Assessing the challenges hindering effective provider-purchaser engagement in Kenya: A Root cause analysis and actionable solutions

FINAL REPORT

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LIST OF ABBREVIATIONS

AKI	Association of Kenya Insurers
CBHIS	Community-Based Health Insurance Schemes
CHAK	Christian Health Association of Kenya
CHMT	Community Health Management Team
COG	Council of Governors
FGD	Focus Group Discussion
HCK	Hindu Council of Kenya
HMO	Health Management Organisations
IDI	In-depth Interview
IRA	Insurance Regulatory Authority
KAPH	Kenya Association of Private Hospitals
KCCB	Kenya Conference of Catholic Bishops
KCOA	Kenya Clinical Officers Association
KDA	Kenya Dental Association
KENCO	Kenya Network of Cancer Organizations
KHF	Kenya Health Federation
KHPOA	Kenya Health Professionals Oversight Authority
JAP	Joint Action Plan
KMA	Kenya Medical Association
MOH	Ministry of Health
MIPAK	Medical Insurance Practitioners of Kenya
NaNAK	National Nurses Association of Kenya

NCD	Noncommunicable Disease
NHIF	National Hospital Insurance Fund
PHI	Private Health Insurance
PPM	Provider Payment Mechanisms
PSK	Pharmaceutical Society of Kenya
RUPHA	Rural Private Hospitals Association of Kenya
SCAFKENYA	Sickle Cell Anemia Foundation- Kenya
SPARC	Strategic Purchasing Africa Resource Center
SUPKEM	Supreme Council of Kenya Muslims
UHC	Universal Health Coverage
WHO	World Health Organization
WOFAC	Women Living with HIV & AIDS in Kenya

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1: EXECUTIVE SUMMARY

Introduction

Kenya has committed to achieve universal health coverage (UHC) by 2030. Moving towards this goal requires health system-wide reforms and strategic purchasing reforms can be leveraged towards achieving UHC. Particularly, reforms to strategic purchasing actions targeting improvement in provider-purchaser engagements are paramount given the roles that providers and purchasers play in ensuring the population receive all needed healthcare services and are protected from financial hardship.

To transition to strategic purchasing, there is a need to strengthen provider-purchaser engagement through reforms on the following: provider selection/empanelment, provider payments mechanism/reimbursements. Making healthcare purchasing more strategic requires the generation and use of evidence about provider behaviour, challenges that may hinder effective engagements and context-specific actionable solutions targeting the real root causes to identified challenges.

Given the need for evidence, the Kenya Healthcare Federation (KHF) spearheaded an exercise (Phase 1 engagement) to adequately understand the challenges hindering effective provider-purchaser engagements in the private health sector in Kenya. Evidence from this study indicated that provider-purchaser engagements in Kenya are characterised by 1) provider selection/empanelment challenges (such as inequalities in empanelment), 2) provider-payment challenges (such as delays in reimbursement, fraud, poor enforcement/honouring of contracts, and inequalities in payment rates) and 3) communication challenges (poor communication and low trust).

While the Phase 1 study elicited the above challenges, the study did not include the public sector providers, multiple purchasers and other key stakeholders in the health sector such as regulators, who also have a significant contribution to the delivery of health services in the Country. KHF further invited more partners including SPARC, ThinkWell, World Health Organization- Country Office, to help diversify the scope of the work to include public

providers. Consequently, there was a need for a Phase 2 engagement that builds on the identified challenges, includes all relevant stakeholders in the health sector and takes a deeper dive into highlighting the root causes of the challenges, generate actionable solutions and develop an action plan for each stakeholder. A provider-purchaser engagement can be leveraged as an approach to inform joint problem diagnostics and hence the development of actions to address health financing and service delivery bottlenecks. This report focuses on the root causes of identified challenges and proposes actionable solutions to policymakers and actors in the health sector.

Methods

Given the objectives of the work, we employed a qualitative cross-sectional study approach employing a coaching approach (facilitative approach) where a process facilitator guided discussions with key representatives from identified stakeholders. We collected data through focus group discussions (FGDs), in-depth interviews (IDIs) and a consensus-building workshop with stakeholders representing public, private, faith-based, social health franchises, medical professional bodies, the National Hospital Insurance Fund (NHIF – at county/branch and national level), the Council of Governors (COG) and the ministry of health (MOH).

Key findings

The study found the following as root causes to challenges hindering effective provider-purchaser engagements in Kenya:

1. **Resource gaps**: Resource gaps was manifested in two ways. First, human resource gaps were resulting from understaffing and/or staff turnover both at the provider and purchaser levels. These gaps contributed to increased workload, delays in claim audits/verification and poor or lack of communication between providers and purchasers. Second, there were infrastructure gaps by providers including both hardware (lack of equipment to facilitate the payment process) and software gaps from purchasers including lack of automated systems to empanelled providers, to raise/lodge and follow-up claims.

2. **Training/capacity gaps:** Providers highlighted staff capacity gaps with the payment process often resulting from staff turnover, change of benefits package or the installation of new information systems or contract terms.
3. **Governance issues:** These include 1) bureaucracy especially on provider empanelment and disbursement on reimbursements of claims, 2) poor accountability mechanisms resulting from inadequate monitoring arrangements that can guard against fraud both at provider and purchaser level, and 3) poor communication channels between providers and purchasers on emerging issues on engagements.

Additionally, the stakeholders identified the following as actionable solutions to promoting effective provider-purchaser engagements in Kenya: 1) Adopt technology to automate processes such as the submission of claims – moving away from submitting manual claims; 2) providers to engage more staff (preferably dedicated to handling claims and purchase-related issues); 3) introduce quarterly/regular training of healthcare providers on claims (and other terms and conditions of the schemes); 4) link purchasing arrangements to quality; 5) diversify and use formal provider friendly communication channels.

Conclusion

Challenges hindering effective provider-purchaser engagements result largely from human resource and infrastructure gaps, capacity gaps and communication & accountability gaps. Reforms aimed at addressing these gaps must focus on building staff's payment process capacity, employment or prioritization of staff to the payment process, adoption of health information systems/technology to automate processes (both on empanelment and payment) and establishment of working communication channels (both automated and in-person processes). Such reforms should be tailored to the stakeholders' actions and monitored to ensure adequate implementation. Stakeholders in the health sector such as the Kenya Healthcare Federation, SPARC and ThinkWell can support the design, implementation and monitoring of the actionable solutions taken up by providers and purchasers through policy dialogues.

Recommendations

Ministry of Health

1. **Spearhead the revision and implementation of standard treatment guidelines:** Standard treatment guidelines are essential for an adequate understanding of the costs of care for purchasers to minimize both differential quality and cost of care.
2. **Develop a framework for public-private contracting:** This will entail the development of a framework that would allow private payers to contract public providers. Public-private contracting will create an avenue for providers' competition that can be leveraged to reduce the cost of care, enhance the quality of care and efficiency. This is also an important aspect of cost containment.

