Global Financing Facility (GFF) for Every Woman and Every Child in-country consultations

Kenya, January 2015

This brief report summarises the Kenya country context within which the GFF consultations took place during the week of January 19, 2015 and lays out some next steps for the GFF in Kenya. It also captures feedback/questions received from in-country stakeholders on the GFF design.

Context of visit

From January 21-23 a high level policy consultation took place led by the Ministry of Health in Kenya, with support from the World Bank, USAID and UNFPA. The overall objective of the meeting was to discuss how to deliver on the 'Promises for Women and Children of Kenya' agenda. The meeting was also an opportunity to consult on the initial GFF design and agree on the next steps for the in country process for Kenya as a frontrunner country.

The consultation brought together senior officials from the national government, county representatives including Governors and CEC Health, development partners (bilaterals and multilaterals), and civil society (NGOs and private sector). A full list of participants is attached in Annex X.

Kenya context

RMNCAH Key Indicators – 2009	**Health Financing**
• MMR: 488/100,000 live births • NMR: 31/1000 live births • IMR: 52/1000 live births from 77/1000 live births in 2003 • U5MR 74/1000 live births from 115 in 2003 • Unmet need for FP: 26%	• High direct Out Of Pocket Expenditure • Low Gvt. commitment to Health - around 6.5% of total budget in 2012/13 • Inefficiencies – in allocation (mismatch) and utilization • High external resource contribution, but mostly off-budget and are also declining and fragmented • Limited insurance/pre-payment

Kenya in recent years experienced positive socio-economic developments. After a peaceful election and transition in 2013, Kenya's growth is projected to rise to 6.0 % in 2014. Kenya's poverty level is estimated to have declined from 47 % in 2005, to between 34 to 42 % today (World Bank, 2013). In the health sector, after a period of stagnant and even deteriorating health indicators in the 1990s, Kenya has started to make progress. The Kenya Demographic Health Survey 2008-09 (KDHS 2008-09) shows significant declines in infant- and under-five mortality from 77 to 52 and from 115 to 74, per 1000 live births during the period 2003 to 2008 (KNBS and ICF Macro, 2010). Successful vertical health programs such as immunization, tuberculosis, malaria and HIV/AIDS are believed to have contributed to these gains in addition to the overall improvements due to sustained economic growth and poverty reduction.

Despite these notable improvements, major challenges remain in health status and access to quality care, both in terms of overall achievements and distribution aspect. The prevalence of stunting has not changed significantly over the past few years, with over a third of Kenyan children stunted. Maternal mortality rates remained stubbornly high between 1990 and 2008 (around 6000 mothers are estimated to die each year), and the achievement of MDG 5 remains out of reach. With child mortality getting increasingly concentrated in the neonatal period, further acceleration of child mortality reduction to achieve MDG 4 is closely linked to improvements in care during pregnancy and childbirth. Health inequities – both geographic and economic – remain at a high level. For example, nearly 90 % of the women in Nairobi deliver their babies in a health facility in sharp contrast to only 17 % in the North-East province; while 85 % of children aged 12-23 months reported receiving all basic vaccine in the richest quintile, the corresponding coverage in the poorest quintile is 65% (KDHS 2008-09).

Health is captured in the Social Pillar of Vision 2030 which is the country's development blue print. The MOH has recently developed the **health policy 2014 – 2030**. This has included the introduction of Free Maternity Services**,** which supports the removal of user fees for maternity and primary health care services in public facilities. In 2014 a 2-year pilot started with support from the World Bank Group is providing Health Insurance Subsidy for the Poor covering 500 households per each of the 47 counties.

There are several strategies targeting RMNCAH, including:

- The National Reproductive Health strategy (2009-2015)
- Child Survival and Development Strategy (2008- 2015)
- The National Road Map for accelerating the attainment of MDGs related to Maternal and Newborn Health in Kenya – 2010
- MNH Implementation plan 2015/16- 2017/18 under development
- Adolescent Health Policy (but no costed plan)
- National CRVS costed plan

Kenya started implementing devolution from the beginning of fiscal year 2014 (July 2013). The devolution provided new opportunities to improve service delivery and enhance accountability to citizens. However, there are also some new challenges for achieving desirable health outcomes, especially during the transition. Nearly two thirds of the Government of Kenya's health budget has now been devolved to counties as part of the equitable resource allocated to counties. County governments have total freedom to allocate across all sectors based on their identified priorities. Health services in Kenya are provided by a wide range of players consisting of public, faith-based organizations, other private-not-for-profit, and private-for-profit sectors. About 40% of services are estimated to be provided by non-government sector nationally, although they concentrate more in the urban area.

The responsibility for the management of the health budget for devolved functions lies now with recently established county governments; at the same time, both central and local governments recognize the need for a major transformation of the health financing system, including the mobilization of additional domestic resources, pooling of funds across different programs and schemes, and introducing payment systems that foster efficiency

and quality of care. Stakeholders agree to translate this joint vision into a health financing strategy over the next ten months.

Development assistance for health accounts for approximately 20% (2012/13) of public health expenditure in Kenya. The latest estimates suggest that 65% of this development aid is off budget. There is a commitment from many partners to better align their support of RMNCAH. Yet there remain many challenges to align budgets and accountability mechanisms.

Various financing analyses have been carried out, yet the impact of the new institutional arrangements - for example, on adequacy and equalities of financing - have not been documented. The analyses that have been conducted include, among others: an analysis of health financing functions; household health expenditure surveys, preliminary design of an essential benefits package; national health accounts; and a public expenditure review.

