

PROFIT

- *Private Health Care Providers*
- *Employer-Provided Services*
- *Innovative Investments and Transfers*

Promoting Financial Investments and Transfers

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PROJECT PERFORMED FOR
U.S. Agency for International
Development *(Office of Population)*

**Deloitte &
Touche**



Member DRT International

In association with:

Boston University Center for International Health

Multinational Strategies, Inc.

Development Associates, Inc.

Family Health International

PROFIT

Promoting Financial Investments and Transfers

Suite 601
1925 N. Lynn Street
Arlington, Virginia 22209

Telephone: (703) 276-0220
Facsimile: (703) 276-8213



COUNTRY ASSESSMENT

KENYA

1993

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Touche**



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Facsimile: (703) 276-8213

September 1, 1993

Mr. Craig Carlson
U.S. Agency for International Development
Office of Population
Family Planning Services Division
Room 809, SA-18
Washington, D.C. 20523-1819

Dear Mr. Carlson:

Deloitte & Touche is pleased to submit the PROFIT (Promoting Financial Investments and Transfers) Country Assessment document for Kenya to the Office of Population (R&D/POP) of the U.S. Agency for International Development.

This assessment document is the product of a visit to Kenya by PROFIT's core staff. The PROFIT team met with Kenya's health care providers, cooperating agencies, and private voluntary organizations involved in family planning activities, as well as USAID/Nairobi. As such, this assessment represents PROFIT's current strategy for developing private sector family planning initiatives in Kenya.

PROFIT looks forward to implementing this strategy with your support and guidance. Please feel free to contact me at (703) 276-0220 should you have any questions related to this document.

Very truly yours,



Donald R. Nicholson
Project Director

DRN/cs

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I. INTRODUCTION

The objective of the PROFIT project is to increase developing country resources -- funds, services and commodities -- for family planning by encouraging private sector involvement. PROFIT will achieve this through by focusing on three routes of involvement:

- Private Health Care Providers
- Employer-provided Family Planning and
- Innovative Investments

In its first year, PROFIT conducted initial visits to Brazil, Colombia, Indonesia, Jamaica, Mexico and Nigeria. Potential project interventions were identified in each country and draft Country Assessments developed. During subsequent country visits, additional information was collected on the potential projects, addressing the concerns of PROFIT functional specialists in the areas of Family Planning, Finance, Investment, Marketing, and Evaluation.

The resulting Country Assessments are designed to provide a summary of relevant demographic data, to identify feasible private sector interventions through PROFIT, to assess potential impact of these projects in terms of PROFIT objectives and to guide the design of PROFIT services for that country. The Country Assessments examine the private sector environment at a high level and focus on the areas where PROFIT may best work in the country. The Country Assessments will be followed by detailed Project Papers on selected interventions.

PROFIT team members Donald Nicholson, Project Director, and A. Michael Van Vleck, Investments Director have conducted one visit to Kenya and have identified specific areas of involvement which, are in accordance with USAID/Nairobi objectives. These goals are discussed in the August 5-14th trip report and are also outlined in Section IV of this report.

The remainder of this document is structured as follows:

- Section II - provides an overview of Kenya's demographics and a profile of the family planning environment. Elements of the macroeconomic, social and political environment which are relevant to PROFIT are identified for brief discussion.
- Section III - examines the areas of Private Health Care Providers, Employer-provided Family Planning, and Innovative Investments, the mandated areas of PROFIT operation, within the context of Kenya.
- Section IV - describes the potential interventions identified in Kenya, outlines the relationship to PROFIT objectives, and examines the potential benefits of the activity.
- Section V - summarizes the next steps to be taken.

II. COUNTRY BACKGROUND

Kenya has experienced a marked decline in the Total Fertility Rate (TFR) from 8.1 in 1977 to 6.7 in 1989. During that period, total contraceptive prevalence also tripled from 7 percent (Kenyan Fertility Study 1987) to 27 percent in 1989 (Kenya Demographic and Health Survey [KDHS]), making it the third highest in Sub-Saharan Africa.

The Government of Kenya's (GOK) substantial spending on human resources is a major contributing factor to Kenya's fertility decline and increased acceptance of family planning. Steady investment in the country's health care system since independence in 1963 has cut infant mortality from over 100 per 1,000 live births to about 60 in 1989 (KDHS), a number substantially lower than other countries in the region. The GOK's substantial investment in the education infrastructure has afforded women access to schooling and encouraged their entrance into the formal labor force. At the same time, specific socio-economic conditions have exerted pressure on Kenyans to limit the size of their families. The rising cost of education for individual families and the declining size of their land holdings have contributed to the reduction in ideal family size from 5.8 in 1984 to 4.4 in 1989 (KDHS).

Concomitant with Kenyans' desire for smaller families has been an expanded availability of contraceptives and access to trained health care providers due to increased GOK commitment to family planning. As a result, use of modern contraceptive methods increased from 10 percent in 1984 (Kenya Contraceptive Prevalence Survey) to 17.8 percent in 1989 (KDHS). Contraceptive method mix is also evenly distributed between clinical and supply methods (See Figure 1).

