BUILDING Effective and Ethical Collaborations in Healthcare

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Resource Guide for Public Private Collaboration in Health

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H.E. President Uhuru Kenyatta led the government to conceptualize the Big Four Agenda to accelerate achievement of the Third Medium Plan under the Kenya Vision 2030. Universal Health Coverage (UHC) is one of the four goals, with the others being food security, manufacturing and affordable housing. Achievement of UHC requires that governments partner with non-state actors.

It is for this reason that the Ministry of Health (MOH) and Council of Governors (COG) initiated the process of developing the Kenya Health Public Private Collaboration Strategy, in partnership with the private sector and development partners. The Strategy’s objectives include identifying priority areas for collaboration and investment, highlighting engagement principles and values, and mapping the institutional ecosystem under which effective and ethical collaborations are expected to operate.

To help operationalize the Strategy and guide implementation, this Public Private Collaboration Resource Guide and Toolkit document was developed. The Resource Guide elaborates on legal, policy and institutional expectations that apply at different stages of a partnership cycle. Aside from supporting the achievement of the Strategy’s objectives, this Resource Guide provides a platform on which training curricular for public private collaborations in health can be established. The Resource Guide will inform public and private establishments on how collaborations can be initiated, contracts developed and awarded, and projects implemented, monitored and handed over at the end. It emphasizes how all these can be achieved whilst complying with key Kenyan policies and laws, including the Constitution of Kenya (2010), the Health Act, the Public Procurement and Asset Disposal Act and the Public Private Partnership Act among others.

Importantly, the Resource Guide recognizes the unique nature of healthcare as a sector, emphasizing the range of collaboration options available, beyond the traditional capital-heavy infrastructure PPP projects.

The MOH and COG recognize the progress made in improving public private engagement at different levels. The county, ministerial and presidential health forums have helped to create a culture of open, deliberate, transparent and continuous engagement. At the same time, the Kenya Healthcare Federation (KHF) has helped to unify, and give a voice to, the private sector for more effective engagement with us. These mechanisms will continue to play an essential role as we embark on the journey of implementing the Strategy. Finally, we appreciate the support that development partners have played, and continue to play, in strengthening policy leadership over public private collaboration.

We believe that this Resource Guide will serve as a useful aid to the Kenya Health Public Private Collaboration Strategy, allowing effective and ethical partnerships.
The Kenya Health Public Private Collaboration Strategy provides a framework to guide public contracting authorities and private organizations wishing to collaborate towards meeting mutually beneficial goals. The framework describes how the country’s ambitious health-related goals, including Universal Health Coverage, can be better delivered, building on the individual strengths of the respective partners. We believe that this Strategy will allow partners in the Kenyan health sector to develop innovative, cost-effective, homegrown solutions to our health systems challenges.

To strengthen the operationalization of the Strategy, the Kenya Health Public Private Collaboration Resource Guide and Toolbox was developed.

The Resource Guide is a comprehensive, practical guide that national and county-level public contracting authorities can use at various stages of the public private collaboration cycle, including establishing engagement mechanisms that lead to partnerships, identification and screening of projects to gauge public private collaboration suitability, undertaking feasibility studies, developing and awarding collaboration contracts, and carrying out post-award contract management activities.

The Resource Guide is timely, considering that health systems globally have suffered from the devastating effects of the Covid-19 global pandemic, which has put a strain on resources. Successful implementation of the Strategy will require commitment and coordination across multiple actors, all of which must be well guided and informed. We are confident that this Resource Guide will contribute towards ensuring that, resulting in effective and ethical collaborations in health.
ACKNOWLEDGMENTS

This Resource Guide was developed for two reasons: first, to help operationalize the Kenya Health Public Private Collaboration Strategy, and secondly, to help institutionalize pre-service and in-service training on initiating and implementing public private collaborations in health.

The Guide was made possible through funding from the SDG Partnership Platform and World Bank Group, in partnership with the Ministry of Health and Council of Governors. It draws upon various Kenyan policy and statutory documents, complemented by case studies and information from partners and experts on public private engagement.

The lead author of the Resource Guide is Dr Francis Wafula. Useful comments and reviews were provided at various stages by the Planning Department at the Ministry of Health under guidance of Mr Samuel Nthenge (Chief Economist) and Mr Stephen Macharia (Director of Planning); Dr Rachel Njeri Gitau (World Bank Group) and Toni Lee Kuguru (World Bank Group); Ruben Vellenga (SDG Partnership Platform) and Brendan Kwesiga (WHO). The toolkit built on work undertaken by the Kenya Health Public Private Collaboration Technical Working Group, which drew on membership from the Ministry of Health, Council of Governors, Kenya Healthcare Federation, Kenya Medical Association, Pharmaceutical Society of Kenya and development partners, including CHAI, WHO, KCCB, PS Kenya, UNICEF, USAID, SDG Partnership Platform and the World Bank Group.

Susan N. Mochache, C.B.S
Principal Secretary, Ministry of Health
# LIST OF ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>AMREF</td>
<td>Africa Medical Research Foundation</td>
</tr>
<tr>
<td>BFMO</td>
<td>Build-Finance-Maintain-Operate</td>
</tr>
<tr>
<td>BOO</td>
<td>Build-Own-Operate</td>
</tr>
<tr>
<td>BOOT</td>
<td>Build-Own-Operate-Transfer</td>
</tr>
<tr>
<td>BOT</td>
<td>Build-Operate-Transfer</td>
</tr>
<tr>
<td>CSE</td>
<td>County stakeholder engagement</td>
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<td>CSR</td>
<td>Corporate-social responsibility</td>
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<tr>
<td>DBFO</td>
<td>Design-Build-Finance-Operate</td>
</tr>
<tr>
<td>DBFOT</td>
<td>Design-Build-Finance-Operate-Transfer</td>
</tr>
<tr>
<td>DCA</td>
<td>Draft concession agreement</td>
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<tr>
<td>KHF</td>
<td>Kenya Healthcare Federation</td>
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<tr>
<td>KEPSA</td>
<td>Kenya Private Sector Alliance</td>
</tr>
<tr>
<td>LDO</td>
<td>Lease-Develop-Operate</td>
</tr>
<tr>
<td>MCA</td>
<td>Multi-criteria analysis</td>
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<tr>
<td>MES</td>
<td>Managed Equipment Services</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSF</td>
<td>Ministerial stakeholder forum</td>
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<tr>
<td>NCD</td>
<td>Non-communicable disease</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Development</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
</tr>
<tr>
<td>PIM</td>
<td>Project Information Memorandum</td>
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<tr>
<td>PPC</td>
<td>Public Private Collaboration</td>
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<tr>
<td>PPD</td>
<td>Public private dialogue</td>
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<tr>
<td>PPADA</td>
<td>Public Procurement and Asset Disposal Act</td>
</tr>
<tr>
<td>PPP</td>
<td>Public private partnership</td>
</tr>
<tr>
<td>PPPC</td>
<td>Public Private Partnership Committee</td>
</tr>
<tr>
<td>PPPU</td>
<td>Public Private Partnership Unit</td>
</tr>
<tr>
<td>PPP-HK</td>
<td>Public Private Partnership Health Kenya</td>
</tr>
<tr>
<td>PRT</td>
<td>Presidential round table</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for proposal</td>
</tr>
<tr>
<td>RFQ</td>
<td>Request for qualification</td>
</tr>
<tr>
<td>SAGA</td>
<td>Semi-autonomous government agency</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SPV</td>
<td>Special purpose vehicle</td>
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<td>UPPP</td>
<td>Unsolicited public private partnership</td>
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<tr>
<td>VGF</td>
<td>Viability gap funding</td>
</tr>
<tr>
<td>UCSF</td>
<td>University of California San Francisco</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal health coverage</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>WBG</td>
<td>World Bank Group</td>
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**DEFINITION OF KEY TERMS**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Contracting authority</strong></td>
<td>A state department [ministry], agency, state corporation or county government which intends to have a function undertaken by it performed by a private party (PPP Act, Section 2)</td>
</tr>
<tr>
<td><strong>Private partner</strong></td>
<td>Defined by the Kenyan MOH to include any organization or individual working outside the direct control of the government, including for-profit organizations (companies and individuals) and not-for-profit organizations. These include medical practitioners, diagnostic centers, ambulance providers, health facilities such as hospitals and clinics, health organizations and industries such as pharmaceutical companies, health insurance companies, Health ICT firms and others, as well as community-based organizations.</td>
</tr>
<tr>
<td><strong>Procurement</strong></td>
<td>Regular procurement from a private party by a contracting authority under the Kenyan Public Procurement and Asset Disposal Act of 2015.</td>
</tr>
<tr>
<td><strong>Public Private Collaboration (PPC)</strong></td>
<td>All arrangements and partnerships between a contracting (public) authority and a private party. These include the PPPs as defined in the PPP Act of 2013 and other forms of collaboration that do not fulfil the PPP requirements. These may include lower value partnerships, service level agreements and information exchange arrangements. The private partner receives a financial or non-financial benefit from the arrangement. Health Public Private Partnerships are one form of PPC.</td>
</tr>
<tr>
<td><strong>Public Private Partnership (PPP)</strong></td>
<td>Arrangements between a contracting authority and a private party governed by the Kenya PPP Act (2013), under which a private party (usually commercial party) undertakes to perform a public function, receives a benefit for performing a public function. For PPPs, the benefit is usually through compensation from a public fund or user charges. PPPs involve risk-transfer from the public to the private partner.</td>
</tr>
<tr>
<td><strong>Risk Allocation</strong></td>
<td>Refers to the process of deciding the party that should bear the cost or benefit of a change in the project’s outcomes that may arise from respective risk factors. The intention is to allocate risk to the party that is best able to manage it.</td>
</tr>
</tbody>
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**OVERVIEW OF THE HEALTH PPC RESOURCE GUIDE AND TOOLBOX**

