
**Mapping and tracking the complexity of financial flows
through non-state non-profit (faith-based) health
providers in Kenya**

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Dedication

To the memory of my mum

Abstract

In strengthening health systems, the World Health Report 2000 indicates that health system improvement strategies must also cover private (for-profit and non-profit) health care provision and financing if progress towards Universal Health Coverage is to be achieved. Yet very little is known about the financing of non-profit providers in Africa – especially not faith-based health providers, who have often historically remained elusive in terms of financial transparency.

This thesis reports on a multiple case study conducted with two non-profit faith-based health providers in Kenya, namely the Africa Inland Church Kijabe Hospital; and Nyumbani-Children of God Relief Institute in Nairobi (Nyumbani) – and situates these within the broader context of health systems financing and public-private partnership in Kenya.

Data was collected from multiples sources including: secondary literature; secondary analysis of existing data (such as the Kenya Health Information System); financial data on projects and annual reports; routine facility and service data; previous research on both organizations; archival data; and supplemented by 6 in-depth interviews with key stakeholders.

The study reveals a highly complex funding environment for non-profit (and faith-based) health providers in Kenya, which is a result of historic health system configurations, and current funding policy and focus (such as the influx of HIV-related funding). The HIV program in AIC Kijabe Hospital is solely funded by USAID; while Nyumbani is also funded by USAID (70%), but has other private sources. In both cases, funding from various sources is

structured differently with varied financial flows and requirements. Faith-based health providers in Kenya are highly dependent on complex donor-funding arrangements, and lack financial resilience as a result. Donors need to better understand the nuance of engagement with such providers.

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Special thanks go to my partner David, for his continued support throughout my studies at the University of Cape Town.

Finally, I would like to thank my friend Isatu for her encouragement and moral support.

Declaration

I, Dr. Lucy Kingangi (KNGLUC002), hereby declare that the work in this dissertation is based on my original work (except where acknowledgements indicate otherwise) and has not, in whole or in part, been submitted towards another degree at this University or elsewhere.

I empower the University of Cape Town to reproduce, for research, either the whole or any portion of the contents in any manner whatsoever.

Signature:

Signed by candidate

Date: October 2017

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Acronyms

ACHAP	African Christian Health Associations Platform
AIC	Africa Inland Church
AIDS	Acquired Immunodeficiency Syndrome
AMREF	Africa Medical Research Foundation
CBOs	Community-based Organisations
CBHI	Community-Based Health Insurance
CCM	Country Coordinating Mechanism
CHA	Christian Health Association
CHAG	Christian Health Association of Ghana
CHAK	Christian Health Association of Kenya
CHAM	Christian Health Association of Malawi
CHAZ	Christian Health Association of Zambia
CHSs	Christian Health Services
CHSCC	Christian Health Services Co-ordination Committee
CRS	Catholic Relief Services
CSO(s)	Civil Society Organisation(s)
DHMBs	District Health Management Boards
FBHP(s)	Faith-based health provider(s)
FBO(s)	Faith-Based Organisation(s)
GOK	Government of Kenya
HCMCs	Health Centre Management Committees
HFMCs	Health Facility Management Committees
HICs	High Income Countries
HIV	Human Immunodeficiency Virus
HMBs	Hospital management Boards
HMSF	Hospital Management Services Board
HPSR	Health Policy and Systems Research
HSSF	Health Sector Services Fund
IHP	Interfaith Health Program (Emory University)
IRHAP	International Religious Health Assets Programme
KEC	Kenya Episcopal Conference (Catholic Church)
KES	Kenya Shillings
KMHFL	Kenya Master Health Facility List
KHMIS	Kenya Health Management Information System
KPHF	Kenya Health Policy Framework
KIIs	Key Informant Interviews
LMICs	Low- and middle-income Countries
MEDS	Mission for Essential Drugs
MOU	Memorandum of Understanding
MOH	Ministry of Health
MTEF	Mid-term expenditure framework
NGO(s)	Non-Governmental Organisation(s)
NHA	National Health Accounts

NHIF	National Health Insurance Fund
NHSSP	National Health Sector Strategy
PCMA	Protestant Churches Medical Association
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PFP(s)	Private For-Profit-Provider(s)
PI	Principal Investigator
PPE	Public-Private Engagement
SAPs	Structural Adjustment Programs
SLAs	Service Level Agreements
SSA	Sub-Saharan Africa
SWAp	Sector-wide approach
SUPKEM	Supreme Council of Kenyan Muslims
TWG	Technical Working Group
UCT	University of Cape Town
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organisation

PART A: PROTOCOL

Mapping and tracking the complexity of financial flows through non-state non-profit (faith-based) health providers in Kenya

Introduction

Over the past decade, emphasis has been placed on the importance of health systems, which comprise the institutions, organisations and resources which together enable delivery of health care services and meet population needs (Mills 2014). According to the World Health Organisation (WHO), functioning health systems are key to achieving universal health coverage (UHC, WHO 2007). However, health systems in low and middle income countries (LMICs) are weak and often failing (World Bank 2013). This may be attributed in part to a limited capacity of the public sector and concentration of human resources in the private for-profit sector (Mills 2014). In strengthening these health systems, the World Health Report 2000 indicates that health system improvement strategies must cover private health care provision and financing if progress towards UHC is to be achieved (WHO 2000).

The private health sector is commonly defined as “all providers outside the public sector” (Patouillard et al. 2007). Private sector providers range from private non-profit providers which include faith-based health providers (FBHPs), local and international non-governmental organisations (NGOs); to private-for-profit-providers (PFPs), communities, private practitioners operating individually, corporate private facilities, traditional healers and drug vendors (Hanson and Berman 1998). However, this definition does not adequately

describe several providers who fall in grey areas. For instance, health services owned by parastatals, services provided in facilities funded directly by social security funds, non-governmental organisations receiving substantial government funding among others (Hanson and Berman 1998). This project focusses on non-profit health providers, specifically FBHPs.

In the past two decades, much attention has shifted towards the role of the private sector within LMIC health systems (Forsberg et al. 2011) provoking controversial debates (Saksena et al. 2010). Those opposing the private sector tend to argue that reliance on the public sector is the best option for any health system to attain equitable healthcare with better health outcomes for all (Marriott 2009; Rannan-Eliya and Sikurajapathy 2008). On the other hand, others argue that the private sector offers efficiency, accountability and sustainability as opposed to the public sector (Preker et al. 2000; Bhattacharyya et al. 2010; Basu et al. 2012). However, the common and growing message is that the private sector cannot be ignored (Bustreo et al. 2003; Preker 2007; Hanson et al. 2008).

Consequently, research has been conducted to call attention to the previously unrecognised scale of the private sector in LMICs (Berman and Laura 1996; Brugha and Zwi 1998; Hanson and Berman 1998; Preker et al. 2000; Harding and Preker 2003; Berman 2015). Evidence from multiple studies shows that the private sector plays a pivotal role in health financing and provision of care in LMICs (Zwi et al. 2001; Ha et al. 2002; Liu et al. 2006; Konde-Lule et al. 2010; Levin and Kaddar 2011; Grépin 2014). For example, a study conducted in Vietnam indicated that the financial burden for households from private health care was roughly half that imposed by public providers (see Ha et al. 2002).

Other studies show that the private sector is available and utilised - even in those countries that are the poorest in the world and by households in low income groups (Berman 2000). For instance, In Uganda and Nigeria, more than half the population in the lowest income quintile seek health services from the private sector (International Finance Corporation 2008). Similarly, in Kenya, close to half of those in the poorest quintile utilise the private sector when seeking healthcare for a sick child (Marek et al. 2005).

Faith-based non-profit health providers continue to act as an essential part of many health systems in sub-Saharan Africa with emerging evidence showing that they contribute to improving equity of access to healthcare in many LMICs in Africa (Kagawa et al. 2012). Recent reports documenting the role and presence of FBHPs in healthcare provision in Africa indicate that they continue to play a substantial role (see ARHAP 2006; WHO 2007; Schmid et al. 2008), with some publications citing a controversial figure that in some post-conflict and fragile states, as much as 70% of all healthcare services are provided by FBHPs (ARHAP 2006), although this must be balanced against the understanding that in some African countries there are no or only few FBHPs present.

Although relatively little is known about FBHPs financing, it is known that they finance their services from a combination of government funding, out-of-pocket funds from patients, bilateral and multilateral donors, funding and in-kind contributions from faith groups and communities (Olivier and Wodon 2012). It is also known that most African governments offer financial support to FBHPs, either through direct grants, staff secondment or service level agreements (SLAs, Appiah 2013). There have been some macro-level attempts made to

assess the financing of ‘faith-based organisations’ (FBOs) – which is a broader category than FBHPs and includes health-engaged faith-based NGOs. For example, Olivier and Wodon (2014) assessed the magnitude and characteristics of donors and other sources of funding toward FBOs in relation to HIV/AIDS response compared to civil society organisations (CSOs). Haakenstad et al (2015) also assessed external funding of FBOs in LMICs who, for the most part, had a role of channelling funds from both public and private actors in high income countries (HICs), in addition to acting as mediators in LMICs (Haakenstad et al. 2015). All such studies are challenged by the fact that there is no coherence of data and no agreement on what constitutes an ‘FBO’, meaning that evidence on faith-based health facilities and international development agencies tend to get merged in most assessments (Olivier and Wodon 2014).

There are astoundingly few proper health systems assessments that provide evidence on financing of faith-based health *facilities*. For example, Rookes (2012) investigated the adaptations made by Christian Health Services (CHSs) in sub-Saharan Africa and Asia in response to declining financial support from traditional mission partners and their implications for service provision. It is apparent from this study that in search of financial sustainability, FBHPs have adopted approaches such as acceptance of increased government funding, particularly in sub-Saharan Africa; relying on funding from international donors; income generating initiatives and increase in user fees-which have sometimes jeopardised their commitment (Rookes and Rookes 2012). However, this study was challenged by the fact that most facilities’ financial data was inaccessible.

Probably the most detailed analysis has been by Ssenkooba (2002), who conducted a full assessment of the Ugandan non-state sector financing. This study compares public and PNFP hospitals in Uganda on: characteristics of hospital management, hospital performance, efficiency and quality of care. In assessing hospital performance, the study examines the financial position of PNFP facilities and indicates that some of the cost recovery mechanisms used by both public and PNFP facilities include user fees (also described as Robin Hood payment mechanisms - see Olivier et al. 2015). In addition, the study indicates that there is a notable difference in revenue streams between PNFP facilities and public facilities. For example, PNFP facilities in Uganda generate 50% of their revenue through user fees compared to just 4% generated in public facilities. These figures may be challenged by the fact that PNFP facilities charge more for their services and are more efficient in revenue collection (see Ssenkooba et al. 2002). These studies do show us the importance of country and health system specific evidence. However, in comparison with the level of research and evidence on public sector financing, the area of non-state non-profit (and faith-based) financing is a massive evidence gap. Therefore, in this following study, we will conduct a case study of FBHPs in the Kenyan health system.

The history of FBHPs in Kenya dates back more than a hundred years. FBHPs emerged from European and American “parent” churches with an aim of providing basic health care to those in most need and to preach the gospel (Rasheed 2009). It has been estimated that FBHPs account for 11.3% of all health facilities in Kenya (Blevins and Griswold 2014) although FBHPs have self-reported higher figures of around 40% (Olivier et al. 2015). In Kenya, FBHPs operate as independent health facilities under the umbrella of the Christian Health Association of Kenya (CHAK), the Kenyan Episcopal Conference (KEC, under the

Roman Catholic Church) or the Supreme Council of Kenya Muslims (SUPKEM) (see Blevins and Griswold 2014). In addition, other independent FBHPs exist, such as the Nyumbani Children of God Relief Institute in Nairobi (Nyumbani).

FBHPs have faced significant changes in the last few decades. For example, FBHPs in Ghana were faced with hardships in the 1980s, which were attributed to shrinking budgets, changes in health financing strategies, burgeoning population, resistance of historic relations to colonialism and the HIV/AIDS epidemic. These factors combined, resulted in major financial challenges for FBHP services (see Rasheed 2009; Yeboah and Buckle 2017). Efforts have been made in support of FBHPs in the Kenyan health system within the last decade. For example, in 2009, the government of Kenya (GOK) and FBHPs (represented by CHAK, KEC and SUPKEM) signed a memorandum of understanding (MOU) which was intended to strengthen partnership and collaborative efforts within the Kenyan health system (Luoma et al. 2010).

FBHPs in Kenya do not work in isolation – but operate within the broader health system. Therefore, it is important to examine their financing within the context of the Kenyan health system. Currently, Kenya finances health care from three main sources: Government, private sources (out-of-pocket payments, community-based health insurance-CBHI and private insurance) and donors (Luoma et al. 2010; Chuma and Okungu 2011; Munge and Briggs 2014; Ministry of Health 2015). Donor funding provides general budgetary support (Munge and Briggs 2014) and supports vital program areas such as HIV/AIDS (Luoma et al. 2010). For example, donors contributed 73% of support in HIV/AIDS activities in 2012/13 (Ministry of Health 2015).

The U.S President's Emergency Plan for AIDS Relief (PEPFAR) is among the largest donors in the Kenyan health sector. PEPFAR works in collaboration with the GOK and other partners such as FBHPs in service delivery and technical support to improve quality, access and impact of the national HIV/AIDS response in Kenya (PEPFAR 2016). Over the past decade, PEPFAR has supported the Kenyan health system through direct funding. Most recent country funding statistics indicate that in 2015, PEPFAR donated approximately USD 489 million towards HIV/AIDS initiatives in Kenya (PEPFAR 2016). According to the National Health Accounts 2012/2013, there has been a significant increase in health expenditure over the past several years. However, the proportion of donor funding for Kenya's health sector saw the first-ever decline from 35% in 2009/10 (KES 52,076,083,793) to 26% in 2012/13 (KES 55,365,348,581). This may be attributed to a significant increase in tax-funded contributions from KES 44,316,876,616 in 2009/2010 to KES 67,840,888,078 in 2012/2013 (Ministry of Health 2015). With decline in proportion of donor funding, questions of sustainability of health financing in Kenya arise. FBHPs tend to weather changeable health sector financing by relying on varied financial streams – which combines state, funder, and internal resourcing (Appiah 2013).

Problem statement

There is little information on the financing of FBHPs in Kenya despite overwhelming evidence indicating their significant contribution to the Kenya health system (see Blevins and Griswold 2014). Available literature on financing of organisations in Kenya makes reference to non-profit organisations at large (Muriithi 2014; Omeri 2015), but does not specifically examine FBHPs. Thus, there is a gap in literature guiding financing of FBHPs in

Kenya vis-à-vis sustainability of service provision. Therefore, this descriptive case study will describe how changes in funding in FBHPs, specifically CHAK's Africa Inland Church (AIC) Kijabe hospital and Nyumbani, have influenced the sustainability of service provision in these organisations over the past decade.

Research question

How have changes in funding (and HIV funding in particular) over the last decade influenced the role and functioning of faith-based health providers in the Kenyan health system?

Definition of key terms

Faith-based health providers: Faith-based health providers refers to those faith-based organizations directly engaged in the provision of health care (Haakenstad et al. 2015).

Funding: Funding refers to “money given by a government or organisation for an event or activity” (Cambridge Dictionary 2017).

Financial sustainability: Financial sustainability refers to the ability of an organisation to maintain its capacity (Bowman 2011). In the context of this study, it refers to the capacity of FBHPs to provide health care.

Purpose and objectives of the study

The main purpose of this study is to describe how changes in funding (and HIV funding in particular) have influenced the role and functioning of FBHPs in relation to sustainability of

service provision within the Kenyan health system over the past decade. The findings of this study are expected to add to efforts of building an evidence base of the contributions of FBHPs in Kenya, which is essential in policymaking.

The objectives of this study are:

1. To identify structures and sources of funding available for non-state non-profit FBHPs in Kenya, specifically CHAK's AIC Kijabe hospital and Nyumbani.
2. To map the trends of finances through CHAK's AIC Kijabe hospital and Nyumbani for the past decade (between 2007-2016).
3. To examine the relationship between sources of funding and the role and functioning of FBHPs in relation to sustainability of service provision in Kenya.

Sub-study arrangement

The following research is a sub-study of a larger research project. The broader project is a research initiative funded jointly by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and PEPFAR, which has supported a consortium of partners, such as the consortium of academic institutions, which includes the Rollins School of Public Health at Emory University (Atlanta USA), University of Cape Town (South Africa) and St. Paul's University (Kenya). These partners are working in collaboration with the African Christian Health Association Platform (ACHAP), CHAK in addition to Nyumbani in four program areas including:

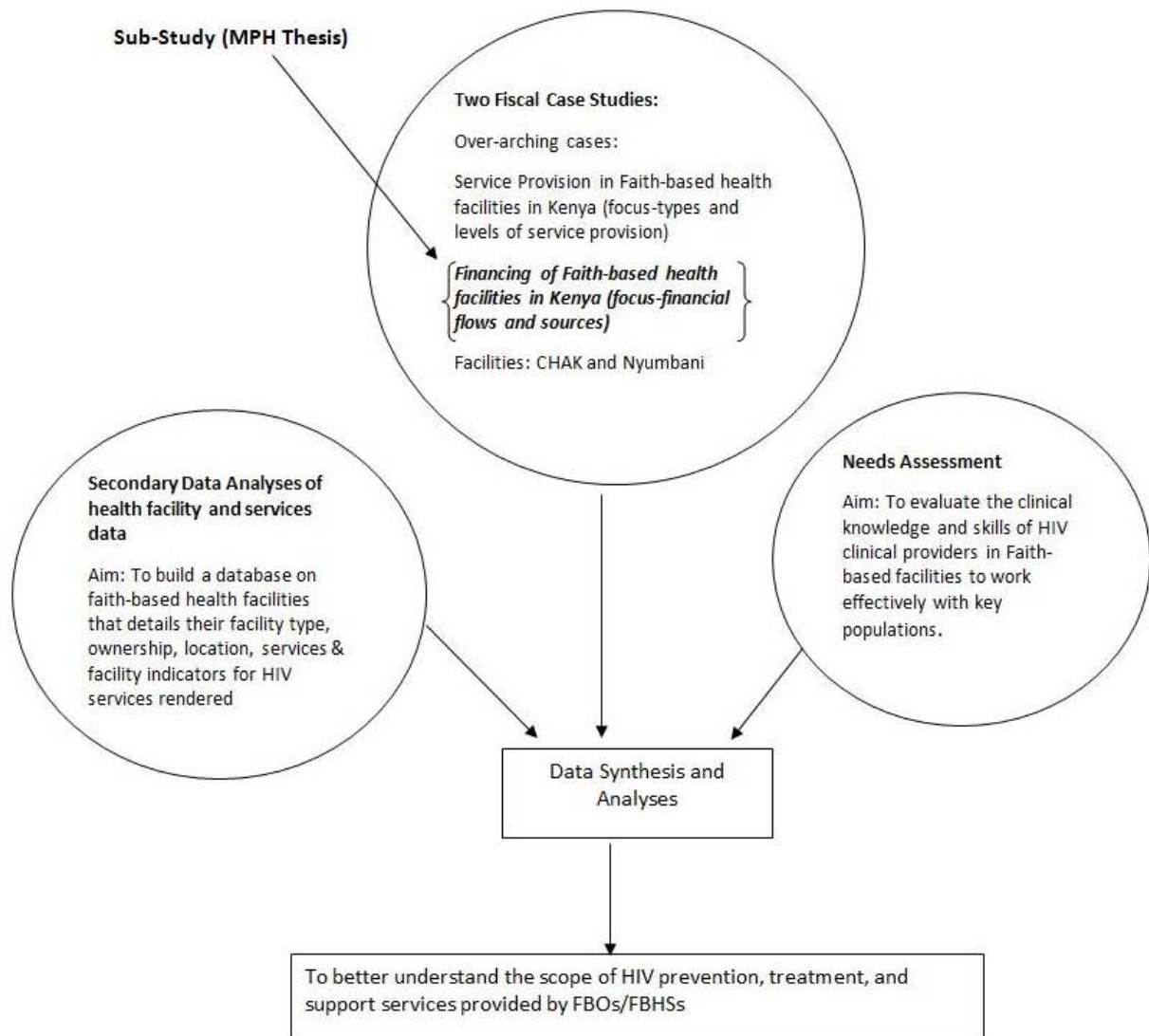
- 1) Building the evidence base of the contributions of faith-based facilities to HIV services through a mixed method analysis

- 2) Understanding the influence of religion on stigma for key populations and working with faith-based health systems to minimise stigma for those populations

- 3) Authoring reports detailing the work of the overall UNAIDS/PEPFAR partnership and the proceedings from the country-level consultations that will be carried out

- 4) Supporting ACHAP as it carries out a set of health and community systems strengthening activities. These combined efforts will help build and strengthen collaborations with FBHPs and help ensure that their resources are aligned, mobilised and sustained in the identified priorities of UNAIDS Fast Track and PEPFAR 3.0 in order to continue the hard-won progress made against HIV infection rates.

Figure 1: Situating the sub-study within the broader research initiative



The full study entails fiscal case studies, secondary data analyses, and needs assessment. This small sub-study forms part of the fiscal case studies as represented in Figure 1. This small sub-study specifically examines CHAK’s AIC Kijabe hospital and Nyumbani as facilities which were pre-selected for the broader study as they are located in Kenya, and are part of the UNAIDS/PEPFAR initiative which seeks to strengthen partnerships with FBOs in several UNAIDS and PEPFAR partner countries in identified focus areas (UNAIDS 2015). The full study will be conducted over a four-month period between February and May 2017. The broader project will seek ethical approval from the African Medical and Research

Foundation (AMREF) ethics and scientific review committee in Nairobi, Kenya (see full AMREF application attached to this application). Dr. Jill Olivier is both the supervisor of this thesis project and co-principal investigator (PI) of the broader project.

Methodology

This is a qualitative study with a flexible design - adopting a descriptive case study approach. Yin (2009, p20) defines case study as “an empirical inquiry that investigates a contemporary phenomenon in depth within its real-life context especially when the boundaries between phenomenon and context are fuzzy”. Case study approach is most suitable for this study because as researchers, we acknowledge the role played by multiple contextual factors within the Kenyan health system in influencing the role and functioning of non-state non-profit FBHPs in Kenya. In addition, it is suitable because this study seeks to answer a “how” question. In addition, as researchers, we cannot control the behaviour of those involved in the study. Furthermore, the boundaries between the influence of financial flows on the role and functioning of FBHPs (phenomenon) and the Kenyan health system (context) are not clear (Baxter and Jack 2008; Yin 2009).

In designing a case study, it is important to define certain parameters of the case study. One such parameter is the case, which can be decisions, individuals, processes, programs among others (Yin 2009). In this study, the case is identified as non-state non-profit FBHPs. This will be a multiple case study with two FBHPs, specifically CHAK’s AIC Kijabe hospital and Nyumbani. These cases were pre-selected for this study in line with the UNAIDS/PEPFAR joint initiative objectives.

This study will be bound by adopting the suggestion by Miles and Huberman (1994) where case studies are bound through clear definition and context (Miles and Huberman 1994). For this study, the boundaries will be key stakeholders of both CHAK's AIC Kijabe hospital and Nyumbani. Binding will place boundaries on the case so that the study does not attempt to answer a research question that is too broad or a research issue that has too many objectives for a single study (Baxter and Jack 2008). These boundaries are similar to the exclusion and inclusion criteria of quantitative studies.

The main case proposition is that source of funding for FBHPs influences the sustainability of the services provided by these organisations. Research conducted on the role of FBHPs in Africa indicates that FBHPs finance their services from a combination of resources which include: government resources, out-of-pocket payments from patients, donors, funding and in-kind contributions from faith groups and local communities (Olivier and Wodon 2012). However, recent research conducted suggests that FBHPs have recently experienced reduced financial support from traditional sources (see Ssenkooba et al 2002; Schmid et al. 2008; Rookes 2009; Rookes and Rookes 2012) which has substantially reduced their growth and commitment to those in greatest need. Furthermore, FBHPs serve certain roles, which range from channelling grants to member facilities to acting as facilitators. These revolving roles continue to evolve with increased FBHPs engagement with government and donors (see Dimmock et al 2012).

Conceptual framing

This interdisciplinary sub-study will not apply a particular conceptual framework. However, it is conceptually framed by the understanding that this study is rooted in the field of Health

Policy and Systems Research (HPSR), which is by nature interdisciplinary drawing on methods and perspectives from a range of disciplines (Gilson 2012). We will also be drawing on health economics approaches and the existing body of work on the financing of health systems. Finally, this research is also framed by the existing work on FBHPs in Africa-which is a small but distinct body of work-see for example, the work of the International Religious Health Assets Program (IRHAP).

Data collection methods

Case study inquiry involves more variables of interest than data points and therefore relies on multiple sources of evidence with convergence of data also known as data triangulation (Baxter and Jack 2008; Yin 2009). Thus, for this study, we will utilise multiple data collection tools, which include primary literature review, secondary literature review, in-depth semi structured interviews and secondary data analysis. This will ensure rigor in the case study.

Primary literature review: This research will draw on primary literature such as organisational documents including contracts (MOUs, SLAs), minutes from organisation meetings, reports, policies and other legislative instruments.