CONTRACEPTIVE METHOD MIX (KDHS 1989)	
<u>Method</u>	<u>Percentage*</u>
Oral Contraceptives	29
Tubal Ligation	26
IUDs	21
Injectables	18
Condoms	3
* Of total modern method usage	

Figure 1

Despite the increased availability of contraceptives, the 1989 KDHS indicates significant unmet need for family planning.

Of the sexually active women who were not contracepting, 62 percent did not want to become pregnant. Among these women, 35 percent cited lack of information or availability of family planning as the reason for not using contraceptives. The KDHS also uncovered potential for increased contraceptive prevalence among the 50 percent of married women not currently practicing family planning, who intended to in the future. Of these women, 37 percent planned to use the injectables, 24 percent the pill, and 13 percent intended to be sterilized.

Responding to this need, the GOK has set ambitious goals for reduction of demographic growth in the next decade. They include a decrease in population growth rate from 3.6 to 2.5 and an

increase in contraceptive prevalence from 27 percent to 40 percent by the year 2000. But the expanding demand for family planning information and services and the GOK's fiscal retrenchment program have put a strain on the public resources available for promotion and service delivery. The GOK recognizes the importance of private sector involvement in family planning provision and has encouraged international donor support in this area. The increasing knowledge, acceptance and use of contraceptives among Kenyans and the growing potential as well as need for private sector involvement provide a positive setting for PROFIT project activities.

- Government Health Care Policy and Commitment to Family Planning. Since Kenya's independence, the GOK has provided strong support for the provision of social services, as evidenced in Kenya's extensive government-funded health care infrastructure. The public system provides the majority of health care and family planning services at low cost or for free. Currently, 70 percent of women using modern contraceptive methods access the public sector, with government hospitals supplying 56 percent and government health centers and clinics serving the remaining 15 percent.

Although the GOK began providing contraceptive information and services through Ministry of Health (MOH) facilities in 1967, contraceptive prevalence in Kenya did not show a significant increase until the early 1980s. At that time, pressured by a severe economic downturn and a rising population growth rate, the GOK began to develop national population policy guidelines. The National Council for Population and Development (NCPD) was established in 1982 to act as the overall coordinating agency for family planning activities. The NCPD was placed under the authority of the Office of the Vice President in order to expand the responsibility for promotion of family planning beyond the Ministry of Health. Kenya's current president, Daniel Arap Moi, is a consistent and outspoken supporter of family planning and has made it a major focus of the GOK's Sixth Five-Year Plan for 1989-1993.

- Economic Environment. Kenya has traditionally been one of the strongest economies in sub-Saharan Africa, due largely to its strong export-oriented agricultural production. Agriculture and ranching are the most important economic activities in Kenya, comprising 27 percent of the GDP and 19 percent of the formal sector employment. Coffee, tea, sugar cane, wheat, sisal, pyrethrum and cotton are Kenya's main exports and their production engages 81 percent of the economically active population. In the past decade Kenya has experienced rapid growth in its horticulture industry. Foreign exchange earnings, mainly from french beans, strawberries, peas and cut flower exports, doubled from \$76 to \$139 million between 1980 and 1990. Kenya also has well-developed manufacturing and service infrastructures. Manufacturing and processing in beverages, tobacco, textiles, petroleum products, electronic appliances and machinery, metal products, paper products, sugar, and other food products contribute 12 percent of the GDP and employ 7 percent of formal work force. Kenya's dynamic tourism industry, which has experienced steady growth since 1963, surpassed coffee as the number one foreign exchange earner in 1987.

A confluence of global and domestic conditions has brought about a weakening in Kenya's economic performance in the last 15 years. Drought, shrinking availability of arable land, declines in international prices of coffee and tea, and world-wide recession slowed economic growth to a standstill between 1981 and 1984. Since 1985, coffee prices have recovered and Kenya's exports of manufactured goods and horticulture products have grown steadily, contributing to a sustained annual economic growth rate of 4.9 percent. Despite the recovery in economic growth, inflation has risen steadily, doubling from 20 percent in 1991 to an estimated 40 percent currently. This increase can be attributed to rising fuel costs, the lifting of price controls, and rapid currency depreciation.

Kenya's bloated public sector, which comprises the central government, local governments, 200 parastatals, and over 125 commercially oriented enterprises with majority government ownership, is a major stumbling block to economic progress. Despite efforts at public sector retrenchment initiated under the Budget Rationalization Program (BRP) in 1985, the number of government ministries is up to 28 from 19 in 1970 and public sector employment increases at over 6 percent a year. Parastatal restructuring which began in the late 1980s has achieved few concrete results. Their losses make up approximately 20 percent of the budget deficit and 17 percent of foreign debt. Due to increased revenues from a fuel tax and user fees in the education and health care systems as well as some success in fiscal control, the GOK has been able to trim the budget deficit from 6.8 percent of the GDP in 1991 to 2.9 percent in 1992.

Kenya's population, which will double by the year 2015, is another major threat to the country's economic progress. The rapid population growth rate puts pressure on Kenya's shrinking arable land resources and sends increasing numbers of young people to urban areas in search of work. Formal sector employment, which grew only 2.3 percent in 1991, will not be able to create the 400,000 jobs per year necessary to accommodate the growing ranks of Kenya's work force.