The Kenya Health PPC Resource Guide aims to inform discussions, engagement and activities aimed at improving how the public and private sectors dialogue, engage and partner to improve health. The Module is guided by:

1. **The Kenyan Legislation**
2. **Kenyan Policies**
3. **Kenya Health Public Private Collaboration Strategy**
4. **Technical resources from organizations involved in supporting initiation and implementation of PPPs**

**Module 0: Overview of the Resource Guide and Toolbox**
1. INTRODUCTION

1.1. Who is the resource guide for?

**NOTE:**
- The Public Private Collaboration Resource Guide for Health is designed to help link tools, guidelines and checklists to the broader processes that seek to support legal, ethical and effective collaboration. For that reason, the resource guide should be viewed as complementary to, rather than duplicating or replacing resources presently available.

This resource guide is aimed at all stakeholders in health. These include healthcare managers and planners at different levels, healthcare financing partners, healthcare providers, and healthcare service user groups and individual users. It is also designed to inform policymakers outside of the formal health system, including legislators, particularly those involved in guiding investment and policy decisions that touch on health. Finally, it is aimed at trainers who have management training and expertise, but do not necessarily have detailed knowledge of public private partnerships.

While the resource guide is intended to assist the diverse range of actors mentioned, it does not replace technical advice and support provided by organs tasked to do so, including the National Treasury (particularly the PPP Committee and the PPP Unit), and the PPP Node at the Ministry of Health. Where in doubt, appropriate consultation should be undertaken.

1.2. What is the purpose of the resource guide?

The resource guide was designed in response to current gaps in the awareness and knowledge on initiating, participating and/or financing partnerships between public entities (public contractors) and private entities (private companies or partners).

The resource guide straddles the growing recognition of the importance of engaging private partners with the need to ensure the public and private entities have full understanding and control of discussions aiming at creating new partnerships.

1.3. How was the guide developed?

The resource guide's development is based primarily on a review of the following: Statutes and policies that govern public private partnerships and other collaborations in Kenya; Published and unpublished literature on the design, content and experiences with instruments deployed to support PPCs; Online resources provided to guide public and private entities on engagement and partnerships.
1.4. What is the structure of the resource guide?

The resource guide starts by defining and characterizing the range of collaborations in health, and the importance of a resource guide (Module 0). It then goes on to look at key steps in establishing and managing partnerships, presenting this across five core modules (Modules 1-5).

- Module 1 unpacks the meaning of public private engagement, and goes further to propose mechanisms for understanding, implementing and evaluating engagement.

- Module 2 provides guidance on identifying and screening potential projects for public private collaboration.

- Module 3 takes the discussions forward by looking at the processes of preparing a PPC project following the project identification phase, including carrying out a feasibility study.

- Module 4 focuses on the procurement processes, with a strong focus on Kenyan policy and legislative requirements for procuring suppliers

- Module 5 looks at the post-award contract management phase, detailing what the contracting authority is required to do to ensure that the private entity meets its obligations.

IMPORTANT NOTE:

- The Resource Guide will use the terms ‘collaboration’ and ‘partnership’ interchangeably in certain sections. This is because policy documents use the latter term more frequently in reference to formally recognized arrangements like public private partnerships. However, the underlying meaning is the same in the context of this document.

This resource guide is meant to be a problem-solver. It outlines key steps and processes that should guide decisions at different points whenever the idea of developing a partnership arrangement arises. Important to note that the resource guide is not designed to carry the universe of processes, checklists and guidelines that cover partnerships. It provides links to other resources that together with the resource guide, allow establishment of well-informed, legal, effective and efficient partnerships.
2. OVERVIEW OF THE PPC PROCESSES

The resource guide is presented following the overall structure of the PPC process, i.e. project identification and screening; project preparation; the transaction phase; and implementation and contract management (figure 1) (1). However, public private collaborations in health are diverse, and may not always follow the classical PPP pathway (Box1). Section 0.3 gives a broad overview of the range of collaborations specified in the Kenya Health Public Private Collaboration Strategy (2020), for which this Resource Guide was developed.

Box 1: Resource Guide scope and focus

PPPs differ from Public Private Collaborations. While the former refers to specific arrangements governed under the Kenyan PPP Act of 2013, the latter recognizes a broader range of collaborations between public authorities and private partners. To ensure that all forms of collaboration meet Kenyan statutory standards, provisions of the PPP Act guided the development of this resource guide. However, individual projects can follow alternative pathways based on various characteristics, including the value of the contract and nature and level of risk involved.
3. PUBLIC PRIVATE COLLABORATION IN HEALTH

Public private partnerships are governed under the Kenyan PPP Act of 2013 (2), supported by the PPP Act’s Regulations of 2014 (3) and the PPP Project Facilitation Funds of 2017 (4). However, collaborations may be executed under the Public Procurement and Asset Disposal Act of 2015 and accompanying regulations (5), which provide for procurement, including service contracting.

While there are not clear boundaries on which laws apply to different situation, short-duration, low-risk arrangements may benefit from the relatively more straightforward provisions under the PPADA of 2015. This may range from contracting out hospital laundry services to service level agreements for maternity services and specimen referral from public primary facilities to private laboratories. On the other hand, longer-duration capital-heavy projects may require full compliance with the PPP Act of 2013. Such projects involve extensive transactional undertakings with complex financing and risk-allocation mechanisms. Large infrastructure projects dominate this category of collaborations. Table 1 summarizes the range of collaborations applicable across the healthcare sector in Kenya.

Table 1: Public private collaboration arrangements recognized by Kenyan policies and laws