NHIF and Private purchasers

1. **Review provider payment mechanisms to include output-based payments;** Fast-tracking the revamping of PPMs with a focus on introducing output-based payment mechanisms will provide an avenue for linking purchasing decisions to performance.
2. **Scale up the automation of processes**: All payers to move to automated systems that permit automated empanelment, claim submission, pre-authorization, and the utilization of an electronic health records system across all providers.
3. **Capacity building of providers**; Purchasers to adequately train providers on new systems and facilitate regular refresher training.
4. **Impose strict sanctions for fraud cases**: This will provide an avenue for fraud management.
5. **Develop and utilize formal channels of communication:** Utilize these formal channels to engage providers frequently.
6. **Establish complaints management framework**

Regulators

1. **Establish central medical insurance management systems:** This will be quintessential in improving purchaser regulation and promoting health system goals.

Providers

1. **Invest in technology:** Providers to invest in adopting technologies such as automation through the e-claim system.
2. **Avail staff for capacity building:** All providers to make sure that at least more than one staff has been trained and/or facilitated to attend refresher training where necessary.

1.0: INTRODUCTION

Kenya has committed to achieve universal health coverage (UHC) by 2030: Achieving UHC means reforming the health system to ensure that the whole population has access to good quality healthcare services of their need whilst protecting them from experiencing financial hardships while accessing care. Moving towards this goal requires reforms across the whole health system. The government has prioritized strategic purchasing reforms in the move towards achieving UHC[1]. Strategic purchasing involves deliberate decisions around the range of services to buy, the set of provider selection to buy from and how to optimize the use of limited available resources. In moving towards UHC, reforms on strategic purchasing actions targeting the enhancement of provider-purchaser engagements are paramount given the roles that providers and purchasers play in ensuring the population receives all needed healthcare services and are protected from financial ruin.

Kenya's health system is characteristically dual/mixed. Kenya has a dual health system comprised of Private providers (accounting for 46% of all facilities), Faith-based providers (accounting for 8% of all facilities) and Public providers (accounting for 46% of all facilities) – Figure 1. Besides the facility composition, both faith-based and private facilities in Kenya contribute a large share of service delivery in Kenya. For instance, both faith-based and private facilities provided 47% and 28% of all cesarean and normal deliveries in 2020 (Table 1).

[1] **Kenya Health Financing Strategy 2020–2030**

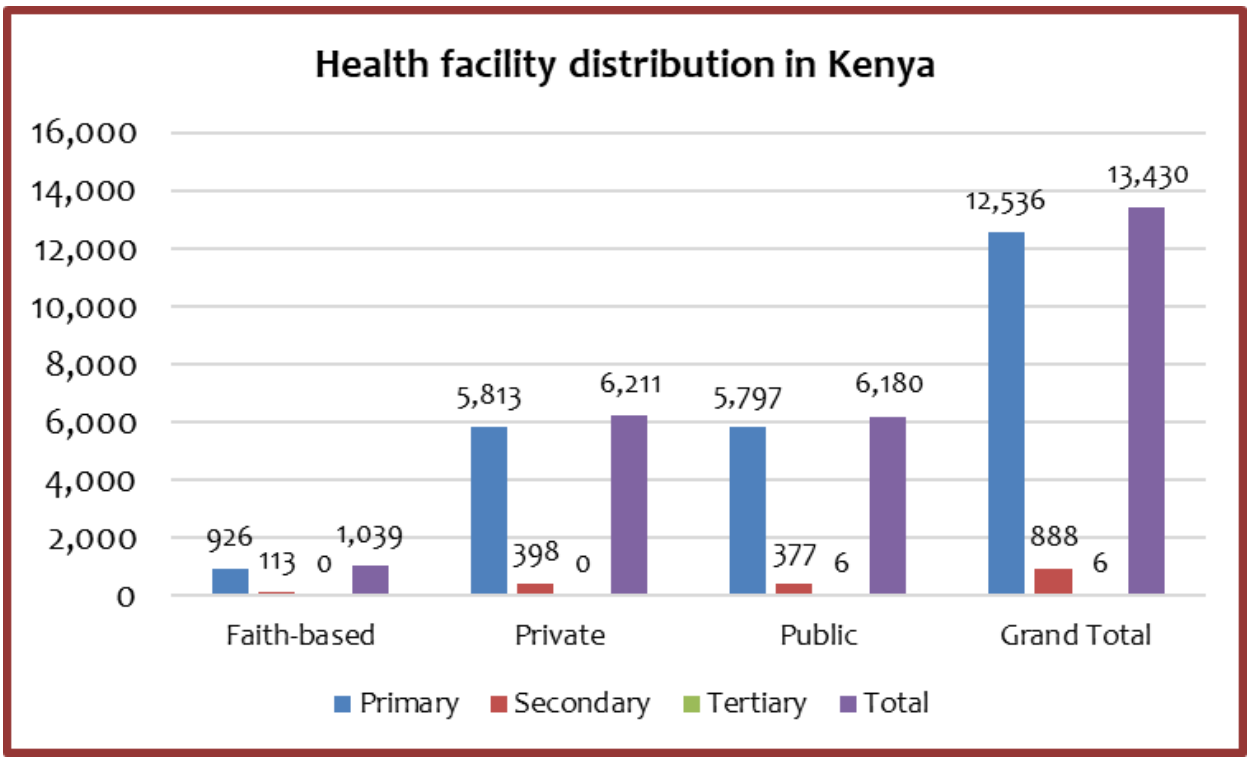

Figure 1: Distribution of health facilities in Kenya - Source[2]

Table 1: Distribution of the number of monthly cesarean and normal deliveries by facility ownership (Public, faith-based or private) in 2020 in Kenya

Data	Cesarean Sections			Normal Deliveries		
Period / Facility Ownership	Ministry of Health	Faith Based Organisation	Private	Ministry of Health	Faith Based Organisation	Private
Jan-20	8,618	2,629	3,661	61,353	7,977	10,722
Feb-20	7,913	2,460	3,408	57,998	7,704	9,944
Mar-20	8,830	2,905	3,844	63,647	8,887	11,525
Apr-20	8,219	2,759	3,903	60,073	8,443	11,927
May-20	9,231	2,813	4,003	65,148	9,002	12,012
Jun-20	8,847	2,926	3,955	60,502	8,591	11,499
Jul-20	9,205	3,078	4,134	62,602	8,861	11,850
Aug-20	8,460	3,133	4,180	60,871	9,671	12,758
Sep-20	8,689	3,430	4,526	62,053	10,636	12,919
Oct-20	8,354	3,481	4,536	57,481	9,909	12,877
Nov-20	8,007	3,120	3,934	56,416	9,099	11,233

[2] http://kmhfl.health.go.ke/#/facility_filter/results - Authors' analysis, data downloaded on 30th August 2021

Dec-20	4,078	4,753	5,942	29,698	17,679	21,560
Total	**98,451**	**37,487**	**50,026**	**697,842**	**116,459**	**150,826**
Percentage contribution	**53%**	**20%**	**27%**	**72%**	**12%**	**16%**

Source: Author analysis of data from the Kenya Health Information System (KHIS)[3]

Besides the pluralistic distribution of providers, the health system in Kenya also comprises public purchasers (MoH, 47 County Governments and NHIF) and private purchasers (comprised of several private health insurances – PHI) (Table 2). These purchasers employ different provider payment mechanisms (PPMs) to reimburse providers. For instance, whereas PHI uses a fee-for-service payment mechanism to reimburse providers, public purchasers use a mix of PPMs. Increasing evidence suggests that purchasers can leverage on PPMs to elicit positive behaviour among providers, especially when PPMs are designed to consider providers' preferences[4].

