as a best practice model to accelerate SDG financing.

Despite effort to strengthen collaboration, there are concerns that engagement at times happens at the national level, yet health services are devolved to counties. Stakeholders interviewed emphasized the need to strengthen county-level PPD for sustained results at the service delivery level.

### **2.3. Health collaborations in Kenya**

Despite evidence of public private dialogue in health, there is little PPP activity in the Kenyan health sector. According to the PPP Unit at Treasury, there were only two approved PPP projects under preparation in 2019: the Kenyatta National Hospital (KNH) 300-bed hospital (feasibility study completed) and the Pwani University's Teaching and Referral Hospital (procurement of transaction advisor was underway). Other projects on the Unit's radar included an accommodation project for KNH and a primary healthcare PPP project that involved the Makueni County government, AMREF and Philips (discussions were still underway by mid-2019). At the county level, three projects were lined up for technical assistance by the PPP Unit at treasury: a 350-bed multi-speciality hospital in Nyamira County; a 200-bed private wing for the Kisii County Referral Hospital, and a cancer centre at the Meru County Referral Hospital. Other collaboration arrangements were in their infancy.



There were also other long-term collaborations that did not necessarily fulfil the PPP criteria. An example was the Managed Equipment Services (MES), a seven-year bundled service purchasing contract held with original equipment manufacturers (OEMs). Under the contract, the OEMs were to provide, maintain and replace medical equipment, train staff on usage and decommission and/or handover functional equipment at the end of the period. The contract covers 98 public hospitals under a structured performance-based payment plan for over seven years. The project was reported to have faced some challenges, mainly linked to insufficient stakeholder consultation. For instance, halfway through the contract period, there were equipment that had not been installed due to the absence of three-phase power at selected hospitals. There were also areas where equipment was underutilized due to the absence of qualified personnel.

In Isiolo, the County Government was working on a co-financing contract with Living Goods, a social enterprise, to manage community health services over a period of four years. The purpose was to have Living Goods provide expertise to strengthen existing community health structures and equip over 700 community volunteers to deliver customized services to households.

Not surprisingly, most PPPs in the pipeline had a strong infrastructure component, being variants of the build-operate-transfer model. However, early indications were that these could have morphed into integrated PPPs, with both an infrastructure and operations components. The concessionaire for the 330-bed capacity Kenyatta National Hospital (KNH) PPP contract, for instance, was expected to manage both clinical and non-clinical components over a specified period.

What was conspicuously missing were discrete clinical services PPPs, or PPPs that were purely based on service and/or management contract models. This reflects experiences reported elsewhere, where infrastructure PPPs dominate. Yet the health sector is unique in the sense that the bulk of expenses are recurrent rather than capital. Based on this observation, one can conclude that there is an overall lack of practical experiences with collaborations that seek to harness alternative private sector strengths such as operational efficiency and innovation capacity.

This is not to say that the private sector isn't engaged at all. Multiple forms of non-PPP collaborations were reported, ranging from private sector inclusion in county planning activities to service-level arrangements involving purchasing of staff time, commodities and equipment, and outright contracting out of services to the private sector. Private sector collaborations in service provision and supplies was primarily through short term arrangements governed under the traditional procurement processes (the Public Procurement and Asset Disposal Act of 2015). More structured collaborations such as service purchasing rarely moved beyond the pilot phase, reflecting challenges in institutionalizing innovative partnerships in an inadequately guided policy environment. In addition, development partner support was often a key driver, raising questions over ownership, sustainability and potential for scale-up.

While most current collaboration do not necessarily meet the requirements for a PPP arrangement under the PPP Act (see section 3.1), they carry a lot of significance for the health sector and must therefore be considered as strategic ways of expanding access to efficient and quality health services. That said, risk-transfer is harder for short-term arrangements. As a result, they may not always deliver the full benefits that

come with PPPs. For instance, it may be hard to guarantee quality when private actors are engaged in short transactional (one-off) projects and have little stake in the long term. PPPs are structured to circumvent this problem through risk-transfer and performance-based payment mechanisms, which means that the private partner is incentivised to keep costs down and deliver quality over longer periods of time.

There were concerns that PPPs, in their current form, could not support system-wide transformation of the health sector. Stakeholders interviewed noted that partnerships needed to evolve from the traditional task-based models to those that entailed joint planning, coordination and implementation, a concept that the World Economic Forum refers to as ‘the ecosystem approach to partnerships’ (4).

The *ecosystem approach* involves getting stakeholders to mobilize around a common goal, each contributing its core skills, with strong government stewardship and oversight. It requires that sporadic or transactional partnerships are avoided. Instead, strategic arrangements must be put in place. Arrangements that are rigid enough to maintain the course, but, flexible enough to adjust accordingly when needed to achieve optimal outcomes. This requires that interaction between the public and private sector actors be better structured and guided, with a focus on openness and transparency.

At sub-national level, the analysis found a lack of awareness among counties on PPPs. Counties lacked expertise to initiate and implement PPPs, a situation made worse by a lack of trust between the two levels of government in some places, particularly on private sector engagement. Counties were unsure on the range of collaborations permitted by law and how they were governed, for instance, which models were subject to the PPP Act of 2013, and which ones could work under normal procurement statutes governed under the Public Procurement and Asset Disposal Act of 2015.

There were no structured private sector engagement capacity building processes targeted at counties. Aside from what is prescribed in the PPP Act of 2013 and public procurement law (the Public Procurement and Asset Disposal Act of 2015), there was no formal or standard procedure, process or toolkit to guide counties and other contracting authorities on initiating and implementing PPPs (3). Engagements that did not involve a financial compensation – such as human resource exchanges and training programs, in-kind subsidies and corporate social responsibility (CSR) programs – were found to be heavily dependent on individual initiative and drive, and, were typically structured according to the circumstances and partners involved, often informally. For these reasons, stakeholders recommended that a Public Private Collaboration Resource Guide be developed alongside the Strategy to help in building capacity on collaborations.

## **2.4. Stakeholder views on health PPPs**

This section reports experiences, opinions and messages from a separate assessment of the state of public private sector engagement in Kenya after devolution (2013-2019). Some of the information included comes from in-depth interviews with key stakeholders and reviewing key documents. The full assessment report is available as a separate reference document (3).



### **2.4.1. Experiences with public private engagement**

There have been notable achievements in public-private engagement, including (but not limited to): the Managed Equipment Services (MES) scheme delivering diagnostic and treatment services that would have been unaffordable; AMREF and Philips primary healthcare units in Makueni; Living Goods and Healthy Entrepreneurs supporting government to provide subsidized products at community level; Safaricom and Huawei exploring opportunities for increasing access to health training and services through tele-Medicine, various large pharma engaging in access to medicine programming, PharmAccess and Carepay's M-TIBA supporting NHIF registration and client management, and a private commercial tea company establishing and supporting a healthcare facility in a county among others.

Interviews conducted with stakeholder at county level revealed both a suspicion between the public and private sectors and an overall willingness for more engagement. Overall, the public private engagement was periodic, rather than continuous and systematic engagement, with most seeing corporate-social responsibility (CSR) activities as the main point of engagement. Examples included activities such as a diabetes walk or educational campaigns on specific diseases, medical camps held at community level with private sector donations. Suspicion was reported across the two sectors. The absence of clear rules for promoting engagement was also mentioned, as were concerns over the lengthy and bureaucratic provisions of the PPP Act.

The underlying nuances suggested a strong belief that government business is restricted and that the private sector only comes in as a last resort option. Overall, while public private engagement was reported, the absence of a proper engagement strategy and toolkit was perceived to be a major barrier.

Issues of corruption were also raised, particularly regarding public sector actors at county level. These were reported to have contributed to stalling of potential PPP arrangements. Private actors complained over massive payment delays, which they said caused them to be reluctant to engage in long-term PPP arrangements. Some counties formally engaged actors (including private commercial actors) in workshops aimed at generating ideas to help set up county-level PPP nodes.

Another major challenge reported was what was described as poor delineation of roles across the two levels of government. Certain services are a shared function, for instance, blood transfusion services, which put an additional layer of bureaucracy where establishing PPPs is concerned. Overall, stakeholders across public and private sectors, and the two levels of government, expressed a strong desire for accessible tools and guidelines for public private engagement and partnerships.