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Policy and Dialogue</td>
<td>Considered the foundation of meaningful collaboration, this refers to the presence of mechanisms for deliberate and continuous dialogue and consultation, even in the absence of specific projects that require contracting.</td>
</tr>
<tr>
<td>Information Exchange</td>
<td>Refers to sharing a common information management system or having interoperable systems that allow information flow across sectors. This may also include sharing of tools, standards, guidelines, best-practice and some innovations.</td>
</tr>
<tr>
<td>Regulation</td>
<td>Refers to public oversight over private activity. Regulation is increasingly changing from top-down command and control models to collaborative models that seek compliance through cooperation, incentives and disincentives.</td>
</tr>
<tr>
<td>Service Level Agreement (SLA)</td>
<td>Agreement between a public authority is private partner, where the latter provides a service to the public on behalf of the former and gets reimbursed based on an agreed framework. For instance, a faith-based facility can have an SLA to offer delivery services and get paid for each delivery by a public authority.</td>
</tr>
<tr>
<td>Small Partnership</td>
<td>Arrangements that are similar to PPPs, with a value of investment cost less than the threshold defined per Section 71(c) of the PPP Act.</td>
</tr>
<tr>
<td>Social Impact Bond (SIB) and Development Impact Bond (DIB)</td>
<td>A pay-for-success financing model where a commissioner (outcome payer, who may be a public authority or development partner) enters into a contract with an investor and a non-profit implementor organization. The investor provides capital for the implementer to deliver the service. If results are achieved, the outcome payer reimburses the investor(s) the costs incurred plus a return on investment. The outcome payer is a government body for SIB, and an aid agency/donor agency/private donor for DIB.</td>
</tr>
<tr>
<td><strong>Procurement</strong></td>
<td>Regular procurement from a private party by a contracting authority under the Kenyan Public Procurement and Asset Disposal Act of 2015.</td>
</tr>
<tr>
<td><strong>Exchange Programmes</strong></td>
<td>Arrangements in which qualified health workers or trainees cross the line between the public and the private health sectors to provide services or to undergo training or internship. This includes staff secondment.</td>
</tr>
<tr>
<td><strong>Government subsidy</strong></td>
<td>Arrangements in which drugs or consumables are provided by the government to private parties at a reduced price or at no cost, and then made available to clients at a lower rate or free of charge.</td>
</tr>
<tr>
<td><strong>Donor programme</strong></td>
<td>Arrangements involving a public authority and private parties, which are essentially funded by international and multilateral partners (except loans).</td>
</tr>
<tr>
<td><strong>Corporate Social Responsibility</strong></td>
<td>An arrangement involving a public authority and private parties, in which the private partner provides funding, products or humans resources without receiving a direct benefit. This can include initiatives undertaken for market development.</td>
</tr>
<tr>
<td><strong>Management contracts and output performance-based contracts</strong></td>
<td>The private partner performs a service over a fixed period (maximum 10 years in Kenyan law) and receives a fixed payment per deliverable. These range from a narrow offering (service contracts) to larger contracts covering operation, maintenance and management. The private partner does not make significant capital investment; focus is day to day/routine activities necessary for operations of a facility. These represent the arrangements with the lowest transfer of commercial risk from public to private entities under the PPP Act. In healthcare, they may cover clinical or non-clinical services.</td>
</tr>
<tr>
<td><strong>Lease and concession contracts</strong></td>
<td>Lease - rights over an asset are transferred from a public to private partner over contract period, with the latter paying a fee. Assets include infrastructure, equipment or both. Private firm operates facility for up to 30 years under Kenyan PPP laws. Private firm meets operations and maintenance costs, but not capital costs on infrastructure. Concession - similar to lease, except the fact that the concessionaire makes capital expenditure on infrastructure, meaning concessions transfer higher risk to private firm. For both, private firm may collect user fees with guidance from the public entity.</td>
</tr>
<tr>
<td><strong>Build-operate-transfer models</strong></td>
<td>Represent the greatest commercial risk transfer. As name suggests, involve significant investment in construction and rehabilitation of infrastructure. There are many variants depending on the need. These models aim to expand infrastructural capacity for public services, renovate and/or refurbish existing infrastructure, and improve the quality of services offered, and are, in many ways, what may be seen as the traditional model of an infrastructure PPP.</td>
</tr>
</tbody>
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**Collaboration pathways and linkage to legislation**

**Kenya Health Public Private Collaboration Pathways**

- **No capital investment needed**
  - Policy and dialogue
  - Information exchange
  - Regulation
  - Objective: Improved engagement and climate
  - Main law/policy: Health Act, Regulatory Acts, Health Policy

- **Low to medium capital investment**
  - Service level agreement
  - Procurement, contracting-out
  - Management or service contract
  - Objective: Improved processes, services and outputs
  - Main law/policy: PPADA, PPP Act

- **High capital investment**
  - Leasing
  - Concession
  - Build operate transfer
  - Objective: Improved processes, infrastructure, services and outputs.
  - Main law/policy: PPP Act, PPP Regulations, PPP Project Facilitation Fund

Source: Author

**Rigor across collaborations**

In theory, public private collaboration arrangements can have foundation on different legislation, including the PPP Act and the PPADA. This will be majorly informed by the size of the contract, nature and allocation of risk, and duration of intended collaboration.

However, we strongly recommend that all forms of collaboration aspire to meet the rigorous standards and follow procedures outlined in this document. The standards and procedures contained herein meet the Kenyan statutory demands, reducing the risk of projects running into legal and political bottlenecks downstream.
4. THE KENYA HEALTH PUBLIC PRIVATE COLLABORATION STRATEGY (2020)

In 2019, the Ministry of Health (MOH) established a multi-stakeholder process of developing the first Kenya Health Public Private Collaboration Strategy. The Strategy development process included establishment of a technical working group (TWG) to lead the process, and a Steering Committee to provide broader guidance. The Strategy document was completed in April 2020.

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

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

This document’s purpose is to help operationalize the intentions and purposes of the Strategy.

5. ROLE OF CASES USED IN THE RESOURCE GUIDE

This Resource Guide and Toolbox document was designed to guide those wishing to initiate, fund, implement or evaluate public private collaborations in healthcare. The two cases included herein were specifically written to enforce the messages through provoking deeper inquiry and analyses.

Author’s note on the use of cases

The cases used herein were not designed to communicate effective or ineffective handling of collaboration or partnership arrangements. The selection of cases was neither meant to praise or vilify the decision to use a public private collaboration approach, nor criticize the structuring, implementation and contract management of the respective partnerships.
Users of this Resource Guide and Toolbox are encouraged to interrogate the cases to understand dilemmas managers face and appreciate the challenges that characterize public private dialogue, as well as initiation, structuring, financing, implementation and contract management for public private collaboration projects.

Next steps

Next Steps: The Kenya Health PPC Resource Guide goes into more detail on operationalizing a collaboration. It explains how to implement stakeholder engagement towards effective collaborations (Module 1); how to identify and screen potential collaboration project(s) (Module 2); how to select the collaboration model and develop the project (Module 3); how to identify and award the project to the most suitable private partner (Module 4); and how to manage the project and private partner till the end of the contract period (Module 5).

1

MODULE 1: HEALTH ENGAGEMENTS AND COLLABORATIONS IN KENYA

Module 1 is the reference source for the resource guide. It is anchored in legislation governing public private sector engagement and collaborations. Key laws include:

- The PPP Act of 2013
- The PPP Regulations of 2014
- The Public Procurement and Asset Disposal Act of 2015
- The Health Act of 2017
- The Kenya Health Policy (2014-2030)
- Other applicable laws and policies

Module 1: Public Private Engagement in Health

1.1. Overview

This section aims to create a common understanding of what the private sector is, and, what public private collaborations (PPCs) are and their role in healthcare.
1.2. Defining the private sector in health

The Kenyan Ministry of Health (MOH) defines the private sector to comprise of for-profit and not-for-profit actors, including medical practitioners, diagnostic centers, ambulance providers and health institutions such as hospitals and clinics, pharmaceutical companies, healthcare insurers and community-based welfare organizations. Services provided include medical consultation and advise, diagnostic services, prevention and promotive services, curative services, rehabilitative services, as well as health products and technology.

1.3. Public-private engagement in health

1.3.1. What is public-private engagement?

The term ‘engagement’ has been define in the context of healthcare services as ‘the deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs.’ (6).

The definition emphasizes the fact that the collaboration must be deliberate and systematic, and, must be linked to national health priorities.

1.3.2. How can effective engagement be achieved?

The Kenya Health Public Private Collaboration Strategy aims to provide a framework that fosters transparent, informed and effective engagement between the public and private sector towards promoting access to quality and affordable healthcare. This document’s purpose is to provide clearer guidance on how transparent, informed and effective engagement can be achieved. However, to do that, the term ‘engagement’ is unpacked and discussed further.

The World Bank proposes five domains that constitute engagement between public and private sectors. These are policy and dialogue, information exchange, regulation, financing and public provision of services. Proper public private engagement is vital at national and county levels if meaningful partnerships are to be formed.

The five domains are not mutually exclusive. Neither are they expected to always follow a fixed sequence. However, meaningful collaboration in financing and providing of public services (which are the primary goal of this document) require that there be effective engagement at the policy and dialogue level, and that there be transparency and exchange of important information. At the same time, proper regulatory mechanisms need to be in place to promote trust and mutual beneficence in financing and provision of services.

Discourse on public-private engagement inadvertently focuses on partnerships and or/collaborations in financing or providing services and products. The bias is reflected in the tone of public-private partnership legislation, strategies and toolkits, which are often relatively silent on the other three equally important domains, namely, policy and dialogue, information exchange and regulation.