Table 2: List of public purchasers in Kenya – Source[5]

Purchasers	Who they purchase from	What they purchase	How they purchase
National Government/ Ministry of Health (MOH)	National Referral hospitals	Essential package for health	Global Budgets
County departments of health (CDOH; n=47)	County public facilities	Essential package for health	Inputs (e.g. salaries, fuel, human resources) are paid for on a line-item basis within programme budgets
National Hospital Insurance Fund (NHIF)	Public and private facilities	Outpatient and inpatient services based on the benefits package for the scheme	Capitation for outpatient, case based group payments (e.g. for day surgeries or outpatient renal dialysis), fee for service (e.g. for diagnostic procedures)
Private health insurers	Private, and international health providers	Outpatient and inpatient services based on package paid by each member	Fee for service, on a monthly basis
Community-based health insurers (CBHI)	Low-cost public and faith-based providers	Outpatient and inpatient services based on package paid by each member	Fee for service, on a monthly basis

Purchasers and providers are essential drivers of UHC. Providers and purchasers are the most crucial players to ensuring that the population receives the services they need whenever they need them, the quality of those services received and the level of financial risk protection. Any decision by these may translate to progress towards UHC or act as a barrier. For instance, the implementation of capitation payment in Kenya has been associated with unnecessary

[3] https://hiskenya.org/dhis-web-pivot/
[4] https://academic.oup.com/heapol/article/35/7/842/5857408
[5] https://wellcomeopenresearch.org/articles/6-81

referral of patients to higher-level facilities, under-provision of services, and, worst, denial of services. However, the appropriate utilization of strategic purchasing actions can unleash the positive potential of effective provider-Purchaser engagements that can be leveraged on cost containment, focus on improving quality and equity of care, and efficiency in service delivery.

Consequently, achieving effective provider-purchaser engagements can be a lever for making progress towards UHC. Provider-Purchaser engagements are primarily centred around strategic purchasing actions/decisions related to provider selection/empanelment and provider payment/reimbursement. Provider-purchaser engagements are considered effective when both provider and purchaser actions are aligned to the ideal actions for provider selection (such as selective contracting) and payment (including having an adequate payment rate to cover the costs of services, timely and predictable reimbursement). For instance, Figure 2 highlights the ideal strategic purchasing actions that purchasers need to implement in relation to providers. Purchasers must ensure equity in the empanelment of providers, timely payment, well-developed PPMs, timely audit/verifications to claims and use of appropriate communication channels to receive and send feedback from/to providers. Reforms targeting these actions can be applied to make healthcare purchasing more strategic. Evidence from other settings indicate that effective provider-purchaser engagements build longer-term trust-based relationships, can guard against fraud, can incentivize providers to deliver timely, high quality and effective healthcare services at agreed rates[6]. These are good ingredients for achieving UHC.

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5306421/

Key strategic purchasing actions by the purchaser/payer in relation to providers

1. Select providers considering the range and quality of services and their location
2. Establish contract/service agreements
3. Develop formularies and standard treatment guidelines
4. Establish provider payment rates
5. Design, implement and modify provider payment mechanisms that are linked to efficiency and service quality
6. Audit claims
7. Protect against fraud and corruption
8. Pay providers regularly and timely
9. Establish and monitor user payment policies
10. Monitor provider performance and act on poor performance
11. Develop, manage and use information systems

Figure 2: Ideal strategic purchasing actions by purchasers in relation to providers - Source: RESYST Framework[7]

However, there is a dearth of evidence on how to guide the implementation of effective purchaser-purchaser engagements in Kenya. While reforms across the health system are being implemented to move the country towards UHC[8], little is known in Kenya about how and what provider-purchaser engagements can be strengthened to mediate challenges that hinder effective provider-purchaser engagements. One study in Kenya assessed the challenges to effective provider-purchaser engagements in the private sector[9]. Although the study highlighted several challenges such as lack of trust between providers and purchasers, inadequate communication, delays in reimbursement, lack of collaboration in decision making among others, the study focused only on private providers and purchasers, did not elicit the

[7] https://resyst.lshtm.ac.uk/resources/what-is-strategic-purchasing-for-health
[8] https://www.tandfonline.com/doi/full/10.1080/23288604.2018.1513267
[9] https://khf.co.ke/purchaser-provider-engagement-initiative-phase-2/

root causes of the challenges and lacked a proper description of actionable solutions that can be adapted to mediate a cohesive engagement between providers and purchasers.

Therefore, there is a need to assess the root causes and actionable solutions to challenges hindering effective provider-purchaser engagements in Kenya: Against this backdrop, this assignment aimed to explore the root causes to challenges hindering effective provider-purchaser engagements in Kenya and provide actionable solutions that can be adapted to attain cohesive and streamlined engagements between providers and purchasers in Kenya.

1.1: Understanding provider-purchaser engagement challenges: a conceptual framework

Engagements between providers and purchasers are centred around four key decisions/actions:

1) Provider selection – this relates to the process of identifying the set of health care providers to engage. Decisions involve whether to include only public and/or private providers, and selective contracting or general empanelment.
2) Provider payment – decisions and actions around how and how much to pay. Key decisions around, inter alia, the choice of the PPM, rate, and frequency of payment.
3) Communication – the platform and frequency of sharing and receiving information during and after the action to the first two decisions.
4) The government or regulatory legal, policies and actions.

Consequently, challenges that may hinder effective provider-purchaser engagements may stem from inadequate or a complete lack of implementation of the above decisions in accordance with the ideal strategic purchasing actions that both providers and purchasers should perform[10]. These challenges are summarized here (Figure 3) according to the four key areas.

[10] https://resyst.lshtm.ac.uk/resources/what-is-strategic-purchasing-for-health

First, on provider selection/empanelment challenges, while, for instance, purchasers are required to select and establish contracts/service agreements with providers not providing incentives for quality, the implementation of provider selection/empanelment may contribute to ineffective provider-purchaser engagements. For example, providers highlighted challenges related to the inequitable empanelment that favoured large and urban providers at the expense of the rural providers.

Second, besides the empanelment challenges, provider-purchaser challenges can stem from payment issues. For instance, both providers and purchasers highlighted delays in reimbursement, rejection of payments, fraud, and payments not incentivizing quality. Additionally, public providers highlighted the inequality in reimbursement for the same set of services where private providers tended to receive higher reimbursement for the same set of services.