- Investment and Financial Environment. Kenya's hospitable investment climate, relative political stability, and well-established industrial infrastructure have made it a much favored recipient of foreign investment in the last decade. Foreign capital, originating primarily from the U.K. and U.S., comprises 50 percent of total investment in Kenya's industrial sector.

Official GOK policy towards foreign investment has been consistently favorable. There are no official restrictions on the percentage of foreign ownership but the GOK is pursuing a policy of increased Kenyan participation. The 1964 Foreign Investment Protection Act provides for repatriation of non-capital profits or interest if a company obtains a certificate of approved enterprise. Also, the ceiling on remittance of dividends by foreign companies was lifted in 1980. In response to increasing capital flight and depleted foreign exchange reserves, the GOK has adjusted exchange controls through the introduction of Foreign Exchange Certificates (Forex C). Forex Cs are issued by banks

as a receipt for a currency deposit; they are interest bearing and are traded by a number of financial institutions. Despite these and other efforts by the GOK to attract investors, foreign direct investment has dropped substantially since the mid-1980s. Foreign investors have been frustrated by the length of the dividend remittance pipeline which often exceeds two years. This is exacerbated by the rapid currency depreciation; one U.S. Dollar which bought 30 Kenyan shillings in February 1993 bought almost 80 Kenyan shillings in August 1993.

Kenya's economic stability is heavily dependent on foreign capital inflows. Official development assistance, which jumped from \$463 million in 1985 to \$1.63 billion in 1990, has financed a sharp increase in public spending and helped to ease Kenya's balance of payments problem. Kenya's current account deficit during the 1980s was approximately \$3 billion and it was paid for almost exclusively by loans from international lending agencies such as the World Bank and the IMF. Foreign donors, frustrated with the slow pace of public sector retrenchment and recurrent incidence of corruption and mismanagement, decided at a Consultative Group meeting in 1991 to cut levels of foreign assistance and suspend balance of payment support.

The GOK has been increasingly cautious about amassing foreign debt over the last decade due to the drastic increase in debt service costs. The debt service to GDP ratio has decreased from 39 percent in 1980 to 29.5 percent in 1990. Total disbursed external debt was \$6.84 billion in 1990; \$971 million was short term debt, \$482 million was owed to the IMF, \$578 was private, and \$4.8 billion was public. Kenya takes pride in the fact that it is the only sub-Saharan African country not to have its debt rescheduled in the last eight years. Kenya's continued success in debt servicing depends heavily on an optimistic balance of trade scenario and international donor support, both of which remain to be seen.

Relative to other African countries, Kenya has an established financial sector infrastructure with over 28 banks and 50 financial institutions. Despite the developed nature of the sector, access to credit is limited. High inflation makes the cost of money exorbitant; inflation has surpassed interest rates which remain between 21 and 27 percent. Other disincentives to the availability of private capital include the following: high corporate taxes, a double taxation of dividends, and credit ceilings aimed at the private sector. Activity on Kenya's stock market has dropped off significantly since the imposition of a capital gains tax in 1975, with only two new public issues in the last two years.

- Bilateral family planning programs. The World Bank, A.I.D., and several other private donor institutions have very established and active presences in Kenya. Kenya is the single largest African recipient of U.S. population assistance, receiving 14 percent of the total A.I.D. Africa budget in fiscal year 1992. A.I.D. population assistance to Kenya last year totalled over \$13.9 million, \$6.5 million of which was bilateral aid. The USAID/Kenya Office of Population and Health currently has five bilateral projects

including HIV/AIDS Control (1993-95), Contraceptive Social Marketing (1990-94), Health Care Financing (1989-95), Family Planning Services and Support (1985-95), and the Private Sector Family Planning II Project (1991-98).

Family Planning Services and Support (FPSS) is the omnibus family planning project which provides assistance through contraceptive logistics management, information education and communication (IEC), clinical training, and institutional training. The Private Sector Family Planning II project (FPPSII) and its predecessor project (FPPS) were mandated to involve private companies, parastatals, NGOs, private doctors and nursing homes, and educational institutions in family planning provision and promotion. Initially, the FPPS program was run through a cooperative agreement between USAID and John Snow, Inc., with the goal of eventually establishing a Kenyan NGO to continue the program management. The NGO has been established and the Family Planning Private Sector Programme is fully "Kenyanized".

The FPPS program provides each recipient organization with two years of financial and/or technical assistance, after which they are expected to be self-financing for costs other than free contraceptive commodities received from the MOH. FPPS currently provides support to five NGOs, 16 commercial entities, 15 private nursing homes and clinics, six parastatals, four community based organizations and four educational institutions. An additional objective of FPPS II is to conduct operations research to develop "innovative approaches to private sector service delivery". This includes exploration of the feasibility of adding family planning coverage to health insurance programs and replication of the Machakos Medical Clinic model, a highly successful private clinic serving several area employers and surrounding communities.

The Health Care Financing project (HCFP) is designed to mobilize additional resources for health care financing in the public sector through the introduction of user-fees, reallocation of resources from curative to primary/preventative services, and overall management and operational technical assistance. Another major area of activity is social financing. HCFP is collaborating with the MOH and Ministry of Finance in reforming the National Hospital Insurance Fund, the public insurance scheme for those employed in the formal sector, as well exploring policy reform that would foster the development of the private health sector and insurance industry.