Secondary literature review: The study will utilise both peer-reviewed literature and grey literature. Secondary literature is essential as it will enable us to gain a broader understanding of FBHPs within the Kenyan health system. Literature reviewed will examine key health systems reforms that have occurred since Kenya gained independence, health financing policies, decentralisation of Kenyan governance structures and the history of

FBHPs in Kenya. All these concepts will be examined borrowing from other LMICs especially in Sub-Saharan Africa.

In-depth semi structured interviews: Primary data will be collected through in-depth semi-structured key informant interviews (KIIs) held with 5 to 15 key stakeholders in both CHAK and Nyumbani. They will be conducted using open-ended questions. In-depth semi structured interviews have been selected as a method of data collection as they will give personal accounts of the participants which are deemed central in research due to the power of using language to illuminate meaning. Also, they will enable us as researchers to grasp the participants' point of view (Legard et al. 2003) in addition to probing, engagement and refinement of preliminary findings and direct enquiry into further meanings (Miles and Huberman 1994). This will allow for a rich picture of the study topic (Rapley 2001).

In-depth interviews will seek to elicit information on:

- a. FBHPs funding sources with a focus on Global funders such as PEPFAR or the Global Fund, National Government, *faith-based partners*, In-kind contributions.
- b. FBHPs funding structures
- c. Sustainability of FBHPs with a focus on cost recovery mechanisms.

Prior to conducting the interviews, an interview guide will be formulated and tested (Appendix 1). Any difficulties identified during pre-testing will be rectified. All interviews will be conducted in either English or Kiswahili as these are the official languages of communication at both CHAK and Nyumbani (the primary researcher, LK, is fluent in both languages). Interviews will be conducted in privacy settings in a location chosen by the

participant to ensure privacy and confidentiality and to minimise disruptions. They will last approximately one hour. All interviews will be audio-recorded with consent from each participant. However, if a participant declines to be audio-recorded, the researcher will conduct note taking. (See below for more on ethics relating to the KIIs). We will conduct member checking by giving back data collected from the interviews to study participants for review. This will ensure accuracy of data.

Secondary data analysis: Secondary data analysis and syntheses will be conducted for this case study. This will include existing data being collected for the broader study (such as PEPFAR financial data), and publicly available data sets such as the health system tracking data from the Kenya Health Management Information System (KHMIS). Secondary data analysis is advantageous for this research because we anticipate it will eliminate the burden of data collection (Heaton 2008) from the high number of CHAK facilities. In addition, financial data on projects and annual reports will enable us to identify sources and trends in funding to both CHAK and Nyumbani in addition to information on expenditure. This is essential in our study because, if used together with other data sources such as secondary literature and in-depth interviews, it will indicate the relationship between sources of funding and the role and functioning of FBHPs in Kenya. Furthermore, use of secondary data will increase rigor and generalizability of our research findings to other FBHPs.

Participant sampling and recruitment

Purposive sampling will be used in sampling research participants. This will entail making strategic choices about; with whom, where and how we will conduct the study, tied to the study objectives (Given 2008). The study will also then use snowball sampling (also known

as chain-referral) where individuals involved in management of CHAK and Nyumbani will be identified from primary literature and key stakeholder meetings held during the research negotiation process. Following identification of initial key stakeholders, they will be asked to identify other potential participants. Direct recruitment will be undertaken where potential study participants will be contacted in person.

Data management

Before each interview, each consent form will be reviewed for completeness. Each interview session will be identified using a unique personal identifier code assigned to each study participant. All participant consent forms, interview transcripts and audio recordings will be stored in password locked computers to avoid loss of data and to maintain data confidentiality. Only the research team will have access to this data. Interviews conducted in Kiswahili will be translated to English. Data collected will then be transcribed by professional transcribers. Transcription will involve whole-document transcription as opposed to translation of selected parts. In addition, transcription will include verbatim such as slang, grammatical errors, background noise, mispronunciations, non-verbal gestures among others to ensure collection of rich data. We will ensure proper data management by having a realistic timeline to avoid rushing the process (Fritz 2008).

Data analysis

Data analysis will be undertaken as an iterative process throughout the study. Narrative thematic analysis and limited (secondary) statistical analysis will be used to analyse findings from multiple forms of evidence. Thematic analysis is most suitable for analysis of data in

this study, as it will enable us reach conclusions from multiple data sources by identifying common themes (Robson 2002). Data analysis will be done within each organisation (within case analysis) and between the two organisations (Cross-case analysis - see Yin 2009).

Ethics

This sub-study will be conducted as part of a broader study conducted in Kenya (with lead PIs from Emory University, Atlanta, USA.) Therefore, ethical approval for the broader project as well as this sub-study has already been obtained from the African Medical and Research Foundation (AMREF) in Kenya. In addition, ethical approval will be obtained from the University of Cape Town – so that this sub-study can be used for degree purposes. Furthermore, permission has been sought and gained from the General Secretary of CHAK and the Executive Director of Nyumbani (letters attached in Appendix).

This case study mainly relies on secondary analysis of publicly available data. However, the additional and informational KIIs require some ethical considerations. Prior to participating in the study (and specifically in the KIIs), each participant will be provided with information about the research and taken through a consent process. Potential participants will be informed that participation in this research is on voluntary basis and there will be no consequences from withdrawing from the study. Participants will be informed on the research purpose, how the research will be performed, anticipated risks, potential benefits, extent of confidentiality and the right to withdraw from the research at any point without suffering negative consequences. All this information will be contained in a written consent form which will be in English (which is language of common use in health professionals in Kenya). Researchers will go through the written consent form with the participants to

ensure that all the information is well understood before consent to participate is given. In addition, participants will be given ample time to decide on participation. After this period, each participant will be asked to sign the consent form (see Appendix 2) thereby indicating willingness to participate in the study.

Privacy and confidentiality: Privacy and confidentiality of the participants' information will be ensured. All Interviews will be conducted in private settings to ensure privacy. In addition, personal identifiers such as participants' names will be removed from interview transcripts and will be replaced by assigned unique personal identification codes to ensure confidentiality. Data collected will be stored in password-locked computers which only the research team will have access. All data will be backed-up on an external drive to avoid loss of data. Participants will be informed that findings from the study will possibly be published in a scientific journal. If published, participants will not be identified in the publication without seeking prior permission. Furthermore, participants will be informed that data collected from in-depth interviews during this study will be held for a period of 90 days following which it will be destroyed using appropriate channels.

Description of risks and benefits: There are no direct individual benefits of participating in this study. There are some minor institutional risks that will be managed. For example, this research focuses on financial data – and there are consequences to such information being reported (for example, if it is shown that FBHPs have large financial reserves, this could have consequences on the level of government subventions to FBHPs). This is unlikely – but such risks will be carefully considered and mitigated by the research team and partner institutions before publications are submitted.

Reimbursement for participation: Participants will not receive any financial reimbursement for participating in the study. However, their efforts will be acknowledged in the dissertation write up published by the University of Cape Town (UCT).

Dissemination of findings

The results of the study will be disseminated in the format of a dissertation at UCT and possibly, a journal article which will be published in a suitable peer-reviewed scientific journal. In addition, meetings will be held with key stakeholders which include leadership in CHAK and Nyumbani before prior to publication.

Research project schedule

This study is scheduled to be conducted between 2016-2017 as indicated in Table 1.

Table 1: Research project schedule

	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUNE 17	JULY 17	AUG 17	SEP 17	OCT 17
Development of Research Protocol												
Literature review												
Ethical Approval from AMREF												
Ethical Approval from UCT												
Development of Interview Questions												
Recruitment of Research Participants												
Secondary Data Collection												
Conduct Interviews												
Preliminary Data Analysis												
Final Data Analysis												
Write-up of Research Findings												
Feed-back to Key Stakeholders												
Submission of Dissertation												

Study budget

This sub-study is funded through a bursary by Health Policy and Systems Division at UCT (through a UNAIDS/PEPFAR Joint research initiative grant). Financial cover includes researcher time and fieldwork costs.

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PART B: LITERATURE REVIEW

The history of the Kenyan private-non-profit health sector within the Kenyan health system: focus on financing

Introduction

According to the 2005/06 Kenya National Health Accounts (NHA) analysis, the private health sector¹ owns and manages two-thirds of all health facilities in the country. The size of the sector is estimated at Kenya Shillings (KES) 20.7 billion – although this figure is considered conservative as it does not include expenses for health policy and education especially in the emergence of private medical schools (Barnes et al. 2010; Kenya Healthcare Federation 2016), nor the contributions made by foreign nationals for healthcare in Kenya (Barnes et al. 2010). The private health sector in Kenya has experienced dramatic growth over the past two decades. One indicator of growth is the increase in the percentage of health facilities owned by the private health sector. In 1992, the private health sector owned and managed 47% of all health facilities in Kenya. By 2006, this figure rose to 59% (see Barnes et al. 2010). The rapid growth of the sector may be attributed to lack of adequate and quality services in the public sector (see Musau et al. 1998; Nyongesa et al. 2015); introduction of user fees in

¹ Refers here to the commercial health sector

the public sector; and health sector reforms in the 1980s and 1990s² (Barnes et al. 2010; Kenya Healthcare Federation 2016).

The Kenyan private sector consists of commercial (for-profit, PFP) stakeholders and non-profit providers – the latter consisting of a few non-governmental organisations (NGOs) and dominated by faith-based health providers (FBHPs, KHF 2016). This review focuses on not-for-profit providers, specifically FBHPs. FBHPs in Kenya are commonly organised as networks of religious groups on denominational lines, but there are some single individual organisations. Those organised as networks include: 1) the Christian Health Association of Kenya (CHAK), which represents Protestant health facilities and community-based health programs; 2) the Supreme Council of Kenyan Muslims (SUPKEM) which represents the Muslim facilities; and 3) the Kenya Episcopal Conference (KEC) which represents the Roman Catholic Church (Barnes et al. 2010; Blevins and Griswold 2014; KHF 2016). Examples of single organisations include Nyumbani Children of God Relief Institute (Nyumbani, Blevins and Griswold 2014).

The history of FBHPs in Kenya dates back more than a hundred years. FBHPs emerged from European and American “parent” churches with an aim of providing basic health care to those in most need and to preach the gospel (Rasheed 2009). It is estimated that FBHPs account for 11.3% of all health facilities in Kenya (Blevins and Griswold 2014) although FBHPs in Kenya have self-reported higher figures of around 40% (Olivier et al. 2015) – these discrepancies are mainly a result of the different denominator being measured (such as facilities, hospital beds, patients). With the notable growth of the private sector and the role

² Refer to sub-section on Key Health Systems Reforms in Kenya

the sector plays, the government should better understand the dynamics of the sector, so as to develop policies that enhance the contribution of private care to national goals (Berman 2000).

Review method

A scoping review was conducted to examine how FBHPs are situated within the Kenyan health system. The review seeks to highlight previous literature on financing of FBHPs in Africa and in Kenya while pulling on other low- and middle-income countries (LMICs) with the intent of identifying key issues in financing of FBHPs. It also seeks to map out key health system reforms in Kenya from independence to-date and the history of FBHPs in Kenya with the intent of understanding reforms and policies that have influenced how FBHPs in Kenya are financed.

The literature search included a search for both academic articles and grey literature using Google Scholar as the primary search engine and database. Key search words used in multiple combinations including: health reform, health system, non-profit providers, non-state providers, faith-based organisation, faith-based health provider, low- and -middle income countr*, Africa, sub-Saharan Africa, Kenya, financ*, fund*, public-private partnership. Academic articles were also identified from the International Religious Health Assets Programme (IRHAP) database at the University of Cape Town. Literature was also identified using reference searches from academic articles already identified from both Google scholar and the IRHAP database. In addition, literature was searched from organisational documents including AIC Kijabe annual reports, AIC Kijabe HIV program reports, Nyumbani annual reports, Nyumbani United States Agency for International

Development (USAID) annual reports, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) annual reports. Several open-access databases were utilised including; the Kenya master health facility (KMHFL)³ and Kenya NHA 2012/13. Data from websites including the World Health Organization website⁴, the World Bank website⁵, and the United States President's Emergency Plan for AIDS Relief (PEPFAR) website⁶ was utilized. Literature was also received from topic experts. The search focused on information related to Africa and Kenya but also pulled on other LMICs. The literature searched was limited to English-language literature.

Financing and faith-based health providers in Africa: Sources of financing

Most FBHPs have experienced major changes in their financial resourcing in the last decades (Olivier et al. 2015). Some of the changes FBHPs have made are in their sources of funding. This may be attributed to reduced funding from parent churches following independence in most African countries (see Rookes 2009). Rookes and Rookes (2012) sought to investigate the adaptations made by Christian FBHPs in Sub-Saharan Africa (SSA) and Asia in response to a decline in traditional funding and their implications in service provision. The study used publicly available data from annual reports, strategic plans, organisational websites and stakeholder interviews to conclude that FBHPs have responded to the decline of funds in three ways: increasing their cooperation with respective governments, relying on funding from international donors, and increasing user fees. The study concluded that despite

³ [Kmhfl.health.go.ke](http://kmhfl.health.go.ke)

⁴ www.who.int

⁵ www.worldbank.org

⁶ <https://www.pepfar.gov>

financial difficulties faced by FBHPs, the majority have retained their commitment to the poor. However, a major limitation here was a lack of facility level financial data.

Currently, FBHPs finance their services from a combination of bilateral and multilateral donors, government funding, out-of-pocket funds from patients, funding and in-kind contributions from faith groups and communities (Olivier and Wodon 2012). FBHPs also source their funding through different mechanisms. For example, donor funding to FBHPs is more in the form of project funding (see Schmid et al. 2008; Rookes 2009). Haakenstad et al. (2015) estimated that the largest share of health development to FBOs in LMICs goes to HIV/AIDS programs. For example, in Rwanda there has been a massive influx of external funding towards FBHPs in the country with the aim to bolster HIV/AIDS care (Maurice 2015).

It has been noted that many FBHPs utilise user fees as a source of financing, due to the need to recover a large share of their costs (cost recovery mechanisms, sometimes described as Robin Hood payment mechanisms – see Olivier et al. 2015). For example, a study by Tsimpo et al. (2012) shows that, in Ghana, FBHPs associated with CHAG have higher out-of-pocket costs compared to public providers. This was attributed to lack of public subsidies when user fees were abolished. User fees serve as a means of encouraging accountability of health care providers and increasing autonomy. However, user fees can be a barrier to accessing healthcare especially in the absence of risk pooling mechanisms (Tsimpo et al. 2012). In assessing user fees in FBHPs, challenges in data collection need to be anticipated, as out-of-pocket payments funding is hidden in FBHP data (Olivier et al. 2015).

Governments engage the private sector through several public-private partnership (PPP) models described by Whyte and Olivier (2017). These include contracting out, sector-wide approach (SWAp), voucher programs, financial support, social marketing, public-private mix and public-private partnership.

Contracting: Contracting is defined as “a voluntary alliance of independent or autonomous partners who enter a commitment with reciprocal obligations and duties, in which each partner expects to obtain benefits from the relationship” (Perrot et al. 1997). For example, the MOH in Malawi contracts selected facilities owned by the Christian Health Association of Malawi (CHAM) to deliver care to vulnerable populations through service level agreements (SLAs) since 2004. SLAs are a national policy priority in Malawi instigated under decentralisation, aimed at ensuring universal financial protection. There has been concerns of sustainability of these SLAs. For instance, issues such as lack of transparency, late payment of bills, poor communication within and between stakeholders, lack of price revision have been identified as the main deterrents in the performance and continuation of SLAs in Malawi (Chirwa et al. 2013).

Contracting may involve “transfers of money or goods conditional on taking a measurable action or achievement of predetermined performance targets”- referred to as Performance-based (Eichler and Levine 2009). Ssengooba (2010) assessed performance-based contracting in a pilot project in Uganda involving both public and PNFP hospitals in five districts. The case study identified that contextual factors such as financial disbursement, staff movements and cost of service provision are constraints in hospitals’ response towards performance-based contracting.

A recent report by the Institute of Tropical Medicine in Antwerp, Belgium (2009) assessing contracting between faith-based and public health sector in Sub-Saharan Africa in Cameroon, Tanzania, Chad and Uganda shows that despite contextual differences, there are great difficulties facing contracting between the faith-based and the public sector. It was evident that for contracts to work adequate financial and human resources were required- these were termed as '*resourceful contracts*'. Challenges facing contracting can be attributed to multiple factors including: poor information and lack of preparation of stakeholders, lack of support mechanisms, lack of monitoring and evaluation systems, failure of government to respect commitments and lack of proper management systems. In addition, it was noted that contracts between PEPFAR and FBHPs in Uganda offered an avenue for improving existing contractual relationships between the faith-based and public-sector due to the quality and sustainability of their monitoring and evaluation mechanisms, donor's respect for commitment and their predictability. However, the findings of this study were challenged by the fact that it was difficult to separate the contracting relationship from contextual effects (Boulenger et al. 2009).

Staff-secondment: Staff secondment is one of the PPP mechanisms through which the partnership between governments and FBHPs is being realised in SSA (see Jacob 2014; Walt and Olivier 2017). This is not only in response to the human resources crisis plaguing health systems in most African countries (Anyangwe and Mtonya 2007; Lange et al. 2008), but also in human resource subsidisation. Staff secondment in Africa is varied. In countries where there is substantial FBHPs such as Ghana and Uganda, there is usually an MOU in place, which indicates how resources are to be shared (see Dimmock et al. 2012). In countries

where FBHPs have a smaller presence such as Mali, there is rarely a contractual relationship (see Schmid et al. 2008).

For example, the Christian health association of Ghana (CHAG) held a contractual agreement with the MOH in Ghana, which began in 2008 where the MOH would post, and pay salaries for newly qualified nurses directly to CHAG facilities just as it did to the Ghana health services (Dieleman 2009). In addition, in Uganda, the government is working with PNFP facilities under the arrangement that staff is recruited, paid and supervised by the government but deployed at a PNFP facility (Barugahara et al 2008). Similarly, in Cameroon staff-secondment exists as a PPP between NFP FBHPs and the Cameroonian MOH (see Kuh 2014).

Key issues in faith-based health providers in Africa

Evidence from research done to assess the flow of international funding to FBHPs in other contexts in LMICs indicate diverse flow of funding from donors. For example, funding from bilateral and multilateral donors has been shown to come to FBHPs through national strategies, as shown in the case of the Christian Health Association of Zambia (CHAZ) being a primary recipient of the Global Fund. Funding can also flow directly from international non-governmental organisations to FBHPs (Olivier et al. 2015).

There exists little literature showing comprehensive tracking of FBHPs funding streams (Olivier et al. 2015). This may be because FBHPs are usually reluctant to share financial data (Schmid et al. 2008). For example, in the Democratic Republic of Congo (DRC)-where FBHPs provide up to 70% of health services-there is historic resistance to share financial data. This

may be due to the perception that HIV response is not well coordinated as a result of an outdated national strategy and dissimilar funding thereby undermining collaboration between the government and Christian FBHPs (Haddad et al. 2008).

Despite inadequacy of data and evidence on FBHPs/FBOs, they have been perceived to receive increased funding in recent years (Olivier and Wodon 2014). Some macro-level assessments have been done to examine financing of 'faith-based organisations' (FBOs) – which is a broader category than FBHPs and includes health-engaged faith-based NGOs. Olivier and Wodon (2014) assessed the magnitude and characteristics of donors and other sources of funding toward FBOs in relation to HIV/AIDS response compared to civil society organisations. The study concluded that well-established faith-based CSOs and secular CSOs access similar sources of funding. It was difficult to measure the strides made in enhancing funding mechanisms for smaller initiatives of both faith-based and secular CSOs, despite being fundamental for support to those who suffer or are at risk of HIV/AIDS. The study also concluded that there was increased availability of funding among both faith-based and secular organisations for the period between 2000 to 2005.

Also, Haakenstad et al. (2015) assessed external funding to FBOs in LMICs who, for the most part, played a role of channelling funds from both public and private actors in high income countries (HICs), in addition to acting as mediators in LMICs. The study estimated funds for health provided to FBOs in LMICs between 1990 to 2013. It was found that developmental assistance for health increased at a rate of 10% per year between 1990 and 2013, with the period of fastest growth being between 1999 and 2008, coinciding with President George Bush's administration. It was also noted that funds provided by the Global Fund to FBOs has

grown since 2002. It was also further noted that Developmental assistance for HIV/AIDS peaked in 2007 and plateaued between 2008 and 2011. This study was challenged by the fact that the data focused exclusively on public funding of FBOs thereby limiting the scope of coverage.

Despite evidence indicating increase in HIV/AIDS funding, there exists conflicting evidence indicating massive reduction in HIV funds to FBOs. For example, in Namibia, PEPFAR support has reduced, prompting closure of six regional offices ran by the Catholic AIDS Action which provided support to approximately 2500 adults and over 3000 orphans and vulnerable children. The organisation has also had to change its home-based care strategy to home assessments and referral to government structures (Caritas 2015).

Concerns have been raised as to whether the substantial international funding provided for HIV/AIDS has indeed trickled down effectively to the local level (Olivier and Wodon 2014). Bonnel et al. (2013) examined the global magnitude of funding in civil society organisations (CSOs)⁷ in India, Kenya, Nigeria and Peru. This study indicated that despite funding to CSOs having increased substantially between the years 2003 and 2009 – since most of this funding went directly to large national CSOs, only a small share of international resources trickles down to local communities. For example, it was noted that in Kenya, despite CSOs having received 32% of the total HIV and AIDS funding, only 2% was disbursed to community-based organisations (CBOs). In addition, it was noted that CBOs supplement

⁷ CSO is a broader term, in this case including non-governmental organisations (NGOs), community-based organisations (CBOs) and faith-based organisations (FBOs),

international funding with other sources of funding such as national funds and volunteer funds.

It is evident that donors are an indispensable source of FBHPs/FBOs financing. It may therefore be assumed that donor funding comes with only positive effects. A case study of Cameroon by Van Wees (2017) sought to identify the implications of donor engagement with FBOs for the health system. This study indicated that despite donor funding intending to strengthen FBO networks and facilities, donor engagement mostly realised negative effects to both FBOs and the health system.

With FBHPs having multiple sources of financing, costing studies have been conducted. For example, a study by Levin et al (2000) reveals that the costs of health services differ between FBHPs and public hospitals. Broader differences were visible when comparing costs between hospitals in the public sector and those run by FBHPs. In addition, between health centres in the public sector and those run by FBHPs. Differences in costs were attributed to differences in roles of facilities, use and availability of materials and equipment, number and level of personnel delivering services, and utilisation of services. A comparative study assessing the differences in the private cost of healthcare between providers suggest that many public providers charge cheaper user fees than FBHPs (Tsimpo et al. 2012). In examining allocation of resources, a costing survey conducted by Flessa (1998) with Evangelical Lutheran Church hospitals in Tanzania concluded that improvement of technical efficiency would not safeguard the survival of the hospital-based health care services as costs of providing care are routinely higher than expected. The study called for reallocation of FBHP health care resources to lower levels of the health care pyramid.

Few studies assess financing in relation to medicines. A rather dated landscaping multi-country comparative study of SSA countries assessing medicine supply and distribution activities of FBOs revealed that, purchase costs were the main budget line in the financial overviews of drug supply organisations. In addition, it showed that part of the income for drug supply organisations was covered through donor support (Banda et al. 2006).

FBHPs in Africa encounter challenges in their operations. A study done in Malawi, Kenya and DRC reveals that, for example, in Malawi, the large number of donors engaging with Christian FBHPs has been identified as a challenge (as well as a strength) in relationships between FBHPs for sustainability of their services. Concerns were raised on the powerful role undertaken by donors, which were perceived to undermine the realities of locals. In addition, it was felt that funding was not reaching programs in the communities, as FBHPs were not able to fully access the National AIDS Commission, and due to the already existing weak relationship FBHPs had with Malawi Interfaith AIDS Association (Haddad et al. 2008).

Sustainability of service provision is key for FBHPs. A study done in Uganda indicated that HIV funding mechanisms are not sustainable and calls for multiple sources of funding with such as direct government funding, National health insurance, out-pocket service, private insurance, community health insurance and co-payment to subsidize costs of care (Kakaire et al. 2016). This is important for future research as it is not clear the role some of these sources of funding play in FBHPs.