### **2.4.2. Achieving more effective engagement**

In Africa, Kenya ranks highly in having a conducive environment for investment, including private healthcare businesses. Drivers include a growing economy and middle-class, progressive regulatory environment that allows corporate ownership of healthcare businesses, structured engagement between the public and private sector representative groups, and availability of fundamentals for business and industry, including real estate,

reliable energy supply and relatively good infrastructure (particularly in more urban locations), compared to most other sub-Saharan African countries.

However, there was an overall feeling that the private sector's potential was untapped. Challenges include demand side factors (for instance, low insurance coverage and low demand for quality), supply side factors (excessive fragmentation of businesses such as small primary healthcare facilities, retail pharmacies and laboratories), and policy and governance-related factors (corruption, poorly streamlined regulation, including replicative registration and licensing requirements for personnel and premises). Yet effective engagement of the private sector requires that there be well-coordinated mechanisms that deliver financially sustainable holistic solutions that harness public and private sector strengths. Previous analytical work, including the 2019 post-devolution assessment, identified the following as priority steps towards achieving more effective engagement of the private sector:

#### ***2.4.2.1. Better guidance to counties on engaging and partnering with private sector***

Health services management and provision are devolved to counties. It is expected that the mandate of counties will continue expanding, therefore requiring additional investment. Stakeholders expressed an urgent need to develop proper guidance, tools and mechanisms to make it easy for counties to engage the private sector at different capacities. These should be responsive enough to inter-county variations, and easy enough for county-level stakeholders to take up and utilize. However, national-level support should continue being available as and when required.

The counties, on their part, should explore ways of harnessing private sector capital and capacities. They should identify areas of need, examine the full range of alternatives, conduct pre-feasibility studies (where potential PPPs exist) and define the model(s) that would be most appropriate for their respective health needs. There were proposals for counties to consider having focal person(s) to engage with investors and other relevant bodies such as the PPP Unit at Treasury and the PPP Node at MOH.

#### ***2.4.2.2. Stronger focus on quality, patient safety and acceptable outcomes***

There were suggestions for the establishment of mechanisms for creating and enforcing patient safety and quality standards for health services and products across sectors. Stakeholders recognized the absence of strong evidence to show whether PPPs resulted in better outcomes and/or how they could be strengthened for higher impact. Some even felt that PPPs may result in no benefit, especially when implemented in a transactional way.

#### ***2.4.2.3. More emphasis on equity when engaging the private sector in health***

Developing mechanisms to promote financial inclusivity was seen as a way of promoting private sector contribution towards UHC. Such strategies could include scaling up insurance to eliminate the need to pay for services at the point of use. Presently, the bulk of service users visiting private facilities are forced to pay out



of pocket, resulting in impoverishment and financial barriers to access. This can be eliminated by separating the provision and purchasing functions and scaling up appropriate demand-side financing mechanisms. Out of pocket payment is simply not a smart option for health services.

#### ***2.4.2.4. Increased public investment in health-related PPPs***

Private finances are more likely to be channelled towards areas that the public entities see as key priority investment areas, including those that the government has shown a willingness to fund/co-fund. This happens a lot in mega infrastructure projects and a lot less in health and other social sectors.

Various reasons contribute to the disparity, including the political appeal of visible assets and the ease of structuring and obtaining financing for infrastructure projects. There is much less experience in structuring management contracts and discrete clinical services PPPs, for instance, yet these have potential to strengthen health services for better outcomes. There is a strong need to develop mechanisms that promote responsible investment of public funds in partnerships that could benefit from other private sector strengths such as facility operations and innovation capacity.

#### ***2.4.2.5. Improved policy and regulatory environment***

Overall, the Kenyan policy and regulatory environment is conducive for private sector activity. However, there was a general feeling that the emphasis for PPP-related legislation and policies is on mega, capital intensive projects that fit better for energy and transport sectors for instance. However, some informants argued that this may be more of a perception than reality, and that in fact, the health sector can exploit existing legislation to achieve strong partnerships. The overall view, nonetheless, was that the government should further improve the regulatory environment and encourage better elaboration of statutory boundaries through sector-specific policies, strategies and instruments. These would promote institutional capacity to initiate discussion, structure contracts and manage risk. The feeling was that priority should go towards creating an environment that is flexible enough to allow innovation in response to changing contexts and inter-county variabilities. There were also suggestions for government to engage with financing institutions and allow necessary statutory amendments to encourage them to support private healthcare enterprises that are providing priority public services.

#### ***2.4.2.6. Encouraging consolidation in private healthcare markets***

Fragmentation continues to hamper, not only responsible engagement of the private sector, but also effective delivery of healthcare services. Overly fragmented markets have a higher risk of inefficiencies and perverse competition, which has been linked to poor quality of care and compliance to standards. Promoting consolidation of certain markets (e.g. retail pharmacies) through regulation and market incentives has potential to harness better services from the private sector.



## 2.5. SWOT Analysis for private sector participation in health

### Strengths

- ❖ Existence of PPP legal, policy, regulatory and institutional framework
- ❖ Existing public-private engagement
- ❖ Additional source of resources into the health sector
- ❖ Private sector permeation has allowed expanded access to health services
- ❖ Private providers known to have higher responsiveness to client needs
- ❖ Providers work amid competition, thus have stronger operations and systems
- ❖ Higher incentive to keep proper records, which has potential to contribute to better sector stewardship

### Weaknesses

- ❖ Evidence of poor quality of services, particularly among small rural providers
- ❖ PPP Act not focused on health/services
- ❖ Limited awareness on PPP framework
- ❖ Private sector fragmentation resulting in harmful competition practices
- ❖ Tension between professionalism & profit among private providers
- ❖ Limited expertise on initiating and stewardship of PPPs among counties
- ❖ Inequity risk higher with private sector provision in the absence of insurance
- ❖ Private sector pulls staff time from public due to poor controls

### Opportunities

- ❖ UHC is a top national priority
- ❖ Government commitment to improving private investment climate
- ❖ Relatively stable political environment
- ❖ Growing middle-class and aging population in need of healthcare
- ❖ Strong public acceptance of private sector provision of health services
- ❖ Growing number of local financing and investment institutions
- ❖ Availability of large numbers of well-trained health staff across the country
- ❖ Strong technological and innovation capacity across the country
- ❖ Established roles for national and county governments mean there is increased scope for engagements.

### Threats

- ❖ Some suspicion in relationship between counties and national government
- ❖ Lack of a strong enforcement mechanism for cross-county initiatives
- ❖ Absence of regulatory framework for e-health – risky for innovators should regulation come up suddenly
- ❖ Poor economic climate in the country – limiting private sector business
- ❖ Poor interlinkages to public systems resulting in inadequate reporting to government and sharing of information
- ❖ Poor regulation of private providers contributing to quacks in the market
- ❖ Concerns over value for money, linked to mistrust over existing PPC arrangements like the MES project.



## **2.6. Health Sector Collaboration Priorities**

Following the situational analysis and SWOT analysis, key priority focus areas and activities were identified by stakeholders for the Strategy. The general view was that strategic objectives should focus less on the characteristics of different models, and more on defining the needs and understanding what different arrangements can deliver whilst ensuring the products align to priority national goals and are sustainable and replicable across areas/regions/counties. The following emerged as particularly important factors to guide deliberations on partnerships in healthcare.

### **2.6.1. Adopting an ecosystem approach to partnerships**

Present experiences depict PPPs as one-off transactional interactions arising from an urgent need to provide a public service in the absence of funding. This thinking will need to change. The focus must, instead, be delivering value for the people, which in turn requires that collaborations focus more on outcomes, whilst ensuring process integrity, transparency and accountability. The ecosystem approach emphasizes joint planning and prioritization under strong government stewardship. This mirrors provisions in the PPP Act of 2013, that require that sector analyses are done to inform partnerships.

### **2.6.2. Emphasizing outcomes rather than transaction inputs and processes**

Unlike the transport, energy, infrastructure and other capital-intensive sectors, healthcare is operations cost-heavy, with more than three-quarters of expenditure going towards human resource for health and health products and technologies for instance. A collaboration strategy must therefore move beyond the infrastructure-type of arrangements that are strongly focused on inputs, and instead, look at how private sector strengths can be channelled towards strengthening operational aspects of health systems. This means focusing on inputs, processes and outcomes that have been shown to deliver value.