- Pop. Office projects. Kenya receives over \$7.4 million in central funding for population activities from several cooperating agencies. Buy-ins to central projects augment the bilateral programs through technical assistance in IEC, training, service delivery, research, NGO organizational development and clinical training projects. Central funding support has been particularly valuable to private sector initiatives given that host governments are typically hesitant to expend limited bilateral funds for innovative programs.

- Enterprise/TIPPS projects. The FPPS project work with large employers and parastatals precluded work by TIPPS and Enterprise in Kenya.

III. SCENARIO FOR PROFIT INVOLVEMENT

The PROFIT Project is mandated to operate in the areas of Private Health Care Providers, Employer-Provided Services, and Innovative Investments. Accordingly, those areas are analyzed below in the Kenyan context.

A. PRIVATE HEALTH CARE PROVIDERS

PROFIT seeks to work with health care personnel, insurers, group practices, hospitals, pharmacists, and professional associations towards the goal of expanding existing family planning service delivery and increasing the availability, quality and method mix of contraceptive commodities.

In the 1970s and early 1980s, Kenya invested heavily in the human and physical infrastructure of the public health care system. Since the mid-1980s, funding to support the public sector's extensive network of health facilities has begun to diminish, due to the GOK's fiscal austerity program, balance of payment and external debt problems, and reduced government revenues. The slowed growth in health financing has left the GOK unable to cover the public health care system's increasing recurrent costs. As a result, health care facilities in the public system are often faced with shortages of drugs, medical equipment and other supplies; limited availability of qualified medical personnel; and lack of funding for infrastructure maintenance.

The overall dearth of funds for maintenance and operation of the public health care system has a direct impact on family planning service delivery. Due to contraceptive commodity "stockouts" and scarcity of qualified trained staff, only 50 percent of public sector health care facilities are able to provide family planning services at any one time. These problems are compounded by the growing demand for family planning services and contracting resources for health care financing. Recognizing the need to mobilize new resources for the health care system, the MOH has included in its Five-Year Implementation Plan for Financing Health Care, provisions to shift the burden of health care financing and service delivery to non-governmental sources including the private sector.

Currently, the private for-profit health care sector comprises hospitals, nursing or maternity homes, fee-for-service medical practitioners and pharmacies. According to the 1989 KDHS, these entities supply only 9 percent of family planning services in Kenya; even in urban areas where incomes tend to be higher, 80 percent of all family planning is provided by the public sector and NGOs. In the past decade, the availability and low cost of public services has inhibited private for-profit sector involvement in family planning service delivery. Between 1984 and 1989, when the GOK significantly increased resources to family planning provision,

public sector family planning usage grew by 14.3 percent, whereas the private sector increase was only .8 percent. Reduced public resources and increased demand creates the potential for expanded private sector involvement.

- Private Practitioners. Kenya has a substantial, well-trained reserve of health care professionals, including physicians and nurse practitioners. Although distribution of doctors is concentrated in urban areas, there are 4,500 doctors in Kenya or over .15 doctors per 1,000 population, which is the fourth highest ratio in sub-Saharan Africa. Currently, over 2,000 physicians practice privately, a number which has grown significantly since the late 1980s when physicians employed by the public sector were allowed to open private practices.

Since 1972, USAID has funded and provided technical assistance to training programs for physicians, nurse practitioners, and other health care professionals. More recently, USAID has supported a program implemented by Pathfinder through the Kenyan Medical Association to train private doctors in IUD insertion as well as counselling and IEC techniques. AVSC is also initiating a program this year to train doctors in voluntary surgical contraception (VSC). Discussions USAID Mission personnel involved provider-training indicated that there is strong support for the training among the doctors and it may warrant the development of a tuition-funded training program.

- Health Care Facilities. In the last two decades, the number of for-profit health care facilities has grown significantly. According to a 1989 MOH report, the private for-profit sector, which includes 50 private hospitals, 16 maternity homes, 26 nursing homes, 60 "health centres", 411 dispensaries, and 16 health clinics, constitutes 25 percent of all Kenya's health care facilities. Currently, over 35 percent of hospitals, about 30 percent of clinics and 25 percent of dispensaries are privately-owned.

While private hospitals provide high-cost, high-quality services to the wealthy and the pervasive charitable and public sector facilities serve the rural and peri-urban poor at low or no-cost, there is an increasing need for moderately-priced health care services for the middle and lower-middle socioeconomic groups. This demand is underscored by the recent appearance of numerous privately-owned hospitals and clinics in Nairobi. Although they are not well-regulated and their quality of service tends to vary, they are notable as an indication that growing numbers of people are willing to pay for more accessible, higher quality health care services.

The MOH and the USAID-funded Health Care Financing Project are now looking to ease the regulatory and financial constraints which historically have limited the growth of the private health sector. These include lack of capital for health care providers, high taxes on medicines and medical equipment, and stringent licensing requirements for starting, owning and operating a business in Kenya. The Five-Year Strategy for Health Care Financing calls for "targeted subsidies for capital, personnel, and land costs in underserved areas", simplified government fees and taxes on private health care facilities,

and a consolidation of the licensing process for opening a private practice. The MOH strategy indicates commitment to expansion of private sector involvement in the health care system.