Table 1: Evidence map on FBHP financing in Africa and other LMICs

Authors	Title of the Study	Country of Focus	Type of Study	Insights
Appiah 2013	Handle with (faith-based) care	Africa	Desk Review	-African governments support FBHPs through contracting, staff secondment or direct grants
Banda et al. 2006	Multi-Country study of the medicine supply and distribution activities of faith-based organizations in Sub-Saharan countries	SSA	Descriptive comparative multi-country study	-Purchase costs were the main budget line in the financial overviews of DSOs -Part of the income for DSOs was covered by donor support
Berman 1996	The role of the private sector in health financing and provision	LMICs	Review with country level data	-Social insurance can significantly influence the private sector behaviour via the market in terms of new investments in certain types of facilities -Decreased public financing may be associated with growth in the private sector -Little research on other sources of private expenditure such as private companies
Blevins et al. 2016	Reflections on HIV-related experiences of two global funding mechanisms supporting religious health providers	LMICs	Review of HIV program level data	-There has been a tremendous shift in funding structures in the past 8 years -Funding through bilateral and multi-lateral programs such as PEPFAR and Global Fund has remained constant but allocation of funds has shifted to prioritize in-country funding rather than international FBOs -Future issues in health financing: advocacy, impacting local communities, and broadening beyond HIV/AIDS
Bonnel et al. 2013	Funding mechanisms for civil society: The experience of the AIDS response	Kenya, India, Nigeria, Peru	Review with country funding profiles and CBOs level data	-Funding provided to CSOs between 2003 to 2009 has become substantial with part of this funding directly reaching large national CSOs -Only a small share of international resources trickles down to local communities -CBOs are able to supplement international funding with other sources of funding such as national funds and volunteer funds
Boulenger et al. 2009	Contracting between faith-based and public health sector in Sub-Saharan Africa: an ongoing crisis: The case of Cameroon, Tanzania, Chad and Uganda	Cameroon, Tanzania, Chad and Uganda	Realistic evaluation with country level cases	-For contracts between faith-based and public sector to work, they need adequate finance and human resources, referred to as 'Resourceful contracts' -Contracting challenges include poor information, lack of stakeholder preparation, support mechanisms, lack of M&E mechanisms.
Caritas 2015	Ending AIDS as a public health threat: Faith-based organisations (FBOs) as key stakeholders	Swaziland, Zambia, Uganda, Kenya, SA, Tanzania	Multiple case study of FBOs	-Talks about the massive reduction in HIV funds to FBOs
Chirwa et al. 2013	Promoting universal financial protection: contracting faith-based health facilities to expand access	Malawi	Mixed method study; facility level data	-Raises concerns of SLA sustainability in Malawi -Identifies deterrents of SLAs e.g.: lack of transparency, late payment of bills, poor communication within and between stakeholders, lack of price revision
Dieleman 2009	Quest for quality: Interventions to improve human resources for health among faith-based organizations	Ghana, Malawi, Uganda, Tanzania	Descriptive case study with country level data	-HR subsidization is contributing in solving the HR crisis in health
Dimmock et al. 2017	Half a century young: The Christian Health Associations in Africa	SSA with focus on countries where	Review of CHAs data	-Challenges faced by CHAs include: increased demand resulting in a strain in health providers; human resources for health crisis; reduced funding from traditional

Authors	Title of the Study	Country of Focus	Type of Study	Insights
		CHAs exist		sources; targeted funding not allowing for long-term or core activities; government support, responsibility and cost recovery; and erosion of Christian values
Flessa 1998	The costs of hospital services: a case study of Evangelical Lutheran Church hospitals in Tanzania	Tanzania	Costing Survey at facility level	-The study concluded that improvement of technical efficiency would not safeguard the survival of the hospital-based health care services of the Lutheran Church in Tanzania as costs of providing care are higher than expected -Reallocation of health care resources to lower levels of health care pyramid needed
Global Fund 2008	Report on the involvement of faith-based organizations in the Global Fund	The Global Fund	Program-level data	-FBOs implement Global Fund programs as principal recipients or sub-recipients for example, World Vision International, Catholic Relief services, Churches Health Association of Zambia among others
Haakenstad et al. 2015	Estimating the development assistance for health provided to faith-based organizations	LMICs	Desk review of agency data and Project level data	-Funds provided by the Global Fund to FBOs have grown since 2002 -Developmental assistance for health increased at a rate of 10% per year 1990-2013 -Largest share of health development to FBOs goes to HIV/AIDS programs -Developmental assistance for HIV/AIDS peaked in 2007 and plateaued 2008-2011
Haddad et al. 2008	The potentials and perils of partnerships: Christian religious entities and collaborative stakeholders responding to HIV in Kenya, Malawi and the DRC	Kenya, Malawi, DRC	Review with country-level HIV financing data	-Challenges facing FBOs -Notes the historical resistance to share financial data-especially in DRC
Kakaire et al. 2016	The future of financing for HIV services in Uganda and the wider Sub-Saharan Africa region: should we ask patients to contribute to the cost of their care?	Uganda and the broader SSA region	Review with country level data	-Current HIV funding mechanisms in Uganda are not sustainable -Calls for multiple sources of funding with options such as direct government funding, National health insurance, out-pocket service, private insurance, community health insurance and co-payment to subsidize costs of care
Kuh 2014	Public Private Partnership in the Cameroonian health system: A case study of staff secondment into the Maroua-Mokolo Diocese	Cameroon	Case study with facility level data	-Secondment (as a PPP mechanism), despite being considered helpful in health systems strengthening, resulted in resistance rather than strengthened partnership
Levin et al. 2000	Costs of maternal health care services in three Anglophone African countries	Uganda, Malawi and Ghana	Case study, cost estimate of maternal health services	-Costs differ between mission and public hospitals -Differences in costs may be attributed to differences in roles of facilities, use and availability of materials and equipment, number and level of personnel delivering services, and utilization levels of services
Maurice 2015	Faith-based organizations bolster health care in Rwanda	Rwanda	Review with HIV country-level data	-Successes in reducing HIV prevalence achieved through massive donor funding -18% of funding for HIV activities for the years 2012/13 came from public funding with the rest being externally funded -Donor funding has halved over the years
Olivier and Wodon 2014	Increased funding for AIDS-engaged faith-based organizations in Africa?	SSA with a focus on Southern African countries	Secondary data review with CSOs studies	-Donor funding has increased in formal and established CSOs -Informal community initiatives are fundamental in providing support to those who suffer from HIV/AIDS and those who are at risk -Rapid scale up of response to HIV/AIDS from CSOs especially the period of 2000-2005 -Questions of sustainability of newly created CSOs have arisen
Olivier et al.	Understanding the roles of faith-based health	Africa	Description review	-FBHPs finance their services form a combination of user fees, government funds,

Authors	Title of the Study	Country of Focus	Type of Study	Insights
2015	providers in Africa: review of evidence with a focus on magnitude, reach, cost, and satisfaction		with country cases	donors, and in-kind contributions from faith groups and local communities -Little comprehensive tracking of funding streams exist -User fees are hidden at evidential level
Reinikka & Svensson 2010	Working for God? Evidence from a change in financing of non-profit health care providers in Uganda	Uganda	Tests two theories of organizational behaviour	-Financial aid leads to more laboratory testing, lower user charges, and increased utilization
Rookes 2009	Commitment, conscience or compromise: The changing financial basis and evolving role of Christian health services in developing countries	Malawi and India	Descriptive case studies at country level	-Funding from parent churches to CHSs have reduced -Funds are more in the form of project funding -Christian FBHPs continue to provide services by providing low cost services, developing hi-tech tertiary services and working closely with respective governments
Rookes and Rookes 2012	Have financial difficulties compromised Christian Health Services commitment to the poor?	SSA and Asia with focus on Malawi and India	Descriptive country case studies	-FBHPs have responded to declining funds by increasing their cooperation with governments, relying on funding from international donors, and increasing user fees -Despite financial difficulties FBHPs have retained their commitment to the poor
Schmid et al 2008	The contributions of religious entities to health in Sub-Saharan Africa	SSA, with close focus on Uganda, Mali and Zambia	Descriptive scoping review with country case studies	-Most FBHPs, previously mission-funded, now funded to some extent by government, but FBHP facilities still reliant on user fees -Funding is received from a variety of funders with differing aims and conditions, much supporting vertical programs
Ssengooba 2002	What could be achieved with greater public hospital autonomy? Comparison of public and PNFP hospitals in Uganda	Uganda	Descriptive cross-sectional survey with data from 13 FBHP facilities	-Government is a major source of qualified health workers (this is an indicator of good collaboration) in Uganda -More than 70% of seconded staff were recruited by local government -There exists both positive and negative perceptions of staff secondment
Ssengooba 2010	Performance-based contracting: case study for non-profit hospitals in Uganda	Uganda	Case study with facility level data	-The case study found that contextual factors such as financial disbursement, staff movements and cost of service provision were constraints in hospitals' response towards performance-based contracting
Tsimpo et al 2012	Differences in the private cost of health care between providers and satisfaction with services: results for sub-Saharan countries	SSA	Review with country-level data	-Cost of healthcare remains a major concern for households -There exists differences in out-of-pocket costs for households between providers, with many public providers being cheaper than FBHPs and private secular providers -Differences in cost between countries are not as large as previously assumed
Van Wees 2017	Implications of donor engagement with faith-based organisations for health systems: a case study example from Cameroon	Cameroon	Mixed method case study	-Despite funding with the intention of strengthening FBO networks and facilities, donor engagement mostly realized negative effects for both FBOs and the health system
Whyle and Olivier 2017	Models of public-private engagement for health services delivery and financing in Southern Africa: a systematic review	Southern Africa	Systematic review	-PPE models in literature: contracting out, SWAp, Voucher programme, financing, social marketing, PPM approach, co-location PPP and DP regulation

Key health system reforms in Kenya

In this next section, we will map out key health system reforms in Kenya from independence to-date and examine the history of FBHPs in Kenya. This will help gain an understanding of reforms and policies that have influenced how FBHPs in Kenya are financed as FBHPs in Kenya do not work in isolation – but operate within the broader health system.

According to the WHO, health development around the world has undergone three generations of reforms (WHO 2000). Similarly, the Kenyan health system has undergone these reforms over the past decades, which include: development of the governmental system in 1960s, centralization and emphasis on primary health care through 1970s and 1980s, and decentralization and restructuring in 1990s (Wamai 2004). This sub-section describes key reforms in the Kenyan health system through these timelines.

Box 1: Kenyan timeline 1960s-1970s

<p>1964: Centralized government system introduced</p> <p>1965: Sessional paper No. 10 on “African Socialism and its application in Kenya” introduced</p> <p>1965: User fees abolished</p> <p>1966: National Health Insurance Fund (NHIF) established</p> <p>1972: Voluntary NHIF membership introduced</p> <p>1977: Adopted the “<i>Health for All</i>” model (also referred to as the Alma-Ata declaration on Primary Health Care-PHC)</p>

The history of the Kenyan health system dates back to the pre-colonial time, with the establishment of mission stations in Kenya in the 1890s (Kimalu et al. 2004). This saw the establishment of a private health sector with provision of health services dominated by voluntary organizations, particularly church missions and societies more so in rural areas (Mburu 1989). After Kenya was colonised by the British in early 20th century, a

discriminative user fees policy was imposed by the colonial government in all public facilities (see Chuma and Okungu 2011). At the time, Kenya had a *majimbo* governance structure (federal structure) which granted significant acknowledgement and accountability to local governing structures. Local authorities had the mandate to oversee health facilities among other responsibilities. When Kenya gained independence in 1963, the new government sought to re-organise resources to benefit the citizens (Collins et al. 1996; Wamai 2009). Changes in governance enabled re-organization of resources. For example, in 1964, the then ruling party Kenya African National Union merged with the opposition party Kenya African Democratic culminating into a centralized system of governance (SPAN and KHRC 2010).

During this transition period, one of the policy documents that guided on-going economic developments was Sessional Paper No. 10 on *“African Socialism and its Application to planning in Kenya”* of 1965. The paper advocated for elimination of three vital challenges- disease, poverty and illiteracy (Collins et al, 1996; Wamai 2009). Consequently, two years later, user fees of KES 5.00 that had been implemented by the colonial government were abolished at all public facilities (Chuma and Okungu 2011; Abuya et al. 2015). Therefore, the health system in Kenya at the time was primarily financed through general taxes (Carrin et al. 2007). However, in 1966, National Health Insurance Fund (NHIF) was established through an act of parliament (Wamai 2009; Chuma and Okungu 2011; Muiya and Kamau 2013; Abuya et al. 2015). Initially, membership was only compulsory for those in the formal sector of employment (Carrin et al. 2007) and earning more than KES 1000 (Abuya et al. 2015). In 1972, voluntary NHIF membership was introduced to incorporate those in the informal sector together with those earning less than KES 1000 (Abuya et al. 2015).

Globalization processes both within and outside the health sector redefined the framework for health policies in Kenya thereby influencing the structure of the health system. For example, in 1977, Kenya adopted the WHO *“Health for All”* model that sought to attain a certain level of health that would permit all people to lead a socially and economically productive life by the year 2000. This saw rapid expansion of health infrastructure and marked improvement of health indicators (Wamai 2009).

Box 2: Kenyan timeline 1980s-1990s

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|--|
| <p>1983: District Focus for Rural Development initiated</p> <p>1986: Sessional paper no. 1 of 1986 on <i>“Economic Management for renewed growth”</i> introduced</p> <p>1987: Became a signatory of the Bamako initiative</p> <p>1988: Structural Adjustment Programmes (SAPs) introduced</p> <p>1989: <i>“Sixth National Development Plan of 1989-1994”</i> introduced</p> <p>1989: User fees introduced in all levels of care except dispensaries</p> <p>1990: User fees suspended in all public health facilities</p> <p>1991: User fees re-introduced through a phased implementation approach</p> <p>1991: Health Care Financing Division (HCFD) created</p> <p>1992: District health management boards and teams formed</p> <p>1994: Kenyan Health Policy Framework 1994-2010 adopted</p> <p>1999: National Health Sector Strategic Plan (NHSSP I) 1999-2004 adopted</p> |
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Despite having financed health devoid of user fees for more than two decades, the GOK faced challenges in obtaining funds which were critical in sustaining health services in the 1980s (Anangwe 2008). Sessional paper No. 1 of 1986 on *“Economic Management for renewed growth”* was introduced and outlined government priorities in health care financing including introduction of user fees in public health facilities and strengthening of the National Health Insurance Fund (Abuya et al. 2015). Despite this policy outlining government’s intent to introduce cost sharing, user fees were not introduced at this time.

The 1980s and 90s was a radical period for planning and re-organizing healthcare through structural adjustment programs (SAPs) in sub-Saharan Africa (Mwabu 1998). Subsequent government policy changes in Kenya were outlined in the “*Sixth National Development Plan of 1989-1994*” and included: the need to supplement government funding in health, increasing the role of the private health sector, decentralization of the health system and shift of focus from curative to preventative care (Abuor 2013). One of the reforms made as part of SAPs was the introduction of user fees in 1989 (Gesami 2000; Carrin et al. 2007; Anangwe 2008). User fees were introduced at Kenyatta National Hospital, 80 provincial and district hospitals and 320 health centres in December 1989 while services at dispensaries remained free (Collins et al. 1996). Policy implementation was done without proper planning resulting into hasty implementation of the user fees policy in Kenya (Collins et al. 1996; Stover 1999). Consequently, the cost-sharing program faced opposition as the public was not informed that the purpose of these user fees was to generate revenue which would be used to improve services.

Due to the unpopularity the program encountered, the then president Daniel Arap Moi withdrew user fees in September 1990 (Stover 1999) in order to put in place institutions that would tackle underlying issues such as administrative and management problems that caused policy failure (Anangwe 2008). A central unit within the Ministry of Health (MOH) known as the Health Care Financing Division was created in 1991 to improve generation of funds and utilization of such funds (Gesami 2000; Anangwe 2008). In addition, the GOK established District health management boards (DHMBs), Hospital Management Boards (HMBs), and Health Centre Management Committees (HCMCs) in 1992 by legal notice No.

162 of the Public Health Act as part of institutional re-structuring in improving delivery of health care and managing the processes of the user fees programme at district level (Opiyo 2011). Each DHMB included two NGO representatives (Wamai 2004). Having made these operational changes, together with adequate preparation and training such as public education campaigns, cost sharing was re-introduced in phases between 1992 and 1993 (Anangwe 2008) as follows: National referral hospitals, April 1992; provincial hospitals, July 1992; district hospitals, January 1993 and health centres, July 1993 (Gesami 2000). Stover (1999) states that funds collected in hospitals were retained at facility level and were not recalled by the Ministry of Finance. In addition, decision-making on expenditure of funds was made by local authorities. Furthermore, financing of health care facilities from the Ministry of Finance was not reduced based on facility collections.

In addition to undertaking SAPs, Kenya became a signatory of the Bamako initiative in 1987 (Wamai 2004) thereby committing to its principles which emphasized cost-sharing; community participation in decision-making and control of resources at facility-level in order to ensure accountability of public health services to users; government participation in ensuring that the population can access a minimum health services package and decentralization of initiatives at the district level (Pangu 1997). This initiative made possible the fast-tracking of decentralization of the Kenyan health system (Wamai 2004).

Decentralised financial systems and decision-making systems were the first ingenuities towards decentralisation of health services in Kenya (Stover 1999). Decentralisation is defined as “the process of giving up of power by the central government to sub national units which may include regional or local governments which may have some geographical

authority” (Katsiaouni 2003). Bossert (1998) suggests that there are four forms of decentralisation. These include: De-concentration, delegation, devolution and privatisation. De-concentration is defined as “shifting of power from central offices to peripheral offices of the same administrative structure” (Bossert 1998). While delegation refers to “the shift of responsibility and authority to semi-autonomous agencies” (Bossert 1998). Moreover, devolution is “the shift of responsibility and authority from central offices to separate administrative structures still within the public administration such as local governments of provinces, states among others” (Bossert 1998). Furthermore, privatisation refers to “transfer of operational responsibilities and in some cases ownership to private providers, usually with a contract to define what is expected in exchange for public funding” (Bossert 1998).

Decentralisation mainly takes four dimensions; administrative decentralisation, political decentralisation, fiscal decentralisation and economic/market decentralisation. Administrative decentralisation refers to where responsibility for planning, financing and management of certain functions is shifted. Political decentralisation refers to both horizontal (between the three arms of government-executive, legislature and judiciary) and vertical (between national and sub-national governments) sharing of power. Fiscal decentralisation refers to allocation of financial resources from central government to self-governing local agencies either by direct transfer from national to local agencies or via designation of taxation power to sub-national entities. Economic/market decentralisation refers to national or sub-national government giving the mandate to private entities, which offer services for the same with the government still bearing legal responsibility in ensuring service provision (NCKK and Institute of Economic affairs et al. 2011). This paper mainly

discusses fiscal decentralisation, which mostly goes together with administrative and political decentralisation (NCKK and Institute of Economic affairs et al. 2011).

Since attaining independence, Kenya has attempted to institute all forms of decentralisation including de-concentration, delegation, privatisation (NCKK and Institute of Economic affairs et al. 2011) and most recently, devolution through various initiatives. For example, in 1983, the GOK initiated a de-concentration initiative, the district focus for rural development, whose goal was to enable a bottom-up participatory approach in development (Barkan and Chege 1989; Ndi 2010; NCKK and Institute of Economic affairs et al. 2011). This new initiative saw the establishment of district development committees, which were chaired by District Commissioners with District Development Officers as secretaries (NCKK and Institute of Economic affairs et al. 2011). The district-focus for rural development initiative de-concentrated the ministries but at the same time failed to empower local authorities as intended leading to creation of minimal responsibilities for directives for those at either local or central levels of governance (Williamson and Mulaki 2014).

In 1994, the country adopted the Kenya health policy framework (KHPF) 1994-2010 with a vision to provide “quality healthcare that is acceptable, affordable and accessible to all” (KHPF 2016). KHPF emphasized the role of the private sector in health and sought to transfer curative health services to this sector. Hence, the GOK committed to providing an enabling environment for the private health sector to health service provision and financing (Oyaya and Rifkin 2003). Implementation of the framework was divided into two five-year strategic plans: The National Health Sector Strategic Plan 1999-2004 (NHSSP I) and the National Health Sector Strategic Plan II 2005-2010 (NHSSP II). The NHSSP I was aimed at increasing stakeholder collaboration under SWAp, improving governance and resource allocation,

moving from curative to preventative care and providing autonomy to provincial and national hospitals. The NHSSP II was intended to reduce health inequalities and reverse the trend of poor health indicators that had been noted during implementation of NHSSP I by improving access, quality, efficiency, effectiveness of services in addition to nurturing partnerships in healthcare for example with FBHPs (Luoma et al. 2010).

Box 3: Kenyan timeline 2000s onwards

<p>2004: “10/20” policy initiated 2004: National Social Health Insurance Bill passed by parliament but not assented to 2005: Sector-wide approaches (SWAp) adopted to the Kenyan health sector 2005: National health sector strategic plan II (2005-2010) adopted 2007: SWAp Code of Conduct signed 2007: Vision 2030 established 2009: Health sector services fund (HSSF) established 2009: Hospital management services fund (HMSF) established 2010: New Constitution enacted 2012: Kenya health policy 2012-2030 adopted 2013: New constitution implemented 2013: Maternity fees at public health facilities abolished</p>
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In line with the NHSSP I objectives, the GOK introduced the “10/20” policy in 2004. Health services provided at dispensaries and health centres were made free for all citizens apart from a minimal registration fee of KES 10 and 20 in respectively. Children under the age of five together with those suffering from malaria and tuberculosis were exempt from payment. In addition, the poor were waived from paying registration fees. Furthermore, delivery fees for all public facilities were abolished in the same year (Chuma et al. 2009). Further in this period, maternity fees were abolished at all public health facilities in 2013 (HPP 2013).

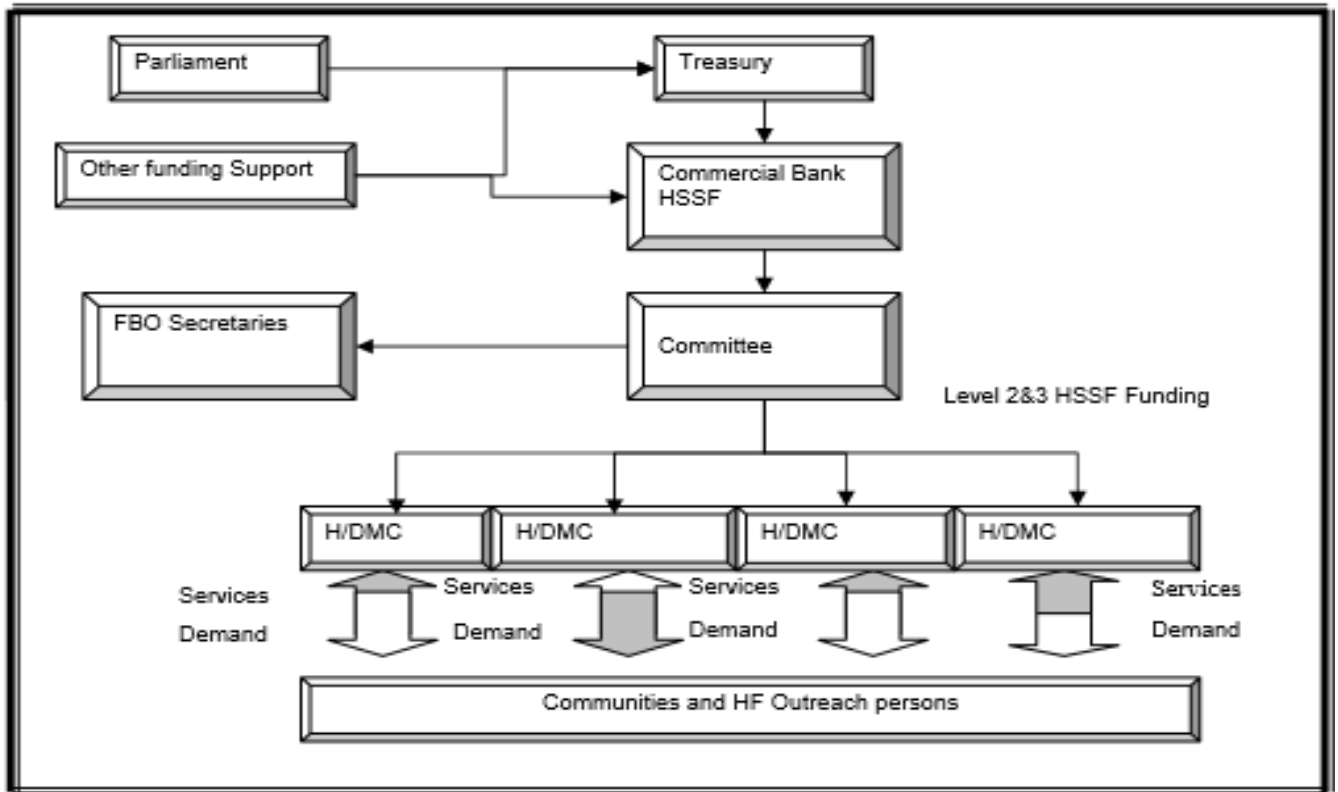
In 2005, SWAp was adopted to the Kenyan health system. SWAp call for “a single sector policy, a single strategy and a single expenditure framework, under government leadership, that is supported by all significant funding for the sector. It incorporates greater alliance on government’s own financial management and accountability systems” (Brown et al. 2001). At this point, the GOK had already initiated the KHPF, NHSSP II and a Mid-Term Expenditure Framework (MTEF) as well as consultation with key stakeholders as part of the pre-conditions necessary for implementation of SWAp (Anyango 2007). SWAp was introduced in a phased approach where the initial phase was intended to harmonize funding and procurement mechanisms, monitoring and evaluation and reporting mechanisms (Anyango 2007). As an indication of their deliberate efforts in making a commitment to delivering on their promises including implementation of NHSSP II, key stakeholders in the Kenyan health system-including donors, signed the SWAp code of conduct in 2007 (Luoma et al. 2010).