For that reason, this section focuses more on how national and sub-national level partnerships and collaborations can be built on strong engagement across the three domains. The emphasis on the rest of the document is on establishing collaborations that address the other two domains.
1.3.2.1. Engagement at national level

Meaningful collaboration requires that systems be in place to allow open and continuous dialogue between the public and private sectors at national levels. Yet, partnership laws are relatively quiet on public-private dialogue. For instance, the only mention of dialogue under the PPP Act of 2013, is in reference to ‘competitive dialogue’, where bidders in a procurement process are individually invited to negotiate with the contracting authority, in order to get the best possible deal before awarding of a contract. However, the dialogue differs from the one referred to hereunder.

According to the Kenya Health Sector Partnership and Coordination Framework (2018-2030), the highest level of the partnership framework is the Health Sector Advisory and Oversight Committee (HSAOC), which provides high-level leadership and governance oversight towards achieving the Country’s health goals, including universal health coverage. The HSAOC is co-chaired by the Cabinet Secretary for Health, the Chair of the Council of Governors Health Committee and the chair of the Development Partners in Health Kenya (DPHK). Members of the HSAOC include the Chief Administrative Secretary (CAS); the Principal Secretary (PS) MOH; the Director General of Health, a representative of Principal Secretary of National Treasury, and representatives from development partners, NGOs, FBOs, and the private sector.

Just below the HSOAC is the Health Sector Interagency Steering Committee (HSISC), a multi-stakeholder organ that is charged with the responsibility of providing technical leadership. The HSISC’s role is to coordinate the multiple stakeholders at national and county levels on technical and strategic support, and policy dialogue. To achieve this, the HSISC receives and reviews reports from the Interagency Coordination Committees (ICCs) and respective Technical Working Groups (TWGs).

Below the HSISC are the Interagency Coordination Committees (ICCs), the technical arms of the partnership and coordination arrangements. The ICCs provide a platform for joint planning, coordination and monitoring of specific investments in health. The expectation was to have five ICCs that mirror the WHO Health Systems building blocks, each led by senior MOH officers, and constituted of representatives from across the board. The ICCs are expected to establish TWGs as and when needed, in order to undertake specific assignments.

The Kenya Health Forum was also established as an annual event that brings together key stakeholders to review performance and share lessons learnt over the previous year. The Forum is co-chaired by the Cabinet Secretary for Health and the Council of Governors and has representation from all key stakeholders. The Forum’s objective is to identify priorities for the coming year.

Finally, the MOH, county health departments and other partners are encouraged to establish partnership structures to strengthen their functions and ensure coordinated effort.

Outside of the formal statutory structure, private sector engagement has mainly been through the Kenya Healthcare Federation. By their own admission, the MOH’s efforts in fostering dialogue mainly targeted non-profit organizations, leaving out commercial enterprises, at least until the Kenya Healthcare Federation (KHF) was established was in 2004 (Box 2).
The KHF has promoted direct engagement of the private sector (for-profit and not-for-profit) considerably, allowing their involvement across a wide range of platforms, including quarterly Ministerial Stakeholder Forums held over the past decade. The KHF allows issues affecting private sector actors to be discussed, first internally, then with the relevant organs outside of KHF.

Moreover, The Government of Kenya, with support of partners, has also established action-oriented partnership platforms, which include strong focus on the health sector, to accelerate attainment of Kenya’s development priorities. In September 2017, The Government of Kenya announced at the UN General Assembly the establishment of the SDG Partnership Platform. The Platform has since received global recognition as a best practice model to accelerate SDG financing.

Citizen engagement is perhaps the weakest point of engagement at the national level. Efforts have often been limited to communication of policy activities being undertaken by public authorities, or (usually) poorly attended or public engagement forums meant to get policies or laws approved.

**ACTIVITY:**

Read the case titled ‘Effective Stakeholder Engagement: A Decade of Experiences with Kenyan Regulatory Reforms’, and, respond to the at the end of this module.

### 1.3.2.2. Engagement at the sub-national level

The County Government Act of 2012 directs that counties establishes formations such as joint committees, technical teams, and citizen commissions, all with the aim of encouraging direct dialogue towards sustained development. Further, the law directs that counties establish mechanisms that allow shared decision making between public and private actors within the counties. Finally, the law gives citizen power to petition the counties on any matter if unhappy with their level of engagement.

The County Government Act of 2012 provides seven mechanisms through which counties can engage citizens directly. (i) Information communication technology-based platforms; (ii) Town hall meetings; (iii) Budget preparation and validation fora; (iv) Notice boards, for instance, for announcing jobs, appointments, procurement, awards and other important announcements of public interest; (v) Avenues for participation of peoples’ representatives including the National Assembly and Senate; (vi) Establishment of citizen fora at county and decentralized units.
In addition, civic education is identified as one of the ways of promoting citizen engagement, with emphasis being placed on promoting awareness on the constitution, economic, social and political and electoral systems. Overall, the guidance is relatively generic and high-level. The implication is that respective sectors should try and define the most appropriate mechanisms to promote engagement.

The law requires that the county governor submit an annual report to the county assembly detailing citizen engagement.

### 1.3.3. What are the types of engagement?

The Organization of Economic Development (OECD) proposed a six-level stakeholder engagement typology based on intentions for each stage. The typology provides a useful basis for planning engagement activities as a contracting authority and/or assessing the extent to which different intentions were served across the engagement period (below).

**A Typology for Engaging Health Sector Stakeholders in Kenya**

Proposed framework to guide engagement of stakeholders in health in Kenya. Stakeholder engagement is a vital component of public private collaboration in health.

1. **Communication**
   - Ensuring stakeholders are well mapped, and information is made available. Purpose is to make stakeholders knowledgeable enough to engage effectively. Information should be simplified for easy understanding by the diverse group of stakeholders.

2. **Consultation**
   - Primary aim is to collect information, input, opinions, perceptions and experiences of the stakeholders. Not all info collected reflect in the final decision. The purpose is to gather as much information as possible to guide the decision(s).

3. **Participation**
   - Focus is providing opportunities to key stakeholders to take part in the formation/moulding of the decision/policy or strategy. At this point, participants may not have direct influence on the final decision(s).

4. **Representation**
   - More structured engagement to ensure collective choices. Usually within a formalized organizational structure, allowing more predictable engagement.

5. **Partnership**
   - Decisions mutually agreed upon. Usually follows other (earlier) forms of engagement. Typically characterized by the signing some form of agreement or contract.

6. **Co-decision and co-production**
   - Beyond partnerships. Power is shared (decision-making power and power to implement decisions).
Contracting authorities need to decide which level applies for various decisions or policy processes. Not all apply across all stakeholders. However, it is helpful to reflect on the entire spectrum every time a stakeholder engagement strategy is being developed at the start of any planning cycle.

Regardless of the level, there are five essential steps in stakeholder engagement. These were first proposed by Business for Social Responsibility (BSR), a not-for-profit network of more than 250 organizations with an interest in promoting sustainable and just business strategies globally.

The BSR Five-Step Approach carries the following steps: developing an engagement strategy, mapping stakeholders, identifying engagement formats for the various stakeholders, carrying out the engagement activities, and finally, developing an action plan that builds on lessons and experiences from the engagement, to strengthen the process as engagement continues.

1.3.3.1. Developing the stakeholder engagement strategy

Helps the contracting authority better understand how and why they should engage with all key stakeholders. The Strategy needn’t be a complex document. It simply needs to recognize its current position with respect to engagement (historical performance), where they need to be (targets, i.e. what should motivate them to engage more/better), and how to engage (range of options).

1.3.3.2. Stakeholder mapping

Next, the contracting authority needs to understand the ecosystem of stakeholders. Here, stakeholders are defined as individuals and/or organizations who affect or are affected directly or indirectly by the authority. It’s a simple four step process that entails identifying the stakeholders, analyzing them in terms of their interests, position and power, visualizing their interrelationships and linkage to the authority’s objectives, and the deciding on the broad engagement typology.

1.3.3.3. Preparation

Then comes the details of the engagement. The authority will need to tailor the engagement format to the respective objectives. For instance, if the objective is communicating messages, they may consider a village public meeting, a town-hall meeting or social media outreach etc.
1.3.3.4. Engagement

It is advised that the authority try as much as possible to help the stakeholders to prepare for the engagement (e.g. pre-event policy briefs), understand stakeholder expectations early in the process, moderate the sessions fairly to give all a voice, focus the discussion whenever people veer off-topic, and manage cultural dynamics, and water down any tension that may arise.