In the area of women's reproductive health, a network of privately owned-nursing and maternity homes is already providing a wide range of services to middle and lower income women. A 1992 Health Care Financing Project study states that reimbursements from the National Hospital Insurance Fund (NHIF), the employment-related public insurance plan, have provided a major source of funding support for these facilities, but PROFIT's discussions with several clinic operators indicated that NHIF reimbursements are erratic and inadequate. PROFIT found that facilities like the Marie Stopes International-supported Eastleigh Nursing Home in Nairobi are successful because they provide more costly obstetric and maternity care, VSC, and curative services and can then cross-subsidize mother and child preventative health care and family planning services. The Eastleigh Nursing Home offers high quality services to one of Nairobi's poorest sections with limited donor support other than MOH-supplied contraceptive commodities. A 1990 study conducted by the Family Planning Private Sector Programme to determine the demand for family planning assistance in the private sector demonstrated a strong interest among private for-profit health care facilities. Of the 69 private health facilities identified, 46 wanted to include or expand family planning services.

- Health Care Insurance. The extensive coverage of Kenya's public health care service delivery and financing systems has impeded the development of a competitive health insurance market. Universal free health care services by the public sector provide the safety net for Kenya's lower socioeconomic groups. Through the National Hospital Insurance Fund, a parastatal established in 1966, the GOK provides inpatient health care coverage to all those employed in the formal sector. NHIF coverage is prepaid and funded by a payroll tax. Membership is compulsory for those earning KShs. 1,000 per month and over and those earning less can join voluntarily, contributing the same and receiving the same benefits. Currently the NHIF has a membership of one million and given that the average family size is six, the NHIF provides inpatient hospital coverage for 25 percent of Kenya's population.

The NHIF faces numerous problems and is currently slated for revamping. There is widespread dissatisfaction with NHIF among its beneficiaries because of its weak claims management and administration which result in long delays between hospital stays and reimbursement. Also, the NHIF offers no choice in the kind and amount of benefits available to beneficiaries. Large surpluses that do not correspond to the volume of claims submitted each year, and the recent exposure of fund mismanagement, do little to engender public support for the institution.

The National Assembly is currently reviewing a bill which involves major reform of the system. It proposes to expand the pool of beneficiaries beyond the formal sector employed, improve the benefits package to include preventative care, and institute mechanisms to ensure increased efficiency and quality of care.

Private insurance companies provide very limited health care coverage in Kenya, serving almost exclusively upper and upper-middle class urban dwellers. Often, those buying private insurance already contribute to NHIF and are looking to augment their existing coverage. PROFIT's discussions with the Health Care Financing Project indicated that of the 38 registered insurance companies in Kenya, only two companies provide stand-alone health care coverage. Health insurance is not considered a profitable investment among insurance companies and is offered as a loss-leader. Some companies underwrite medical risks, but only in conjunction with other insurance coverage. Typically employers purchasing group accident, death and disability, or workmen's compensation insurance can also access medical coverage. In these schemes, the employee pays for his or her health care up front and is reimbursed by the employer. The result is that health insurance coverage is limited to salaried private and public sector employees.

A primary goal of the MOH Health Care Implementation Plan is to expand the population covered by health insurance while, at the same time, controlling the cost of health care financing. The plan incorporates a critical role for the private firms involved in health service and financing and proposes a number of policy and regulatory reforms to improve the environment for the private sector. To create a more competitive insurance market and generate demand for private insurance, the plan proposes to phase out compulsory NHIF contributions and introduce legislation requiring insurance for employees' work-related health problems. The plan also includes provisions to foster the development of alternative service delivery mechanisms that emphasize cost containment and utilization control, such as health maintenance organizations (HMOs) and prepaid plans.

PROFIT's discussions with a health services firm called African Air Rescue Inc. indicated that there is growing demand in Kenya for pre-paid health care plans. While traditional Kenyan insurance companies are getting out of health insurance and see it as a liability, African Air Rescue Inc. is increasing its business. AAR's unique combination of a strong service orientation and effective cost-control mechanisms has been successful in attracting new beneficiaries and keeping costs down.

Like an HMO, AAR operates its own out-patient health care facilities and employs a full staff of health care professionals. AAR ambulatory units transport ailing patients from their homes to the AAR outpatient facilities before taking them to the hospital. In this way, AAR is able to control the internment process as well as provide an invaluable service to its beneficiaries. AAR personnel visit its hospital patients up to twice a day which has helped to deter over-utilization of hospital services. A strong preventative health emphasis through once-a-year physicals and a recently-opened family planning

clinic, promote early detection of serious health problems. A supportive policy environment and increasing demand for high quality, affordable services create the potential for growth in the market for this kind of health plan.

- Non-Governmental Organizations. Clinics and hospitals run by non-governmental organizations provide 18 percent of all family planning, 10 percent of which is supplied by the Family Planning Association of Kenya (FPAK), the International Planned Parenthood Federation (IPPF) affiliate. The NGO sector, has broad coverage in poorer and rural areas where public sector services are inadequate or absent. The Christian Health Association of Kenya, FPAK, the Crescent Medical Aid Society, and the Seventh Day Adventist Church-run hospitals, clinics and community based distribution (CBD) programs throughout the country. Currently, 15 NGOs run CBD programs and employ over 2,000 field educator/providers. The bulk of community-based distribution is carried out by a few Christian hospitals and FPAK. FPAK has also been involved in workplace-based social marketing of non-clinical family planning methods.