In 2007, the then president Mwai Kibaki launched Vision 2030 following a consultative process with various stakeholders in the public and private sectors in addition to civil society, media and non-governmental organizations (GOK 2007). Among other sectors, it seeks to improve the quality and efficiency of the Kenyan health system by devolution of funds to the districts and focusing on preventive as opposed to curative care. Furthermore, it endeavours to reduce existing inequities in access to healthcare especially in women and children (GOK 2007).

This period also saw other key health reforms. Of note is further decentralisation of financing and decision-making processes in the health system. For example, in 2009, the GOK established the hospital management services fund (HMSF), whose role was to

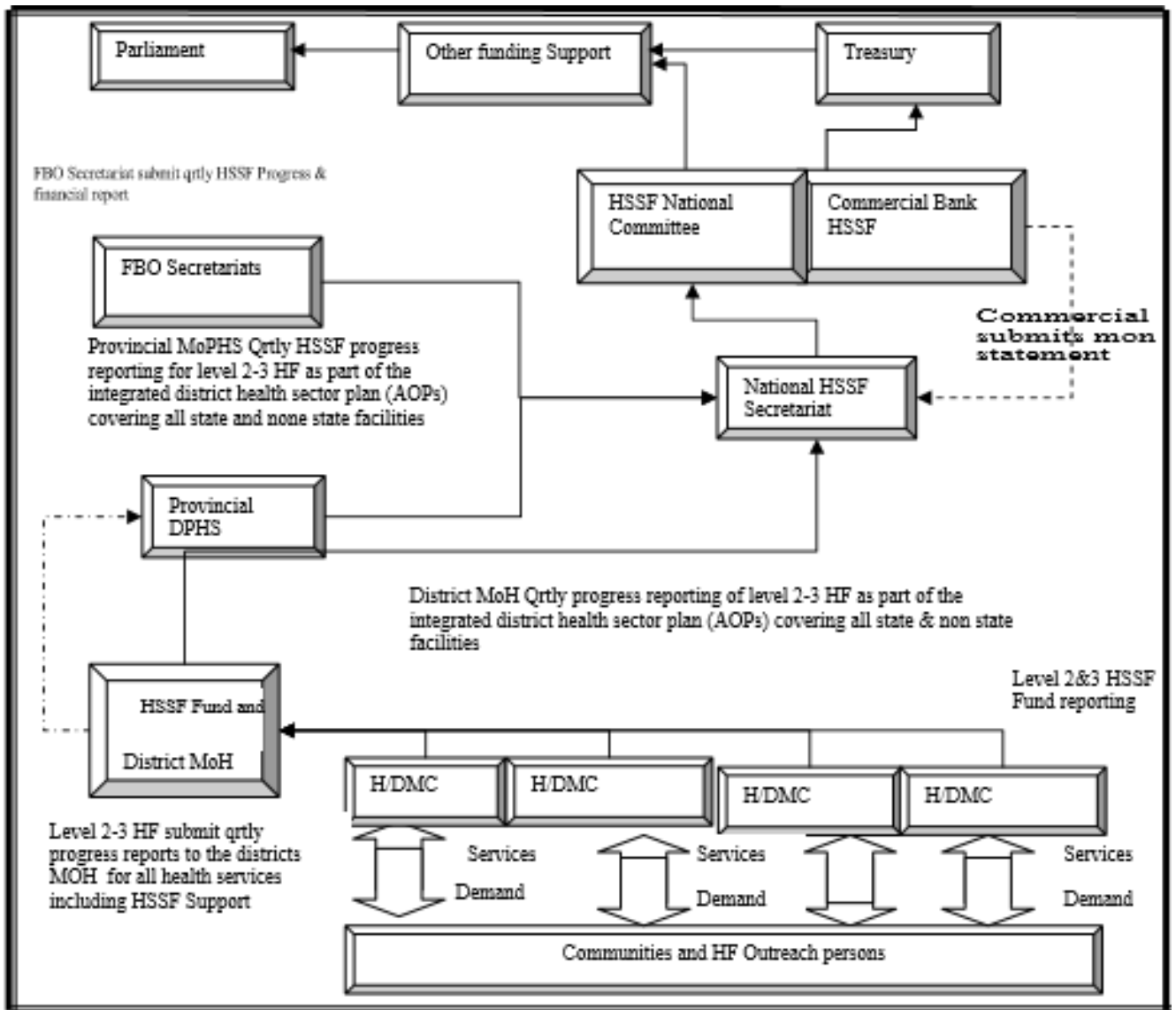
strengthen facility management and governance through capacity building. In addition, Health Facility Management committees (HFMCs) replaced the existing HFMBs through legal notice No. 155 of the Government Financial Management Act (Opiyo 2011). In the same year, the GOK established the health sector services fund (HSSF) through a Ministry of public health and sanitation policy which is contained in legal notice No. 401 (amended in 2009). HSSF was aimed at enabling direct disbursement of funds to public dispensaries and health centres to improve health services (HERAF 2011; HERAF 2012). HSSF was intended to empower the community by actively engaging them in identifying health priorities and planning and implementing initiatives through HFMCs (Waweru et al. 2013). For instance, HFMCs provided support in setting of user fees within health facilities as fees were charged for services such as drugs, injections and laboratory services (Chuma et al. 2009). They also oversaw expenditure of 75% of funds raised through user fees in these facilities (Waweru et al. 2013). Under HSSF, funds from the GOK and development partners were pooled in a central fund then credited directly into facility bank accounts. Following which HFMCs managed funds at facility level (Waweru et al. 2013) as indicated in Figure 1 and the HSSF reporting process in figure 2.

Figure 1: Flow of HSSF funds



Source: HERAF 2011

Figure 2: HSSF Reporting Process



Source: Ramana 2013

Kenya implemented a new constitution in 2013, which further decentralised the health system. This new constitution introduced a devolved system of governance where 47 counties have their own governments-which are interdependent and relate through consultation and cooperation-are delegated to provide government services to the people (HPP 2014). These governments have a relatively high degree of autonomy as regards

budget allocations for healthcare (KHF 2016). The Kenya health policy 2012-2030 adopted in 2012 proposes the establishment of a health department in each county whose role is to create and provide an enabling institutional and management structure with the mandate of coordinating and managing delivery of healthcare at county level (KHF 2016).

Faith-based health providers in Kenya

FBHPs play a significant role in the Kenyan health system, with faith-based health facilities comprising 11.3% of all health facilities in the country (both public and private) and 70% of all health facilities in the non-profit sector (see Blevins and Griswold 2014). FBHPs in Kenya are structured along diverse religious lines as follows: Faith-based health facilities in Kenya are distributed along similar religious lines (see Table 2).

Table 2: Distribution of faith-based health facilities in Kenya, by ownership

Type of facility	CHAK	KEC	SUPKEM	OTHER-FB	FB TOTAL
Dispensary	283	232	5	160	680
Eye Centre	1	1	0	0	2
Health Centre	42	80	3	44	169
Health Programme	0	4	0	1	5
Maternity Home	2	1	0	0	3
Medical Clinic	26	25	2	32	85
Nursing Home	3	3	0	4	10
Other Hospital	14	48	1	22	85
Stand-Alone VCT Centre	7	7	1	17	32
Other (Specialty, government-only)	1	0	0	0	1
TOTAL	379	401	12	280	1,072
PERCENTAGE	35.35%	37.41%	1.12%	26.12%	100%

Source: Blevins & Griswold 2014

History of faith-based health providers in Kenya

FBHPs have an extensive history in Kenya dating over 100 years (Rasheed 2009). They have maintained a strong presence in the country even after attaining independence (Olivier et

al. 2015) despite numerous health system reforms. This sub-section examines key developments in FBHPs in Kenya since their establishment.

Box 4: Timeline of key FBHP networks - CHAK, KEC & SUPKEM

<p>1930s: Establishment of a hospitals' committee of the National Council of Churches of Kenya (NCCCK)</p> <p>1946: Protestant Churches Medical Association (PCMA) registered</p> <p>1961: Kenya Episcopal Conference (KEC) established</p> <p>1982: PMCA changed name to Christian Health Association of Kenya (CHAK) and took on broader mandate</p> <p>1983: KEC medical department and PCMA (now CHAK) formed Mission for Essential Drugs and Supplies (MEDS)</p> <p>1986: MEDS officially launched</p> <p>1987: CHAK re-constituted as a non-profit organization</p> <p>1996: CHAK refocused priorities</p> <p>1996: Direct financial support of FBOs withdrawn</p> <p>2004: Technical Working Group (TWG) with the Ministry of Health (MOH) and faith-based health services (FBHS)-MO-FBHS-TWG was formed</p> <p>2005: MEDS registered as a trust with an independent legal status</p> <p>2005: Paris declaration adopted</p> <p>2005: Revised CHAK Strategic Plan 2005-2010 launched</p> <p>2006: 'Nairobi Declaration' signed</p> <p>2007: CHAK hosted the African Christian Health Associations platform (ACHAP)</p> <p>2008: Church Health Services Coordination Committee (CHSCC) launched</p> <p>2009: Memorandum of understanding (MOU) signed between the Government of Kenya (GOK) and faith-based health providers (FBHPs)</p> <p>2009: CHAK Guest House & Conference Centre established</p>
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CHAK is a national network of health centres, dispensaries, hospitals, and health education facilities affiliated with protestant denominations in Kenya (Blevins et al. 2017). CHAK was originally established in the 1930s as a hospitals' committee of the National Council of Churches of Kenya (ACHAP 2014; CHAK 2014a). However, in 1946, the committee changed its name to Protestant Churches Medical Association (PCMA) following autonomous legally registration. At this point, its mandate was limited to disbursement of government funds to health facilities affiliated to protestant churches. In 1982, PMCA further changed its name to

the current name, CHAK and undertook a broader mandate of enabling the role of the church in healthcare (CHAK 2014a).

KEC was established in 1961 (ACHAP 2009). In 1983, the medical department of KEC formed an alliance with PMCA-now CHAK-aimed at purchasing and resale of drug supplies at no profit to church health facilities in Kenya. This joint venture was named Mission for Essential Drugs and Supplies (MEDS) with each organization having a 50/50 ownership basis guided by a constitution signed between CHAK and KEC. The organization was officially launched in 1986 and has contributed highly in healthcare services in Kenya since then (MEDS 2017, Rasheed 2009).

In 1987, CHAK was re-constituted as a non-profit organization. In 1996, CHAK refocused its priorities from acting as an implementer to being a facilitator. Consequently, the organization focused on advocacy, capacity building, networking, communication and facilitation (Dimmock et al. 2012). In 2004, CHAK joined forces with other FBHPs-including KEC and SUPKEM-to create a technical working group (TWG) that would serve as a regular platform of engagement with the MOH (MOH-FBHS-TWG) whose main objective was to formalize the longstanding relationship with the MOH (Barnes et al. 2010). TWG is chaired by the MOH with CHAK as its secretariat (Kinyoe 2012).

CHAK has been involved in several partnership opportunities over the past decade. For example, in 2005, the Paris Declaration - an agreement that indicated commitment in increased efforts for countries and organizations in aligning and managing funding with indicators - was adopted by FBOs in Kenya (Rasheed 2009). In 2007, CHAK became host to

the Africa Christian Health Associations Platform (ACHAP), a platform of advocacy and networking of Christian health associations in sub-Saharan Africa (Kinyoe 2012). Also, in 2009, CHAK, KEC and MEDS came together to form the Church Health Services Coordination Committee (CHSCC), a partnership structure. CHSCC facilitates government and donor engagement in service delivery and healthcare financing (CHAK 2014b). These were among some of the events that prepared the country in fostering partnerships with the GOK. Subsequently, in 2009, FBHPs-represented by CHAK, KEC and SUPKEM signed an MOU with the GOK (Rasheed 2009). So far, some of the accomplishments relating to the MOU include: staff secondment (with medical officer interns and with medical consultants); support with in-kind supplies: dispensary drug kits to FBO dispensaries, family planning commodities, anti-retroviral drugs and vaccines; supervision of FBO facilities by MOH; and a reported good working relationships with MOH, with inclusion in technical working groups and committees and training opportunities (PEPFAR 2012).

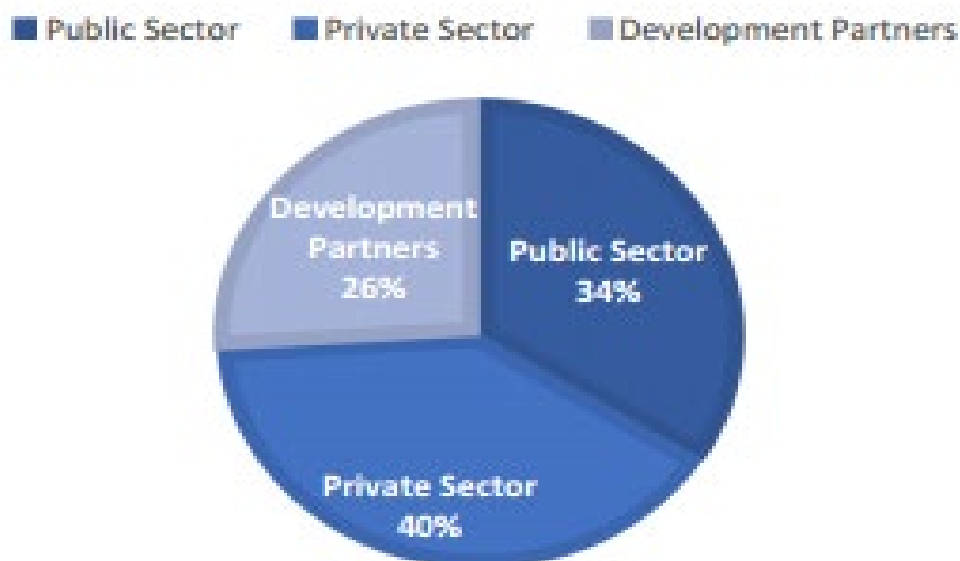
Like other FBHPs in SSA, FBHPs in Kenya have encountered several challenges over recent decades. For example, there is a reported lack of trust between FBHPs and government. FBHPs fear that partnerships with the governments, may lead to loss of their identities, while governments view FBHPs as competitors (Dimmock et al. 2012). Also, most FBHPs now find themselves heavily dependent on donor funding – and increasingly dependent on targeted funds. A recent study shows that Christian Health Associations, such as CHAK experience increased targeted funding – not allowing for long term or core activities. This may place additional stress on provision of essential health services versus health programs (Dimmock et al. 2012). With the withdrawal of direct financial grants to FBHPs by the MOH for services delivered in clinics in 1996, FBHPs in Kenya have experienced reduced funding

both from traditional sources, and now modern ones – which continues to hurt FBHPs. In addition, there has been minimal interaction between FBHPs and health providers in the for-profit health sector, which may lead to uncertainty related to financial viability (see Barnes et al. 2010).

Financing of faith-based health providers in Kenya

This section examines funding of FBHPs within the context of the Kenyan health system. In Kenya, health is funded from three key sources; Government, private sources (out-of-pocket payments, community-based health insurance-CBHI and private insurance) and donors (Munge and Briggs 2014; Ministry of Health, 2015; Chuma and Okungu 2011; Luoma et al. 2010). Overall, the private sector is the major financier of health in Kenya, supporting approximately two-fifths of the health sector (Ministry of Health 2015) as illustrated in figure 3.

Figure 3: Kenya total health expenditure 2012/2013



Source: KHF 2016

Government funding: Healthcare funding from the GOK is from general tax financing. According to the Kenya National health accounts 2012/13, this consists of 34% of the total health expenditure (THE, Ministry of Health 2015). As noted above, the GOK supports FBHPs in Kenya through staff-secondment agreements where the MOH in Kenya seconds a certain number of healthcare workers to FBHP facilities (KHF 2016). The GOK also engages with mission providers through voucher programs (see Watt et al. 2015).

Donors: Kenya has a wide range of donor organizations that are active in the country. USAID is currently the largest donor in both public and private sectors. Other multilateral donors in the health sector in Kenya include: The Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), International Finance Corporation (IFC)/World Bank (Health in Africa Initiative), WHO, Department for International Development, Japan International Cooperation Agency, Deutsche Gesellschaft fur Internationale Zusammenarbeit, and Danish International Development Agency. In addition, there are many smaller NGOs (KHF 2016).

Most donor funding in Kenya is disease-program specific to programs such as malaria, HIV and tuberculosis (Chuma and Okungu 2011). For example, USAID works through PEPFAR in partnership with GOK to combat the HIV/AIDS epidemic. PEPFAR was launched in 2003 as a U.S government investment to enable people living with HIV globally to access treatment and care (USAID 2017). The PEPFAR program in Kenya is the largest PEPFAR program in the world (U.S Embassy Kenya 2014). The program works through the GOK and other development partners such as the National AIDS Control Council and the National AIDS &

Sexually Transmitted Infections Control Programme, the MOH and Ministry of education to meet the country's needs in HIV response. PEPFAR coordinates with civil society organizations, Global Fund, UNAIDS, United Nations Children's Fund, the World Bank, the WHO, and other developmental partners in offering complementary services in HIV response in Kenya. The program works through over 100 supported implementing partners in various program areas including facility-based care, treatment and support; community-based care, treatment and support; prevention of mother to child transmission; and voluntary male circumcision (U.S Embassy Kenya 2014).

The Global Fund was created in 2002 as a financial institution and has focused on country ownership and performance-based financing. In carrying out its mission, the Global Fund has established a Country Coordinating Mechanism (CCM) in each country. CCM is a multi-sectoral body with representation from key stakeholders in health including the government, civil society and FBO representatives. Each CCM determines the organizations that become principal recipients and sub-recipients that implement programs (Blevins et. al 2016; Global Fund 2008). For example, Catholic Relief Services (CRS) is a Global Fund principal recipient with a long history working in HIV/AIDS sector in Eastern and Southern Africa-and specifically in Kenya. World Vision International¹ has also actively engaged with Global Fund as a sub-recipient in Kenya for the malaria program (see Global Fund 2008).

The Kenya Coordinating Mechanism is composed of committees at two levels: The National Oversight Committee provides overall leadership for coordination of the Global Fund grants

¹ An international FBO with a global presence

in Kenya; and several Interagency Coordinating Committees providing technical support for each of the disease components (Tuberculosis, Malaria and HIV/AIDS). The National Oversight Committee is composed of 16 members with two of those representing FBOs² and two others representing the private sector (Blevins et al. 2016).

Bonnel et al. 2013 indicates that HIV/AIDS funding to FBHPs in Kenya is disbursed through two main funding mechanisms: the government budgetary system and off-budget channels. Most external resourcing of HIV/AIDS funds are disbursed off-budget and funds go through donor-managed projects or through NGOs without going through the government budget. For example, funding is provided by the Global Fund to Care International³; or funding is provided by PEPFAR to large international CSOs. Funds disbursed through the government's funding channel include the government's own funds, funds from the Global fund's contribution to the MOH, and funds from the World Bank-Total War against HIV and AIDS project. Donors also engage mission providers through voucher programs (see Njuki et al. 2015). In 2004, donor funding accounted for 13% of funding within the CHAK network (Dieleman 2009).

Health insurance: In Kenya, the national health insurance, NHIF currently covers approximately 15% of the population (KHF 2016). NHIF covers outpatient benefits based on a positive list of services using capitation payment mechanism with inpatient benefits varying between hospitals depending on hospital category and/or contract (Munge et al.

² Which is a broader category than FBHPs and includes health-engaged faith-based NGOs

³ Care International acts as the civil society Principal Recipient

2015). NHIF accords funds to users seeking medical care from FBHPs. However, particular services sought from FBHPs require the individual to pay. Where full coverage is not provided, remaining cost of services is sourced from out-of-pocket payments, private insurance or medical cover from employers (Chuma et al. 2013). As of 2004, NHIF funding accounted for 9% of funding within the CHAK network (Dieleman 2009).

Healthcare in Kenya is also financed through community based health insurance schemes (CBHIs). However, coverage is limited with only approximately 1.2% of the population covered and membership mainly targets rural areas (Resyst 2014). Premiums are paid on voluntary basis by members and benefits are offered at pre-determined public and faith-based institutions, most of which are in close geographical proximity to where members reside. Benefits offered are varied. A small number are linked to the NHIF in which case both organizations supplement cost of services (Mulupi et al. 2013). For example, Chogoria hospital-a CHAK facility sponsored by the Presbyterian Church of East Africa (see Blevins & Griswold 2014)-has a hospital health insurance scheme, which has been in existence since 1991. Initially, the scheme operated as a collaboration between the hospital and Apollo insurance company where the hospital entered into a contract with the insurance company to provide a defined range of health services to members of the scheme who would be enrolled from the community. However, in 1998, this contract was terminated and the hospital now self-insures (Musau 1999).

User fees: User fees in Kenya account for approximately 27% of funding for health (Maina and Kirigia 2015). Having initially been abolished after independence (Chuma and Okungu

2011; Abuya et al. 2015), user fees were re-introduced in the 1980s (Gesami 2000; Carrin et al. 2007; Anangwe 2008) as a consequence of a combination of factors including economic stagnation, reduced donor-funding and international donor pressure (Mwabu 1995). With evidence revealing that user fees were a significant barrier to healthcare access (Mwabu et al. 1995; Collins et al. 1996), user fees were withdrawn in dispensaries and health centres in line with the “10/20” policy in 2004 - apart from a minimal registration fee of KES 10 and 20 in respectively (Chuma et al. 2009). In other efforts to provide equitable health services, maternity fees were abolished at all public health facilities in 2013 (HPP 2013). FBHPs have continually charged user fees to ensure continuity of service provision. In 2004, user fees accounted for 71% of funding within the CHAK network (Dieleman 2009). A recent study done to assess adherence of the user fees policy abolition in Kenya shows that FBHPs continue to charge user fees. It also shows significant increase in utilisation for services in FBHP facilities - however, this may not translate to better health outcomes (Maina and Kirigia 2015).

Key issues in faith-based health provider financing in Kenya

A recent study examining health care financing strategies in faith-based hospitals in Kenya and their impact on financial sustainability noted that faith-based hospitals in Kenya fund their services from multiple sources including user fees, entrepreneurial activities, insurance, donor funding, government, among others. It was also noted that the largest proportion of funding came from user fees generated from inpatient, outpatient and laboratory charges. A substantial number of respondents in this study indicated that donor funding is a vital source of funding for faith-based hospitals despite being on the decline

over recent years. It was clear that health insurance is a potential source of funding which has not been fully tapped into (Abuor 2013).

Flessa et al. (2011) conducted a Kenya health sector costing study in 207 health facilities representing public, faith based/Non-governmental and private-for-profit organizations. The study concluded that cost of health services in Kenya varies markedly across private providers. It also showed that costs of health care services in Kenya are significantly high compared to the Kenyan domestic product, with a large share of the expenditure being fixed costs. This indicates that increasing health coverage may not necessarily increase cost of care. The study findings were limited by the fact that research findings from patients and facilities were collected over a period of two months, which may not be considered representative of national average costs given seasonal disease patterns and external variations.

FBHPs in Kenya encounter challenges in their operations. For example, the bureaucratic nature of the National AIDS Control Council was shown to restrict allocation of resources and open communication to rural communities leading to poor implementation of monitoring and evaluation processes. In addition, there was mistrust in terms of financial management between CREs and donors demonstrated by placement of donor personnel in management of projects. Concerns were also raised that donors forced their own agendas onto local organizations and program-focus could change without adequate notice. In

addition, there were concerns on lack of long-term financial planning, as funding was required to be spent in a limited amount of time (Haddad et al. 2008).

With most FBHPs relying on heavily donor funding, questions of sustainability of services provision arise. A recent study assessing sustainability of faith-based enterprises examines 11 faith-based projects in Kenya with varied income-generating initiatives. This study revealed that FBHPs embrace profit-making enterprises as alternative sources of funding. This study was limited by small sample size, regional focus of the study and the early stage of the pilot research (Ndemo 2006).