1.3.3.5. Action plan

The focus here is translating the engagement outputs into actionable points that can shape whatever was the subject driving the engagement. At the same time, the contracting authority must have mechanisms to communicate the actions back to the stakeholders.
1.4. PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH

The terms ‘public private engagement’ and ‘public private partnership’ are often used interchangeably, perhaps wrongly so. As explained under section 1.3, engagement is a broader concept that refers to deliberate and systematic collaboration towards certain priority goals.

The term ‘public-private partnership’ has a clear and specific connotation provided under the Kenyan laws (section 1.4). However, deliberate effort is made here to expand the definition to include another category, ‘Health Partnerships’, which may include other forms of partnerships that may not fit the explicit criteria specified under Kenyan laws. As a starting point, the resource guide recognizes diverse definitions and purposes espoused under the following documents:

- The statutory definition and explanation of PPPs (PPP Act of 2013)
- The policy position on partnerships in health (under the Kenya Health Policy, 2014-2030)
- The policy intentions and dimensions specified under the Kenya Public Private Collaboration Strategy for Health (2020)

1.4.1. The PPP Act

The PPP Act (2013) defines PPPs as ‘Arrangements between a contracting authority and a private party, under which a private party undertakes to perform a public function, receives a benefit for performing a public function through compensation from a public fund of the collection of charges or fees, and is generally liable for risks arising from the performance of the function.’

1.4.2. The Health PPC Strategy

In addition to the formal definition for PPPs in the PPP Act of 2013, the Kenya Health PPC Strategy (2020) defines non-PPP collaborations that include alternative arrangements between a public authority and a private party that do not fall under the PPP Act’s definition of a PPP (can refer back to Table 1 under Module 0).

1.5. LEGAL, POLICY AND REGULATORY FRAMEWORK FOR PARTNERSHIPS IN HEALTH

Table 2 provides a summary of the policy and statutory provisions governing public and private sector engagement and partnerships in health.
<table>
<thead>
<tr>
<th>Law or policy (Institution)</th>
<th>Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPP Policy Statement (2011)</td>
<td>PPP definition and principles. Provided for enactment of PPP Act, elaborating what the PPP process should look like, including risk allocation.</td>
</tr>
<tr>
<td>PPP Act (2013) (PPP Committee PPP Unit, PPP Nodes)</td>
<td>Defined PPPs, creates PPP Committee and functions, PPP Unit (Treasury) &amp; PPP Node (Ministries), determines the PPP pipeline and processes, and established the project facilitation fund. Established PPP Unit and specifies functions. Similarly, established PPP Node in Section 16, specifying its roles to include supporting contracting authorities on PPP matters such as identifying and prioritizing PPP projects, appraising projects to ensure they meet social, commercial, legal and economic viability thresholds, and support authorities in tendering processes etc.</td>
</tr>
<tr>
<td>PPP Regulations (2014) (PPP Unit)</td>
<td>Elaborated in detail the membership and roles of the PPP Nodes. Guides PPP processes beyond the identification step (covered in the PPP Act).</td>
</tr>
<tr>
<td>Public Procurement and Asset Disposal Act, 2015</td>
<td>Established the Public Procurement Regulatory Authority (PPRA) and Board, spelling out membership and roles. Also established the Public Procurement Administrative Review Board, plus membership and roles (primarily to determine tendering and asset disposal disputes). Specifies county roles in procurement and disposal, and, established procurement processes.</td>
</tr>
<tr>
<td>PPP (Project Facilitation Fund) Regulations 2017)</td>
<td>Spells out the functions of the PPP-PFF to include supporting contracting authorities, supporting the PPP Unit activities, providing viability gap funding (VGF) and helping with contingent liabilities. Provides details on how the support applies to all the above. Says VGF only available for capital costs and recoverable land costs, that the award needed to have been competitive, and that services will be provided against user charges (or some sort).</td>
</tr>
<tr>
<td>Kenya Health Policy (2014-2030)</td>
<td>Policy Objective 6 emphasizes the need to strengthen collaboration with the private sector for higher impact. Policy principle 3 highlights to governments intention of partnering with the private sector to expand geographic access and range of services.</td>
</tr>
<tr>
<td>Health Act (2017)</td>
<td>States that the Kenyan health systems has national and county level public &amp; private institutions. Gives public and private providers equal mandate in providing quality care to Kenyans. Gives national government duty of promoting development of public and private institutions. Mandates national government to lead development of strategy for private sector partnership. Clarifies that national &amp; county governments can enter into PPPs to improve health services, adding that partnership with private companies is allowed to serve public health goals. Expresses the equal application of standards for public and private facilities. Spells out the intention to optimize use of private health facilities to relieve public sector burden.</td>
</tr>
<tr>
<td>County Governments Act (2012)</td>
<td>Gives counties power to enter into partnerships with private entities for any work, service or function, as long as they comply with PPP-related laws. Requires counties to use public-private partnerships as one of the principles for strengthening citizen engagement.</td>
</tr>
<tr>
<td>Public Finance Management Act (2012)</td>
<td>Guides management of finances by the national and county governments. Establishes the County Revenue Fund into which all moneys raised should go. However, exemptions supported by other statutes are exempted, meaning revenues from PPP arrangements may be retained and used for specified purposes instead of being banked in the CRF account.</td>
</tr>
</tbody>
</table>
SUMMARY: Stakeholder engagement and partnerships

- Engagement refers to the deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs.

- It takes place at the global and national level, as well as sub-national (county) level, which included community level.

- A six-step typology identifies six types of engagement. These are (in order of depth) communication, consultation, participation, representation, partnership and co-production.

- Five-Step Approach to engagement carries the following steps: developing an engagement strategy, mapping stakeholders, identifying engagement formats, implementing the engagement activities, and developing an action plan that builds on lessons and experiences.

- The stakeholder engagement process steps taken will depend on the nature of the project and the capacity/characteristics of the target group. It is expected that a combination of processes be used for different groups, at different times.

ACTIVITY:

- Read the case titled ‘Effective Stakeholder Engagement: A Decade of Experiences with Kenyan Regulatory Reforms’, and, respond to the questions below.

CASE SUMMARY:

- Summary: The Case explores a 10-year journey of regulatory reforms in Kenya, using engagement as the primary lens.

QUESTIONS/DISCUSSION POINTS

- Map all the stakeholders/groups of stakeholders that were part of the engagement process over the two-year reform period.

- Can you think of a reform that your organization is thinking of making (e.g. a new partnership, or introducing a new service)? Using the reform as a reference, map all groups of stakeholders that you think should be engaged.

- What unique features of the reform area made engagement a vital strategy?
Can you draw any parallels with your own organization? Think of a change that could have started early, but, didn’t. What were the implications for buy-in?

Why was it necessary for engagement to start early in this case?

From the case, what have been challenges engaging the following stakeholders? (a) Communities/the public (b) Professional associations (c) Regulatory agencies (d) Other government departments, other than the one responsible for regulation (DHSQAR)

Can you draw parallels with your organization? What would be challenges to effective engagement with the various stakeholders you mapped above?

A key lesson from the case was the need to ‘engage early and engage often.’ (a) What do you think would be barriers to doing that at your organization? (b) How would you surmount those barriers to ensure engagement starts early and continues throughout?

Engagement processes can lead to capture, which refers to a situation where the intentions of the collaboration or policy change are redirected towards benefitting one party at the expense of the greater good. (a) In the example you thought of before, do you see a risk of capture happening? (b) What steps could you take to reduce the risk?

2 MODULE 2: PROJECT IDENTIFICATION

Module 2 provides a step by step breakdown of what happens at the start of a potential partnership arrangement to the point where a decision is made.

The Module is guided by:

- 1. The Kenyan Legislation
- 2. The PPP Knowledge Lab Partnership Resources
- 3. Other technical resources from organizations involved in supporting initiation and implementation of PPPs
Module 2: PPC Project Identification and Screening

2.1. Identifying the need

Defining the need is possibly the most important, yet ignored, step in the PPC process. Two approaches apply: a broad (strategic planning) approach and a narrow (specific) approach. These are explained briefly due to...
their importance in discussions around PPCs. However, details are beyond the scope of this resource guide, as the approaches are highly dependent on how the public entity is structured and operates, and, are likely to differ considerably across organizations. Links to further reading materials and guidelines are provided where necessary.