Third, communication is key for effective provider-purchaser engagements. However, communication issues are prevalent and are related to poor feedback mechanisms especially from the purchaser related to reasons for delays in reimbursement, response to providers' requests, bureaucracy and lack of or poor collaboration in decision-making.

Last, existing challenges hindering effective provider-purchaser engagements can be classified as regulatory issues. For instance, providers highlighted the lack of frameworks to ensure the enforcement of contracts. Providers had no clear ways to hold purchasers accountable for a breach of contracts. Purchasers seemed to have a higher balance of control. While there is some regulation for private health insurance, there are still great opportunities to strengthen how the regulator protects both the providers and consumers.

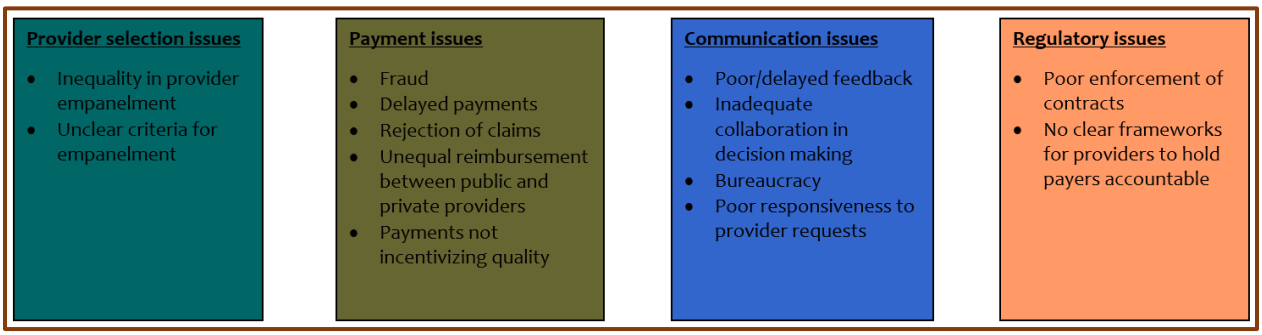

Figure 3: Summary of challenges hindering effective provider-purchaser engagements

2.0: METHODS

2.1: Study Design

Overall, the engagement adopted a cross-sectional qualitative study design employing a coaching approach (facilitative approach) where a process facilitator facilitated discussions with representatives from identified stakeholders. The coaching approach was adopted as it draws on an expert in Kenya, supported by global experts to facilitate the provider-purchaser listening sessions in a more inclusive, transparent and evidence-grounded manner.

Primarily, data were collected using interviews – incorporating both focus group discussions (FGDs) and in-depth interviews (IDIs) with representatives of providers (public, private – for-profit and faith-based and social health franchises), purchasers, government regulatory, oversight agencies, health insurance beneficiaries and medical professional bodies and through a 3-day workshop with other representatives from the different groups highlighted in Table 3. Table 3 Summarises the list of stakeholder clusters and their representatives engaged.

A workshop was conducted in October 2021 to validate the findings from the interviews, build consensus among stakeholders and develop a joint action plan (JAP) that summarises the actionable solutions, resources required, indicators for monitoring progress and timelines for implementation of these actions.

Table 3: Stakeholders engaged and the number of FGDs/IDIs

Stakeholder Cluster	Stakeholder representative	Number of FGDs/IDIs
Private Healthcare Service Providers/FBOs	Rural Private Hospitals Association of Kenya (RUPHA)	2
	Christian Health Association of Kenya (CHAK)	
	Supreme Council of Kenya Muslims (SUPKEM)	
	Kenya Conference of Catholic Bishops (KCCB)	

	Kenya Association of Hospitals	
	Hindu Council of Kenya (HCK)	
Social Health Franchises	Tunza by PS Kenya	2
	Amua by Marie Stopes International	
	CFW by Sustainable Healthcare Federation	
	Huduma Poa Network by Kisumu Medical and Education Trust	
	Association of Health Franchising in Kenya	
	Goldstar Network	
Medical Professional Bodies	Kenya Association of Private Hospitals (KAPH)	2
	Pharmaceutical Society of Kenya (PSK)	
	Kenya Medical Association (KMA)	
	National Nurses Association of Kenya (NaNAK)	
	Kenya Clinical Officers Association (KCOA)	
	Kenya Dental Association (KDA)	
Public Healthcare Service Providers	National Teaching and Referral Hospitals	2
	Select County CHMTs	
	Ministry of Health – Primary Healthcare Department	
	Council of Governors	
	County Health Facilities	
Purchasers	National Hospital Insurance Fund (NHIF)	4
	Select County CHMTs	2
	Ministry of Health –Tax-funded strategic programs	2
	Community-Based Health Insurance Schemes (CBHIS) • M-Tiba	2
	Private Insurers (HMOs): • Association of Kenya Insurers (AKI) • Medical Insurance Practitioners of Kenya (MIPAK)	2

Government Regulatory, Oversight and Policy Agencies	Insurance Regulatory Authority (IRA)	2
	Kenya Health Professionals Oversight Authority (KHPOA)	
Health Insurance Beneficiaries	Women Living with HIV & AIDS in Kenya (WOFAK)	2
	Kenya Network of Cancer Organizations (KENCO)	
	Faraja Cancer Support	
	NCD Alliance Kenya	
	Diabetes Management Institute Kenya	
	Sickle Cell Anemia Foundation- Kenya (SCAFKENYA)	
	Cerebral Palsy Society of Kenya	
Ministry Of Health (MoH)	Division of Planning and Health Financing	3
	Accreditation Department	
	Department of Standards and Quality Assurance and Regulations	
Council of Governors	Health Experts	1

2.2: Sampling

Purposive sampling was employed to select stakeholder representative groups for each of the stakeholder clusters deemed important. Each stakeholder representative then recommended at least two representatives for the FGDs and at least one representative for IDIs.

2.3: Data Collection

The interviewees were invited to take part in the FGDs or IDIs. All FGDs were virtually done using Zoom, whereas IDIs were conducted using a mix of both Zoom and face-to-face interviews. The interviewees provided consent before the beginning of the FGDs/IDIs. The interviews were audio-recorded and transcribed verbatim. Also, data was collected through a stakeholder workshop that targeted representatives from the public and private providers

and purchasers as well as other stakeholders in the health financing space (Appendix 1 lists the stakeholders engaged in the workshop).

2.4: Data Management and Analysis

Transcripts from the IDIs and FGDs were charted using MS Excel using a coding framework focussing on the root causes and solutions to challenges hindering effective provider-purchaser engagements. The data were analysed using a thematic approach (Maguire and Delahunt, 2017). Emerging themes were discussed with the study collaborators (SPARC, WHO, ThinkWell, and Kenya Healthcare Federation) when presenting the initial findings and consensus was reached on the final themes.