Table 3: Evidence map on FBHP financing in Kenya

Authors	Title of the Study	Type of Study	Insights
Abuor 2013	Health care financing strategies and their impact on financial sustainability	Survey at facility level	-Faith-based hospitals in Kenya are funded via user fees, entrepreneurial activities, insurance, donor funding and the government
Barnes et al 2010	Private Health Sector Assessment in Kenya	Review with country level data	-The private health sector plays a significant role in providing quality care in the Kenyan health system, is larger than other sectors in Kenya, and has strong donor support. -Growth of the private sector is driven by demand-side health financing -Recommends strengthening of MOH stewardship of the private sector by establishing a new PPP framework; support efforts to create a mixed health insurance system
Bonnel et al. 2013	Funding mechanisms for civil society: The experience of the AIDS response	Review with country funding profiles and CBOs level data	-Funding provided to CSOs (2003-2009) has become substantial with part of this funding directly reaching large national CSOs -Only a small share of international resources trickles down to local communities -CBOs are able to supplement international funding with other sources of funding such as national funds and volunteer funds
Blevins and Griswold 2014	Essential partners: The scope of the contributions of faith-based health systems to HIV prevention, treatment, and support in Kenya	Country level case study to assess scope of services provided by FBHP facilities in Kenya	-Scope of services provided by faith-based health facilities in Kenya -CHAK's financial situation as at 2014: CHAK's net worth has grown in 10 years from USD 253,254 in 2002 to USD 1,384,580 in 2012; projects supported by CHAK; partnerships with CHAK
Blevins et al. 2017	The percentage of HIV treatment and prevention services in Kenya provided by faith-based health	Secondary analysis of health service data in Kenya with country, county and facility data	-FBHPs provide 22% of HIV services in Kenya -Unanswered questions include: variety of funding sources; expenditures; funding agreements with national government among others
Caritas 2015	Ending AIDS as a public health threat: FBOs as key stakeholders	Mixed method study with FBO data	-Talks about the massive reduction in HIV funds to FBOs
Flessa et al. 2011	Basing care reforms on evidence: the Kenya health sector costing model	Step-down costing methodology, data from 207 facilities (public, FB, NGO, PFP facilities)	-Cost of health services in Kenya varies markedly across private providers -Costs of health care services in Kenya are significantly high compared to the Kenyan domestic product, with a large share of the expenditure being fixed costs
Gatome-Munyua et al 2015	An assessment of the cost and quality of private health services in Kenya	Costing and quality study with facility-level data	-Kenya's health financing system is inequitable; insurance can reduce catastrophic health expenditure -Strengthening health outcomes through the private sector project is providing data on cost and quality to inform health financing decision-making -Costing and quality results vary by facility level/ownership; Data on cost/quality informs programming
Haddad et al. 2008	The potentials and perils of partnerships: Christian religious entities and collaborative stakeholders responding to HIV in Kenya, Malawi and the DRC	Review with country-level HIV financing data	-Funds provided by the Global Fund to FBOs have grown since 2002 -Developmental assistance for health increased at a rate of 10% per year between 1990 and 2013 -Largest share of health development to FBOs goes to HIV/AIDS programs -Developmental assistance for HIV/AIDS peaked in 2007 and plateaued between 2008 and 2011
Kinyanjui	An efficiency analysis of hospitals owned	Data envelopment	-36% of FBO facilities were operating under variable returns to scale technical efficiency

Authors	Title of the Study	Type of Study	Insights
2014	by faith based organizations in Kenya	analysis: input oriented	-20% facilities were scale efficient
Mokua 2006	Cost analysis of essential curative health services in church health facilities	Facility level costing study	-Level of costs varies with different diseases -Different health facilities have diverse structures and infrastructure which influence costs differently
Munguti et al. 2006	Cost analysis of reproductive health services in PCEA Chogoria hospital, Kenya	Cost analysis with facility-level program data	-The study indicates that reproductive health services at Chogoria hospital were not sustainable
Musau 1999	Community-based health insurance: Experiences and lessons learnt from East and Southern Africa	Mixed Methods study	-This paper examines the strengths and weaknesses of community-based health insurance (CBHI) schemes currently operating to meet basic health care needs of rural populations in East and Southern Africa
Musau et al. 1998	Cost analysis for PCEA Chogoria Hospital- Case study report prepared for MSH APHI Financing and Sustainability project, USAID Kenya	Mixed Methods study	-Assessed level of unmet needs and demand for health care services: main health problems are malaria and upper respiratory infections; area is poorly served by government health facilities -Care seeking behaviour: highest awareness was with government facilities -Quality and satisfaction with health care services: Better satisfaction with mission hospitals than government facilities
Ndemo 2006	Assessing sustainability of faith-based enterprises in Kenya	Modified ethnographic and anthropological study	-FBOs in Kenya embrace the idea of profit-making enterprises as alternative sources of funding
Njuki et al. 2015	Does a voucher program improve reproductive health service delivery and access in Kenya?	qualitative data from a quasi-experimental research design	-Reproductive health output-based aid (RH-OBA) program was viewed as a feasible system in increasing service utilization and improving quality of care -Program benefits include: stimulation of competition between facilities and capital investment
Nyongesa et al 2015	Evaluation of health care quality in public and faith based hospitals in Kiambu and Nairobi countries, in Kenya	Mixed method study with facility-level data	-Patient's choice of hospital is influenced by outcome of medical treatment in faith-based hospital -Patients perceived high satisfaction of services in faith-based hospitals as compared to public hospitals
Watt et al 2015	Can reproductive health voucher programs improve quality of postnatal care? A quasi-experimental evaluation of Kenya's Safe Motherhood voucher scheme	Quasi-experimental evaluation	-The government supports mission hospitals through voucher program as a PPP mechanism

Conclusions

This review suggests that the non-profit sector, particularly FBHPs play a vital role in health service provision in Kenya accounting for 11.3% of all health facilities in the country (see Blevins and Griswold 2014). However, little evidence exists on how these providers finance their services (see Table 3). In recent decades, FBHPs in SSA have faced changes in their resource financing. For example, following independence, there was resistance of historic relations to colonialism, changes in health financing strategies, financial hardships in the 1980s, growing population and the HIV/AIDS epidemic (see Rasheed 2009; Yeboah and Buckle 2017).

It is known that FBHPs in Kenya finance their activities from multiple sources including user fees, entrepreneurial activities (profit-making enterprises, see Ndemo 2006), health insurance, donor funding, in-kind contributions from faith-based groups and communities; and support from the government (Abuor 2013) through secondment of staff to health facilities – both public and faith-based health facilities (see KHF 2016). Health costing studies done show that cost of health services vary across various providers in the private sector (see Flessa et al. 2011). However, there remains unanswered questions relating to FBHP financing. This study seeks to bridge this gap of knowledge by examining FBHPs in Kenya and their funding sources and structures; funding flows; and trends in expenditures (see part C). This is important because the government and donors must better understand the role played by FBHPs as it is key in developing effective partnerships with FBHPs.

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Part C: Article Manuscript

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Trends, complexities and tensions underlying the funding of faith-based health providers in Kenya: the case of two HIV/AIDS programs

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Abstract

In strengthening health systems, the World Health Report 2000 indicates that health system improvement strategies must also cover private (for-profit and non-profit) health care provision and financing if progress towards Universal Health Coverage is to be achieved. Yet very little is known about the financing of non-profit providers in Africa – especially not faith-based health providers, who have often historically remained elusive in terms of financial transparency. This article reports on a multiple case study conducted with two non-profit faith-based health providers in Kenya, namely the Christian Health Association of Kenya's Africa Inland Church Kijabe Hospital; and Nyumbani-Children of God Relief Institute in Nairobi (Nyumbani) – and situates these within the broader context of health systems financing and public-private partnership in Kenya. Data was collected from multiples sources including: secondary literature; secondary analysis of existing data (such as the Kenya Health Information System); financial data on projects and annual reports; routine facility and service data; previous research on both organizations; archival data; and supplemented by six in-depth interviews with key stakeholders. The study reveals that FBHPs have diversified

¹ Instructions for authors are in Appendix 10. Authors' contribution and information are also excluded. For the purpose of this thesis, the student is the sole and first author of the work

their funding sources over the past decade, away from traditional sources and have moved towards 'secular' sources. FBHPs in Kenya are shown to be highly dependent on complex donor-funding arrangements, and lack (financial) resilience as a result. In addition, FBHPs have shown high responsiveness and resilience to health systems changes. User fees remain as an important source of financing. It is concluded that donors and national policy-makers need to better understand the nuance of engagement with FBHPs.

Keywords: *non-profit providers, non-state providers, faith-based providers, Africa, Kenya, financing*

Key messages

- FBHPs have shifted their funding sources – away from traditional denominational sources, towards sources standard for non-profit providers (faith-based or not).
- Financial constraints faced by FBHPs have increased their reliance on donor funding, which has in turn resulted to lack of financial resilience.
- FBHPs have shown high responsiveness and resilience to health systems changes, thereby governments should tap into them in supplementing health care service provision especially to the poor and under-served populations.
- Issues of funding and financing remains a sensitive issue in non-state, non-profit sectors.

Introduction

Health systems, which comprise the institutions, organisations and resources which together enable delivery of health care services and meet population needs (Mills 2014),

need to be functional if universal health coverage (UHC) is to be achieved (WHO 2007). However, health systems in low- and middle-income countries (LMICs) are often weak and failing (World Bank 2013). In strengthening health systems, the World Health Report of 2000 suggests that strategies must cover private health care provision and financing if progress towards UHC is to be achieved (WHO 2000).

The private health sector is commonly defined as “all providers outside the public sector” (Patouillard et al. 2007). Private sector providers commonly include private non-profit providers and private-for-profit providers (PFPs). Examples of private non-profit providers include faith-based health providers (FBHPs), local and international non-governmental organizations (NGOs); while PFPs commonly include private practitioners operating individually, corporate (profit-making) private facilities, traditional healers and drug vendors (see Hanson and Berman 1998; Mills et al. 2002; Basu et al. 2012; Foster 2012; KHF 2016). However, this definition does not adequately describe several providers who fall in grey areas. For instance, health services owned by parastatals, services provided in facilities funded directly by social security funds, or NGOs receiving substantial government funding - among others (Hanson and Berman 1998).

Recent reports documenting the role and presence of FBHPs in healthcare provision in Africa indicate that they continue to play a substantial role in roughly half of the African countries (see ARHAP 2006; Schmid et al. 2008; WHO 2007). Some have cited a controversially high figure of 70% FBHP service provision in some post-conflict and fragile states (ARHAP 2006) - although this must be balanced against the understanding that in some African countries there are no or only few FBHPs present. Although the role and

contributions of FBHPs are well argued, relatively little is known about their financing - due in part to the complexity of the funding environment underlying their operations (Olivier and Wodon 2012). Over the last few decades, FBHPs have experienced major changes in their health systems' configuration and their financial resourcing. For example, at the time during which most African countries gained independence (1950s-1970s), traditional funding from parent churches dwindled for most African FBHPs, and as a result they sought support from local governments and different international donors (Dimmock et al. 2012). FBHPs now commonly finance their services from a combination of sources including government funding, out-of-pocket payments from patients (user fees), resources from bilateral and multilateral donors, as well as funding and in-kind contributions from local faith groups and communities (Olivier and Wodon 2012).

FBHPs in Kenya account for 11.3% of all health facilities (Blevins and Griswold 2014) although FBHPs have self-reported higher figures of around 40% (Olivier et al. 2015).² They are structured along religious lines either as networks or as single organisations. FBHPs networks include: the Christian Health Association of Kenya (CHAK, representing Protestant health facilities and community-based health programs); the Supreme Council of Kenyan Muslims (SUPKEM, representing the Muslims); and the Kenya Episcopal Conference (KEC, representing the Roman Catholic Church) (KHF 2016; Barnes et al. 2010; Blevins and Griswold 2014; PEPFAR 2015). Single organisations include, for example, the Nyumbani Children of God Relief Institute discussed in this paper (Nyumbani, Blevins and Griswold 2014).

² These discrepancies are mainly a result of the different denominator being measured such as facilities, hospital beds, patients

Like FBHPs in Africa, FBHPs in Kenya are known to finance their services from multiple sources including user fees, health insurance, donor funding, the government and entrepreneurial activities (Musau 1999; Dieleman 2009; Abuor 2013; KHF 2016) - CHAK is engaging in direct income generation by operating a guesthouse (see Dimmock et al. 2017). This research focuses on capturing financial flows through FBHPs in Kenya by tracking sources, structures, flows and trends of funding. The findings of this study are likely to be applicable to FBHPs, donors and government, in strengthening collaboration between these key health systems stakeholders.

Methods

This paper reports on a descriptive multiple case study that was conducted in 2016-2017 in Kenya. The cases were two non-profit FBHPs in Kenya, namely the Christian Health Association of Kenya's Africa Inland Church (AIC) Kijabe Hospital and Nyumbani-Children of God Relief Institute in Nairobi (Nyumbani). These facilities were pre-selected as they are located in Kenya, and are part of a larger UNAIDS/PEPFAR research initiative which sought to strengthen partnerships with FBHPs in several UNAIDS and PEPFAR partner countries in identified focus areas (UNAIDS 2015). This interdisciplinary sub-study was conceptually framed by the understanding that this study was rooted in the field of Health Policy and Systems Research (HPSR), which is by nature interdisciplinary drawing on methods and perspectives from a range of disciplines (Gilson 2012). We also drew on health economics approaches and the existing body of work on the financing of health systems. Finally, this research was also framed by the existing work on FBHPs in Africa - which is a small but

distinct body of work - see for example, the work of the International Religious Health Assets Program (IRHAP).

As is expected in case study methodology, data was collected from multiples sources including: primary sources from key organisations – such as the CHAK-KEC-SUPKEM-and Government of Kenya (GOK) Memorandum of Understanding (MOU); program reports such as AIC Kijabe HIV program reports (2004-2015); and in-depth interviews (n=6) with key stakeholders (see appendix 1) were used to supplement secondary literature.

Secondary review of scientific and grey literature in English was also conducted and integrated. Some secondary data analysis was conducted – integrating data from sources such as the Kenya Health Information System³, the Kenya Master Health Facility List⁴, Nyumbani Annual reports (2007-2016), Nyumbani USAID Integrated program reports (2007-2015), AIC Kijabe Annual reports (2011-2015), PEPFAR data indicating allocations to CHAK (2011-2016) and Nyumbani (2006-2016), the WHO website, the World Bank website, the National Health Accounts (2012/13), Global Fund Annual reports (2002-2016); as well as previous empirical research conducted on Nyumbani and CHAK.

For the interviews, snowball (chain-referral) sampling was utilised, in which individuals involved in management of CHAK and Nyumbani were identified from primary literature and key stakeholder meetings held during the research negotiation process. Following identification of initial key stakeholders, they were asked to identify other potential

³ <https://hiskenya.org>

⁴ Kmhfl.health.go.ke

participants. Direct recruitment was undertaken where potential study participants were contacted in person.

Ethical clearance for this study was obtained from the African Medical and Research Foundation in Kenya (AMREF), and from the University of Cape Town Human Research Ethics Committee (HREC Reference: 305/2017). Approval was also sought and gained from the General Secretary of CHAK, the Executive Director of Nyumbani and the institutional review ethics committee chair at AIC Kijabe Hospital. Consent was obtained prior to data collection. The identity of study participants was kept confidential and anonymity was maintained for interviewees-and where necessary, names of organisations were also removed. Recorded interviews were transcribed verbatim in English, which is the main language of communication in both CHAK and Nyumbani.

Narrative thematic data analysis and descriptive statistical analyses was used to analyse findings from multiple forms of evidence. Initial data analysis began during data collection and guided further data collection in an iterative process. Data from each case was analysed separately. Distinct arguments were then made from findings from both cases to develop generalizable claims. Cross-case analysis was then conducted (see Yin 2009) and policy implications were developed. Reflexivity was considered to manage researcher bias. Member checking was done to ensure that there was a match between participants' views and the researcher's reconstruction of them.

Study limitations include the fact that the study involved only two cases and therefore did not involve other kinds of FBHPs that exist in Kenya. In addition, there were only a relatively

small number of key informant interviews conducted – intended to supplement and inform the broader data collection and analysis. This limitation was mitigated by extensive literature review. In addition, the study was conducted over a relatively short period of time (September 2016 to September 2017) – which created some limitations in terms of data collection. The study was also challenged by the fact that there is major resistance to FBHPs releasing financial data (see Schmid et al. 2008), and as this resistance was experienced in this study, it imposed further limitations on data collection.

Background to faith-based health providers within the Kenyan health system

Kenya is a lower-middle income country with a population of 46,050,000 people as of 2015 and GDP per capita of USD 1,358 as of 2014. General government expenditure on health as percent of total government expenditure was 13% in 2014 (WHO 2014b). This indicates the priority the Kenyan government has given to funding health relative to other public expenditures such as education whose expenditure was 17% in the same year (World Bank 2017). This is lower than the 15% target of the Abuja declaration (McIntyre and Kutzin 2016).

Box 1: Kenyan Demographics

General Health Indicators	Statistics
Population (2015)	46,050,000
GDP per capita (US Dollars)	1,358
Neonatal mortality rate (per 1,000 live births)	22.2
Maternal mortality ratio (per 100,000 live births)	510
Government expenditure on health % general government expenditure (includes donor funds)	13%
Out of pocket expenditure as % of total health expenditure	26%

Source: WHO 2014b

The initial scoping review conducted for this study showed that Kenyan health system has evolved through three generational reforms: development of the governmental system in 1960s, centralization and emphasis on primary health care through 1970s and 1980s, and

decentralization and restructuring in 1990s (Wamai 2004). After gaining independence in 1963, the Kenyan government proposed “free healthcare for all Kenyans” in the quest for economic development (Wamai 2009). Two years after independence, this concept was realized and user fees were abolished at all public facilities (Chuma and Okungu 2011; Abuya et al. 2015). By 1966, new healthcare financing options emerged such as the establishment of the National Health Insurance Fund (NHIF, Wamai 2009; Chuma and Okungu 2011; Muiya and Kamau 2013; Abuya et al. 2015). Initially, NHIF was only available to those in formal employment (Carrin et al. 2007) and earning more than KES 1000 (Abuya et al. 2015). In 1972, voluntary NHIF membership was introduced to incorporate those in the informal sector together with those earning less than Kenya Shillings (KES) 1000 (Abuya et al. 2015). Currently, coverage is estimated at close to 100% for those in formal employment but coverage in the informal sector remains low (Chuma et al. 2013).

During this period, development of the structure of the Kenyan health system was influenced by the initial decentralised nature of government and consequent centralisation in 1964 (SPAN and KHRC 2010). The health system was also influenced by globalisation processes such as the 1977 WHO “*Health for All*” model which called for attainment of a certain level of health that would permit all people to lead a socially and economically productive life by the year 2000 (Wamai 2009).

In 1980s, the Kenyan economy stagnated and it became impossible to continue running public health facilities without user fees (Anangwe 2008; KHF 2016). A review of priorities in healthcare financing suggested the introduction of user fees in public health facilities and strengthening of NHIF (Abuya et al. 2015). Therefore, in 1989, user fees were introduced

(Gesami 2000; Carrin et al. 2007; Anangwe 2008). However, the process of user fees policy implementation was hasty and lacked proper planning hence faced opposition by the public (Collins et al. 1996; Stover 1999). Failure of the implementation process led to re-structuring of the health system to tackle existing administrative and management problems (Anangwe 2008). Key changes included the creation of generation and utilization of funds (Gesami 2000; Anangwe 2008). As part of the re-structuring process, District Health Management boards (DHMBs), Hospital Management Boards (HMBs), and Health Centre Management Committees (HCMCs) were established in 1992 in order to improve healthcare delivery and management processes (Opiyo 2011). Following re-structuring, user fees were re-introduced in phases between 1992 and 1993 (Anangwe 2008) as follows: National referral hospitals, April 1992; provincial hospitals, July 1992; district hospitals, January 1993 and health centres, July 1993 (Gesami 2000).

As re-structuring continued, the country adopted the Kenya health policy framework (KHPF) in 1994 with a vision to provide “quality healthcare that is acceptable and accessible to all” (KHF 2016). This provided an enabling environment for the private health sector to service provision and financing (Oyaya and Rifkin 2003). The KHPF has since been implemented through two 5-year plans: The National Health Sector Strategic Plan 1999-2004 (NHSSP I) and the National Health Sector Strategic Plan II 2005-2010 (NHSSP II). In line with the NHSSP I objectives, the “10/20” policy was initiated in 2004. This saw the introduction of free healthcare services in all public facilities apart from a minimal registration fee of KES 10 and 20 in dispensaries and health centres respectively. Furthermore, delivery fees in all public facilities were abolished in the same year (Chuma et al. 2009).

Faith-based health providers in Kenya

Currently, Kenya has just under 9,500 different types of health facilities. Of these, 11.3% are registered as 'faith-based' (see Blevins et al. 2017). Both public and FBHP sectors have a majority of dispensary-type facilities (see Table 1).

Table 1: Number and percentage of faith-based health facilities in Kenya

Type of Facility	CHAK	KEC	SUPKEM	Other-FB	FB-Total	All facilities	% FB
Dispensary	283	232	5	160	680	4,293	15.8
Eye Centre	1	1	0	0	2	10	20.0
Health Centre	42	80	3	44	169	1,041	16.2
Health Programme	0	4	0	1	5	12	41.7
Maternity Home	2	1	0	0	3	48	6.3
Medical Clinic	26	25	2	32	85	3,013	2.9
Nursing Home	3	3	0	4	10	189	5.3
Other Hospital	14	48	1	22	85	235	36.2
Stand-Alone VCT Centre	7	7	1	17	32	154	20.8
Other (Specialty, government-only)	1	0	0	0	1	433	0.2
TOTAL	379	401	12	280	1,072	9,428	11.3

Source: Blevins et al. 2017

Faith-based health facilities comprise 70% of all health facilities in the private non-profit sector (Blevins et al. 2017, see Table 2).

Table 2: Number and percentage of FBHP facilities in the private non-profit sector

Type of Facility	Faith-Based	Non-Faith-Based	TOTAL	% Faith-Based
Dispensary	680	199	879	77.5
Eye Centre	2	0	2	100.0
Health Centre	169	34	203	83.3
Health Project	0	6	6	0.0
Health Programme	5	3	8	62.5
Maternity Home	3	5	8	37.5
Medical Centre	0	4	4	0.0
Medical Clinic	85	120	207	41.1
Nursing Home	10	6	16	62.5
Other Hospital	85	7	92	92.4
Stand-Alone VCT Centre	32	73	105	30.5
Other (Specialty,	1	3	4	25.0

government-only)				
TOTAL	1072	460	1534	69.9

Source: Blevins et al. 2017

This section will now examine the funding of FBHPs within the context of the Kenyan health system. Healthcare in Kenya is funded mainly from three key sources; Government, private sources (out-of-pocket payments, community-based health insurance-CBHI and private insurance) and donors (Luoma et al. 2010; Chuma and Okungu 2011; Munge and Briggs 2014; Ministry of Health 2015). In 2012/2013, the private sector⁵ was the main financier of health, accounting for 40% of the total health expenditure (THE); the public sector for 34% and development partners for 26% (KHF 2016). THE in Kenya has risen over the years, from KES 163 billion in 2009/10 to KES 234 billion in 2012/13 (Ministry of Health 2015).

In the secondary literature review conducted prior to this study (see table 3), we found that the Government provides support to FBHPs in Kenya in the form of staff-secondment to FBHP facilities (KHF 2016) and also through voucher programs (see Watt et al. 2015). In addition to government funding, healthcare provided by FBHPs is funded through health insurance including the national health insurance (NHIF, see Dieleman 2009) and community-based health insurances (CBHIs, see Mulupi et al. 2013; Musau 1999). In 2004, nine percent of funding within the CHAK network was from NHIF (see Dieleman 2009).

FBHPs in Kenya also rely primarily on user fees for their financing - despite user fees being withdrawn from the public sector in Kenya in 2004. For example, user fees was said to

⁵ Private sector means the Kenyan commercial sector

account for 71% of funding within the CHAK network in 2004 (see Dieleman 2009). A recent study done to assess adherence of the user fees policy abolition in Kenya shows that both FBHPs public facilities continue to charge user fees. It also shows a significant increase in utilisation of all services. However, this may not translate to better health outcomes (Maina and Kirigia 2015).