The private non-profit sector draws upon MOH resources for about 30 percent of their operating costs and also relies heavily on international donor assistance funds. These sources of funding have begun to taper off in the last few years calling into question the viability of this system. Many of these facilities have adopted user fees but often those that serve the urban and rural poor are forced to waive the fees.

B. EMPLOYER-PROVIDED FAMILY PLANNING

PROFIT seeks to assist firms with large employer populations in offering family planning as an employee benefit. PROFIT can assist by providing technical assistance, cost/benefit analyses, investment in on-site clinics and collaboration with providers seeking to service employee populations.

Kenya's large and diversified agriculture and manufacturing industries should present many opportunities for self-sustaining employer-provided family planning programs. But the current regulations governing mandatory employer-provided social services do not facilitate them. Aside from the NHIF and some private insurance schemes, the only form of social security available to Kenyan workers is the National Social Security Fund (NSSF). The NSSF provides for age, disability and survivor benefits and is the only mechanism requiring employer contributions. Because employees pay for their own hospital coverage through the NHIF and also have access to free health care services, employers have little incentive to share in the cost of health care and family planning services. According to discussion with FPPS, some employers do offer health care services but often only to higher level employees.

FPPS administrators indicated that they have had success in employer-provided programs with several large agriculture production and manufacturing companies since their establishment in 1980. The entities most receptive to family planning have been the

larger plantations, like the tea estates, which already provide housing, medical care and sometimes schools for their employees. But on the whole, given the current economic situation, employers are reluctant to take on up-front costs for benefits accrued only in the long term. FPPS was more optimistic about the success of including or expanding family planning services through medical facilities which serve several companies and the surrounding communities. Private medical facilities like the Machakos Medical Clinic and the Eldoret Nursing Home provide curative services within the facilities and run outreach clinics with strong IEC components in and around the companies' grounds.

- Industrial Estates. The emergence of state-operated export processing zones (EPZs) and private industrial parks has offered new potential for growth in Kenya's export-oriented manufacturing and agricultural processing sectors. Currently, there are four private industrial estates as well as two government EPZs being planned and developed in various locations around the country. The existing private Sameer Industrial Park outside of Nairobi, which was opened in 1991, has tenants involved in food processing and the manufacture of machine components, rubber products and leather goods. Due to the number of women these facilities typically employ, industrial parks represent a viable mechanism for the on-site provision family planning services and education.

PROFIT is mindful of the restriction posed by Section 599 of the Foreign Assistance Act which prohibits the use of U.S. appropriated funds in providing "assistance for the purpose of establishing or developing, in a foreign country, any export processing zone or designated area...in part or in whole, to activities carried out within that zone or area". When considering potential initiatives with industrial estates, PROFIT will consider the impact of any proposed project activities on U.S. jobs and whether industrial estates in Kenya receive government subsidies or incentives.

C. INNOVATIVE INVESTMENTS

PROFIT's mandate of innovative investments includes the following areas of activity: the promotion of commercial production, marketing and distribution of contraceptive products; work on the policies and regulations which have an adverse impact on the family planning environment, availability of contraceptives, or the expansion of private sector involvement in family planning; the use of innovative financial tools and techniques to leverage PROFIT's investment funds.

- Local Production, Distribution, and Marketing of Contraceptives. The Kenyan family planning program is dependent on imported contraceptives, the bulk of which are donated by USAID, United Nations Fund for Population Activities, the Swedish International Development Agency, and the British Overseas Development Administration. In fiscal year 1992, Kenya received over \$2 million in contraceptive commodities from USAID, including 36.7 million condoms, 72,400 IUDs, 7,200 cycles of pills and 2,500 sets of Norplant. The MOH, Division of Family Health, Central Medical Store in Nairobi supplies all family planning programs in the country with free contraceptives.

Given the pervasiveness of donated product and limited size of the commercial market, the feasibility of local contraceptive production in Kenya is questionable. According to a comprehensive study on the potential for local contraceptive production world-wide conducted in 1990 by the Program for Appropriate Technology in Health (PATH), the volume of contraceptive distribution does not justify local production but condom usage may support the establishment of a quality assurance testing and packaging facility for condoms. PROFIT's research into the condom market indicates that due to substantial supplies of condoms donated recently for AIDS/STD prevention and the high value added tax on condoms as well as packaging materials, the market would not support a local testing and packaging facility at this time.

Kenya does have a well-developed commercial pharmaceutical production and distribution system. Currently, six multinational pharmaceutical firms are in production in Kenya and 20 to 30 have an active presence. Generic drugs that are locally produced and sold under their own brand name have 80 percent of the drug market; and patented imported contraceptives comprise the remaining 20 percent. As international donor agencies begin to phase out their supply of free contraceptive commodities and the GOK looks to the private sector for contraceptive distribution, Kenya's extensive pharmaceutical sector could be mobilized to produce and distribute contraceptives.