The project identification stage is extremely important in the PPC cycle. There is evidence suggesting that the greatest risk to PPCs is initiating projects that are not grounded in expressed demand or clearly prioritized need. Such projects are more likely to fail. For this reason, the World Economic Forum proposed an ecosystem approach to partnerships. Most PPCs are characterized by one-off transactional interactions arising from an urgent need to provide a service in the absence of enough public funds. This thinking is changing. Post-SDG focus is now on delivering value for the people, not just value for money based on one-off, non-scalable/replicable engagements. This new approach requires that PPCs focus more on outcomes, whilst maintaining the focus on process integrity, transparency and accountability. The World Economic Forum’s push for the ecosystem approach, and the post-SDG focus on value for the people underscore the recent shift in focus towards optimal outcomes from the communities’ perspective.

Strategic planning approach

Considered the ideal approach. Projects that grow from multi-stakeholder, well-developed sector planning processes are more likely to fit in with the broader government purposes, as they reflect national priorities based on addressing multiple needs. The approach (often) entails some form of sector needs assessment/analyses and prioritization. Public participation is often a vital component, as is engagement of non-state actors.

Methodologically, the process includes traditional strategic planning steps such as situational analyses or sector deep dive studies and multi-stakeholder engagement and feedback, including active community participation from the inception of the process. Strategic planning tends to follow predefined time cycles that link to broader sector policy or government agenda.

For Kenya, the Vision 2030 and the Kenya Health Policy (2014-2030) provide the broad policy framework, spelling out priority investment areas over several medium-term periods. Specific sector priorities are defined in County Integrated Development Plans respective and Health Sector Plans.

**Individual need identification**

There may be times when a narrow need emerges outside of the formal strategic planning processes. These may follow unforeseen events, or, may arise due to sudden change in predefined priorities. This is often considered the less desirable approach, as it may raise questions or result in major governance-related problems. The contracting authority must present a strong case for deviating from predefined priorities. The approach is a valid one and may still play a role in strengthening health services.

Like the broad approach, identification of individual need requires analytical work (situational analyses, sector diagnostic studies/deep dive) to define the need.
At the end of the need identification stage, the contracting authority will typically have a list of projects, which may be ranked in order of priority. The list is also referred to as a ‘pipeline’.

NOTE: At this stage, there should be no mention of how the needs should be met. This should be addressed at the PPC screening stage.

2.2. Options analysis and economic benefits

Once the need has been clarified, the contracting authority needs to look at all feasible options available, their appropriateness, and their merit using objective criteria. At this stage, demonstrable benefit over alternative options is needed. Focus MUST be on the output parameters, including value-for-money and performance, rather than merely focusing on inputs (PPP Certification.com). The risk with focus on inputs is that it blocks innovation. For instance, issuing a tender that calls for a partner to ‘develop a certain service or infrastructure using defined parameters’ may not deliver as much value as one that calls for a ‘partner to solve a certain problem, at a certain budget ceiling, using innovative solutions that must be practical and tested’.

Assessment of the economic value of the options may be achieved through a variety of methods, including cost-benefit analysis (CBA), cost-effectiveness analysis (CEA) or multicriteria analysis (MCA) among others. Cost-benefit analysis allows the comparison of options and identification of the one with the highest value. It may be used for selecting the most appropriate option or may be used later to gauge the economic sense of the selected option. The CBA gives the net present value (NPV) of a project, and, is presented as the difference between the net aggregate economic benefits and the net aggregate economic costs of the project over its lifetime. Only projects with a positive NPV should be considered for further action.

Economic evaluation techniques such as cost-effectiveness analyses studies provide an alternative approach, with a stronger focus on health outcomes (rather than costs). Economic evaluation allows selection of the best course of action based on comparing costs and outcomes of alternative options. Four main types of economic evaluations can be identified: Cost Benefit Analysis (CBA), Cost Effective Analysis (CEA), Cost Utility Analysis (CUA) and Cost Minimization Analysis (CMA).

The MCA approach is mainly aimed at solving a decision problem where multiple options exist. It allows the contracting authority to choose based on an explicit set of objectives. Measurement may involve quantitative measures constructed from a combination of quantitative and qualitative data.

CAUTION:

Excessive focus on a narrow set of needs has at times been driven by external parties (non-governmental organizations, development partners and other agencies).

Such partners may have an interest in a specific area. Though well-meaning, this may weaken the health system and redirect resources from priority needs, even where the project is funded externally. As much as possible, vertical support should be integrated within the sector development plan for sustainability and impact.
Figure 3: Key steps in screening potential PPC projects

Checklist 1: Key questions the contracting authority must ask at the PPC screening stage

<table>
<thead>
<tr>
<th>Need/benefits of the project</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of the need that the project helps address;</td>
<td></td>
</tr>
<tr>
<td>The contribution of the project to the government’s general goals and policy;</td>
<td></td>
</tr>
<tr>
<td>Description of how optimal the proposed solution is when there are various technical</td>
<td></td>
</tr>
<tr>
<td>alternatives/solutions for the need, or a description of the reasons for making that</td>
<td></td>
</tr>
<tr>
<td>assessment if it is the case;</td>
<td></td>
</tr>
<tr>
<td>Description of benefits, including some objective indicators of benefits (demand in</td>
<td></td>
</tr>
<tr>
<td>transport, number of homes served with water supply, and so on;</td>
<td></td>
</tr>
<tr>
<td>Description of any relevant indirect costs; and</td>
<td></td>
</tr>
<tr>
<td>If a cost-benefit analysis (CBA) and/or multi-criteria analysis has been conducted, this</td>
<td></td>
</tr>
<tr>
<td>should be clearly stated. If such analyses were not conducted and are considered</td>
<td></td>
</tr>
<tr>
<td>relevant, this should be advised in this report and/or in the “readiness” section.</td>
<td></td>
</tr>
</tbody>
</table>
2.3. PPC Suitability and affordability

The next question is, is a PPC the most suitable way to meet the need, regardless of the economic value? Would it work under the present financing environment, and legal policy and regulatory environment? Is it commercially viable and attractive enough to attract the right private partner(s)? Checklist 2 summarizes some of the questions the contracting authority must ask at this stage.

Checklist 2: Key questions to ask on the suitability of a PPC approach to a problem

<table>
<thead>
<tr>
<th>Suitability of the project</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of the PPC, that is, the basic concept of who would be assigned to which functions, what the payment mechanism would look like, and so on.</td>
<td></td>
</tr>
<tr>
<td>Affordability: Can the project be self-financed under a user-paid PPC model or is there a need for public contributions?</td>
<td></td>
</tr>
<tr>
<td>Does the project have any significant risks or uncertainties that are not manageable by a partner? If this is the case, does it make sense for the public sector to assume those risks?</td>
<td></td>
</tr>
<tr>
<td>Can the project be accommodated within the “legal” framework?</td>
<td></td>
</tr>
<tr>
<td>Is the project large enough to justify the implicit transaction costs?</td>
<td></td>
</tr>
<tr>
<td>Would there be investor market appetite for the project? Does the private sector have the necessary capabilities to face these challenges?</td>
<td></td>
</tr>
<tr>
<td>Does the investment make sense for a single operator to assume the responsibilities and risk (unitary project)? and</td>
<td></td>
</tr>
<tr>
<td>Are the stakeholders and their interests well surveyed and understood?</td>
<td></td>
</tr>
</tbody>
</table>

It isn’t enough that the project delivers economic value and meets the regulatory requirements; the contracting authority must think about affordability. How will the PPC be financed? Health services, unlike infrastructure-types of PPCs, pose unique equity-related challenges that make it harder to consider payment options that involve user charges. Bearing that in mind, can the contracting authority meet the financial obligation? And what will be the opportunity cost? Checklist 3 summarizes some key questions worth asking.
Checklist 3: Questions to ask on the PPC affordability

<table>
<thead>
<tr>
<th>Affordability of the project</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can the project be funded in the sense that the required long-term obligations by the contracting authority are affordable?</td>
<td></td>
</tr>
<tr>
<td>If the answer is “No”, yet traditional delivery is not possible, the project can still be screened for PPC potential, with an additional question: “Are innovative structures available that can make the project affordable if delivered as a PPC?” For example, a PPC may give synergistic commercial development opportunities to the private sector that reduces the need for user charges or budget funding;</td>
<td></td>
</tr>
<tr>
<td>Assuming the project is affordable in the long term, the final question is on cash flow for the contracting authority in the short term. It should be considered in the context of both traditional delivery and PPC delivery. The question is: “Are there constraints on government financing (for example, borrowing restrictions) such that, even though the project is affordable in the long term, the government cannot finance its investment in the project in the short term?” If the answer is “yes”, then we finally come to the issue of whether a PPC can be structured to overcome that issue.</td>
<td></td>
</tr>
</tbody>
</table>

2.4. Project readiness

At the end of the screening process, one of three options may be reached: the project is strong enough to be developed as a PPC and should go to the next stage; the project is not suitable as a PPC and should be delivered through alternative models (e.g. traditional procurement, if funds are available; and, there is insufficient data to make an informed decision (further analysis needed).