### **2.6.3. Encouraging integrated PPP models**

There is value in learning from experiences elsewhere, particularly for health collaborations. While there is some experience with build-operate-transfer PPP models for health, evidence of impact is limited. There are suggestions that infrastructure heavy PPPs in health work better if combined with service elements. The argument is that partnerships that combine infrastructure and operations/management incentivise the private partners to be more forward-looking in designing and developing infrastructure that can more easily allow optimization of operations and service delivery, thereby lowering operations costs over the lifetime of the project. They may even be willing to do that in cases where they incur higher costs at the initial stage to lower operations costs in the future. That increases the likelihood of the public entity taking over optimized projects at the end of the partnership period.

### **2.6.4. Focusing more on primary healthcare services**

Primary health services are greatly underfunded in Kenya, yet evidence indicates that they have the highest



potential for improving outcomes over time (5). Overall, PPP arrangements to date have scarcely explored strengthening PHC. The value of focusing PPPs on mega projects is sensible. It seeks to harness capital from private sources to complement the strained government budget. However, there are concerns that excessive focus on capital-heavy projects ignores the importance of collaborative efforts towards strengthening PHC, which can benefit from other private sector strengths, for instance, technological capacity. Worse still, infrastructure projects are more likely to generate negative publicity, particularly when perceptions of vested interests emerge. In the end, partnerships risk being viewed in negative light, forestalling potential benefits from other private sector strengths.

### **2.6.5. Defining a clearer stewardship role for counties**

Policy making is a mandate of the national government, albeit with input from counties and other partners. However, lines are increasingly blurring following devolution of health service delivery. There is recognition that intercounty variations and differences in priorities requires that counties have a bigger say on policy matters affecting them. Further, the national government has made effort to share certain functions with counties, underscoring MOH's commitment to making devolution of health services work. That means that the Collaboration Strategy must, from an operations perspective, carve out a stronger and clearer role for counties, emphasizing the need to strengthen their capacity to drive the partnerships agenda. This does not negate the need for a continuous engagement with the national government (particularly the PPP Unit at Treasury and PPP team at MOH) from the time of conceptualizing partnership ideas through to the project identification and development stages.

The success of PPCs in health in Kenya will strongly depend on how the roles of the three central players (National Treasury PPP Unit, MOH PPP Team and County Governments) are defined and how the three work together to commission collaborations in health. The institutional arrangements, including where necessary, the legislation being put in place, need to be clear on this.



# CHAPTER 3:

## POLICY, REGULATORY AND INSTITUTIONAL FRAMEWORKS

This section discusses the collaboration frameworks for health Kenya under two broad sections. The first presents the legal, policy and regulatory frameworks, while the second discusses the institutional framework. The idea is to understand the PPP ecosystem, and appreciate how it can be applied to health projects that both meet the PPP threshold requirements, and smaller collaborations that entail public private engagement, but do not necessarily meet the threshold. Regardless of the nature or scale of collaboration, all stakeholders must ensure they have a clear understanding of the PPP frameworks. Conflicting with statutory partnership laws would invalidate any collaboration. For that reason, this section is mainly focused on highlighting the PPP statutory and institutional frameworks. Figure 3.1. shows the overall PPP process for Kenya as governed under the PPP Act of 2013, and other supporting legislation discussed under section 3.1.

### The PPP Processes (PPP Act of 2013)

The Public Private Partnership Act of 2013 (PPP Act) defines the key procedures to be followed for PPPs in Kenya. This flow diagram puts all the key processes into four phases for easier understanding.



Source: Wafula F (2019)

Figure 1: Stages of a typical PPP process

### 3.1. The legal, policy and regulatory framework for health collaborations

#### 3.1.1. Overview of the legal, policy and regulatory framework

Table 1 provides a summary of the legal, policy and regulatory framework governing health collaborations (PPPs) in Kenya.

Table 1: Legal, policy and regulatory framework for Health PPPs

Legislation or policy	Institution	Provisions
PPP Policy Statement (2011)	PPP Committee	<ul style="list-style-type: none"> <li>Defined and outlined principles for PPPs, and provided for the enactment of the PPP Act, formation of PPP Committee, and establishment of a PPP project Fund in the coming years.</li> <li>an Act of Parliament to govern PPP arrangements</li> <li>Spelt out what the PPP process under the Act should look like, including risk allocation and contractual arrangements.</li> </ul>
PPP Act (2015)	General PPP Committee PPP Unit (Treasury) PPP Node (MOH)	<ul style="list-style-type: none"> <li>Defines PPPs and establishes and spells out the roles for the PPP Committee, PPP Unit (Treasury) and PPP Node (Ministerial level)</li> <li>Determines the PPP project identification process.</li> <li>Determines the process for handling solicited and unsolicited partnerships</li> <li>Established the project facilitation fund</li> <li>Specifies the functions of the committee to include formulating policies, ensuring PPPs mirror national priorities, approving PPP projects and funding support from treasury, oversee the PPP Unit, and coordinate legislation review among others.</li> <li>Established PPP Unit under Section 11. Specifies functions of the Unit to act as the technical arm of the PPP Committee, with roles that include building capacity on PPPs, conducting civic education, maintaining inventory of PPPs, developing a transparent process for PPPs, doing research on PPPs and assisting in various ways, the public entities wishing to engage in PPPs, among others.</li> <li>Established PPP Node in Section 16, specifying its roles to include supporting contracting authorities on PPP matters such as identifying and prioritizing PPP projects, appraising projects to ensure they meet social, commercial, legal and economic viability thresholds, and support authorities in tendering processes etc.</li> </ul>
PPP Regulations (2014)	PPP Unit (Treasury)	<ul style="list-style-type: none"> <li>Elaborates in detail the membership and roles of the PPP Nodes</li> <li>Guides PPP processes beyond the identification step (covered in the PPP Act). Elaborates on project preparation and appraisal, engagement and role of transaction advisors, procurement processes for PPPs, dealing with privately initiated investment proposals and project facilitation funding from Treasury.</li> </ul>



<p>Public Procurement and Asset Disposal Act (PPADA) (2015)</p>	<p>Public Procurement Regulatory Authority</p>	<ul style="list-style-type: none"> <li>▪ Establishes the Public Procurement Regulatory Authority (PPRA) and Board, spelling out membership and roles. Roles include monitoring public procurement and asset disposal, enforcing standards, providing technical support on procurement and disposal matters and investigating complaints.</li> <li>▪ Establishes the Public Procurement Administrative Review Board, spelling out membership &amp; roles. Reviews and determines tendering/asset disposal disputes.</li> <li>▪ Spells out county government roles in procurement and disposal, and, outlines the organizational structure of procurement entities at national and county level.</li> <li>▪ Establishes procurement rules, methods and procedures among others.</li> </ul>
<p>Public Procurement and Asset Disposal Regulations (2016)</p>	<p>Public Procurement Services Agency Board (PPSAB)</p>	<ul style="list-style-type: none"> <li>▪ Establishes the institutional framework for public procurement (PPSAB)</li> <li>▪ Spells out county roles in procurement more clearly, including set-up of procuring entities and development of procurement contracts</li> <li>▪ Spells out the basic procurement rules for all public entities.</li> <li>▪ Expounds on the classification of procurement methods.</li> <li>▪ Spells out inventory control and management and disposal of public assets.</li> </ul>
<p>PPP (Project Facilitation Fund) Regulations 2017</p>	<p>PPP PFP Secretariat PPP Committee PPP Unit</p>	<ul style="list-style-type: none"> <li>▪ Spells out the functions of the PPP-PFF to include supporting contracting authorities (public entities wishing to enter into PPP arrangements), supporting the PPP Unit activities, providing viability gap funding (VGF) for eligible projects and helping to meet contingent liabilities from projects.</li> <li>▪ Provides details on how the support applies to all the above.</li> <li>▪ Specifies that contracting entities must have a node to benefit from Fund, and that project in question is already on the approved PPP list.</li> <li>▪ Specifies that VGF is only available for capital costs and recoverable land acquisition costs, that the award needed to have been competitive, and that services will be provided against user charges (or some sort).</li> <li>▪ That the Treasury CS may approve other VGF criteria when need arises.</li> </ul>
<p>Kenya Health Policy (2014-2030)</p>		<ul style="list-style-type: none"> <li>▪ Policy Objective 6 - strengthening collaboration with private sector for impact.</li> <li>▪ Policy principle 3 highlights to governments intention of partnering with the private sector to expand geographic access and range of services.</li> </ul>