Tables generated from the consensus-building workshop were summarised in Microsoft Word and actionable solutions were categorised into three main categories: 1) Short-term actionable solutions – these were identified as the suggested solutions that can be implemented within 1 year; 2) Medium-term actionable solutions – these were the solutions to be implemented within 2 to 3 years, and 3) Long-term actionable solutions – these were still important actionable solutions but suggested by stakeholders to be requiring implementation over a long term (beyond 3 years).

3.0: RESULTS

3.1 Root causes to challenges hindering effective provider-purchaser engagements

3.1.1 Resource gaps

Resource gaps was one of the root causes of a majority of the challenges that hindered effective provider-purchaser engagements. These resource gaps were manifested in two ways:

1. **Human resource gaps**: This was a common factor across both providers and purchasers, specifically, gaps in human resources involved in the payment process (i.e. lodging of claims from providers and reviewing and paying claims from the purchasers' side). Amongst providers, pre-existing staff gaps resulted in existing staff taking

multiple roles and tasks, which led to the heavy workload that contributed to, among other things, delays and errors in lodging claims. Consequently, purchasers delayed reimbursements and partially paid or rejected claims. Besides, public sector facilities did not adequately prioritize staff to be engaged in the payment process.

"*I think for facilities delaying in claiming is that because some of the facilities actually lack resources…. Some lack critical staffs. Some multitask – in fact for our facility, the person claiming* [is the same] *person registering patients.*" FGD 1 – Public providers

"*…. like in my facility, the person who does the claims actually has other tasks that he has to do during the day. So inadequate human resource is quite burdening for us…. So, this person doesn't have time to actually do the claims and then go over them before submitting them to see if there are any errors to those claims.*" FGD 1 – Public providers

Additionally, human resource gaps was attributed to staff turnover that resulted in staff gaps known to purchasers which led to poor communication between purchasers and providers.

"*I think one of the challenges we face with hospitals is…the staff turnover, you were communicating to this person, this person left, they never communicated that the person left so you keep sending communication to that person and the person is no longer in office.*" FGD 2 – Private Health Insurance

Besides, providers expressed staff shortages for the purchasers that exacerbated delays in reimbursement of claims. Inadequate staff contributed to the piling up of unverified claims (workload) yet to be paid.

"*And when you look at them, I think also they are understaffed. That's one of the reasons that we've realized it could be that they are understaffed so that you at times even fighting for a claim that had stayed with them for a year.*" FGD 1 – Private healthcare providers.

2. **Infrastructure gaps:** Poor infrastructure among healthcare providers was also an important source of resource gaps that was attributed to existing challenges expressed by healthcare providers. Infrastructure gaps relate to both hardware and software issues. For instance, providers highlighted the lack of required equipment such as printers and photocopiers to facilitate the lodging of claims.

"*I think the facilities actually lack some critical resources to make the claim in real-time… some of them lack even equipment to process the claims even photocopying papers.*" FGD 1 – Public providers

Other infrastructure gaps among providers included the lack of infrastructure for specific departments such as pharmacy and a laboratory which are crucial for the empanelment of providers.

"*So the NHIF has a checklist and this checklist was favouring bigger facilities because in this checklist you had a component like a pharmacy, lab and so on. So you find a facility that is small, maybe doesn't have a pharmacy department would still be assessed on pharmacy* [before empanelment]." FGD 2 - Social Health Franchises

Besides, healthcare providers and purchasers highlighted technology gaps that result in most of the challenges experienced by both providers and purchasers. First, providers highlighted the lack of access to a reliable network, lack of automation of claims which contributed to delays in reimbursement, errors in submission of claims and fraud.

"*The process of claiming is largely manual. The process is still cumbersome in terms of processing claims, they require that you do manual claim, you attach the supporting documentation. So it's a bit tedious actually to make claims in the current process.*" FGD 2 – Public health providers

Whereas, purchasers, particularly the NHIF highlighted network gaps with existing technology that caused delays in processing claims, notification of admissions, and

other activities requiring providers to reach the NHIF, especially during system downtimes.

"*We as NHIF, we use systems and these systems require network. Sometimes we have issues with networks whereby the facilities are unable to do some things on our clients and it becomes a problem to us because sometimes they reach us as branch but sometimes when it is issue of network there is nothing we can do.*" NHIF quality assurance branch manager

3.1.2 Training/Capacity gaps

Training or capacity gaps refer to unmet knowledge and skill gaps by healthcare providers from high staff turnover and the lack of regular training (especially when purchasers change benefit packages). The high staff turnover resulted in the loss of key staff with the requisite knowledge, skills and established relations with purchasers. These contributed to delays in lodging claims, errors in documentation for the submitted claims and/or high workload. There are very few opportunities to update provider staff on reviewed terms and conditions of the schemes.

"*… delays are occasioned by issues of capacity – capacity in the sense of manpower, in other words, people who are well versed with the tech-know how to handle claims.*" FGD 1 – Private healthcare providers

In terms of regular training, healthcare providers needed refresher training for their staff handling claims, especially when purchasers changed benefits packages or full training for new staff employed by providers to handle claims. For instance, the lack of or inadequate training resulted in errors while lodging claims that, in turn, made claims to delay in getting reimbursed or rejected.

"*… I think one of the things that I see as a gap is also on the documentation part which sometimes is poor from the provider's perspective which leads to delayed payments because*

sometimes….[there is lack of] *regular support to the providers in terms of training to ensure that they fill in the documents correctly."* FGD1 – Social Health Franchises

"*… I remember when NHIF used to use free maternity service now they changed to Linda mama, we really lost some quite amount of monies in the change because there was no training on how to claim the Linda mama."* FGD 1 – Public health providers

3.1.3 Governance issues

Stakeholders highlighted three key governance issues to contribute to challenges hindering effective provider-purchaser engagements. One was bureaucratic processes that delayed reimbursement of claims. For instance, providers reported complicated administrative procedures, especially with the NHIF when claims are submitted for payment. The claims may have to go through several departments at the branch level and then at the NHIF headquarters.

"*I can say that … there is a lot of bureaucracy also on NHIF that we have a satellite office, we have the branch level but you see now all the decisions [especially on payments] are also done at HQ."* FGD 2 – Public Health Providers

"Insurances have *bureaucracies…. within approvals – you realize that it has to go around four departments for it to be paid."* FGD 1 – Private health providers

Besides the bureaucratic procedures at NHIF, other bureaucracies with the national treasury have caused financial delays from the national treasury to NHIF and in turn, delays from NHIF to providers. For instance, poor budget projections, challenges with cash flow and revenue collection result in delayed remittances of funds from the national government/treasury to NHIF (for schemes such as EduAfya and Linda Mama).