There is a real opportunity to engage the private sector in resource mobilization to support the Global Financing Facility (GFF) in Kenya. During the visit to Kenya the team specifically focused on meeting for-profit actors of the private sector including financiers (investors, banks, HNWI), large corporations (health and non-health), and technical/advisory partners. The goal was to identify how private sector capital could complement, support, and leverage public funding from the GFF to increase coverage of critical RMNCH products and services.

The team identified three potential areas for the GFF that would support the increased partnership and resources from the private sector: 1) increasing health insurance coverage and efficiency, 2) supporting innovative financing mechanisms such as revolving loan facilities, partnerships with local banks to reduce the cost of borrowing, or social impact bonds, and 3) developing a Kenya Private Sector Health Alliance. While two such health alliance entities exist, there is room to strengthen, combine, and improve their capabilities by ensuring the right mix of Financiers (Private Equity, banks, and high net worth individuals), and corporates- both with clear link to health (BD, GSK, Philips) as well as corporates with broader influence (Nakumatt, Safaricom). This alliance could support sustainable financing build bridges between government and private sector.

GFF Opportunity and next steps

There is a strong consensus from all stakeholders that the GFF represents a very timely and critical opportunity for Kenya. The political commitment is clearly there, at both national and county level. It was agreed that

- A comprehensive nationwide RMNCAH investment framework will be developed to bring together and prioritize key areas for investments, including integrating the needs of adolescents.
- A consultative process will be used for the development of the investment framework, which will be inclusive of government, private Sector, development partners and civil society.
- A review will take place of existing data and information, studies and analyses in preparation for the development of a comprehensive health financing strategy. This

will be done in close synchronization with, and in support of, the development of the RMNCAH investment framework. Under the government's leadership, including both the Ministry of Health and the National Treasury, this effort will involve the many partners already providing technical assistance for health financing, including USAID, GIZ, KfW, WHO, JICA and World Bank Group.

- Particular attention needs to be given to the high burden counties and innovative approaches to service delivery will be needed to address the needs in conflict prone areas
- A strengthened Civil Registration and Vital Statistics system is important for planning, monitoring and evaluation of RMNCAH interventions. The current CRVS plan for Kenya is comprehensive and costed, however, it may need some more work to operationalize it in the county contexts.

The financing of the investment case will be from domestic resources as well as through the alignment of key financiers, including JICA, USAID, IDA/ GFF, Global Fund and potentially others. The approximate total resource envelope is estimated to be US$2 Billion during the next four years. A contribution of US$12 million from the RMNCH TF implemented by UNFPA will support the most immediate needs in 6 counties.

Specific next steps on the RMNCAH Investment case

Kenya, as a front runner country, is well placed to demonstrate an inclusive process for developing an RMNCAH Investment Case for Every Woman and Every Child that reflects the needs and aspirations of County Governments while addressing the National Priorities highlighted in its Vision 2030 through a national framework and county plans. It will involve all key stakeholders including civil society and private sector representatives. It will be evidence-based with strong focus on results and systems for M&E, including CRVS. On the latter point, WB, UNICEF and WHO will work closely together to ensure strong integration of CRVS into the RMNCAH investment case. This work will also serve to mobilize additional domestic resources leveraged by support from Kenya's development partners.

Steps	**Timing**
1. Identify Core Technical Teams (RMNCAH and UHC) representing County and National Governments	2 Feb
2. Agree on sustained TA support	9 Feb
3. Constitute a consultative group involving a wider range of stakeholders (CSOs and Private Sector)	9 Feb
4. Hold First Round technical consultations	23-27 Feb
5. Review existing and planned data including rapid assessments-	Feb-Mar
6. Hold Second Round technical consultations and prepare zero draft of Investment Case	20-24 April
7. Receive feedback from the consultative group	27 April
8. Share First draft Kenya Investment Case for RMNACH	30 April
9. First Draft of health financing Strategy	30, November

Issues and questions for consideration by the GFF Business Planning Team

The overall approach to the RMNCAH investment case and the longer-term health financing strategy was well received. A number of issues and questions were raised – while some are more specific to Kenya's context, others may be relevant to address as part of the overall design of the GFF:

- Given the large potential scope of the RMNCAH Investment Case, how to best work across sectors? Is there a need for a 'secretariat' to facilitate this?
- How will resources flow, in particular in a context like Kenya with health budgets now being devolved? Who is eligible to received funding at country level?
- How does the GFF relate to other related initiatives like SUN, FP2020, APR, etc.?
- How does the GFF differ in its financial flows and operating model from Global Fund and GAVI?
- Resource allocation was raised: who would decide how much Kenya would receive?
- How to best ensure accountability, in particular in a devolved context: financial accountability and controls; programmatic accountability
- Partners asked whether there would be resources to support TA at various levels (regional level – inter-country? National level? Sub-national level)?
- Private sector raised a number of important considerations, for ex.: issue of fees at faith-based facilities; investment in training facilities; affordable credit to encourage new private facilities in remote areas, coupled with guaranteed access for patients (subsidy/insurance); need for better accreditation system and quality control; opportunity for cross-country efficiencies, especially in terms of pharmaceuticals; leveraging innovations and mobile technology
- What can GFF do to ensure strong civil society involvement both in planning/prioritization phase as well as in support of implementation, in particular at community level?