Health Act (2017)		<ul style="list-style-type: none"> <li>▪ Recognizes that the Kenyan health systems has public &amp; private institutions at national &amp; county, and, gives public and private providers equal mandate.</li> <li>▪ Gives the national government the duty of promoting the development of public and private institutions to meet health goals, and to provide policy guidelines for PPPs for health to enhance private sector investment.</li> <li>▪ Sections 23 and 92 clarify that nothing under the Act prevents national &amp; county governments from entering into PPPs to improve health services, and further says that CSs, Governors, Counties or facilities can may partner with private companies to serve public health goals.</li> <li>▪ Sections 60 talks of equal application of standards for public and private facility, with Section 86 spelling the intention to optimize use of private health facilities to relieve public sector burden</li> </ul>
County Governments Act (2012)		<ul style="list-style-type: none"> <li>▪ Section 6 gives counties power to enter into partnerships with private entities for any work, service or function, as long as they comply with PPP-related laws.</li> <li>▪ Section 87 requires counties to use public-private partnerships as one of the principles for strengthening citizen engagement.\</li> </ul>
Public Finance Management Act (2012)		<ul style="list-style-type: none"> <li>▪ Guides management of finances by the national and county governments</li> <li>▪ For counties, Section 109 establishes the County Revenue Fund into which all moneys raised should go. However, exemptions supported by other statutes are exempted, meaning revenues from PPP arrangements may be retained and used for specified purposes instead of being banked in the CRF account.</li> </ul>

The main legislation governing PPPs in Kenya is the PPP Act of 2013, operationalized further through the PPP Regulations of 2014 and the PPP Project Facilitation Fund Regulations of 2017. The PPP Act was established following a 2011 Policy Statement signed by the Treasury Cabinet Secretary. The three pieces of legislation establish institutions and mechanisms for governing PPP arrangements across sectors, as summarized in table The Public Procurement and Asset Disposal Act (PPADA) of 2015 sets rules to govern all matters related to procurement and establishes two key institutions to oversee these; the Public Procurement Regulatory Authority (PPRA – body for guiding, monitoring and advising on procurement activities) and the Public Procurement Administrative Review Board (body to listen to complaints and appeals). Prior to enactment of the PPP Act, preceding procurement legislation guided the bulk of public private engagement activities. That still works to date. Some partnerships may not meet the PPP threshold, and would be sufficiently governed under the PPADA of 2015.

The PPP framework is adequately designed to cater for all sectors, including social services and health. However, concerns have frequently been raised over what is seen as a strong emphasis on projects with high capital costs and recoverable land assets, which often provide strong collateral. For this reason, and others, the PPP Act is presently under review in parliament.



The County Governments Act of 2012 gives counties power to enter into partnerships with private entities for any work, service or function, provided they comply with PPP-related laws. The Act encourages counties to view PPPs as a vehicle to strengthen citizen engagement. The Public Finance Management Act on the other hand establishes the County Revenue Fund to serve as a collection account for all county activities. However, the Act gives exemptions for provisions supported by other legislation, including the PPP Act. That means that counties can partner with private contractors to set up special purpose vehicles (project companies) to facilitate implementation of PPPs, and that funds can be collected into these accounts for services rendered.

As far as the health sector is concerned, the main legislation is the Health Act of 2017, established to operationalize provisions of the Kenya Health Policy 2014-2030. Both the Act and Policy emphasize the importance of public private sector engagement and collaboration to achieve the sector's health goals. Two provisions in the Act back PPPs. First, the Act mandates the national government to coordinate the development of guidelines for PPPs in Health. Secondly, it specifies that counties and national public entities may enter in PPP arrangements to support the achievement of health goals.

### **3.1.2. Partnership models under the Kenyan laws**

In Kenya, public private partnership arrangements are primarily governed under the PPP Act of 2013, supported by the PPP Act's Regulations of 2014 and the PPP Project Facilitation Funds of 2017. However, partnerships may also be governed under the Public Procurement and Asset Disposal Act of 2015, which carries provisions for procurement, including service contracting. There are not clear boundaries on which laws apply to which situation; however, experience dictates that smaller contracting arrangements prefer going the PPADA way, as it is primarily focused on the transactional aspects of the arrangement, as opposed to the PPP Acts which carries extensive provisions better suited for high-Dollar value projects (particularly infrastructure projects).

The Kenyan laws recognize a broad range of partnership arrangements. These are discussed below, in order of the level of risk-transfer from the public to the private partner.

#### **3.1.2.1. Management contracts and output performance-based contracts**

According to the Kenyan laws, these two represent arrangements with the lowest transfer of commercial risk from public to private entities. Under such contracts, the private partner performs a limited service over a fixed period. The contract may specify a fixed payment to be made so often, giving the public entity cost certainty and better budget control. It also transfers service risk from the public entity to the private partner, meaning that any cost variations would be borne by the latter. They are (usually) relatively easy to implement due to the low commercial risk-transfer. However, they may not have enough appeal for the public sector in low-resource settings, who see public-private partnerships as a vehicle for tapping into private capital to fill short-term budget gaps. Management contracts generally require that there be existing infrastructure.

Management contracts vary in scope, from a narrow offering (sometimes called 'service contracts') to relatively larger contracts covering operation, maintenance and management (referred to locally as 'output performance-based contracts'). The Kenyan laws have a 10-year cap for management contracts. The private

partner is usually not expected to make significant capital investment in the facility. The focus is day to day/ routine activities necessary for operations of a facility. However, for healthcare, the management contracts may cover clinical or non-clinical services. An example of a simple management contract may be contracting out client registration and/or queue management services at a hospital, where a private firm provides and operates electronic registration or queue management systems.

### **3.1.2.2. Lease and concession contracts**

Under a lease arrangement, rights over an asset are transferred from a public entity to a private partner over a specified period, with the latter paying rent or royalties. Assets may include infrastructure, equipment or both. The private entity operates the facility over the contract period, which is capped at 30 years under the Kenya PPP Act of 2013. The private partner may collect user fees (where applicable) with guidance from the public entity. The private partner is usually not expected to make capital investments but will meet operations and maintenance costs. Under lease contracts, the bulk of the investment risk remains with the public entity, although the private partner absorbs considerable commercial risk. The private sector investment is generally lower than that for a concession or build-operate-transfer model, meaning the bulk of investment risk remains with the government.

Under a concession, a public entity confers full rights of a public utility asset to a private partner (concessionaire), who then provides services to the public on behalf of the public entity. The concessionaire is directly linked to the service users, providing services and where applicable, collecting fees. The concession model is similar to the lease model, except for the fact that the concessionaire will be expected to make capital expenditure on infrastructure. For that reason, concessions demand significant private sector investment in construction, operation and maintenance, which in turn, implies higher risk transfer. Concessions often cover the entire utility value chain, which makes them relatively heterogeneous (meaning they may demand different inputs at different points).

### **3.1.2.3. Build-operate-transfer models**

The BOT models generally represent the greatest commercial risk transfer PPP arrangements. As the name suggests, they involve significant investment in construction and rehabilitation of infrastructure. There are variants to the BOT model, including the Design-Build-Finance-Operate-Transfer (DBFOT) contract, where the private partner is responsible for the listed functions for an agreed period, after which the facility reverts to the government. Other variants include the Build-Own-Operate (BOO), the Build-Operate-Transfer, the Build-Lease-and Transfer, Rehabilitate Operate Transfer, the Rehabilitate Own Operate, the Design-Build-Finance-Maintain-Operate, the Build-Own-Operate-Transfer among others. These models typically aim to expand infrastructural capacity for public services, renovate and/or refurbish existing infrastructure, and improve the quality of services offered.