> "*Linda mama is a government-funded scheme implemented by NHIF, and the public facilities treat the Linda mama cases, and forward claims for settlement to NHIF and the ministry is actually the sole implementer of the program, the Linda mama program and the main funder for the program. So basically the Linda mama – we can only settle the*

Linda mama claims upon receipt of the premiums from the ministry. So usually delays are occasioned by late settlement of the Linda mama premiums." NHIF staff, National level

"*Well, upon following up and – I think sometimes the issue is on the insurers' side because as we are speaking right now, Linda mama, NHIF has not paid since the month of November and we've been very consistent with our claims. So, when we follow up on that the reason that we get is delay in funding from the national level."* FGD 1 – Public providers

"*…actually, the main reason for delay of payment is because of depressed cash flows on the insurance companies' side, that's the purchasers side."* FGD 1 – Medical Professional Bodies representatives

Second, there were poor accountability mechanisms from both providers and purchasers. There were no adequate monitoring arrangements that guard against corruption and fraud. For instance, private healthcare providers highlighted bribe demands from NHIF officers to enable their facilities to be empanelled. As a result, there were delays in empanelling private providers, development of mistrust and inequalities in empanelling providers in rural settings.

"*I dare say this, some elements* [people] *within the insurance* [NHIF] *would want to have their hands oiled in order to have you empaneled."* FGD1 – Private healthcare providers

Additionally, some private providers submitted fraudulent claims either for services not rendered or services to a patient other than the beneficiary.

"*Again I've seen, and I've heard service providers and especially when we don't have numbers, and especially when we are also frustrated, we tend to, yes you know this is a fraudulent case, but you go ahead and process the claim which I think it's not the right thing."* – FGD 2 Private healthcare providers

Third, there was no formal communication platforms/channels that purchasers and providers could engage. The lack of, inadequate utilization of, or the use of communication channels unfriendly to providers contributed to poor communication and ease of access to feedback on challenges. These led to a communication breakdown as information from purchasers did not reach providers or providers did not know the right channel to address specific issues.

"I think one of the main reasons is that there is no formal channels of communication as in there is no established mechanism for communicating for instance now a med sup in a particular facility which has challenges does not know whether he or she should communicate directly to the regional manager or branch manager for NHIF or should communicate through the director. So there is no that formal engagement between NHIF and the department of health and even the facilities on how they're going to resolve the various outstanding issues regarding claims and payments and around that – in that regard so there is no that formal communication or engagement meetings between the department of health and NHIF and even other purchasers on how to solve issues regarding claims." FGD 1 – Public Providers

3.2 Actionable solutions

Several actionable solutions targeting the root causes of the challenges faced by both providers and purchasers were also identified. These actors felt that adopting technology to automate processes, employing more staff, building staff capacity, and strengthening the regulators' action. These are discussed below.

3.2.1 Adopt technology

Technology was identified as the main solution to most of the root causes identified by stakeholders. Particularly technology will aid the automation of claims and patient identification at the facility (e.g., through biometric systems for NHIF). For instance, providers highlighted the potential of automated systems in removing documentation challenges resulting from errors while submitting claims manually, ease of invoicing and its utility in fast-tracking claim submissions, reducing bureaucratic processes and guarding against fraud.

"And the issue of invoicing, you know, it should be like an automated system because if everything is in the system why should you wait for an e-mail to be told that you make an invoice of this much by just a text. Then this whole thing is – we don't have control fully. And I wish that they could make that system in place so that – you know, it's not that we manipulate anything." FGD 2 – Medical Professional Bodies representative.

"I can't overemphasize the issue of improving the system. I know facilities can visualize the purchase of claims made and for what service but I think that there is an opportunity to automate the claiming system especially as we move towards implementing UHC." FGD 2 – Public health providers

Furthermore, stakeholders during the consensus-building workshop indicated the need to scale up the automation of the e-claim system already employed by NHIF to all contracted public and private providers (Table 4).

3.2.2 Engage/Prioritise staff for handling payment processes

Human resource gaps emanating from understaffing and/or staff turnover was a root cause for the challenges experienced by providers and purchasers. Providers especially in the public sector highlighted the need for more staff preferably dedicated to the payment process, for instance, lodging claims, following up with delays in reimbursements and acting as the liaison persons with purchasers for ease of communication and addressing of challenges.

3.2.3 Capacity build: Conduct quarterly provider training

Capacity gaps across both private and public providers were highlighted as a major root cause for a majority of the challenges highlighted by providers. Regular training was identified as the most effective solution to address capacity gaps among providers. Healthcare providers highlighted a preference for more regular (quarterly) refresher training that can leverage on the online platforms (such as Zoom, Microsoft Teams etc.) that would be less costly to deliver but with a wider reach to providers. The use of self-care mechanisms to allow providers access answers to frequently asked questions and sharing access to data for the different schemes would reinforce training.

"…Yeah, now for the trainings we would prefer quarterly trainings – every quarter because like for our side the clerical officers are on a casual basis so we have changes every few months." FGD 1 – Public Health providers

Besides, purchasers recommended that providers should train/capacity build more than one staff either during the formal training sessions or internal health facility trainings (using trained staff) to avoid capacity gaps in case of a staff turnover. For instance, the NHIF

"*…we are telling them* [providers] *in the training is they should make sure that they share the information with their colleagues within the hospital and administrators in the respective facilities we are also advising them to continuously bring on board staff to make sure that what is happening – something that they understand just to make sure that in case there is a turnover of specific officers or staff that have been trained, the facility will not face any challenge."* IDI 1 – National NHIF Staff.

The capacity building was also highlighted by stakeholders in the workshop as an avenue for fraud management. Staff can be trained on fraud management approaches and ways to monitor these both at the provider and purchaser levels.

3.2.4 **Develop and utilize formal communication channels**

Purchasers need to establish working communication channels to engage with providers in both sending and receiving feedback, complaints and changes to the benefits package. These channels would then be adopted by providers to facilitate communication from the facility liaison person or administrator in case of staff turnover.

"I think one of the main reasons is that there is no formal channels of communication as in there is no established mechanism for communicating or engagement meetings between the department of health and NHIF and even other purchasers on how to solve issues regarding claims. So I think when there is an established mechanism of how issues or how challenges are being resolved or how to resolve them or even SOPs on how we can resolve particular issues I think that's the missing link in terms of communication between NHIF and the facilities and even the department of health." FGD 1 – Public health providers

"They also need to improve on communication and engagements that they need to view facilities as the stakeholders in terms of – so that communication should really flow and we really urge that they need to open that." FGD 2 – Public health providers

3.2.5 Develop standard treatment guidelines

Another key actionable solution suggested by stakeholders during the workshop included the development of standard treatment guidelines that would promote equity and quality in access to care for all Kenyans and will aid cost-containment.

3.2.6 Review provider payment mechanisms to include output-based payments

Both providers and purchasers highlighted the need to revamp existing provider payment mechanisms to incorporate incentives for providers to improve on the equity, efficiency, and/or quality of care provided. For instance, providers highlighted a challenge with existing capitation payment given that the rate is low and has never been reviewed since its introduction in 2015. Most importantly, stakeholders during the workshop highlighted the need to shift to output-based payments that have incentives for improving quality and efficiency. The healthcare financing strategy (MoH, 2020) and Healthcare Financing reforms expert panel (MoH, 2020) further recommended unbundling of responsibilities of NHIF to ensure that key responsibilities e.g. developing benefit package, empanelling of providers and recommendations of premium.