Table 3: What is known about financing sources of FBHPs in Kenya from the secondary literature

Funding source	Explanation and examples	References/Sources
Government of Kenya	Secondment: in the form of MOH providing faith-based health facilities with a certain number of health care workers	KHF 2016
Government of Kenya	Voucher programs: For example provision of faith-based facilities with reproductive health vouchers (safe motherhood postnatal care)	Watt et al. 2015
National health insurance	For example, FBHPs are linked to NHIF, NHIF funding accounted for 9% of funding within the CHAK network in 2004.	Dieleman 2009; Mulupi et al. 2013
Community-based health insurance	For example, Chogoria hospital in collaboration with Apollo insurance	Musau 1999
User fees	For example, Historically, in Kenya, user fees were the least significant source of funding for FBHPs, in 2004, user fees accounted for 71% of funding within the CHAK network	Dieleman 2009
USAID	Largest donor, implements programs through implementing partners, funds vertical programs	U.S Embassy Kenya 2014; USAID 2017
Global Fund	Channels funds through principal or sub-principal recipients such as Care International, CRS, World Vision International among others	Bonnel et al. 2013; Blevins et al. 2016; Global Fund 2008

Source: author’s synthesis drawing on Global Fund 2008; Dieleman 2009; Mulupi et a. 2013; Bonnel et al. 2013; U.S Embassy Kenya 2014; Watt et al. 2015; Blevins et al. 2016; KHF 2016; USAID 2017

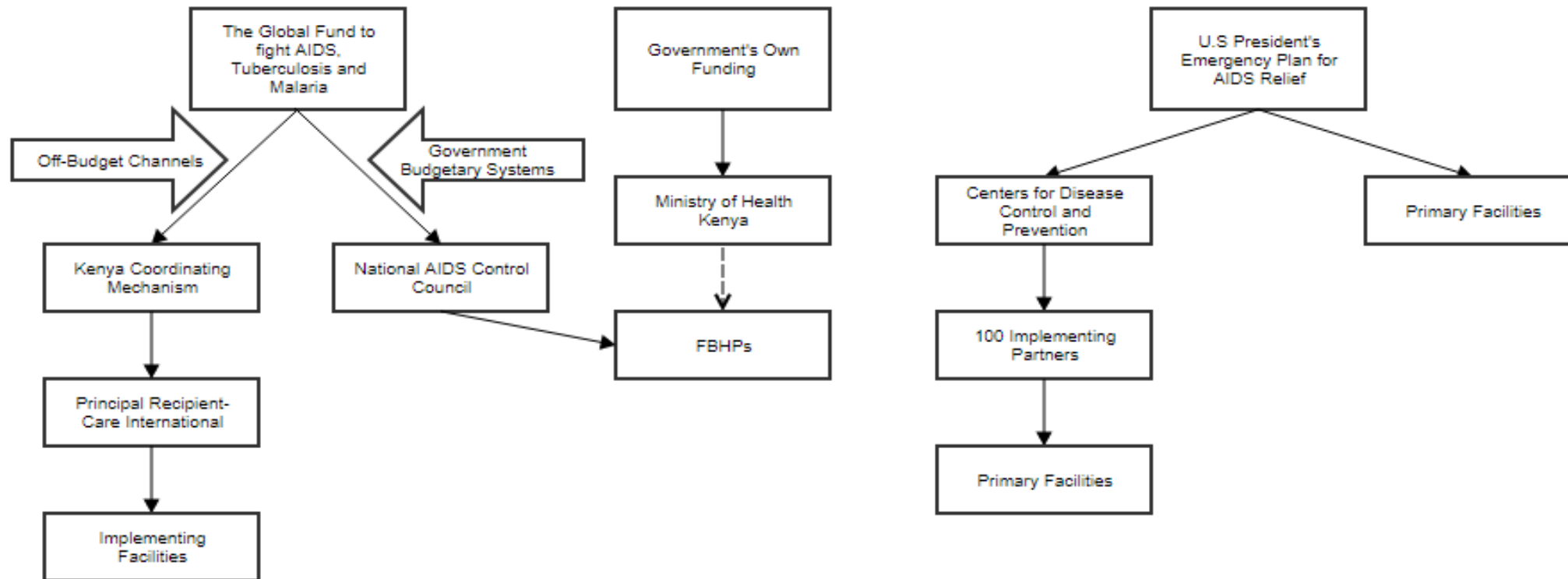
FBHPs in Kenya are also supported by a wide range of international donors, such as the United States Agency for International Development (USAID), or The Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) (KHF 2016). Donor funding in Kenya is mostly

aimed at vertical disease-programs such as those of malaria, HIV and tuberculosis (Chuma and Okungu 2011). For instance, USAID works in collaboration with the U.S President's Fund for (PEPFAR) and the GOK in the fight against HIV/AIDS (USAID 2017). PEPFAR works with multiple developmental partners including civil society organisations⁶ (CSOs) through more than 100 implementing partners in various program areas in combating HIV/AIDS in Kenya (U.S Embassy Kenya 2014). The Global Fund works with principal recipients (such as the Catholic Relief Services, CRS, and Care international), and sub-recipients (such as World Vision International), in providing services in their program areas of malaria, HIV/AIDS and tuberculosis (see Global Fund 2008).

HIV/AIDS funding to FBHPs in Kenya is disbursed through the government budget as well as off-budget channels (see Bonnel et al. 2013; Caritas 2015; NACC 2017) is indicated in Figure 1. For example, Global Fund disburses funds through either of these channels, whereas PEPFAR disburses funds solely through off-budget channels.

⁶ Civil society organisations (CSOs) are a broader grouping of non-governmental organizations (NGOs), community-based organizations (CBOs) and faith-based organizations (FBOs)

Figure 1: Financial flows to different FBOs⁷ in Kenya⁸



Source: Author's synthesis drawing on Bonnel et al. 2013; Caritas 2015; NACC 2017

Note: Primary facilities and implementing facilities include (but not limited to) faith-based health facilities

⁷ Which is a broader category than FBHPs and includes health-engaged faith-based NGOs

⁸ -----> symbolizes funding through staff secondment and voucher programs as opposed to direct funding, which was withdrawn in 1996

Case 1: Africa Inland Church Kijabe Hospital

AIC Kijabe Hospital is a FBHP or 'mission hospital' located in a small village on the eastern escarpment of the Great Rift Valley in Kenya. The hospital was founded in 1915 as an outpatient clinic initially named Theodora Hospital and was later renamed AIC Kijabe Hospital. It is a faith-based hospital sponsored by the Africa Inland Church (AIC) Kenya (Kijabe Hospital 2016). The facility is a registered member of the Christian Health Association of Kenya (CHAK) - a national network of more than 300 Protestant health facilities (PEPFAR 2012). Currently, the hospital is recognized as a level 5, Tertiary Teaching and Referral Hospital (Muchendu 2017) with a bed capacity of 383 (Kijabe Hospital 2016) serving approximately 10,000 inpatients, 120,000 outpatients and has one of the busiest operating theatres in East Africa. Kijabe is a multi-specialty facility providing services which include: emergency care, outpatient clinics, paediatric care, maternal and child health, obstetrics and gynaecology, surgical care and a large HIV/AIDS/TB clinic (Muchendu 2017).

The HIV program was started in 1999 (Kijabe A1 2017). The program is composed of five main components: clinical care, treatment adherence and support, strategic information, financing and administration (Korir 2017). Initially, the program had five satellites clinics including: Marira clinic (located along the Nairobi-Nakuru highway); Njabini Catholic dispensary in Nyandarua (35km away from the main clinic); Holy Cross dispensary and home-based program in Thigio (43km away from the main clinic); Holy Family Catholic Medical Health Center in Githunguri (38 km away from the main clinic); and Naivasha Medical Center (45 km away from the main clinic). Naivasha clinic has since become a stand-alone clinic as of 2013 (Kijabe A1 2017; Korir 2017).

Sources, structures, flows and trends of funding

When the program was initiated in 1999, there was no funding available. Funds were mobilized from private donors through Dr. Fielder, who is a friend of the hospital (Kijabe A1 2017). In 2004, the program began receiving funds from USAID. Between 2004 and 2013, funds were channelled through *AIDS Relief*, then to the *Catholic Mission Medical Board-Kenya (CMMB)*, before reaching AIC Kijabe hospital (Muchendu 2017; Kijabe A1 2017) as shown in Figure 2. Initially, the program received KES 5,556,252⁹ in 2004 (Korir 2017; Kijabe A1 2017). In consequent years, funding has steadily reduced (see Figure 2, figures adjusted for inflation).¹⁰

In March 2013, funding rolled over from CMMB to CHAK. Following this, channelling of USAID funds to Kijabe changed as shown in Figure 4. At the same time, in 2013, the Naivasha clinic became a fully-fledged site and was able to get direct funding (Kijabe A1 2017; Kijabe A2 2017) as indicated in Figure 5.

Currently, the Kijabe Hospital HIV Program is solely financed by USAID. Funding is structured in the form of five-year contractual agreements between Centers for Disease Control (CDC)/Kenya and PEPFAR. The contract is disseminated to local implementing partners through annual contracts. The first five-year contract ran from September 2012 to September 2016 under the CHAK HIV/AIDS project known by the acronym '*CHAK/CHAP*' (Kijabe A1 2017; Kijabe A2 2017). The program received a six months extension to aid in transition (Kijabe A1 2017). In March 2017, the second five-year round of funding was

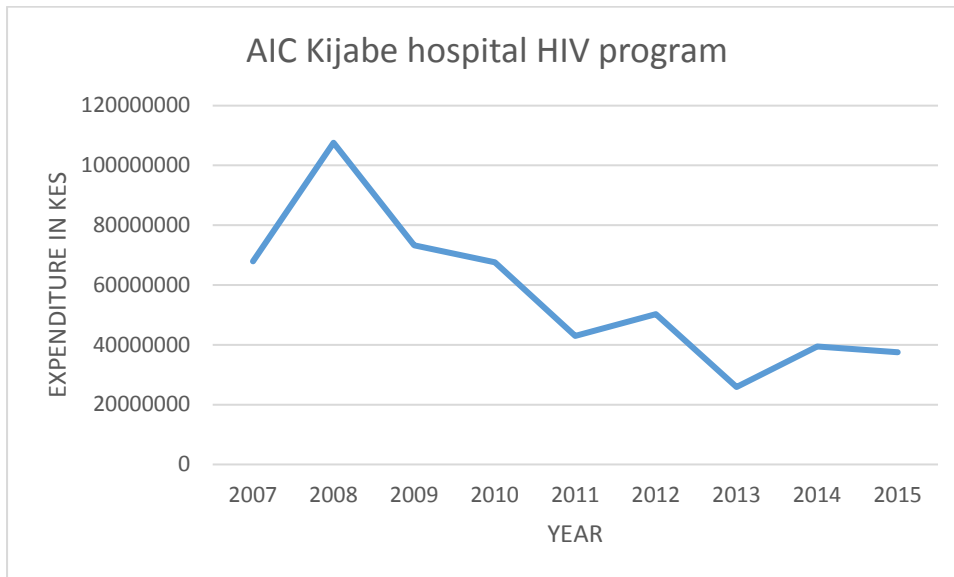
⁹ Figure not adjusted for inflation

¹⁰ See trends in expenditure for AIC Kijabe hospital HIV program

initiated under the current contract dubbed ‘CHAP Uzima’ (Kijabe A1 2017; Kijabe A2 2017).

There was a drastic budget reduction from ‘CHAK/CHAP’ to ‘CHAP Uzima’ (Kijabe A2 2017).

Figure 2: Trends in expenditure for Africa Inland Church Kijabe hospital



Source: Author’s synthesis drawing on Korir 2017; Muchendu 2017

Note: In analysing expenditure in Kijabe HIV program, we adjusted expenditures to the most recent year of data (2017) using the annual inflation rates for Kenya, with consumer price index as a measure of inflation. The inflation rate is based on the World Bank website: <https://data.worldbank.org>

Over the past decade, expenditure in Kijabe HIV program has steadily declined. This is consistent with reports from stakeholders:

“So, when the program started, I am made to believe that there was a lot of funding that was coming through, because again there was a lot of need to sensitize the community...so, there was a lot of community mobilization going around. There was

need to train the healthcare workers on how to manage HIV/AIDS so I understand there was a lot of funding during that time...2004 to 2009 there was no issue at all with funding. However, in 2010, there was a significant reduction in funding..."

(Kijabe A1 2017)

Despite decline in funding, HIV programming needs have increased *"It has been in an increasing trend. If you look at the numbers cumulatively, I think since we started program, currently we should be doing about 9,000 to 10,000 patients-that is both Kijabe and its satellites"* (Kijabe A1 2017)

Financial challenges

AIC Kijabe Hospital HIV program has experienced reduced funding over the years, prompting the program to make adjustments to the bouquet of services provided. For example, stakeholders indicated that although counselling and adherence support was critically important, due to reduced funding they had to prioritise care and treatment:

"Much as the funding is going down, they are supporting care and treatment. So, what happens most of the time is reduction in the number of staff. HR is what is affected most of the time. Like now with the new grant, we've had to do away with a few testing counsellors and some people from the treatment adherence and support. So, for Kijabe and its satellites, I think we lost 13 individuals with this new grant."

(Kijabe A1 2017)

It was clear that donors did not call for elimination of any particular service, but due to a shrinking basket, the program has had to work around a set budget thereby eliminating 'non-essential' services:

"...what I know is that, you are given a budget. So, it's upon you to work with that budget or to work from that budget. So, if previously you received 35 million, this year you receive 30 million, it's upon you to work around..." (Kijabe A2 2017)

The program also reported that with reducing financial support, patients are now required to pay for laboratory services:

"In 2015, they decided they will not be funding anymore laboratory work. So, biochemistry, haematology - they were faced-out. So, the patients have to pay for themselves." (Kijabe A1 2017)

It was reported that in addition to reducing financial support, in-kind support has also reduced:

"Then there has been a reduction in the supported opportunistic infections drugs because in the beginning we had about 40 drugs that were being supported by the program. Currently, we are only doing about 16...I think 18 which are supported for by the program." (Kijabe A1 2017)

With reduced funding, issues of sustainability arise. The hospital has a resource mobilization unit which support the poor patients. However, it is not clear how much funds this unit has currently or even how the unit runs.

Figure 3: Financial flow through AIC Kijabe HIV Program between 2004-2013

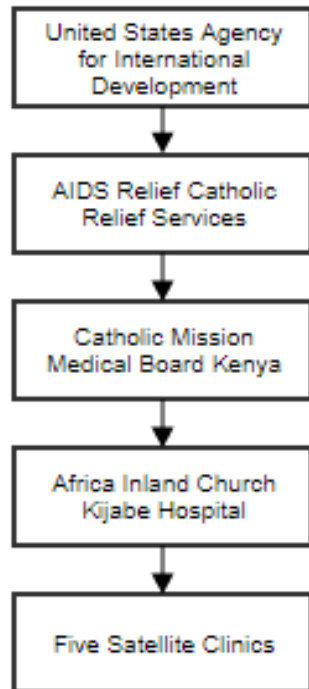


Figure 4: Financial flow through AIC Kijabe HIV Program between 2013-March 2017

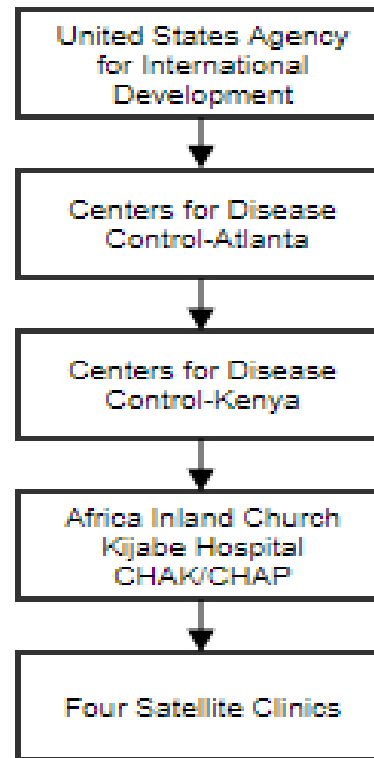
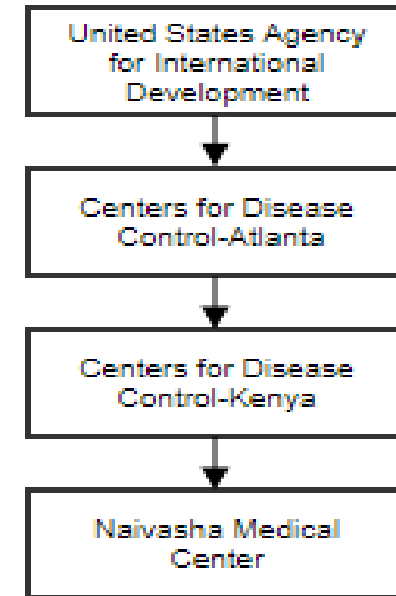


Figure 5: Financial flow through Naivasha Clinic between 2013-to-date



Source: Author's synthesis drawing on Muchendu 2017; Kijabe A1 2017; Kijabe A2 2017.

Case 2: Children of God Relief Institute (Nyumbani)

Nyumbani (Swahili for 'home') is a non-profit organization in Kenya, which provides comprehensive medical and home-based HIV/AIDS care to the poorest and most vulnerable population in Kenya. The organization has four programs: Nyumbani Children's Home, Nyumbani Village, Nyumbani Lea Toto Community Outreach and Nyumbani Diagnostic Laboratory (Nyumbani 2017). Nyumbani Children's home is a refuge home located in Karen, Nairobi and currently caters to more than 120 HIV positive children aged between new-born to 23 years of age (Nyumbani 2017a). The home was founded in 1992 by the late Father Angelo D'Agostino (Nyumbani 2017a; Deloitte Kenya 2012), as an orphanage to take care of abandoned HIV positive orphans. At the start, it had only three orphans (Deloitte Kenya 2012).

However, as the years passed by, there was an increase in demand for services provided which led to the establishment of Nyumbani Lea Toto Community Outreach in 1998. The program was intended to cater for HIV positive children in their homes/communities with the help of their caregivers thereby providing holistic home-based care (Deloitte Kenya 2012). Currently, the program operates in six centres in informal settlements surrounding Nairobi (Kawangware, Kangemi, Kariobangi, Kibera, Dandora and Mukuru), serving more than 3,000 HIV positive children living with a caregiver (Owens 2009).

In 2006, Nyumbani Village was created to care for both HIV infected and affected children (Syano 2011). The village is a self-sustaining initiative located in Kitui district in Eastern province in Kenya on a 1000-hectare piece of land. The concept of the village originated

from the need to provide a family atmosphere for orphaned children who were already being cared for by their grandparents. The program caters for several program areas: palliative care, social support, staff capacity, community capacity building and prevention (PWC 2011). These areas of need were identified in agreement by both Nyumbani and USAID: *“We sit down as two partners and agree. There are a few contractual agreements. For example, I must do a three month report”* (Nyumbani B4 2017). Currently, the village serves approximately 582 orphans and 57 grandparents living in a blended family style (Owens 2009).

The first Nyumbani diagnostic laboratory was built in 1998 (Nyumbani 2017c). Subsequently, through donor support, a new laboratory was opened in 2011 to provide specialized HIV to the community and to monitor HIV/AIDS patients on treatment against HIV infection. The laboratory provides services such as HIV testing including HIV viral load, HIV drug resistance, mycobacterium tuberculosis gene expert. In addition, it provides HIV counselling services (Nyumbani 2017b, Nyumbani 2017c).

Sources, structures, flows and trends of funding

Nyumbani is mainly donor-funded but also receives funding from private sources, faith groups and local communities, in-kind support and one-off financial support from the GOK and user fees from the public. International donors are comprised largely of organisations such as the USAID, provide approximately 70% of funding, World Children’s Fund, Medicines for Humanity, Gandhi World Hunger Fund and Concern Worldwide (Nyumbani B1 2017; Nyumbani B2 2017).

Funding to Nyumbani flows through varied channels depending on the source. For example, USAID funds Nyumbani through grants (Deloitte 2008; Nyumbani B1 2017; Nyumbani B2 2017; Nyumbani B3 2017; Nyumbani B4 2017). USAID/Kenya initiated funding to Nyumbani through the Lea Toto Community Outreach in 1999. Initially, funding was awarded through Catholic Relief Services (CRS, Deloitte Kenya 2008; Nyumbani B1 2017; Nyumbani B2 2017; Nyumbani B3 2017) as indicated in Figure 6.

Figure 6: Financial flow through Lea Toto program 1999-August 2003



Source: Author's synthesis from Deloitte 2008; Nyumbani B1 2017; Nyumbani B3 2017.

In August 2003, USAID/Kenya revised the grant implementation arrangement and awarded direct funding to the Lea Toto program without passing funds through CRS (Deloitte Kenya 2008; Nyumbani B1 2017; Nyumbani B2 2017; Nyumbani B3 2017; Nyumbani B4 2017) - see Figure 7. This channel of funding has remained to date.

Figure 7: Financial flow through Lea Toto program starting August 2003 to date



Source: Author's synthesis from Deloitte Kenya 2008; Nyumbani B1 2017; Nyumbani B2 2017; Nyumbani B3 2017; Nyumbani B4 2017.

This change resulted from USAID/Kenya having engaged with Nyumbani in developing capacity for Nyumbani to be eligible for direct funding:

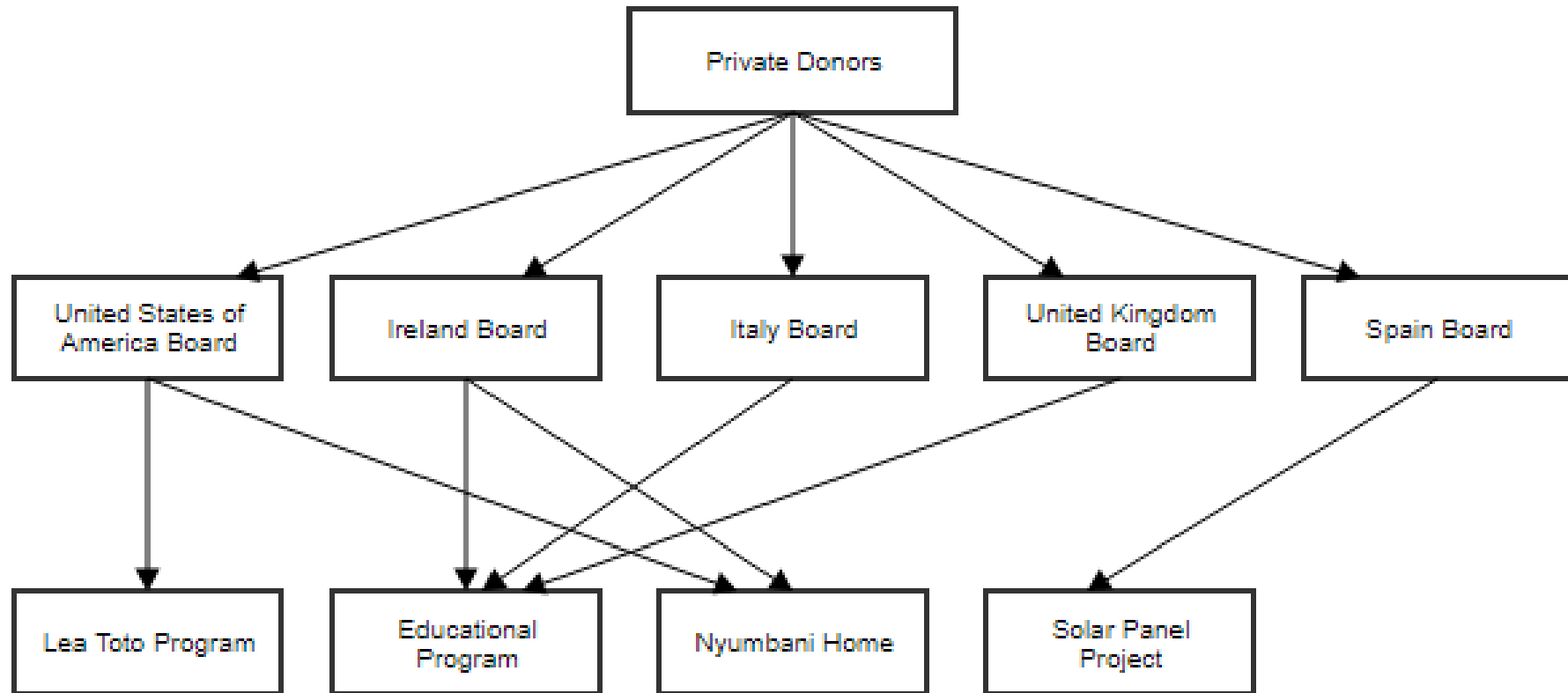
“The slogan was that, you don’t have the capacity to manage the funds. You know, by then. That’s why they channelled the money through Catholic Relief Services. But eventually, they did evaluation, guided us in developing the instruments and infrastructure and the human resource to manage that and the guidelines, and eventually we were approved to get direct funding.” (Nyumbani B2 2017)

Private individuals donate funds to Nyumbani by fundraising through five International Nyumbani Boards from the United States of America (USA), the United Kingdom (U.K), Italy, Ireland and Spain. Funds from these boards are channelled directly to the four programs (Nyumbani B1 2017; Nyumbani B2 2017; Nyumbani B3 2017). For example, the U.K board supports primary school education in the Village; the Italian board supports polytechnic education in the Village; the Irish board supports Nyumbani by giving 10 Euros per month per child in the home also support; the Spanish board has for the past two years provided support by collaborating with engineers without borders in installation of solar panels in the Village; and the USA board provides a monthly subsidy of USD 12,000 to the home (Nyumbani B1 2017; Nyumbani B2 2017) - see Figure 8.

Nyumbani also receives funding from other entities. For example, Medicines for Humanity supports the opportunistic infections program both at the home and at Lea Toto program; Local donors and faith groups and communities offer both monetary and in-kind

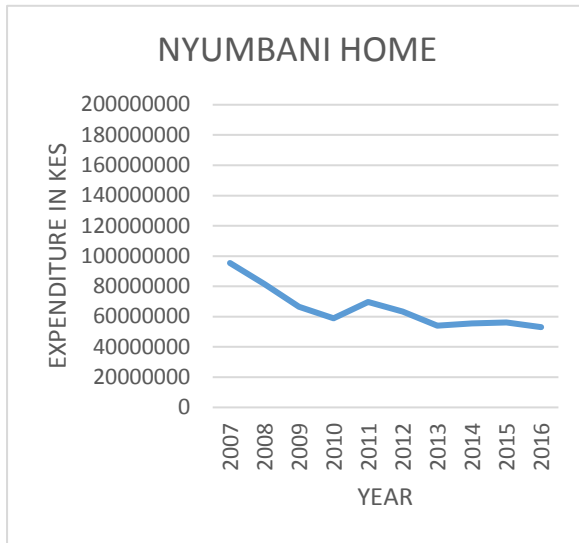
contributions; GOK supports Nyumbani through the opportunistic infections program; and user fees generated from the laboratory (Nyumbani B1 2017; Nyumbani B2 2017; Nyumbani B3 2017; Nyumbani A4 2017), which consist approximately 13% of their income (see Ernst and Young 2007; Deloitte Kenya 2008b; Grant Thornton 2009; Grant Thornton 2010; Deloitte Kenya 2011; Deloitte Kenya 2012b; Deloitte Kenya 2013b; Deloitte Kenya 2014; Deloitte Kenya 2015b; RSM Eastern Africa 2016).