## **3.1.3. Partnership classification in healthcare – global experiences**

The traditional PPP classifications present challenges in healthcare, where infrastructure is often a means, rather than the final product, and where service delivery consumes the bigger chunk of the budget. For instance, whereas construction costs contribute nearly all costs for a road PPP, staff salaries and commodities along consume more than 80 percent of the costs in healthcare.



There is recognition that health and other social sectors have unique peculiarities that make them harder to fit into the traditional PPP frameworks. It is partly for that reason that this document is called a Public Private Collaboration Strategy (as opposed to Public Private Partnership Strategy).

For these reasons, there have been attempts to simplify the classification for PPPs in healthcare. The Global Health Group at the University of California at San Francisco and PricewaterhouseCoopers proposed a simpler approach, where the partnerships were defined based on six key functions: i) financing/co-financing a project), ii) designing, iii) building, iv) maintaining, operating, and delivering (6). These create three broad categories: a) Infrastructure-based models; b) Discrete clinical services models; and c) Integrated PPP models (combining infrastructure and discrete services).

Infrastructure models have to do with constructing and/or carrying out renovations. In a hospital set-up, this may include building, refurbishing, replacing and maintaining. Like other sectors, infrastructure models in healthcare tend to be capital intensive, designed to meet a cost-heavy need that would have otherwise diverted public funds from more urgent uses.

Discrete clinical services models focus on adding new services and/or expanding existing capacity. These are often, either subjected to normal procurement contracting, or embedded in the more complex integrated PPP models (below). As PPPs generally require significant risk transfer to the private entities, discrete clinical are often seen as not fitting the traditional definition of PPPs. Yet, these are of vital importance in the health sector.

Finally, integrated models combine the two components to provide a comprehensive package that meets health needs of the public. These are generally more complex than the other models. They exploit two known strengths of the private sector; capital and operations management capacity. Their appeal rests in the fact that they can both accelerate development of infrastructure and improve operational efficiency. Integrated PPP models have fairly good acceptance in health. A 2016 review found that the majority of health PPPs were integrated, typically including construction or refurbishment, operation and provision of clinical services (7). However, lots of variations exist within this category, making it hard to gauge the level of risk and appropriate contract duration, and therefore, decide the most appropriate mix or investment level.

#### **3.1.4. Non-PPP collaborations in health**

Table 2 gives a summary of other forms of collaboration that do not necessarily meet the threshold/features of a PPP as defined by the PPP Act of 2013. The section carries a wide range of models and approaches, some being strategic and others operational.

It is worth noting that the models are not all mutually exclusive and that it is possible to use a mix of different approaches at different stages of a partnership, for instance, dialogue, leading to service level agreements, which may build enough experience to deliver a management contract PPP. It is also important to appreciate differences in the intentions behind the models. While some partnerships are market-based and driven by commercial investment (for instance, procurement), others may be driven by a more social goal (for instance, development impact bonds). These are two ends of a spectrum. In practice, arrangements may have a balance of the two extremes.



Table 2: Other forms of public private collaboration arrangements

Collaboration	Description
<b>Policy and Dialogue</b>	Considered the foundation of meaningful collaboration, this refers to the presence of mechanisms for deliberate and continuous dialogue and consultation, even in the absence of specific projects that require contracting.
<b>Information Exchange</b>	Refers to sharing a common information management system or having interoperable systems that allow information flow across sectors. This may also include sharing of tools, standards, guidelines, best-practice and some innovations.
<b>Regulation</b>	Refers to public oversight over private activity. Regulation is increasingly changing from top-down command and control models to collaborative models that seek compliance through cooperation, incentives and disincentives.
<b>Service Level Agreement (SLA)</b>	Agreement between a public authority is private partner, where the latter provides a service to the public on behalf of the former and gets reimbursed based on an agreed framework. For instance, a faith-based facility can have an SLA to offer delivery services and get paid for each delivery by a public authority.
<b>Small Partnership</b>	Arrangements that are similar to PPPs, with a value of investment cost less than the threshold defined per Section 71(c) of the PPP Act.
<b>Social Impact Bond (SIB) and Development Impact Bond (DIB)</b>	A pay-for-success financing model where a commissioner (outcome payer, who may be a public authority or development partner) enters into a contract with an investor and a non-profit implementor organization. The investor provides capital for the non-profit to deliver the service. If results are achieved, the outcome payer reimburses the investor(s) the costs incurred plus a return on investment. The outcome payer is a government body for SIB, and an aid agency/donor agency/private donor for DIB.
<b>Procurement</b>	Regular procurement from a private party by a contracting authority under the Kenyan Public Procurement and Asset Disposal Act of 2015.
<b>Exchange Programmes</b>	Arrangements in which qualified health workers or trainees cross the line between the public and the private health sectors to provide services or to undergo training or internship. This includes staff secondment.
<b>Government subsidy</b>	Arrangements in which drugs or consumables are provided by the government to private parties at a reduced price or at no cost, and then made available to clients at a lower rate or free of charge.
<b>Donor programme</b>	Arrangements involving a public authority and private parties, which are essentially funded by international and multilateral partners (except loans).
<b>Corporate Social Responsibility</b>	An arrangement involving a public authority and private parties, in which the private partner provides funding, products or humans resources without receiving a direct benefit. This can include initiatives undertaken for market development.



### 3.2. The institutional framework for health collaborations

The institutions discussed under section 3.1. govern all matters related to PPPs across sectors, including health. This section gives a summary of the roles and relationships across the institutions. Government roles include assessing the merits or value of potential partnership projects, including examining technical feasibility, financial sustainability and affordability for the contracting authority, project attractiveness for potential private sector partners, value for money (with the public route as the comparator), and assessing to ensure appropriate transfer of risk. During implementation, the government tracks performance against agreed metrics, thereby ensuring the public gets value for money.

Importantly, the government approves each step of the PPP process (see figure 2 for an overview of the entire process). This includes (i) approving the projects priority list from the public entities (could be a county or a semi-autonomous government agency, for instance), (ii) approving the project proposal, once pre-feasibility is done and allowing the definitive feasibility study to be done, (iii) approving the feasibility study, and allowing transaction, (iv) approving various component throughout the transaction phase, including pre-qualified bidders and the tendering process, (v) approving the winning bid before award, including changes introduced during negotiation, (vi) overseeing the post-award management processes, and (vii) finally, approving the completion and overseeing handover, where applicable.

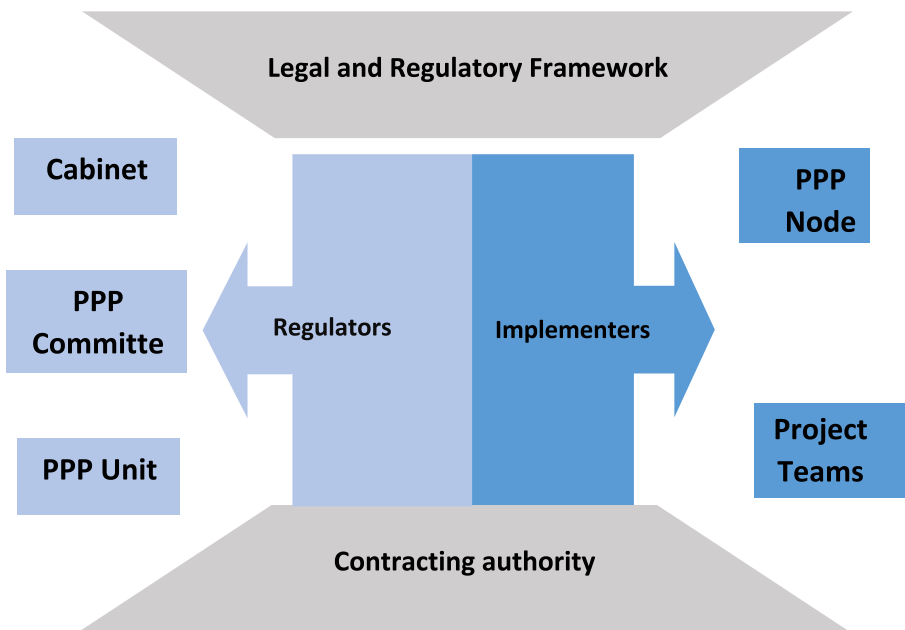


Figure 2: Key institutional arrangements for PPPs in Kenya

#### 3.2.1. Regulatory and/or oversight institutions

Three sets of institutions oversee PPP matters directly: cabinet and parliament, the PPP committee and the PPP Unit. The respective roles include budgeting and appropriation and oversight (cabinet and parliament), developing PPP policies and approving projects based on practicalities, funding and national priorities (the PPP Committee), and executing the mandate of the PPP Committee as the technical arm (the PPP Unit).