3.2.7 Develop a framework for public-private contracting

Private purchasers highlighted the lack of a proper framework to contract public providers as a key challenge hindering their engagement and harnessing the public sector network of providers. Consequently, private purchasers during the workshop highlighted the need for a clear framework that would allow the contracting of public providers of all levels by the private purchasers. Incorporating this would not only improve the list of available providers

for private health insurance subscribers but also create competition among providers that can promote health system goals, and provide another source of revenue for public providers. This would also further strengthen the cost-containment that would be both beneficial to the purchaser and clients.

3.3 Joint Action Plan (JAP)

Table 4 highlights the validated actionable solutions, indicators for monitoring action/progress and the timelines for implementation as agreed by stakeholders during the consensus-building workshop. From this engagement, it was clear that both purchasers and providers are committed to achieving a harmonious engagement. A phased approach is suggested for the implementation of this JAP. The phased approach was selected based on 1) the resource needs for implementing the actions, and 2) what was considered as a low hanging-fruit not requiring more resources or time to implement fully.

Phase 1 can involve **dissemination and resource mobilisation**. Dissemination of the finding at the decision making level across purchasers, particularly the NHIF, and the ministry of health is instrumental for obtaining buy-in and champions for implementing the suggested solutions. The KHF can utilize its convening power to schedule meetings with the policymakers and stakeholders for dissemination of findings and leveraging on the short-term actionable solutions as the low hanging fruits for implementation. Additionally, other partners including the WHO, SPARC and ThinkWell can support the implementation by providing technical and financial support.

Phase 2 can involve the **implementation of the actionable solutions**. The implementation can begin with the short-term and medium-term actionable solutions as the low hanging fruits in the implementation process as plans for implementing more resource-demanding and longer-term solutions are underway.

Table 4: List of actionable solutions, resource needs, indicators for assessing progress and timelines

Actionable Solution	Resource Mapping	Mapping Departments /Organization	Indicators for assessing progress	Timelines
Short-term Actionable solutions (To be Implemented in 1 year)				
1. Regular purchaser/provider engagements and capacity building **Requirements:** • NHIF/PHI and Provider Liaison • 24-hour contact centres • Communication framework with clear SLAs • Feedback surveys • Quarterly meetings (in-person and online platforms)	• Human resource • Feedback tools	• NHIF • PHIs • Private provider • Public provider	• % Of providers allocated to a Provider Liaison Officer • % of communications responded within SLA • No of feedback surveys done & response rate • % of quarterly meetings held • % of providers trained on claims management process	6 months
2. Develop and utilize formal channels of communication	• Human resources • Computers • Internet connectivity • Power	• All providers • All purchasers	• % of communication responded within SLA • No of feedback surveys done & response rate	6 months
3. Fraud management **Requirements:** • Capacity building • Sanctions	• Healthcare Fraud Policy	• NHIF • PHIs • Private provider • Public provider	• Action plan for a Healthcare Fraud Policy • Annual fraud training for providers • % of staff trained on fraud	6 months

• Fraud analytics • Controls • Automation • Strategic purchasing		• IRA • AKI		
4. Review PPMs to include output-based payments Requirements: • PPM reforms • Price control for medical services, pharmaceutical, professional fees	• PPM	• NHIF • MOH • PHIs • All providers • HMIS providers • IRA • AKI • MoICT	• Review of EBPH • Costing studies • Adoption of risk-adjusted capitation payments for primary care • % Adherence to Recommended Retail Prices for pharmaceuticals	1 year
5. Complaints Management Framework **Requirements:** • Comprehensive framework with clear SLAs • Appoint an independent arbitrating body	• Complaints Management Framework	• NHIF • MOH • PHIs • Private provider • Public provider • HMIS providers • IRA • AKI • MoICT	• Completion of the complaints management framework • Appointment of the independent arbitrating body (Ombudsman) to arbitrate serious provider-payer conflicts	1 year
6. Common framework on debt management **Requirements:** • 30-day credit period • Quarterly reconciliations	• Debt management policy	• NHIF • PHIs • Private provider • Public provider • IRA	• % of claims outstanding after the 30 days • % of providers signed off within the next financial year • Quarterly published reports on debt management	1 year

• Annual sign off and clearance		• AKI •	• Timely disbursements of NHIF funds • % of corporate clients who have premium outstanding after 30 days	
Medium-term Actionable solutions (To be Implemented in 1 – 2 years)				
7. Scale-up automation – e-claims, online pre-authorization, electronic health records, both private and public providers and purchasers **Requirements:** • Interoperability • Standardization	• Computers • Software • Biometric devices • Internet connectivity • Power	• NHIF • PHIs • MOH • MoICT • ISPs • Kenya Power •	• % of providers with HMIS (HER) • % of providers with internet connectivity • % of providers with power • % of providers connected to e-claims • % of claims transmitted electronically • % of claims processed automatically	1 – 2 years
8. Revise standard treatment guidelines Requirements: • Dissemination • Enforcement • Regular audits	• National Standard Treatment Guidelines	• MOH & stakeholders	• Completion of guidelines of priority healthcare needs • Monthly/Quarterly Clinical Audits on Adherence to NSTGs	1 – 2 years

9. Develop a framework for public-private contracting **Requirements:** • Financial autonomy for public providers	• Public provider – Private Payer Contracting Framework	• MOH • COG • PHIs • AKI	• % of counties achieving financial autonomy • % of public providers that have contracted PHIs	1 – 2 years
Long-term Actionable solutions (To be Implemented in over 2 years)				
10. Central medical insurance management system **Requirements:** • Mandatory data sharing • Interoperability • Legal framework as a regulatory requirement	• Computers • Software • Biometric devices • Internet connectivity • Power	• All payers • All providers • HMIS providers • IRA • AKI • MOH • MoICT	• Development of the architecture and policy of the CMIMs	2 – 3 years

4: CONCLUSION

Promoting effective provider-purchaser engagements can be leveraged as an approach to enhancing Kenya's health system performance towards achieving UHC. Particularly, targeting interventions to human resource gaps, communication gaps, staff capacity gaps, provider payment mechanisms, and infrastructure gaps can promote harmonious and collaborative engagements between providers and purchasers. Actionable solutions that can be adopted in both medium and long-term include the employment staff particularly dedicated to the payment processes, adopting technology or information systems to automate processes, engaging in at least quarterly training to providers that can be conducted virtually, and the development and utilization of formal communication channels for sharing of information or prompt feedback between providers and purchasers.

Besides, the engagement of all stakeholders in this analysis accords significant goodwill for the implementation and monitoring of suggested solutions. Key players such as the Kenya Healthcare Federation, SPARC and ThinkWell can advance further deliberations such as facilitating capacity building among providers, providing platforms for provider-purchaser engagements and monitoring and advising on the implementation gaps to the proposed solutions.