Should the decision be to ‘proceed’, then the contracting authority must submit the screening report to the PPP Unit at Treasury for approval (for PPCs) or seek relevant permission for private sector engagement (for lower value health partnerships).

2.5. Project management plan and team

Next, a project management plan should be developed, including assigning a project manager. Here, the focus should be on developing a staffing plan, recognizing internal capacities and the need (if any) for external expertise/support in taking the next major step, which is preparing for the feasibility study (project preparation phase). Should a need for advisory support be identified, a funding plan should be identified as well.

Project identification and screening

- Important that the need is well understood and defined
- Need may be identified through analytic work (e.g. sector diagnostic, situational analyses or other objective methods)
Even after identifying need, there must be a priority list to inform what comes first.

Stakeholder engagement helps in prioritization.

An ecosystem approach is recommended. This allows future collaboration and partnership projects to be linked to strategic plans.

Options analyses helps in deciding how the priority project(s) will be implemented (e.g. through public sector, or through PPP, or even through contracting/other PPCs).

Crudely, affordability and economic benefit must be demonstrated.

A project management plan and team (manager) is established at this point.

**ACTIVITY:**

- Read the case titled ‘The Queen Mamohato Memorial Hospital’, and, respond to the questions below.

**CASE SYNOPSIS:**

This is a case for the Queen Mamohato Memorial Hospital in Maseru, Lesotho, a public private partnership project running over an initial 18-year period (2008 – 2026). The case carries unique features not characteristic of health PPPs in the sub-Saharan African region, and is meant to both demonstrate to the trainees the process and experiences with projects of that scale, and challenge them to think through alternative pathways and decisions that could have been taken to contribute to a different outcome.

**QUESTIONS/KEY DISCUSSION POINTS:**

- Strategic decision or desperation? Was the government well-prepared to engage in the discussions on the partnership?

- Health system readiness? In your opinion, was the Lesotho health system ready for the QMMH PPP undertaking? Was there a market failure? Was the need clear?

- Benefit of hindsight: What would you have done differently if you were involved in the early stages of the QMMH PPP?
Module 3 moves the process closer to the transaction phase. Here, key elements of the project are examined, with a focus on building the case for a partnership through feasibility studies. The Module is guided by:

- The Kenyan Legislation, specifically, the PPP Act (2013), PPP Regulations (2014) and Public Procurement and Asset Disposal Act (2015)
- The PPP Knowledge Lab Partnership Resources
3.1. Defining the project scope

This has to do with marking the boundaries between the public sector and private sector and defining the nature of the interface (Box 3). This can be a daunting task, particularly where there is a combination of service and infrastructure elements, which is a likely scenario for healthcare projects. It is not possible to design the technical requirements without a clear picture of the scope.

**BOX 3: DEFINING THE SCOPE**

‘A hospital project may be conceived as a pure infrastructure project (developing and managing the physical facility), or it may include provision of the clinical services. When there is no transfer of clinical services to the private partner, a decision must be taken on whether or not to include soft services (e.g. catering and cleaning) in addition to hard services (e.g. maintenance of the facility), or which soft services to include in the boundaries of the contract. For example, in Canada, the Abbotsford Hospital and Cancer Centre PPP included a full suite of soft services (but not clinical services). However, all subsequent health care projects developed in the region have defined a much narrower scope for their contracts.’

The PPP Knowledge Lab Partnership Resources

3.2. Designing the technical requirements

With the scope well defined, the contracting authority will need to define the technical specifications of the project. Defining technical specifications allows proper design and costing of the project, as well as enabling the assessment of risks that the public and private partners will be exposed to, and the possible pricing of the services.

The exact details of the technical specifications will vary across projects but will typically specify the project design and performance requirements, and where applicable, specify the construction requirements. It is recommended that the design focus on outcomes, rather than input and process elements, to allow the private partner to innovate and enjoy flexibility. Performance requirements must specify the features of the service to be provided, service output, role of the public/private sector, as well as requirements for performance monitoring, maintenance plan for infrastructure/ equipment etc, and, requirements for project handover when the contract ends.
Designing of technical requirements should be guided by historic data from projects that bear similar characteristics, serve comparable needs, and/or, share similarities in complexity and level of risk. This may be absent in cases where projects seek to address new needs or are based on innovation and new technologies. In that case, the project team may benchmark from outside of the country, or, look for practical comparators from other related sectors.

The project team must ensure that technical specifications do not conflict with any other Kenyan laws, and, should align with policy and political preferences. For instance, there may be concerns over the private sector offering certain types of services.

3.3. Conducting the feasibility study

According to the PPP Act of 2013, a feasibility study should inform the viability of carrying out a project under the Kenyan environment and should achieve four key things: defining the technical specification of the project; examining the project’s fit with the legal environment (legal feasibility); conducting a social, economic and environmental impact assessment of the project; and determining the affordability and value for money with reference to the most appropriate public sector comparator.

With the scope defined and technical specifications spelt out, the feasibility study is conducted. The study focuses specifically on the legal, social, economic and environmental aspects, as well as affordability and value for money. In addition, the contracting authority may conduct commercial feasibility and market sounding.

3.3.1. Legal feasibility

This is primarily aimed at ensuring the project can be done under prevailing policies and laws. The feasibility study should seek to identify possible legal and regulatory obstacles that may pose risk to the project, and a clear plan on managing these over the life of the project. Addressing legal requirements may require that some technical aspects of the project are relooked and/or altered. Legal expertise MUST be sought for this component, regardless of the nature of the project.

3.3.2. Social aspects

The focus here is understanding the impact the project will have on the catchment population and users of the service/infrastructure. Also called the social impact analysis, the exercise involves collecting and analyzing information on the impact on communities, and how negative consequences can be managed before project is approved. It strengthens political and social support for the project, and, helps in the estimation of the full economic costs. More importantly, it ensures the project does not conflict with social norms of the communities affected directly or indirectly.
Checklist 4: Key questions to ask during a social impact analysis exercise

<table>
<thead>
<tr>
<th>Social impact analysis</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the project produce any population or demographic movement, such as the change in size of the communities affected by the project?</td>
<td></td>
</tr>
<tr>
<td>Will the project significantly alter the economic structure of the local economy or generate any significant change in relative prices, such as land value? What kind of social impacts can these economic changes produce?</td>
<td></td>
</tr>
<tr>
<td>Will there be a significant change in the general access that the communities have to natural resources, such as drinking water and energy?</td>
<td></td>
</tr>
<tr>
<td>Does the local community have effective governance mechanisms to deal with the long-term effects of the project in areas such as land use regulation, negotiations over business transactions, and other such issues?</td>
<td></td>
</tr>
<tr>
<td>Will the project increase or decrease the demand for public goods or services, such as education or health?</td>
<td></td>
</tr>
<tr>
<td>Are there groups (indigenous groups, women, ethnic minorities, and so on) who will be differentially impacted by the project?</td>
<td></td>
</tr>
<tr>
<td>Will the project interfere with the local labour market during or after construction?</td>
<td></td>
</tr>
<tr>
<td>Does the background of project staff (for example, urban, educated, skilled, foreign language-speaking, expatriates, different customs, and so on) differ significantly from local communities and provide potential for misunderstanding and conflict? and</td>
<td></td>
</tr>
<tr>
<td>Will an influx of newcomers seeking opportunities associated with the project disrupt traditional social structures and create undesirable effects, such as crime, violence, disease, or conflict due to religious and ethnic rivalries?</td>
<td></td>
</tr>
</tbody>
</table>

3.3.3. Economic impact assessment

As explained under Section 2.2, economic feasibility starts early. Ideally, it should start at the project identification and screening stage, where a cost-benefit analysis (and other approaches) may be applied. At this stage, additional information (including more project details and a better risk management framework) may necessitate updating of the analyses. Experts in economic analyses should be consulted to provide a solid foundation for the project.