Figure 8: Flow of funds from private donors to Nyumbani

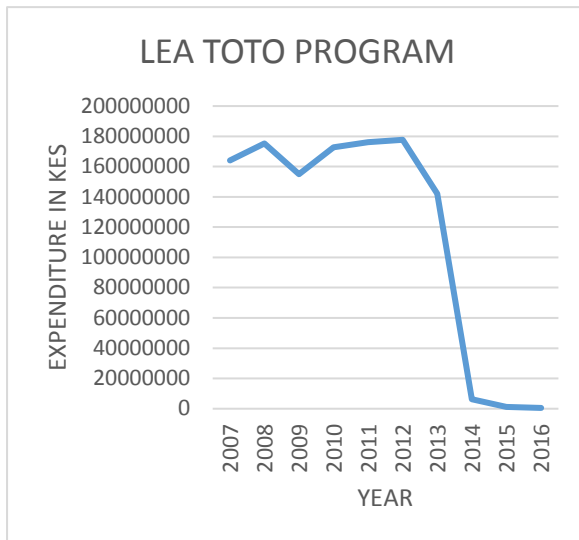


Source: Author's synthesis drawing on Nyumbani B1 2017; Nyumbani B2 2017; Nyumbani B3 2017; Nyumbani A4 2017.

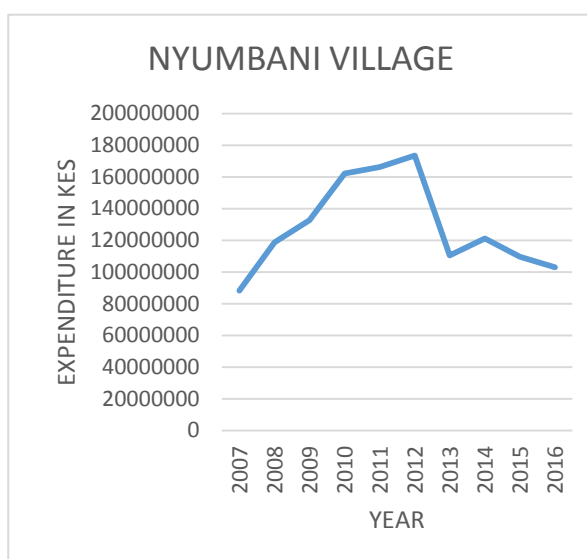
Figure 9: Trends in expenditure for Nyumbani



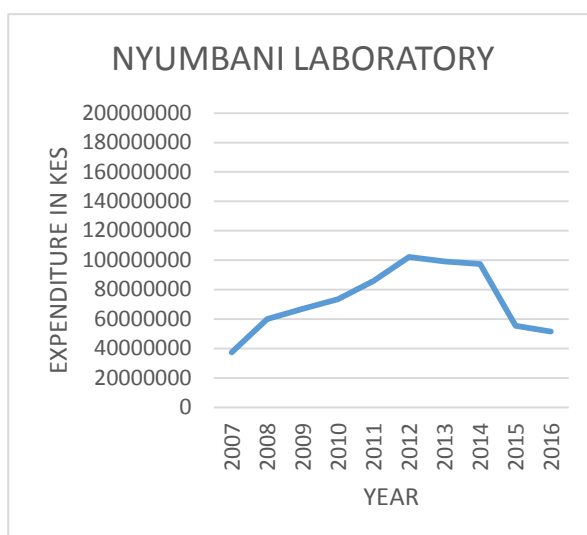
Nyumbani Home is a refuge home for HIV positive children aged between new born and 23 years.



Lea Toto program is a community outreach that provides holistic-home based care to HIV positive children in their homes/communities with the help of their caregivers.



Nyumbani Village provides holistic care for both HIV infected and affected children by providing comprehensive medical care, kindergarten to grade 12 education, vocational education, psychological support, shelter and food



Nyumbani laboratory provides specialized HIV testing and other testing to the community and monitors HIV/AIDS patients on treatment against HIV infection.

Source: Author's synthesis drawing on Ernst and Young 2007; Deloitte Kenya 2008b; Grant Thornton 2009; Grant Thornton 2010; Deloitte Kenya 2011; Deloitte Kenya 2012b; Deloitte Kenya 2013b; Deloitte Kenya 2014; Deloitte Kenya 2015b; RSM Eastern Africa 2016.

Note: In analysing expenditure in each of the programs in Nyumbani, we adjusted for inflation to the most recent year of data (2017) using the annual inflation rates for Kenya, with consumer price index as a measure of inflation. The inflation rate is based on the World Bank website: <https://data.worldbank.org>

Over the past decade, the four programs at Nyumbani have experienced varying trends in their expenditure. For example, Nyumbani laboratory experienced an increase in funding between 2007 to 2012 but expenditure plateaued between 2012 and 2014 and declined between 2014 to 2016. This may be attributed to the fact that when the laboratory was started, it was one of the few in the country providing specialized HIV testing. However, such other laboratories have since come up: *“It was the only lab that had focused on HIV and AIDS. But then of late, many labs have come up and they are competing it”* (Nyumbani B2 2017).

The Lea Toto program experienced a steep decline in expenditure from 2012 to-date, which has been attributed to reduced donor funding on HIV/AIDS in general: *“When we started, HIV was a really good funded area in all the donations and all that, but, in the last five years, I would say yeah. We’ve had a challenge, funds have not been coming the way we want”* (Nyumbani B4 2017).

Nyumbani Village experienced a gradual rise in expenditure between 2007 to 2012 but then experienced a decline in funding between 2012 to 2016. For the Home, there was a gradual decrease in expenditure in Nyumbani Home between 2007 and 2016.

Financial challenges

As noted above, Nyumbani has experienced several challenges in their financing. Concerns were raised on the fact that Nyumbani has increasingly become over-reliant on donor funding over the years – and HIV/AIDS funding in particular. This may be attributed to lack

of consistency in other forms of funding. For example, Nyumbani has had once-off funding from the Government and also from the Global Fund through the National AIDS Control Council: *“The last time we got funding from Global fund was in 2004. We tried to apply for funding again but we didn’t get it”* (Nyumbani B2 2017). Children in Nyumbani are transitioning into adolescents and young adults. This has led into diversified and increased needs and in turn the need for increased funding. *“We started with kids. Now these kids are growing to become adults. How do I manage them? That’s a real challenge”* (Nyumbani B4 2017).

As a result, Nyumbani has put in place sustainability strategies – it is not known whether these strategies will result in financial sustainability in the long term – as some might even add cost. Such programs include the economic empowerment program for the youth, which trains the youth on technical and life skills, and for caregivers, which provides caregivers with allocation for funding small businesses (Nyumbani B1 2017; Nyumbani B4 2017).

Another strategy is the tree planting initiative at Nyumbani Village initiated with the goal to become self-sustaining in the future by use of sales from the trees as source of income. However, this strategy worked well in the beginning but is now under threat of collapse:

“Our assumption is that we will self-sustain in the village, because in the 1000-acre land, we have the farm area and the trees are there. We are supposed to start cutting the trees from next year - which is not going to happen. So, we don’t know how we are going to convince USAID to support us for some more years.” (Nyumbani B3 2017)

Also, the Nyumbani laboratory was seen as a sustainability mechanism due to its income-generating capabilities as it offers specialized testing and is open to the public: *“At first, it worked out very well as it was the only lab that focused on HIV and AIDS but then of late, we have many labs that have come up and they are competing with it”* (Nyumbani B2 2017). (However, this also suggests that perhaps because the laboratory has less demand, it also therefore has less cost.)

Cross-case discussion

In this section, we will conduct a cross-case analysis of findings from each individual case¹¹, (see Yin 2009), keeping in mind that the two FBHPs are different in character and context. In fact, that is an important finding and reminder – that there are many different types of FBHPs in Kenya (and in SSA). For example, while both cases are faith-based institutions engaged in HIV service provision in Kenya – they are also very different. Nyumbani is a single organisation with multiple program components, many of which are more ‘development activity’ than ‘health service’ – such as orphan support (see Blevins and Griswold 2014). In contrast, AIC Kijabe is a large hospital that is part of a religious network (CHAK), which is running an integrated HIV Program through several satellite clinics (see Barnes et al. 2010; Blevins and Griswold 2014, PEPFAR 2015; KHF 2016). In the international literature on faith-based health providers, we are constantly reminded that there are multiple types of ‘FBOs’ and even multiple types of ‘FBHPs’ – and that it is important that research, and policy is

¹¹ In this study, the case is identified as non-state non-profit FBHPs. We used two FBHPs: CHAK’s AIC Kijabe Hospital and Children of God’s Relief Institute (Nyumbani)

developed that takes these important differences into account (see Olivier et al. 2015; Geoff 2009).

Faith-based health providers' sources of funding

In both cases, we found that FBHPs have shifted their funding sources – away from traditional denominational sources, towards sources standard for non-profit providers (faith-based or not) - unfortunately the exact levels of historical denominational support remain unknown – but this shift away from dependence on these resources is well documented. Said differently, Nyumbani has multiple sources of financing, while the AIC Kijabe HIV Program currently only has a single source (USAID) – but both are totally reliant on 'secular' sources. *“So, [we] have diverse sources, so it's not just in terms of church based. It's diverse in terms of funding”* (Nyumbani B2 2017). This finding substantiates the speculative argument made in the secondary literature, that FBHPs in Kenya and in SSA have generally moved away from 'traditional' sources of finance - towards a combination of state funding, out-of-pocket payments from patients, donors, funding and in-kind contributions from faith groups and communities (see Olivier and Wodon 2012) – and in these cases primarily donor funding.

In fact, this case study shows a trend of increased reliance on donor funding over the last decade. For example, currently the Kijabe HIV program is solely reliant on donor funding: *“For the care and treatment of the patients, it's 100% USAID funding for this institution”* (Kijabe A1 2017). Similarly, Nyumbani has become more reliant on donor funding over the last few years: *“The Lea Toto program is funded over 80% by PEPFAR”* (Nyumbani B1 2017). Other studies also show that FBHPs in SSA are increasingly reliant on international donor

funding, and that this trend has been substantially influenced by the increased availability of HIV/AIDS funding from around 2005 (see Olivier and Wodon 2014; Haakenstad et al. 2015; Olivier et al. 2015).

This may imply that FBHPs increasingly lack (financial) resilience as reliance on donor funding may result in FBHPs being overly influenced by donor priorities and less responsive to the communities, or the bottom line (see Gilson et al. 1997). This is substantiated by the broader literature, which speaks of the reliance of civil society organisations generally on HIV/AIDS funding, and the potential damage to the health system that is likely to occur as this donor funding is reduced and priorities shifted (see Foster 2012). This case study substantiates the reflection that FBHPs in Africa have become vulnerable (less resilient), and their routine service provision under threat, as a result of over-reliance on donor funding and HIV/AIDS-related vertical program prioritisation (and HIV/AIDS funding in particular, see Dimmock et al. 2017). For example, *“For Kijabe, I don’t know of any other program that supports. So, like am saying, what we end up doing, some cost is pushed now to the client. So, they have to chip in and pay for some services”* (Kijabe B2 2017). Both cases also demonstrated the continued importance of user fees – as a key source of funding for FBHPs. However, user fees were not always for traditional costs (the HIV service per se), but were often added for other ‘additional’ services. For example, in Kijabe where despite the program being 100% USAID funded, user fees are utilised for ‘additional’ services - it was difficult to quantify user fees at evidential level.

“There are some investigations that the client has to take care of. For instance, when you are about to be enrolled into care, the doctor needs some initial investigations

like CD4+ count, like creatinine levels, like such initial investigations. Initially, the client wouldn't pay even a cent for that. Currently, clients have to pay from their own pockets.” (Kijabe B2 2017)

While this case study was not able to conduct a full assessment of user fee practices – it was highlighted as important. It also substantiates the increased calls in the literature for empirical research on user fees and access to FBHPs at a *facility*-level (see Olivier et al. 2015). It has been noted that there is some resistance to assessment at a facility-level, especially relating to non-public financial information (see Schmid et al. 2008; Haddad et al. 2008). Future research would need to take such reluctance or caution into account, and consider ‘embedded research’ in which trusting relationships are developed between researchers and the health system over time (Olivier et al. 2017). In this particular case, the cost of doing that type of research would be balanced by its substantive relevance and importance.

It should be noted that the Kenyan Government and public sector moved away from user fees in 2004 (see Chuma et al. 2009) – so in this regard FBHPs are not in line with national priorities and reform agendas. This may be particularly problematic when faith-based facilities are the only facilities available, as people have no choice but to pay user fees, which limits access of health services for the poor and marginalized in the society, and may contradict the mission of FBHPs (see Gilson et al. 1994; Olivier et al. 2015). Conflicting values, with regard to care, has been shown to foster suspicions on both government and FBHPs, thereby challenging partnership between these health system stakeholders (see Ager et al. 2015).

The secondary literature has indicated that FBHPs have shifted towards closed collaborative relationships with Government in the last few decades (see Barugahara et al. 2008; Dieleman 2009; Rookes and Rookes 2012; Dimmock et al. 2012; Chirwa et al. 2013; Jacob 2014; Walt and Olivier 2017). However, to the contrary, neither of these cases evidenced strong collaboration – especially in relation to financial subsidisation. For example:

“The Kenyan government, there hasn’t been substantive support as such. Of course, we are a legal entity and we are existing because of them, but we haven’t received any substantive support from them.” (Nyumbani B2 2017)

“In-kind, [the Government] supports the TB program. So, we received drugs and supplies from the TB and Leprosy program.” (Kijabe A1 2017)

Attempts should be made to mitigate the effect of user fees on utilisation of health services in faith-based health facilities. This can be achieved through providing exemptions to the poor or increased collaboration with the Government through agreements where FBHPs provide free services for particular groups in the population or certain illnesses in exchange for government funding or utilising mandatory pre-payments such as health insurance.

Despite health insurance being a significant source of health financing for the Kenyan health system (Resyst 2014; Munge et al. 2015; KHF 2016) and specifically in FBHPs (see Musau 1999; Dieleman 2009), there was no evidence on utilisation of health insurance in these cases – suggesting that FBHPs are rarely tapping into financing relating to health insurance.

This conflicts with secondary literature which shows that use of insurance in health care can reduce catastrophic health expenditure (see Gatome-Munyua et al. 2015). Information on health insurance in FBHPs is needed to inform health-financing decision-making. Therefore, further research on this area may be required.

Resilience and responsiveness

Both cases demonstrated a strong adaptability to change over time. For example, Nyumbani had shifted through funding sources over time, and adapted quickly to the change when USAID funding was first channelled through implementing agencies (CRS), and then later directly: *“Now they call us direct funding but initially we used to get funds through an intermediary but now we get direct funding from USAID”* (Nyumbani B4 2017).

In Kijabe, while the funding sources did not shift, there were significant operational changes such as when implementing agencies changed over time¹²:

“So, from 2004, different organizations have been funded to support the HIV project or program in Kijabe. I know of AIDS relief, I know of Accord, I know of I think CMMB and lately CHAK ... we used to call it CHAK/CHAP. After every like five years, there’s a kind of transition...[most recently] changed from CHAK/CHAP to what they are calling CHAK Uzima.” (Kijabe A2 2017)

These findings support a significant amount of literature, which suggests that FBHPs have high levels of responsiveness and resilience to change (see Ewert 1993; Birungi et al. 2001;

¹² See figure 3, 4 and 5

Boulenger and Criel 2012; Olivier et al. 2015; Dimmock et al. 2017; Maulit 2017). This shows that FBHPs have an advantage in supplementing government resources, as indicated in cases where they have better infrastructure compared to government (see Gilson et al. 1997; Foster 2012). Also, in increasing access in under-served areas (see Gilson et al. 1997; Chirwa et. al 2013; Jennings 2015). With the WHO calling for a focus on building resilient health systems (WHO 2014a), further research is needed to understand whether other private non-profit (and even public) facilities could learn better practices about being ‘adaptive’ to health systems shock or change. However, this should be done having in mind challenges limiting the resilience of private non-profit providers such as reduced funding from traditional sources (see Ssengooba et al. 2002; Schmid et al. 2008; Rookes 2009; Rookes and Rookes 2012).

Trends in faith-based health providers funding

We saw fluctuating trends with regards to overall funding. In Kijabe, we saw a general decrease over 2007 to 2015 (see Figure 2). In Nyumbani, we saw a general decrease over 2012 to 2016 (see Figure 9). There were differences in trends at different periods of time, but in general, for both cases, the current trends shows funding steadily decreasing over the last 5-10 years:

“The basket has been shrinking with time because of course again with time, the disease has been controlled, kind of, because we have remained at 5.6% in this country since 2010. So, basically, it’s becoming controlled and patients have become stable. So, slowly with time, they’ve been withdrawing.” (Kijabe A1 2017)

In the international literature, there are significant contradictions about the financing levels for 'FBOs'. Some argue that FBOs (and FBHPs in particular) are chronically under-funded, while others argue that there has been a steady increase of funding allocation to FBOs over the last decade – especially as a result of the PEPFAR initiative (see Olivier and Wodon 2014; Haakenstad et al. 2015). These contradictions are mainly as a result of the fact that different 'FBOs' in different contexts have different financial resources and constraints – so generalisations are not useful (see Olivier et al. 2015). At least in these two cases, it seems that these two local Kenyan HIV/AIDS-related FBHPs – are recently seeing a trend of reduction in overall support.

More recently, it has been argued that FBOs are facing a potentially devastating loss of support as international funds for HIV are on the decline – and because FBOs have become so invested in HIV/AIDS service provision (see Caritas 2015). Certainly, these two cases both showed the expected massive decrease in HIV/AIDS-specific financing available to FBHPs in Kenya, specifically during the period from 2007 and 2012 (see Figure 9). This goes against the trend that has been seen for all types of 'FBOs' across all of SSA, from around 2004-2010 (see Haddad et al. 2008; Bonnel et al. 2013; Olivier and Wodon 2014; Maurice 2015; WHO 2017).

Conclusions

FBHPs in Africa remain relevant in provision of healthcare services (see ARHAP 2006; WHO 2007; Schmid et al. 2008). In Kenya, faith-based health facilities account for 11.3% of all health facilities (see Blevins and Griswold 2014), and provide 22% of HIV services (see Blevins et al. 2017). Although the role of FBHPs is well known, little is known about their

financing. This multiple case study examined funding sources and structures, funding flows, and trends in expenditures, of two HIV/AIDS programs in Kenya – namely CHAK’s AIC Kijabe hospital and Nyumbani.

We found that these two cases finance their services from a combination of donors, private sources, user fees, government, and local communities, as is the case with other FBHPs in Africa and in Kenya (see Olivier and Wodon 2012; Abuor 2013). FBHPs have shifted - away from traditional sources, towards secular sources. They have also become more reliant on donor funding, which may imply that these providers lack (financial) resilience due to the influence of donor priorities, and as a result may potentially damage the health system, as FBHPs become less responsive to communities (see Gilson et al. 1997). Given this, donors should continue to nurture relationships with FBHPs, to allow for realignment of priorities and agendas.

FBHPs have a strong adaptability to change over time both in shifting funding sources over time and in operational changes. FBHPs have shown high responsiveness and resilience to health systems changes. Therefore, as governments provide health care services to the poor and under-served populations, they should tap into FBHPs through stronger partnerships and government subsidy of user fees.

One of the areas that remains under-researched is the utilization of user fees in FBHPs at facility level. User fees are an important source of financing, even in a context where the Kenyan Government and public sector moved away from user fees in 2004 (see Chuma et al. 2009). User fees may limit access of care to the poor and marginalised. Future research is

needed to conduct full assessments of user fee practices. Taking into account that there is some resistance to assessment at a facility-level, especially relating to non-public financial information (see Schmid et al. 2008; Haddad et al. 2008), ‘embedded research’ should be considered, in which trusting relationships are developed between researchers and the health system over time (Olivier et al. 2017). In addition, efforts should be made for further inquiry in understanding the role played by health insurance in FBHPs financing in Kenya.

The findings of this study are likely to be applicable for donors and the government of Kenya to better understand the nuance of engagement with FBHPs. This is key in developing effective partnerships with these healthcare providers.

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Appendix 1: Data table

Data Source	Questions Answered
Nyumbani Annual reports <ul style="list-style-type: none"> • The Home • The Village • Lea Toto • Lab 	-Sources of finances, for example: PEPFAR, Private donors, government, among others. -Channels of funds (Financial flows) -Breakdown of sources of finances, for example: what percentage is from PEPFAR, private donors among others -Financial trends of separate portfolios between 2007-2016, that is: home, village, Lea Toto program and lab
Nyumbani USAID Integrated Program reports between 2007-2015	-Nyumbani background -Sources of Funds -Flow of Funds -Contents of Funding Agreement between USAID and Nyumbani -Total finances from USAID to Nyumbani -Type of funding-whether fixed or not
AIC Kijabe Hospital HIV Program Reports	-AIC Kijabe Hospital background -AIC Kijabe Hospital HIV Program background -AIC Kijabe Hospital HIV Program financial income and expenditures for the years 2004-2015
In-depth Interviews with Key stakeholders Nyumbani	Nyumbani Interviewee B1 Key Points: -Nyumbani is over-reliant on donor funding -Existence of a sustainability program in the Lea Toto program together with community empowerment initiatives -Raised concerns on sustainability -Program successes-viewed by adults who were once part of the program and are now successful professionals Nyumbani Interviewee B2 Key Points: -Evolving support in donor funding -Nyumbani is over-reliant on donor funding -Donor funding has been sustained due to diligent grant management Nyumbani Interviewee B3 Key Points: -Nyumbani has diverse sources of funding -Funding has increased over the years -Raised concerns on sustainability Nyumbani Interviewee B4 Key Points: -Existence of a sustainability program in the Lea Toto program -USAID contract is an agreement that is monitored using various mechanisms including 3-monthly reports
In-depth Interviews with Key stakeholders CHAK: AIC Kijabe Hospital	Kijabe Interviewee A1 Key Points: -HIV Program is solely funded by USAID -Funding has been declining since 2013 resulting in changes in -bouquet of services such withdrawal of counselling and adherence services for some patients and introduction of laboratory charges -Concerns of sustainability Kijabe Interviewee A2 Key Points: -HIV Program is solely funded by USAID -Concerns on reduced funding leading to reduced staff versus workload -Change of bouquet of services -Concerns of sustainability

Appendix 2: In-depth open-ended Interview guide with executive key informants

Approach: -

- Introduction to be done by the interviewer and must include the purpose of the research
- Obtaining consent using form in Appendix 2.
- Consent form signed by the interviewee and interviewer.

Questions will be asked in an open-ended format, and will be framed around the following key concerns: -

1. Background to the interviewee (position and history in that institution), as well as to the institution (CHAK or Nyumbani)
2. Background to financial flows in that institution, including:
 - a. Historical changes in finances
 - b. Major financial threats over the last decade
3. Funding structure and sources (with information on levels, nature of contract, fiscal flow directions):
 - a. Global funders such as PEPFAR or The Global Fund
 - b. National government
 - c. Faith-based partners
(including local congregations, denominational bodies, and/or individuals)
 - d. In-kind contributions
4. Sustainability of faith-based health providers with a focus on cost recovery mechanisms.

Appendix 3. Consent form and information sheet – for key informants



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Title of Study: Mapping and tracking the complexity of the financial flows through non-state non-profit faith-based health providers in Kenya

Introduction

I am a researcher from the School of Public Health and Family Medicine at the University of Cape Town. I am conducting research on financing of faith-based health providers in Kenya, specifically the Christian Health Association of Kenya and Nyumbani-Children of God Relief Institute in Nairobi.

This small sub-study is part of a broader research initiative by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the US president's Emergency Plan for AIDS Relief (PEPFAR) together with other partners such as the African Christian Health Association Platform (ACHAP), Emory University (Atlanta, USA) and St. Paul's University (Kenya).

I am interested in learning from you the funding structure and sources of your organization and how these might have affected sustainability of service provision over the past decade. I believe you can help me by sharing your experience working with faith-based health providers. This information will be useful in understanding the contributions faith-based

health providers make in Kenya. This information will hopefully be used in strengthening the Kenyan health system and response to HIV/AIDS.

You are requested to participate in an interview that will take a minimum of 30-45 minutes. The interview will be conducted by me, and will start by making sure you are comfortable. You can use English, Kiswahili or both when responding or asking questions, depending on which language you are comfortable. I can also answer questions about the research that you might have.

Then, I will ask you questions about the funding structures and sources in your organization, and how these might have affected sustainability of service provision over the past decade.

I will not ask you to share personal beliefs, practices or stories, and you do not have to share any knowledge that you are not comfortable sharing.

The interview can take place in any location of your choice and no one else but me and you will participate in that interview. If you agree, the entire interview will be voice-recorded (for note-taking purposes), but you will not be identified by name in the script. The script will be downloaded and stored electronically in the computer which can only be accessed with a password. The information recorded is confidential, and no one else except me will have access to the script. The recording will be discarded after 90 days.

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. You do not have to

answer any question or take part in the discussion if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

There will be no direct benefit to you, but your participation is likely to help us understand the sources of funding in your organization, how these funds are structured and how they have affected the sustainability of service provision by your organization. You will not be provided any incentive to take part in the interview, but your time is highly appreciated.