5: RECOMMENDATIONS

Ministry of Health

1. **Spearhead the revision and implementation of standard treatment guidelines:** Standard treatment guidelines are essential for promoting the quality and equity of care provided across different providers.
2. **Develop a framework for public-private contracting:** This will entail the development of a framework that would allow private purchasers to contract public providers. This will create an avenue for provider competition that can be leveraged to reduce the costs of care, enhance quality of care and efficiency.

NHIF and Private purchasers

1. **Review provider payment mechanisms to include output-based payments**: Fast track the revamping of PPMs with a focus on introducing output-based payments mechanisms. These will provide an avenue for greater impact.
2. **Scale up the automation of processes**: All purchasers to move to automated systems that permit automated empanelment, claim submission, pre-authorisation and the utilization of an electronic health records system across all providers.
3. **Capacity building of providers**: Purchasers to adequately train providers on new systems as well as refresher training quarterly.
4. **Impose strict sanctions for fraud cases**: This will provide an avenue for fraud management.
5. **Develop and utilize formal channels of communication:** Utilise these formal channels to frequently engage providers.
6. **Establish complaints management framework**
7. **Peer learning between purchasers on how to improve purchaser-provider engagements.** The NHIF can learn from private health insurance oh areas of better engagement especially benefit package communication, pre-authorization and processing of claims.

Regulators

1. **Establish central medical insurance management systems:** This will be quintessential in improving purchaser regulation and promote health system goals.

Providers

1. **Invest in technology:** Providers to invest in adopting technologies such as automation through the e-claim system.
2. **Avail staff for capacity building:** All providers to make sure that at least more than one staff has been trained and/or facilitated to attend refresher training where necessary.

6: APPENDIX 1 – LIST OF PARTICIPANTS FOR THE JOINT ACTION WORKSHOP

PURCHASER PROVIDER ENGAGEMENT INITIATIVE CONSENSUS AND VALIDATION WORKSHOP PARICIPANTS LIST

DATES: 12TH-15TH OCTOBER 2021

VENUE: LAKE NAIVASHA SIMBA RESORT

	NAME	ORGANIZATION	COUNTY
I. MINISTRY OF HEALTH			
1.	JARED NYAKIBA	MOH REPRESENTATIVE	NAIROBI
2.	KABORO MBUGUA	MOH DIVISION OF PLANNING AND HEALTHCARE FINANCING	NAIROBI
3.	MAUREEN KANGAE	MOH DIVISION OF PLANNING AND HEALTHCARE FINANCING	NAIROBI
4.	ROBINA MWENESI	MOH	NAIROBI
5.	STEPHEN MACHARIA	MOH DIVISION OF PLANNING AND HEALTHCARE FINANCING	NAIROBI
II. COUNCIL OF GOVERNORS			
6.	PROFESSOR WASUNNA	HEALTHCARE FINANCING SPECIALIST	NAIROBI
GOVERNMENT REGULATORY, OVERSIGHT AND POLICY BODIES			
7.	ANNE CHELAGAT	INSURANCE REGULATORY AUTHORITY (IRA)	NAIROBI
III. MEDICAL PRIVATE PURCHASERS/INSURERS			
8.	DR. ELIJAH MATOLO	MEDICAL PRACTICE MANAGER, UAP OLD MUTUAL GROUP	NAIROBI

9.	NICKSON ONGÈRA	ASSISTANT MANAGER, PROVIDER RELATIONS HEALTHCARE DIVISION, MINET INSURANCE	NAIROBI
10.	FELIX LUBWA	CASE MANAGER, BRITAM	NAIROBI
11.	DR. EZRA OMOLO	HEAD OF STRATEGIC PURCHASING & PROVIDER PARTNERSHIP, JUBILEE INSURANCE	NAIROBI
IV. PUBLIC MEDICAL PURCHASERS/NHIF			
12.	DOUGLAS OWINO	MANAGER QUALITY ASSURANCE & CONTRACTING, NHIF	NAIROBI
13.	GILBERT OSORO	MANAGER UHC, NHIF	NAIROBI
14.	JAMES LETANGULE	MANAGER CLAIMS MANAGEMENT, NHIF	NAIROBI
V. PRIVATE HEALTHCARE PROVIDERS			
15.	DR. BRIAN LISHENGA	C.E.O RURAL PRIVATE HOSPITALS ASSOCIATION (RUPHA)	NAIROBI
16.	STEVE OSIRI	BUSINESS DEVELOPMENT OFFICER, KENYA MEDICAL AND EDUCATION TRUST (KMET)-KISUMU	KISUMU
17.	SYLVIA WAMUHU	TUNZA BY PS KENYA	NAIROBI
18.	BENARD MWEGA	NATIONAL NURSES ASSOCIATION OF KENYA (NANAK)	NYERI
19.	TRIZAH IRERI	KENYA PROGRESSIVE NURSES ASSOCIATION (KPNA)	KWALE
20.	DR. SIMON KIGONDU	KENYA MEDICAL ASSOCIATION (KMA)	NAIROBI
VI. PUBLIC HAELTHCARE PROVIDERS			
21.	DANIEL ROTICH	MOI TEACHING AND REFERRAL HOSPITAL	UASIN GISHU
22.	DOMINIC MBURU	NAKURU LEVEL 5 HOSPITAL CHAO	NAKURU
23.	DR. MABRUK	MTWAPA LEVEL 4 HOSPITAL	KILIFI
24.	AUGUSTUS MAUNDU	KALAWA HEALTH CENTER, MAKUENI COUNTY	MAKUENI
25.	DR. BLASTUS KAKUNDI	MBOONI SUB-COUNTY HOSPITAL	MAKUENI
VII. PATIENT GROUPS			
26.	CHARLES MUYA	KENYA NETWROK OF CANCER ORGANIZATIONS	NAIROBI
VIII. OTHERS			

27.	DR. NJOKI FERNANDES	KHF HEALTRHCARE FINANCING COMMITTEE CHAIR	NAIROBI
28.	DENNIS OKAKA	KHF HEALTRHCARE FINANCING COMMITTEE VICE CHAIR	NAIROBI
29.	DR. WALTER OBITA	KHF BOARD DIRECTOR INCHARGE OF HEALTHCARE FINANCING	NAIROBI
30.	MOSES MARANGU	KHF PROJECT COORDINATOR	NAIROBI
IX. PARTNERS			
31.	OLUDARE BODUNRIN	STRATEGIC PURCHASING AFRICA RESOURCE CENTRE (SPARC)	NAIROBI
32.	JACOB KAZUNGU	PROJECT CONSULTANT	NAIROBI
33.	LEONORA MBITHI	STRATEGIC PURCHASING AFRICA RESOURCE CENTRE (SPARC)	NAIROBI
34.	DR. ANNE MUSUVA	COUNTRY DIRECTOR, THINKWELL	NAIROBI
35.	BONIFACE MBUTHIA	TECHNICAL ADVISOR, THINKWELL	NAIROBI
36.	BRENDAN KWESIGA	TECHNICAL OFFICER, WHO	NAIROBI
37.	ANABAY MAMO	M&E OFFICER, WHO	NAIROBI