Two other bodies support procurement processes, which are inherent in partnership arrangements between the public and private entities: The Public Procurement Regulatory Authority which guides, monitors and advises on procurement activities, and the Public Procurement Administrative Review Board which handles complaints and appeals.

### 3.2.2. Implementing institutions

The PPP Nodes at the respective public institutions carry the responsibility of advising and supporting potential contracting authorities wishing to engage in PPPs and other forms of partnerships. The PPP Act of 2013 creates the PPP Nodes, giving them a mandate of helping public entities to identify and prioritize PPP projects, appraise potential projects for social, legal, commercial, environmental and economic viability, support the establishment and implementation of procurement processes, and support the monitoring of the project to ensure it keeps to project milestones among other roles.

Actual implementation is the mandate of contracting authorities. The PPP Act of 2013 defines a contracting authority as a ‘state department, agency, state corporation or county government which intends to have a function undertaken by it performed by a private party’. The private party, on the other hand, is defined as ‘a party that enters into a project agreement with a contracting authority and is responsible for undertaking a project on behalf of the contracting authority under the PPP Act.’ Typically, the contracting authority would be expected to form a project company (also called a special purpose vehicle) with the private party to implement the PPP project (with the public entity being a minority shareholder). However, this isn’t always the case. The private company can implement the project without having to form a company with the contracting authority. Figure 3.3. shows the overall structure of a PPP in Kenya, and the roles of different partners.

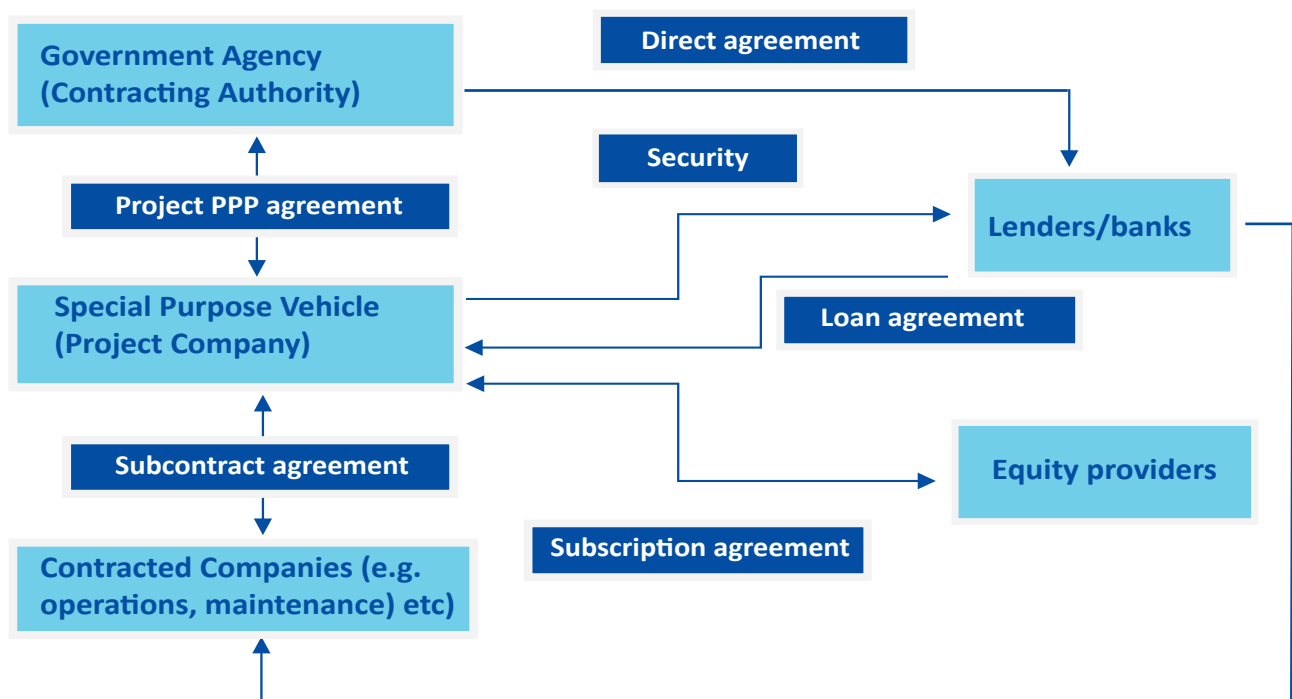


Figure 3: Contractual structure of a PPP in Kenya



### 3.3. Financing public private collaborations in Kenya

A defining feature of PPPs is risk allocation between the public and private entities, primarily achieved through payment mechanisms. Demand risk refers to a difference between forecasted demand and actual consumer demand, and, is often a key driver of the decision on which payment model the public entity prefers to have structured in a PPP contract. Different services have varying levels of demand risk, usually linked to the ability to estimate and forecast demand based on what is known.

Public entities and private companies wishing to engage in partnerships have various financing mechanisms available. These may be categorized broadly into three: government funding, corporate funding and project funding. The funds meet two types of costs: project costs (for instance, construction or set-up costs) and operation and maintenance costs (including overheads and direct costs). Typically, PPPs have either one or a combination of payment mechanisms, for instance, bank loans for set-up costs, and usage payments for operations and maintenance.

#### 3.3.1. Government funding for PPPs

Governments often see PPPs as a way of bridging the gap between demand for goods and services and available resources. In that sense, health PPPs are a way of increasing private sector investment in health. However, services rendered must be paid for, often over longer periods of time. Furthermore, there are certain risks in projects that can only be mitigated effectively through government support. Most of the experiences with government support for PPPs comes from infrastructure projects. This Strategy draws on some of these, highlighting those that may apply to the health sector.

##### 3.3.1.1. Direct funding provided under the PPP Project Facilitation Fund Regulations

The Kenyan government may co-finance a partnership directly through provisions outlined in the PPP Facilitation Funding Regulations of 2017. The PPP Act of 2013 established the Fund, whose roles include direct support towards the contracting authority. Costs covered include third party costs incurred in the preparation of PPP projects, provision of viability gap funds for viable PPP projects and serving as a source for contingent liabilities, should they arise. The three options are discussed briefly.

##### a) Direct support for the project preparation phase

The PPP Project Facilitation Fund Regulations provide funding for consultancy services towards the development of the proposal, feasibility studies, tendering processes, transaction advisory services, as well as any other services requested by the contracting authority, and, approved by the PPP Committee. However, such funds are limited to projects initiated by contracting authorities; privately initiated investment proposals (unsolicited PPPs) are not funded through this stream. Private parties that wish to initiate a PPP are expected to meet all preparatory phase costs, including the feasibility study.

### **b) Viability gap funding**

Viability gap funding (VGF) refers to a capital grant from the public entity to the private partner, designed to improve the commercial viability of a PPP project. Typically considered where projects have a strong economic justification but low commercial viability. The VGF model is often seen as a safer alternative to providing operating subsidies that frequently draw on national budgets, which can be unpredictable over long periods of time. According to the PPP Project Facilitation Fund Regulations (2017), the Kenyan government's VGF funding may fund capital grants during construction under a PPP project and may also provide recoverable advances to the contracting authority. In addition, VGF funds may fund loans or equity (and similar arrangements) to support the PPP project.

### **c) Contingent liabilities funding**

Finally, the PPP Project Facilitation Funds may be used to handle short-term liquidity gaps from contingent liabilities arising from project implementation. The Fund allows projects to proceed despite certain unforeseen occurrences.

#### ***3.3.1.2. Indirect government support (funding)***

Governments may also provide indirect support through a variety of instruments at their disposal. For health services, these may include waiving certain statutory fees, including license fees, taxes and levies. Governments may also provide indirect financing through equity investment in a PPP project. For instance, the government may give land in return for a certain share of the project company (company set up to implement the PPP project). Finally, governments may give loans or guarantees to private companies (or the project company) as a way of lending support towards the project.