For now, commercial distribution is limited to condoms and pills and the market is very small. Between 1978 and 1989 the number of women buying contraceptives from pharmacies dropped almost 60 percent, which is striking in that Kenyan women prefer temporary methods available in pharmacies. A 1991 study conducted by the Futures Group faults the availability of public sector supply methods.

The social marketing program funded by a cooperative agreement between Population Services International (PSI) and USAID/Nairobi has been in operation since 1990. PSI purchases all the program's contraceptive commodities on the world market and works with a local distributor, to conduct the market research, advertising, and promotion. PSI began marketing condoms for family planning through a local distributor called Continental Industries Inc. and then switched to the British pharmaceutical chain, Boots UK. PSI has discontinued the condom for family planning and will launch the AIDS/STD prevention "Trust" condom through a new distributor, in conjunction with the AIDSCAP project in October. PSI had an agreement with Boots UK to market the Wyeth oral contraceptive Lorondal, but has terminated the relationship due to disappointing sales. PSI, which maintains the rights to Lorondal, may find another distributor or allow Boots to continue distribution.

■ Regulatory Reform

The proposed reform of regulations restricting the growth of the private health care service delivery and insurance sectors is discussed above in the Private Health Care Providers sections.

■ Financial Transfer Mechanisms

Kenya has no debt swap program but development organizations are eligible for the "interbank exchange rate", the preferential exchange rate offered when converting hard currency to Kenyan shillings. As of July 1993, the official exchange rate was Ksh 65.00 to the US\$ 1 and recent transactions have yielded rates of Ksh 82.00 to the US\$ 1. In order to access the interbank exchange rate, a commercial bank must close the transaction and the converted funds must be deposited into a bank account in Kenya. According to the Debt for Development coalition, many multinational corporations in Kenya maintain blocked funds and are willing to pay a premium for hard currency. The conversion of blocked funds must also involve a Kenyan commercial bank and all the rules governing the interbank market apply to these transactions. The transactions can be as small as \$10,000, or \$50,000 if the transaction includes a multinational, and take between two and three days to process.

IV. POSSIBLE AREAS FOR PROFIT INTERVENTION

The previous section described the Kenyan health care and family planning environment in the sectors relevant to PROFIT's mandate. In summary, the following conditions in Kenya create a positive environment for private sector interventions to promote family planning:

- A large unmet need both in availability and quality of family planning services
- Scarcity of public resources for health care and family planning
- Proposed reform of policies and regulations hindering private sector involvement in health care and family planning
- A growing network of private health care providers involved in or interested in providing family planning

PROFIT's mandate is to increase the resources for family planning by encouraging greater private sector involvement. PROFIT seeks to invest in sustainable commercial ventures that will have a positive impact on family planning and employs a flexible, innovative financing approach. Given the aforementioned conditions, the most appropriate area for PROFIT investment in Kenya is in the private market-based providers of health care services and financing.

PROFIT is mindful of USAID/Nairobi's extensive activities in family planning and the private sector, particularly through the Family Planning Private Sector Programme and the Health Care Financing Project. PROFIT seeks to coordinate appropriately with Mission-funded programs and has identified specific interventions which would mobilize additional private sector resources for the Mission's existing activities.

Based on initial research and information gathered during PROFIT's August 5-14th visit to Kenya, PROFIT makes the following recommendations for possible interventions.

A. PRIVATE SECTOR STUDY

Description

The **Five-Year Implementation Plan for Financing Health Care in Kenya** issued by the MOH in conjunction with the HCFP delineates an expanded role for the private sector and introduces cost-sharing mechanisms to the public social financing system. The plan calls for increasing the proportion of curative health care services provided by non-governmental entities. The MOH plans a shift in the burden of health care financing to the private sector through the development of prepaid health care schemes and the introduction of risk sharing mechanisms such as co-payments into the government-funded health care financing scheme.

According to HCFP personnel, implementation of the plan requires further study of the nature, size and coverage of the existing private health services and insurance system. PROFIT proposes to provide assistance to the HCFP for the hire of a consultant or consultants to study private sector initiatives which would complement existing work with the MOH on social financing and private sector expansion.

Relationship to PROFIT Objectives

One of PROFIT's objectives is to assist host governments in reforming policy and regulations which limit the growth of family planning provision in the private sector. Results of the study will be used facilitate the MOH efforts to create a more enabling environment for private providers of health care, including family planning services.

Expected Impact

The specific outcome of the study will be a comprehensive assessment of Kenya's private health services and insurance system and recommendations for private sector initiatives, in accordance with the MOH health care financing implementation plan. At this point, it can be determined whether PROFIT will have a role in the implementation; one potential intervention would be assisting in the development of a low cost health insurance plan with some coverage of family planning.

B. PRIVATE SECTOR LOAN FUND

Description

A 1990 FPPS study indicated a substantial demand among private health care facilities, both for-profit and NGO-supported, for family planning assistance. Research by the Health Care Financing Project shows that a major obstacle to establishing or expanding private health care services has been lack of access to capital. Given these circumstances, PROFIT seeks to study the feasibility of creating a credit support facility for private health care providers. Through the proposed fund, private practitioners, nursing homes, private hospitals, and qualified NGOs could access loans as well as technical assistance to initiate or extend existing family planning service capacity. Initially, loans offered would be small and further financing would be contingent upon credit worthiness and ability to repay.