I will share the findings of this study with you by holding a stakeholder meeting and thereafter publishing a dissertation at the University of Cape Town (and possibly in a journal article).

Contact Details

You have the right to contact the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC) if you have any questions or concerns about your participation in this research www.health.uct.ac.za/research/humanethics/forms Tel: +27 21 406 6492.

This research has also been approved by AMREF (in Kenya).

For ethical concerns or queries

University of Cape Town,
The Faculty of Health Sciences
Human Research Ethics Committee
E 52, Room 24, Old Main Building,
Groote Schuur Hospital,
Observatory, 7925
Telephone: +27 21 406 6492
Fax: +27 21 406 6411

The Research Officer
AMREF Kenya
Wilson Airport, Lang'ata Road
Office Tel: +254 20 6994000
Fax: +254 20 606340
P.O Box 30125-00100
Nairobi, Kenya

Student Supervisor

Dr. Jill Olivier
University of Cape Town
School of Public Health and Family
Medicine
Faculty of Health Sciences
Anzio Road, Observatory, 7925
Tel: +27 (0) 21 406 6489
Fax: +27 (0) 21 448 8152
E-mail: jill.olivier@uct.ac.za

Student Researcher

Dr. Lucy Kingangi
University of Cape Town
School of Public Health and Family
Medicine
Faculty of Health Sciences
Anzio Road, Observatory, 7925
Tel: +254 (0) 797166855
E-mail: wambui.kingangi@gmail.com

If you agree to participate, please complete the next page (you will be given a copy of this entire form for your records).

Consent Section:

I _____ have been invited to participate in research about “Mapping and tracking the complexity of the financial flows through non-state non-profit faith-based health providers in Kenya”

I have read the foregoing information, (or it has been read to me). I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to participate in this study interview.

I also consent for the interview to be voice recorded (please tick inside the box) Yes

No

Signature of Interviewee _____

Location _____

Date _____

A copy of this form has been provided to the participant.

I _____ confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher /person taking the consent _____

Date _____

Appendix 4. Research information brief



RESEARCH INFORMATION BRIEF



MAPPING AND TRACKING THE COMPLEXITY OF FINANCIAL FLOWS THROUGH NON-STATE NON-PROFIT FAITH-BASED HEALTH PROVIDERS IN KENYA

This small sub-study is part of a broader research initiative by the **Joint United Nations Programme on HIV/AIDS (UNAIDS)** and the **US president's Emergency Plan for AIDS Relief (PEPFAR)** together with other project partners such as the interfaith consortium of academic institutions, which includes the Rollins School of Public Health at Emory University (Atlanta USA), University of Cape Town (South Africa) and St. Paul's University (Kenya). These partners are working in collaboration with the **African Christian Health Association Platform (ACHAP)**, the **Christian Health Association of Kenya (CHAK)** in addition to **Nyumbani-Children of God Relief Institute in Nairobi** in four program areas including: 1) Building the evidence base of the contributions of faith-based facilities to HIV services through a mixed method analysis 2) Understanding the influence of religion on stigma for key populations and working with faith-based health systems to minimize stigma for those populations 3) Authoring reports detailing the work of the overall UNAIDS/PEPFAR partnership and the proceedings from the country-level consultations that will be carried out 4) Supporting ACHAP as it carries out a set of health and community systems strengthening activities. These combined efforts will help build and strengthen collaborations with faith-based health providers (FBHPs) and help ensure that their resources are aligned, mobilized and sustained in the identified priorities of UNAIDS Fast Track and PEPFAR 3.0 in order to continue the hard-won progress made against HIV infection rates.

Aim of this sub-study: FBHPs play a pivotal role in provision of health services in Kenya. Despite their well-articulated role, little research has been conducted on their financial flows – either in support of their sustainability, or how they support access of those in need. This study aims to map financial flows to and through FBHPs in Kenya, and to describe in particular how HIV-related funding has influenced their health system functioning. The findings are expected to add to efforts of building an evidence base of the contributions of FBHPs in Kenya which is essential in policy making.

Research Question: How have changes in funding (and HIV funding in particular) over the last decade influenced the role and functioning of faith-based health providers in the Kenyan health system?

Approach: Multiple case study with two FBHPs which include the Christian Health Association of Kenya and Nyumbani-Children of God Relief Institute in Nairobi. The case study will involve collection of data from multiples sources which include: 1) Secondary literature-use of published research papers from previous studies 2) Analysis of secondary data-use of existing data which was collected in previous research for other purposes, for instance, the Kenya Health Information System which contains data on CHAK health facilities 3) Financial data on projects and annual reports 4) Routine data-for instance data on facility services 5) Previous research done on both organizations 6) Archival data 7) In-depth interviews with key stakeholders (5-15). Data collected during the study will then be analyzed and findings presented to key stakeholders before being published in form of a dissertation at the University of Cape Town (and possibly later in the form of an article).

Ethics: The main study as well as this sub-study will carefully comply with all good research ethics practices. The research has been cleared through local (AMREF) ethics committees, as well as the University of Cape Town Health Sciences Human Research Ethics Committee. We are aware that data relating to finances can be extremely sensitive (which has been one of the challenges of developing evidence on this topic). We commit to treating all provided data with utmost respect, privacy, and ethical intent. All participating institutions will be provided several opportunities to comment on results prior to publication.

Case proposition: The main case proposition is that the source of FBHPs funding influences their sustainability. Research shows that FBHPs commonly finance their services through a combination of sources which include: government resources, out-of-pocket payments from patients, donor assistance, funding and in-kind contributions from faith groups and local communities. However, current research conducted suggests that FBHPs have recently experienced reduced financial support from traditional sources which has substantially reduced their growth and commitment to those in greatest need. Furthermore, FBHPs serve certain roles which range from channeling grants to member facilities to acting as facilitators. These revolving roles continue to evolve with increased FBHPs engagement with government and donors.

Timeline: November 2016-April 2017-Develop Research proposal and conduct literature review

April 2017- June 2017-Data collection, Analysis and Writeup

May 2017-June 2017- Key Stakeholder feedback and Hand-in Dissertation

Researcher	Supervisor	Key Participant Advisors:
Dr. Lucy Kingangi University of Cape Town, Health Policy and Systems Division, School of Public Health and Family Medicine wambui.kingangi@gmail.com Tel: +254(0)797166855	Dr. Jill Olivier, Senior Lecturer & Research Coordinator University of Cape Town, Health Policy and Systems Division, School of Public Health and Family Medicine, Anzio Road, Observatory, 7925, South Africa Tel: +27 (0) 214066489 jill.olivier@uct.ac.za	ACHAP: Mr. Mike Mugweru CHAK: Dr. Samuel Mwenda Nyumbani-Children of God Relief Institute: Sister Mary Owens

Appendix 5. Broader project SOW (Emory Agreement)

[With the location of this sub-study highlighted]

**Statement of Work
from the University of Cape Town (UCT)**

for

The Academic Consortium of the UNAIDS/PEPFAR Joint Initiative to Strengthen Partnerships with Faith-Based Organizations

led by Emory University

From: Dr. Jill Olivier, <i>University of Cape Town, School of Public Health and Family Medicine</i>
To: John Blevins, <i>Interfaith Health Program, Rollins School of Public Health, Emory University</i>
Date: 01 October 2016

The following proposed *Statement of Work* briefly details how UCT will carry out specific activities delegated to the Academic Consortium as they relate to the larger Joint Initiative. It should be read in conjunction with the original '*Academic Consortium Concept Note*' which details the background to the project and the consortium activities. This *Statement of Work* primarily describes the UCT set of activities (in relation to the Consortium)

Background to The Joint Initiative

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the US President's Emergency Plan for AIDS Relief (PEPFAR) have engaged the Interfaith Health Program (IHP) of the Rollins School of Public Health at Emory University (Atlanta USA) to be the lead entity of an interfaith consortium of academic institutions. The Academic Consortium will work with UNAIDS and PEPFAR leadership along with other project partners to build and strengthen collaborations with faith-based organizations (FBOs) and faith-based health systems (FBHSs). These combined efforts will help ensure that the resources of FBOs/FBHSs are aligned, mobilized, and sustained in the identified priorities of UNAIDS Fast Track and PEPFAR 3.0 in order to continue the hard-won progress made against HIV infection rates.

I. Joint Initiative Timeframe: UCT's involvement in the Joint Initiative is expected to run for **18 months**, from 1 October 2016 to 31 March 2018 – split into two contractual periods (**1 October 2016 - 31 March 2017** and **1 April 2017 - 31 March 2018**). This document addresses the first six months only (with the second period to be re-contracted in 2017, if funding is attained).

II. Joint Initiative Scope of Work: The Academic Consortium is tasked with four program areas:

- 1) Building the evidence base of the contributions of faith-based facilities to HIV services through a mixed-method analysis;
- 2) Understanding the influence of religion on stigma for key and priority populations and working with faith-based health systems to minimize stigma for those populations;
- 3) Authoring reports detailing the work of the overall UNAIDS/PEPFAR partnership and the proceedings from the country-level consultations that will be carried out; and
- 4) Supporting the African Christian Health Association Platform (ACHAP) as it carries out a set of health and community systems strengthening activities.

UCT's involvement will be as follows (showing responsibilities and deliverables from the UCT team)

Activity 1: Building the evidence base of the contributions of faith-based facilities to HIV services through a mixed-method analysis			
Deliverable	UCT Role	Timeframe	Specific Responsibilities
1.1 Analysis of national health facility data platform and health services data platform in Kenya	Emory as primary <i>(mainly input, Emory responsible for deliverable)</i>	Initial summary complete by end November 2016, full analysis by March 2017	Emory will conduct a secondary data analysis of these two platforms to create the following county-specific data files (Excel format) prioritizing the high incidence and high burden counties in Kenya with all counties to follow (post-November). Those data files will provide health services data for the county as a whole and for services provided by faith-based facilities. The level of analysis will be at a facility level for the FBOs. At minimum, data on the following variables will be generated: <ul style="list-style-type: none"> • Currently in HIV care (disaggregated by gender and age) • Currently on ARTs (disaggregated by gender and age) • PMTCT services • Proportion of services provided by government, for-profit providers, civil society (non faith-based), and faith-based providers • Other analyses will be conducted depending on the data elements available in the health services data platform Emory will provide these data files to UCT; working together, both universities will develop a report that details findings from the secondary analysis.
1.2 Analysis of PEPFAR-specific databases on HIV services in Kenya and Zambia (prevention and treatment) funded by PEPFAR through funds awarded to PEPFAR prime partners.	UCT team concurrent with Emory <i>(Jointly responsible for deliverable)</i>	Initial analysis of dataset by end November 2016, full analysis by March 2017	UCT will work alongside Emory to conduct a secondary data analysis on health services and prevention data for services provided by PEPFAR. These data will be limited to services carried out by PEPFAR's prime partners and not by sub-grantees engaged by those prime partners. PEPFAR (through the Office of the Global AIDS Coordinator in Washington, DC) will provide the data files and Emory and UCT will jointly conduct the analysis. <i>Extent of initial analysis will depend on availability of datasets well in advance of the deadline (so might be limited to an initial summary assessment of what analysis is possible)</i>
1.3. Analysis of PEPFAR-specific databases on expenditures in Kenya and Zambia	UCT team concurrent with Emory <i>(Jointly responsible for deliverable)</i>	Initial analysis of dataset by end November 2016, full analysis by March 2017	Concurrent with the data files referenced in 1.2, PEPFAR has agreed to provide fiscal data files that will allow for an expenditure analysis to be conducted. UCT will work alongside Emory to conduct a secondary data analysis on these expenditure data cross-referencing the health services data provided by PEPFAR. <i>Extent of initial analysis will depend on availability of datasets well in advance of the deadline (so might be limited to an initial summary assessment of what analysis is possible)</i>
1.4 Case Study on services and financing of three faith-based programs: 1) the Christian Health Association of Kenya, 2)	UCT team as primary with Emory as	Complete by end March 2017	Following initial discussions with these three faith-based programs and agreement on approach in collaboration with Emory, UCT will conduct case study analyses of the three programs to describe the following:

<p>the Churches Health Association of Zambia, and 3) Nyumbani—Children of God Relief Institute in Nairobi</p>	<p>Secondary (UCT responsible for deliverable)</p>		<ul style="list-style-type: none"> History of the organizations Current services, with a focus on HIV services Funding structure and sources, with a focus on funding from 1) global funders such as PEPFAR or The Global Fund, 2) national government, and 3) faith-based partners (including local congregations, denominational bodies, and/or individuals), and 4) in-kind contributions that each faith-based programs can leverage in distinctive ways precisely because they are faith-based. <p>NOTE: Emory anticipates working with UCT to develop the framework that will determine the scope and the limits of the topics explored and recognizes that UCT may have research history in this area that can inform an improved approach to this work</p>
<p>Activity 2: Understanding the influence of religion on stigma for key and priority populations and working with faith-based health systems to minimize stigma for those populations</p>			
Deliverable	UCT Role	Timeframe	Specific Responsibilities
<p>2.1 Literature Review on stigma, religion, and key populations</p>	<p>Concurrent with Emory (mainly input)</p>	<p>Initial review by November 2016, update by end March 2017</p>	<p>Both UCT and Emory have conducted literature reviews on stigma, key populations, and religion in the fields of religious studies, cultural studies, and health sciences. The universities will combine the citations from this literature review. TIMEFRAME: Complete by November 2016</p>
<p>2.2 Formative research on the effects of stigma on access to HIV services for key populations (MSM, sex workers, people who use drugs, and adolescent girls and young women) and the influence of religion on this</p>	<p>Secondary to Emory and St. Paul’s University (mainly input)</p>	<p>Initial review by November 2016, update by end March 2017</p>	<p>Emory and St. Paul’s University carried out a pilot phase of this formative research in 2015. In this project, this pilot methodology will be expanded with key informant in-depth interviews and semi-structured interviews. Emory and St. Paul’s will assume responsibility for carrying out the qualitative research fieldwork with UCT joining the other universities for analysis and interpretation of the qualitative findings.</p>
<p>2.3 Needs assessment with services providers from CHAK and CHAZ on their learning needs for clinical knowledge and attendant clinical skills to provide quality HIV care for key populations groups</p>	<p>Concurrent with Emory (Emory responsible for deliverable)</p>	<p>Complete by end January 2017</p>	<p>Emory and UCT will work with CHAK, CHAZ, and ACHAP to conduct a needs assessment on the learning needs of HIV care providers working with key populations groups. Based on the findings of this needs assessment, UCT and Emory will draft recommendations to PEPFAR and UNAIDS for follow-on training (employing grantees with expertise in this program area) on these topics.</p>
<p>Activity 3: Authoring reports detailing the work of the overall UNAIDS/PEPFAR partnership and the proceedings from the country-level consultations that will be carried out</p>			
Deliverable	UCT Role	Timeframe	Specific Responsibilities
<p>3.1 Prepare interim report (end November 2016) to USAID in</p>	<p>Concurrent with Emory and</p>	<p>Complete by end</p>	<p>The three universities will share responsibilities in drafting this interim. This report will be an internal document to be submitted by UNAIDS to USAID detailing progress on deliverables as of November 2016. As</p>

anticipation of year two funding for the project	St. Paul's <i>(Emory responsible for deliverable)</i>	November 2016	the members of the academic consortium, UCT, SPU, and Emory will work together to draft a report on the progress made on their contributions.
3.2 Prepare year-end project report for the general public in April 2017	Concurrent with Emory and St. Paul's	Complete by April 2017	The academic consortium is responsible for working in collaboration with PEPFAR and UNAIDS to author the project report on the first year of the project across all consortia. By January 2017, the members of the academic consortium will decide on their primary responsibilities on this deliverable
Activity 4: Supporting ACHAP as it carries out a set of health and community systems strengthening activities.			
Deliverable	UCT Role	Timeframe	Specific Responsibilities
4.1 Work with ACHAP to strengthen the functionality of its technical working groups	Concurrent with Emory	Complete by February 2017	ACHAP proposes to strengthen the functionality of its existing technical working groups as part of this project. Emory and UCT will offer technical assistance on these efforts as ACHAP advises.
4.2 Develop training modules (plenary, concurrent sessions, and pre-conference institute) on health systems strengthening to be offered at the ACHAP Biennial in February 2017	Concurrent with Emory	Complete by February 2017	Emory and UCT will work with ACHAP to determine learning objectives, content, and training modalities for these modules.
4.3 Paired mentorship in health systems strengthening	UCT as primary <i>(providing support, ACHAP responsible for deliverable)</i>	Complete by March 2017	UCT will work with ACHAP to carry out a mentorship model for health systems strengthening in which the senior leadership from a smaller CHA spend time for intensive on-site learning with the senior leadership from a larger, well managed CHA. Responsibilities will include: learning assessment and personalized training agenda, on-site participation/support from UCT, and follow-on support as the smaller CHA works to implement knowledge, skills, and procedures learned.
MISCELLANEOUS ACTIVITIES: In addition to the four activities listed above, the Academic Consortium is charged with offering support to other project consortia as they work to complete their activities			
Deliverable	UCT Role	Timeframe	Specific Responsibilities
M1: As needed, provide technical assistance to other consortia	Emory, UCT, and St. Paul's concurrently	Contingent on requests	Based on the specific focus of any requests received, the members of the academic consortium will determine which member will take primary responsibility
M2: Resources for an online platform	Emory, UCT, and St. Paul's	Complete by February 2017	Emory will host an online platform with materials relevant to the project. Two focuses already identified will be fact sheets/infographics/reports detailing findings from activity 1 (above) and resources to support health systems strengthening activities for ACHAP members.

Appendix 6: AMREF ethical approval



Amref Health Africa in Kenya

REF: AMREF – ESRC P211/2017

March 13, 2017

John Blevins,
Emory University
Email: jblevin@emory.edu
Tel: +1 404-213-8514

Dear Dr Blevins,

RESEARCH PROTOCOL: UNDERSTANDING THE SCOPE OF HIV PREVENTION, TREATMENT, AND SUPPORT SERVICES PROVIDED BY FAITH-BASED ORGANIZATIONS IN KENYA

Thank you for submitting your research protocol to the Amref Ethics and Scientific Review Committee (ESRC).

This is to inform you that the ESRC has approved the renewal of your protocol. The approval period is from March 13, 2017 to March 13, 2018 and is subject to compliance with the following requirements:

- a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
- b) All changes (amendments, deviations, violations etc) are submitted for review and approval by Amref ESRC before implementation.
- c) Death and life threatening problems and severe adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the ESRC immediately.
- d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to Amref ESRC immediately.
- e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period (attach a comprehensive progress report to support the renewal).
- f) Clearance for export of biological specimen or any form of data must be obtained from Amref ESRC, NACOSTI and Ministry of Health for each batch of shipment/export.
- g) Submission of an executive summary report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/or plagiarism.

Please do not hesitate to contact the ESRC Secretariat (esrc.kenya@amref.org) for any clarification or query.

Yours sincerely,

Prof. Mohamed Karama
Chair, Amref ESRC



CC: Dr. George Kirathi, Director Institute of Capacity Development, Amref Health Africa and Vice Chair

Appendix 7: CHAK letter of support



CHRISTIAN HEALTH ASSOCIATION OF KENYA

P.O. BOX 30690
GPO 00100
NAIROBI
KENYA

Telephone: 254-20-4441920/4445160/4441854
Cellphone: 254-(0)733-334419/0722-203617
Fax: 254-20-4440306
Email: secretariat@chak.or.ke
Website: www.chak.or.ke

09 December 2016

AMREF
Kenya Ethics & Scientific Review Committee (ESRC)

Dear Sir/Madam,

The Christian Health Association of Kenya (CHAK) is a national network of the Protestant Churches Health facilities and programmes in Kenya with a Secretariat based in Nairobi. As a representative of CHAK, I am familiar with Dr. John Blevins research project entitled "HIV prevention, treatment, and support services provided by Faith-Based Organizations in Kenya" that will start in February 2017. The research project was designed and will be implemented with CHAK and a consortium that includes Emory University (Atlanta, Georgia) and the University of Cape Town (Cape Town, South Africa) to support programmatic efforts of a joint initiative between United Nations Programme on HIV/AIDS (UNAIDS) and the US President's Emergency Plan for AIDS Relief (PEPFAR) in Kenya.

I understand that this research will be carried out following sound ethical principles and that any participant involvement in this research study is strictly voluntary and provides confidentiality of research data, as described in the protocol. The project team has the support of the Christian Health Association of Kenya to collect and analyze data from the CHAK supported faith-based health facilities across Kenya and analyze data using the research tools outlined in the protocol.

Yours sincerely,

Dr. Samuel Mwenda
General Secretary
Christian Health Association of Kenya

Appendix 8: UCT ethics research approval letter



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7936
Telephone: (021) 406 6492
Email: sumayh.ariel@uct.ac.za
Website: www.healthuct.ac.za/fhs/research/humanethics/forms

06 July 2017

HREC REF: 305/2017

Dr J Olivier
School of Public Health & family Medicine
Falmouth building

Dear Dr Olivier

PROJECT TITLE: MAPPING AND TRACKING THE COMPLEXITY OF FINANCIAL FLOWS THROUGH NON-STATE NON-PROFIT HEALTH PROVIDERS IN KENYA (Masters candidate-Ma L Kingangl)

Thank you for your response letter dated 20 June 2017, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 July 2018.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.healthuct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student, L Kingangl will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate Institutional approval before the research may occur.

Yours sincerely

PROFESSOR F. BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB000C1938

HREC 305/2017

Appendix 9: AIC Kijabe Hospital approval letter



To Whom It May Concern:

This letter is to confirm that Lucy Kingangi has been given permission to carry out her research project in Kijabe hospital entitled:

'Mapping and tracking the complexity of financial flows through nonstate, non-profit (faith-based) health providers in Kenya'.

She is allowed to contact staff to invite them to take part in interviews. She is also able to view publically available documents held by the hospital. Should she require access to further information which is no publically available she will be required to seek permission from the hospitals IREC.

Please do not hesitate to contact me if you require further information.

Yours Sincerely,

D. Peter Halestrap
BMBCh, MRCP, DCH, DRCOG, BA (Oxon)
IREC Chair

Appendix 10: Journal style guide: health policy and planning

Instructions for Authors

Health Policy and Planning improves the design, implementation and evaluation of health policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. *HPP* is published 10 times a year.

HPP has a double-blinded peer-review policy. All types of papers are peer reviewed and all article abstracts from each issue are translated into French, Spanish and Chinese.

- Guidance
- Types of papers
- Submission process

Guidance

Improving chances of publication

As well as the high overall quality required for publication in an international journal, authors should take into consideration.

- Addressing *HPP*'s readership: national and international policy makers, practitioners, academics and general readers with a particular interest in health policy issues and debates.
- Manuscripts that fail to set out the international debates to which the paper contributes, and to draw out policy lessons and conclusions, are more likely to be rejected, returned to the authors for redrafting prior to being reviewed, or undergo a slower acceptance process.
- Economists should note that papers accepted for publication in *HPP* will consider the broad policy implications of an economic analysis rather than focusing primarily on the methodological or theoretical aspects of the study.
- Public health specialists writing about a specific health problem or service should discuss the relevance of the analysis for the broader health system. Those submitting health policy analyses should draw on relevant bodies of theory in their analysis, or justify why they have not, rather than only presenting a narrative based on empirical data.
- Primarily focus on one or more low- or middle-income countries.

The editors cannot enter into correspondence about papers considered unsuitable for publication and their decision is final. Neither the editors nor the publishers accept responsibility for the views of authors expressed in their contributions. The editors reserve the right to make amendments to the papers submitted although, whenever possible, they will seek the authors' consent to any significant changes made. The manuscript will not be returned to authors following submission unless specifically requested.

Should you require any assistance in submitting your article or have any queries, please do not hesitate to contact the editorial office at hpp.editorialoffice@oup.com.

Manuscript format and style for all articles

Only articles in English are considered for publication.

Prepare your manuscript, including tables, using a word processing program and save it as a **.doc**, **.rtf** or **.ps** file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left justified and not hyphenated.

The **title page** should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter
- Corresponding author's name, address, telephone/fax numbers and e-mail address
- Each author's affiliation and qualifications
- Keywords and an abbreviated running title
- 2-4 Key Messages, detailing concisely the main points made in the paper
- Acknowledgements
- A word count of the full article

In the **acknowledgements**, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

Please be aware that the requirements for online submission and for reproduction in the journal are different: (i) for online submission and peer review, please upload your figures separately as low-resolution images (.jpg, .tif, .gif or .eps); (ii) for reproduction in the journal, you will be required after acceptance to supply high-resolution .tif files. Minimum resolutions are 300 d.p.i. for colour or tone images, and 600 d.p.i. for line drawings. We advise that you create your high-resolution images first as these can be easily converted into low-resolution images for online submission.

Figures will not be relettered by the publisher. The journal reserves the right to reduce the size of illustrative material. Any photomicrographs, electron micrographs or radiographs must be of high quality. Wherever possible, photographs should fit within the print area or within a column width. Photomicrographs should provide details of staining technique and a scale bar. Patients shown in photographs should have their identity concealed or should have given their written consent to publication.

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