#### ***3.3.1.3. Usage payments***

This refers to payments made by the contracting authority to the private company based on level of use of a service or infrastructure. The payments are meant to cater for the range, nature and volume of services provided. These work best in cases where poor or unreliable historical data make it hard to forecast demand, making it difficult to effectively and fairly transfer risk to the private partner. Usage payments may be linked to performance. The term 'usage payment' is at times used to describe cases where a public entity provides operating subsidies to the private company undertaking a PPP project.

#### ***3.3.1.4. Availability funding***

Under this arrangement, the contracting authority pays the private partner as compensation for the latter ensuring that certain agreed services or infrastructure are provided, regardless of the level of use. This model may be used where certain essential services are needed, but demand estimation is difficult, and financial viability hard to achieve. It may also work well in cases where the government wishes to increase uptake/demand for a service through demand creation activities, but where the service availability is insufficient. Availability funding is often seen as an option of last resort, but may have an important role in health, where



the equity goal outweighs the efficiency and/or profitability goals. The model applies where (i) public services are urgently needed, and (ii) resources are scarce, and (iii) demand is expected to be low with uncertain growth projections. It recognizes that the private sector is risk averse, and, is unlikely to invest where returns are uncertain, and yet, it may have the capital or expertise needed to provide certain services quickly, if they can be guaranteed a minimum return.

### **3.3.2. Corporate financing for PPPs**

Under corporate financing, the private company sources funds from financing institutions. This differs from the project financing model (section 3.3.3) in that financing is sought against the company's own balance sheet, as opposed to a separate project company being established to fund and implement the PPP project. As expected, financing may be limited. For that reason, corporate financing is often seen as a good option for low-value projects. However, it may also work where the contracted company is large and can afford to meet the costs of the project. Corporate financing is a relatively easier undertaking (e.g. compared to project finance, see 3.3.3), with lower costs of funding.

### **3.3.3. Project financing**

Project financing entails lending to a special purpose vehicle or project company, created specifically for purposes of implementing the PPP project. The Kenyan PPP Act of 2013 defines a project company as 'a special purpose vehicle incorporated by a successful bidder for purposes of undertaking a project under the Act'. By law, the project company may have shared ownership between the public and private partners, with the former having a minority stake. The company is set up after awarding the winning bid. Company revenue is governed under contractual agreements between partners and may include some of the financing options discussed under this section. Because the company is a new establishment, project financing is generally a complex undertaking. It often entails extensive due diligence activities by potential funders, who will want to be sure about the project's viability and whether the risk allocation is adequate (i.e. checking bankability of a project). These procedures take time.

### **3.3.4. User fee financing for funding PPPs**

This refers to payments received directly from service users. They are often seen by the contracting authorities as an easy way of allowing the private company to recoup its investment. They are popular for some capital-intensive infrastructure projects and those services considered non-essential for communities. The model allows the public entity to quickly provide a service to the public, particularly where there are major budgetary constraints. User charges typically represent significant risk transfer and would normally be accompanied by another payment form.

For health services, user fees have been demonstrated to have a negative impact on access and equity, and consequently, health outcomes over time (8,9). While it may play a role for certain non-essential services, official government policy must always be considered when designing PPP contracts that may require this form of payment. For Kenya, primary and essential services (including emergency services) are exempted from

user fees. Furthermore, the user fees model naturally contradicts with the Kenyan government's commitment towards universal health coverage (UHC) by 2022, whose goals include removing financial barriers to access. For these reasons, user fees are considered an inappropriate form of financing PPP arrangements, particularly for essential healthcare services. Experiences with user fee PPPs is limited in the health sector. However, there are strong arguments against payment models that are based on user fees and operating subsidies due to equity concerns and political nature of budgeting and appropriations procedures.

### 3.3.5. Impact bonds

Impact bonds are simply financing mechanisms that use unique partnership arrangements to improve the delivery of a social outcome. Two forms of impact bonds have gained prominence over the past decade: Social Impact Bonds (SIBs) and Development Impact Bonds (DIBs).

A SIB is a pay-for-success financing model that involves a commissioner (outcome payer) entering into an agreement with an investor (or group of investors) and a non-profit implementing organization. Under the arrangement, the investor provides capital to the non-profit implementer to deliver a social service over a specified period, with clear and verifiable outcome performance measures. If the outcomes are achieved, the outcome payer reimburses the investor(s) the costs incurred and an agreed return on investment on top (usually seen as a fraction of savings made). The principle difference between SIBs and DIBs is who pays for the outcome. For SIBs, the payer is a government body. For DIBs, success is paid for by an aid agency, development partner or philanthropic organization.

Impact bonds are often seen as an innovative way of helping governments to pay for proven preventive interventions, which are often poorly funded, as resources go to the more urgent uses (for instance, curative services). The bonds can allow the government to both deal with the urgent problem and at the same time, get ahead of issues that may morph into urgent problems in the future.

An example of a SIB is funding for an innovative behavior modification intervention that seeks to improve non-medical control of diabetes. An example of a success measure could be a reduction in the proportion of pre-diabetics who progress to type II diabetes. The government will only pay if the targets are achieved and verified by an independent evaluator. The value of such an arrangement lies in the fact that the government only pays for success. In this case, paying for prevention, which saves future (usually higher) costs of treatment and related problems (for instance, days away from work). Another example would be SIB funding for strengthening safety and/or quality within the health system to avert management challenges for global pandemics such as Covid-19. Attainment of certain infection prevention and control targets would create a system that has the capacity to control the spread of pathogens, lowering the risk of hospital transmission and improving isolation capabilities. Being relatively new instruments, the evidence base for SIBs and DIBs remains weak. However, these provide an attractive alternative to scaling up proven interventions across low-resource settings.

### 3.3.6. Blended finance instruments

Blended finance has gained prominence as an alternative mechanism for development-leaning projects. The



term ‘blended finance’ refers to a variety of funding mechanisms that entail the use of catalytic capital to boost private sector investment in development projects/public goods. Put otherwise, it is an approach to pooling and aligning investments from organizations with different purposes, that would have otherwise invested separately. According to the United Nations Development Programme (UNDP), 50-80% of resources needed to achieve Sustainable Development Goals (SDGs). The blended finance model is seen as a way of using available public resources to attract additional financing from the private sector and channel it towards public good. However, these arrangements may be relatively complex, especially since they are relatively new in social sectors, and have scarcely been understood or evaluated across low and middle-income countries. This poses some risk for governments wishing to apply the models. At the same time, private partners may be skeptical or unsure about investing heavily in untested interventions. For these reasons, deployment may benefit from partnerships with reputable agencies (for instance, the UNDP and World Bank Group’s Multilateral Investment Guarantee Agency - MIGA), who may help governments design and package solutions in ways that both protect their interests and appeal to private investors.

*‘There are always risks with any new approaches. But given the unprecedented ambitions and opportunities presented by the SDGs, we strongly believe that piloting, adjusting, and reiterating these new types of partnerships is the way forward and that we at the UNDP have an important role to play in brokering development partnerships.’ UNDP, 2017*

Blended finance options include social impact bonds and output-based vouchers systems.

### **3.4. Summary**

Contracting authorities have a variety of options available for financing partnerships. Model selection requires detailed understanding of underlying risk (and therefore, ability to assign risk), level of knowledge on projected demand and the overall purpose of the service under consideration. Overall, a combination of financing instruments may be applied at various points, for instance, government funding for preparatory work and project funding for implementation. There is room to explore other (relatively new and untested) models such as blended financing but these may require partnership with trusted third parties such as UN agencies, who would guide both parties to minimize risk. Of all financing options available, user fee is perhaps the least suitable for health services due to ideological conflict with both the purposes of the health systems broadly (equity is a key goal of a health system) and the Kenyan government’s health sector goal (universal health coverage).