Currently, the FPPS program offers the only family planning assistance available to private providers in Kenya, through purchase of equipment and training of health care personnel. Its central role in Kenya's private family planning sector and strong capability in provider training make FPPS well-suited to implement the loan fund. FPPS would be charged with soliciting loan proposals, screening loan applicants, and providing loan recipients with the necessary family planning training. PROFIT would supply FPPS with the technical assistance necessary for the administration of the fund.

Relationship to PROFIT Objectives

Establishment of a loan fund for private providers accomplishes PROFIT's primary goal of increasing access to family planning services; the technical and financial assistance offered to health care facilities will expand the number and capacity of family planning providers. Financial sustainability is also central to PROFIT's mandate not only to expand the private sector but also to reduce the burden on the public health care system, which is critical in Kenya's case given reduced government funds for health care financing. Specifically, the fund will help these entities work toward sustainability by introducing the regimen of debt repayment and reducing dependency on development assistance funds.

Expected Impact

PROFIT would need to conduct further study into the nature and size of target market, the structure of the loan fund and the extent of assistance required by FPPS to determine the loan fund's specific impact. Broadly, providing loan financing to private providers will expand the availability of high quality, affordable reproductive health and family planning services. In the future, this network of private facilities could play an important service delivery role in a low cost health insurance plan.

C. MARIE STOPES INTERNATIONAL'S EASTLEIGH NURSING HOME

Description

Marie Stopes International, a British-based non-profit organization involved with the provision of reproductive health and family planning services and education in developing countries, has a network of six family planning clinics and three nursing homes in Kenya. These facilities provide services and information on-site or through outreach programs serving mostly rural areas. MSI also provides training for physicians in Norplant and IUD insertion as well as counselling and education techniques.

The Eastleigh Nursing Home, the largest of the MSI facilities, is located near one of the poorest sections of Nairobi called the Mathare Valley. The Eastleigh facility provides a full range of reproductive, obstetric, and family planning services to a primarily indigent patient population and is still able to recover most of its costs. With a strict program of consistent, detailed financial reporting and mandatory phased-in sustainability imposed by MSI, Eastleigh generates sufficient revenues to cover operating and overhead costs. MSI policy of sustainability extends to the management and operation of its facilities in that it has also worked toward "Kenyanization" of personnel and ownership.

MSI seeks to increase the delivery of services through the Eastleigh Nursing Home which will require the expansion and renovation of the existing facility. Currently, MSI is leasing the building and is concerned that investment in the facility may induce the owner to increase the rent. Limited access to capital precludes MSI's purchase of the facility at this time. PROFIT proposes to provide loan capital for the purchase of the existing

facility and real estate, construction necessary for service expansion, and installation of a diagnostic laboratory. The total cost of the project is estimated at US\$200,000. Further analysis of Eastleigh's financial status will be required to determine the terms and cost of the loan.

Relationship to PROFIT Objectives

Investment in the Eastleigh Nursing Home fulfills PROFIT's objective of expanding the capacity of the private sector to provide family planning services with specific emphasis on the underserved. The loan would be used to enhance the capabilities of a health facility clearly dedicated to high quality service delivery to those most in need. The loan also enables an organization with a proven commitment to financial independence to achieve full sustainability.

Expected Impact

The Eastleigh Nursing Home is currently providing a high level of reproductive health and family planning services. For the six month period between January and June of this year, Eastleigh saw a total of 11,267 patients and provided 4,375 couple years protection (CYP) primarily through surgical contraception. Investment in the Eastleigh facility will help meet growing demand for reproductive health and family planning services by increasing current service capacity and speeding up turn-around time. MSI also anticipates that with the installation of laboratory facilities, Eastleigh would provide diagnostic services to other MSI-supported facilities.

**Appendix A
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- Inventory of Population Projects in Developing Countries Around the World (UNFPA 1991/1992)**
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- Potential Demand for Family Planning Assistance in the Private Sector in Kenya (Inserra, 1990)**

Appendix B
DEMOGRAPHIC STATISTICS

		<u>1990</u>
Population (000)	Total	23,585
	Male	11,794
	Female	11,791
	Urban	5,559
	Rural	18,026
	Percent Urban	23.6
Population/year 2000		32,818
Functional age groups (%)	Child (0-4)	19.1
	(5-14)	30.0
	Youth (15-24)	19.5
	Elderly (60+)	4.5
	(65+)	3.0
	Women (15-49)	42.3
Median age (years)		15.4
Population density (/km ²)		41
Agricultural population density (hectare of arable land)		7.2
		<u>1990-95</u>
Average annual change (000)	Population Increment	860
	Births	1,125
	Deaths	265
	Net migration	0
Annual Growth (%)	Total	3.4
	Urban	6.6
	Rural	2.3
Crude birth rate		43.7
Crude death rate		10.3
Net migration rate (/1000)		0.0
Total Fertility Rate (/woman)		6.3
Gross reproduction rate (/woman)		3.1
Infant mortality rate (/1000 births)		66
Life expectancy at birth (years)	Males	57.1
	Females	60.8
GNP per capita (\$US, 1989)		370

Source: UNFPA, Inventory of Population Projects in Developing Countries Around the World (1991/92)