# CHAPTER 4:

## VISION, MISSION, GOAL, OBJECTIVES AND PRINCIPLES

### Vision:

A healthy, productive and globally competitive nation achieved through partnerships

### Mission Statement:

To provide a framework that fosters transparent, informed and effective engagement between the public and private sector towards promoting access to quality and affordable healthcare

### Goal

To create an environment that allows effective and transparent engagement between the public and private sectors to achieve equitable access to quality health services

### Strategic objectives

1. Support the creation of a policy and regulatory environment that allows effective private sector participation in meeting public health goals
2. Leverage private sector efficiency strengths, and innovation and technological capacity to improve public health service delivery
3. Harness private sector resources and channel them towards equitable financing of public health services
4. Guide contracting authorities on identifying and prioritizing projects that have the potential to deliver better value through collaboration with the private health sector
5. Develop mechanisms for effective information sharing to promote transparency and accountability between the public and private health sectors
6. Build the capacity of stakeholders to initiate and engage in public private dialogue and establish mutually beneficial collaborations that deliver value

### Principles / values

- ❖ Transparency and accountability
- ❖ Equity
- ❖ Integrity
- ❖ Value for money
- ❖ Mutual beneficence
- ❖ Inclusivity/Participatory
- ❖ Social responsiveness
- ❖ Sustainability
- ❖ Demonstrated impact on public health



## Specific objectives

### Strategic objective 1: Support the creation of a policy, regulatory and institutional environment that allows effective private sector participation in meeting public health goals

<b>Objective</b>	<b>To support the creation of a policy and regulatory environment that allows effective private sector participation in meeting public health goals</b>
<b>Description</b>	Private sector participation requires active government involvement. This should primarily be through legislative, policy and regulatory reform, including those that touch on practice, contract matters and fiscal policies.
<b>Specific objectives</b>	<p>1.1. To support review the PPP Act of 2013 and PPP Regulations of 2014 to improve the regulatory environment for health PPPs.</p> <p>1.2. To identify and operationalize incentives (e.g. tax exemption) for health services, products and technologies of high public health importance.</p> <p>1.3. To ensure strong institutional oversight in the initiation and management of PPCs in health for proper impact.</p>

### Strategic objective 2: To leverage private sector efficiency strengths, and innovation and technological capacity to improve public health services delivery

<b>Objective</b>	<b>To leverage private sector efficiency strengths and technological capacity to strengthen public healthcare services delivery</b>
<b>Description</b>	This objective recognizes that private sector engagement goes beyond infrastructure and related purposes. Effective service delivery requires structured collaboration between public and private sectors, with emphasis on how some of the latter’s strengths can be transferred to the former.
<b>Specific objectives</b>	<p>2.1. To establish mechanisms for harnessing and combining private sector expertise and capacities with public sector strengths to improve health services provision to the public.</p> <p>2.2. To establish mechanisms for ensuring that skills, expertise and systems gained during the collaboration periods are sustained beyond the life of the contract.</p> <p>2.3. To develop a framework to guide sharing of human, physical and technological resources between public and private partners for improved public service delivery.</p> <p>2.4. To support and incentivize private sector innovations that specifically aim to solve high priority public health challenges.</p>

### Strategic objective 3: Harness private sector resources towards equitable financing of public healthcare

<b>Objective</b>	<b>To harness private sector resources towards equitable financing of public healthcare</b>
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<b>Description</b>	The amount of resources needed for universal health coverage exceeds what the public sector can provide on its own, emphasizing the need to develop and operationalize mechanisms for channeling private sector finances towards public sector purposes.
<b>Specific objectives</b>	<p>3.1. To establish a framework to guide the mobilization of resources from private sector to complement public service provision.</p> <p>3.2. To operationalize the framework guiding resource mobilization.</p> <p>3.3. To identify and apply innovative public private collaboration financing models that promote equity.</p>

**Strategic objective 4: Guide contracting authorities on identifying and prioritizing projects that can deliver better value through collaboration with the private sector**

<b>Objective</b>	<b>To guide contracting authorities on identifying, screening and prioritizing projects that can deliver better value through collaborative arrangements with the private sector</b>
<b>Description</b>	A major challenge public sector contracting authorities face is knowing which projects should be considered for partnership arrangements. This results in fragmented, poorly coordinated pilots that neither get to scale nor deliver value for money when pitted against the public sector alternative. There is need to develop a process to guide public authorities on what route to take.
<b>Specific objectives</b>	<p>4.1. To provide tools/guidance on identifying needs that could be filled through collaboration with the private sector.</p> <p>4.2. To provide tools/guidance on assessing options to determine suitability for implementation through collaboration with the private sector.</p> <p>4.3. To guide contracting authorities on establishing pipelines of projects amenable to execution through collaboration for better planning.</p>

**Strategic objective 5: Develop mechanisms for effective information sharing to promote transparency and accountability between the public and private sectors**

<b>Objective</b>	<b>To develop mechanisms for effective information sharing to promote transparency and accountability between the public and private sector</b>
<b>Description</b>	Poor information flow between public and private entities hamper planning and effective engagement, raising queries, even where engagement benefits are demonstrable. This objective emphasizes the value of effective communication as a mandatory component of public-private engagement.



5.1. To support the establishment of county-level mechanisms to promote effective and transparent communication and engagement between the public and private sectors.

**Specific objectives**

5.2. To establish mechanisms for public disclosure of processes and terms of engagement between the public and private sectors.

5.3. To establish accountability mechanisms to promote integrity and fairness in engagement between the public entities and the private partners.

**Strategic objective 6: Build the capacity of stakeholders to initiate and engage in public private dialogue and partnerships in an effective and transparent way**

**Objective** To build the capacity of stakeholders to effectively engage in public private dialogue and initiate and manage partnerships

**Description** A key challenge with PPCs is information asymmetry, partly caused by inadequate capacity to engage in partnerships. While this affects both the public and private actors, it is particularly worse among public actors. The objective underscores the value of including capacity building in planning and executing effective partnerships.

**Specific objectives**

6.1. To build the capacity of national and county officers and institutions to engage with the private sector, and, initiate and manage PPPs effectively.

6.2. To build the capacity of private sector partners to engage and partner with public contracting authorities in an ethical manner.

6.3. To sensitize all stakeholders on the potential areas/sources of conflict and dispute in the initiation and management of PPCs.

6.4. To empower communities to understand PPPs, effectively engage and participate in discussions, and hold the parties to account.

## CHAPTER 5:

### MONITORING AND EVALUATION

**T**he purpose of the Kenya Health Public Private Collaboration Strategy (2020) is to define strategic directions that partnerships in health should take, rather than giving a prescriptive list of activities that contracting authorities should do. In that regard, this is a unique strategy document. It cannot carry the traditional monitoring and evaluation (M&E) framework, with specific activities, baseline estimates and/or targets for achievement over a Strategy period. For that reason, this section is limited to defining the approach to M&E, rather specific activities, resource needs and timelines.

The overall responsibility for the oversight of the implementation lies with the Public Private Partnership Node at the Ministry of Health. The team will draw on support from the PPP Unit at Treasury, the institution directly responsible for technical guidance on PPPs in Kenya. Its mandate will be keeping track of, and reporting on, all collaboration activities taking place among contracting authorities.

To coordinate material and technical resources needed, and ensure they are channeled towards strengthening PPPs, the MOH PPP team will lead the establishment of an Inter-Agency Coordination Committee (ICC) for Health PPPs. Under the Health PPP-ICC, there will be a monitoring and evaluation technical working group (TWG). The M&E TWG will work with the MOH PPP team and the larger MOH M&E team to track and report progress on health PPPs and partnerships. The M&E TWG will also guide counties on M&E activities linked to PPPs and other forms of partnership. The TWG will develop bi-annual progress reports and annual M&E reports, which will guide the processes of improving the design, implementation and contract management of PPPs and other health partnerships.

The primary responsibility of identifying PPP projects and their M&E plans will lie with the respective contracting authorities, guided by the Kenya Health PPP Toolkit. However, it is expected that all projects undertaken will reflect the general purposes of the respective contracting authorities.

In line with the ecosystem approach to partnerships emphasized in this document, the Strategy recommends that contracting authorities work with all partners to develop multi-year plans, to be implemented and monitored periodically. It is these plans that will guide the investment cases/concept notes, some of which may be considered for implementation as PPPs. Detailed information on identification, screening, project preparation and post-award contract management of partnerships is provided in the Kenya Health PPP Toolkit.



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