3.3.4. Environmental impact assessment

Most infrastructure projects have significant environmental impact. These often come during the construction phase but may also come up during the operation phase (for instance, risk of discharging affluent into the environment). In Kenya, the National Environment Management Authority (NEMA) is responsible for environmental policy and general management/oversight. However, depending on the nature of the project, sector-specific rules or laws by the local authorities may also apply. For instance, the Public Health Act (Cap 242) and the Health Act of 2017 have provisions that may touch on environmental matters, depending on the exact nature of the project.
Key steps here include mapping the policy, legal and regulatory frameworks, and, carrying out a detailed assessment to quantify the expected impact on the environment.

Scope of the EIA

- A full description of the area to be influenced by the project in order to characterize the main environmental fragilities before the construction of the infrastructure. This should include both the physical (land, water, and so on), and biological (flora, fauna, and so on) characteristics of the area;

- An analysis of the project’s environmental impact on the area previously described (including direct and secondary impacts), immediate or long-term effects, and temporary or permanent consequences. These effects, depending on the nature of infrastructure, may involve greenhouse gas emissions, fauna disruption, waterway interventions, wastewater disposal, and so on;

- An identification of the consequences of the construction of the asset in terms of its main inputs, such as material consumption, water usage, and energy sources; and

- A full description of the physical and biological aspects of the area after the construction and operation of the infrastructure.

Box 2: The scope for an environmental impact assessment

The next step is developing a mitigation plan for all identified risks. Mitigation strategies may include changing the design of the project at this stage, coming up with some form of compensation plan at the start of the project, or proposing definitive actions to be undertaken during the project implementation phase. Regardless of the option taken, clarity must be emphasized.

The final stage entails obtaining the necessary permits and licenses (provisional at this stage, to demonstrate that all possible barriers have been removed). The contracting authority must be aware that in addition to local standards or requirements from environmental agencies, there may be additional requirements linked to financing institutions (e.g. they may subscribe to additional global environmental standards). The contracting company must be aware about these, and, discuss the implications explicitly in the feasibility report.

3.3.5. Affordability and value-for money

Financial feasibility relies heavily on identification and management plan for different risks arising from the project, which can then allow estimation of risk-adjusted costs. At this stage, the emphasis should be on developing a comprehensive risk register. CAUTION: Failure to identify all risks puts the entire project at risk.
Two types of costs are estimated at this stage: capital costs, and, operational and maintenance costs, both distributed over the life of the project. It is recommended that efficiency gains by private sector be reflected in the cost estimates, rather than estimating these based on typical public sector estimates. Realistic assumptions must nonetheless be applied to avoid overly optimistic estimates that may mislead the PPP Committee in their decision. To cater for unforeseen risk, the project team may add an ‘expected risk value’ over and above the computed estimates, with the idea being able to give figures that include the economic value of risk (as opposed to purely financial costs).

### ESTIMATING RISK-ADJUSTED COSTS

*Say the costs of managing a certain set of non-clinical services (e.g. laundry services) at a hospital was KES 15 million each year. However, whenever there has been a cholera outbreak in the area, additional inputs have been needed (staff, linen etc.), increasing the operations costs by up to KES 2 million.*

*Based on prior experience within the county, the probability that an outbreak will occur within a year is 20 percent. For that reason, the value of KES 400,000 (20% of 2 million) should be added to the operations expenditure for the year. The reverse can also apply, where certain efficiency gains result in lowered expenditure. The final values must reflect the weighted average of the possible cost outcomes, considering each probability.*

### 3.4. Submitting the feasibility report for approval

The contracting authority then submits the ‘Feasibility Study Report’ to the PPP Unit for review and evaluation. The report must be submitted within two months of the study. The PPP Unit then submits the Feasibility Study Report to the Debt Management Office (DMO), which is responsible for assessing fiscal risks and contingent liabilities for the project. The DMO sends back a report to the PPP Unit with recommendations (where applicable). The PPP Unit combines the DMO report with the Feasibility Study Report and submits the package to the PPP Committee for review and approval. Additional cabinet approval may be required if the PPP Committee deems it necessary.

One important factor that the PPP Committee considers is the technical capacity of the contracting authority to take the project forward (to the procurement stage). Should the PPP Committee be unsatisfied with the capacity of the contracting authority, they may direct that the authority seeks the services of a transaction advisor.

### 3.5. PPP project contract preparation

#### 3.5.1. Structuring the PPP project

Once the PPP Committee approves that a project may proceed as a PPP, the next thing is allocating responsibilities, rights and risks to the contracting authority and the private party.
This stage is broadly referred to as structuring the PPP contract. It precedes the procurement phase. PPP project structuring aims to define the contractual terms, specifying important information such as who bears what risks, and how will the private partner receive compensation.

According to the World Economic Forum (WEF, 2013), careful project preparation and risk allocation are the primary determinants of whether the project delivers value for money, whilst remaining attractive enough for the public sector. The Report proposed four broad factors that the contracting authority must consider at the project preparation phase: ensuring the presence of a strong team and financing for the preparatory work (composition will depend on the project); checking the bankability and commercial attractiveness of the project; carrying out a balanced and fair risk-allocation process; and preparing the environment for the project, including building needed capacities to support the project’s preparation and implementation.

Project structuring begins with a proper development of the project concept, which includes defining the technical aspects, expected outputs and intended beneficiaries. This is followed by identifying project risks, allocating the risks to the party best able to manage them, then translating the risk allocation into a contract for the project.

3.5.2. Identifying and assessing project risks

Here, the contracting authority develops a risk register based on the project concept (table 3). Risks are defined broadly as unexpected deviations from the project’s purposes. These may be categorized broadly as construction, operation and maintenance, demand risks and/or economic/financial risks.

At this stage, the contracting authority may rank the risks based on qualitative or quantitative criteria. The former may provide a heat map, while the latter gives a clear quantitative ranking of risks based on multiple criteria.

Table 3: Sample table showing the project concept (description) note

<table>
<thead>
<tr>
<th>Name of the project</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates:</td>
<td></td>
</tr>
<tr>
<td>Contract type:</td>
<td></td>
</tr>
<tr>
<td>Outputs:</td>
<td></td>
</tr>
<tr>
<td>Period:</td>
<td></td>
</tr>
<tr>
<td>Total construction cost (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Life of the asset (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Control of the asset/service:</td>
<td></td>
</tr>
<tr>
<td>Funding: [who ultimately pays for the asset? The government or the users of the asset/service?]</td>
<td></td>
</tr>
<tr>
<td>Risk sharing agreements:</td>
<td></td>
</tr>
<tr>
<td>Financing: [how the private partner finances the project. Mix of debt and equity?]</td>
<td></td>
</tr>
<tr>
<td>Accounting: [how will the contracting authority/government account for the project in the fiscal accounts?]</td>
<td></td>
</tr>
</tbody>
</table>
3.5.3. Allocating risks and transferring them into the contract

Next, decisions must be made on which party should bear which risk. Ideally, three broad principles should guide the process: the party’s ability to manage the risk; their capability to manage the impact of the respective risks; or their ability to absorb the risks at the lowest possible cost. It is generally advised that risk allocation be designed to address two objectives: to incentivize the parties to manage the risk well based on their capacities, and to insure respective parties against risks that they may not be happy taking on/able to take on. PPPs must generally carry significant risk-transfer to the private entity, although this needn’t be the case for other forms of PPCs. For instance, under management contracts, the public entity is likely to bear the bulk of the risk. As a principle, the higher the risk transfer to the private partner, the higher the returns paid to the partner in question.

*Figure 5: Relationship between type of partnership and risk allocation*

<table>
<thead>
<tr>
<th>Design</th>
<th>Finance</th>
<th>Construct</th>
<th>Operation &amp; management</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service contract</td>
<td>Management contract</td>
<td>Lease</td>
<td>Concession</td>
<td>BOT models</td>
</tr>
</tbody>
</table>

Adapted from *PPP Guidelines for Practitioners, Government of India*
There are certain risks that may not be transferrable. For instance, risk against political instability or change in government. For some of these, the World Bank Group’s Multilateral Investment Guarantee Agency (MIGA) may provide protection. There may also be scenarios that were missed during the project structuring phase, and which emerge as risks later in the life of the project. While such unforeseen circumstances are inevitable, there must be clear guidelines on how they should be handled downstream.

**The Kenyan PPP laws allow contracting authorities to issue a ‘guarantee’ or ‘binding letter of comfort’ to help the private partner to manage political risk and other unforeseen risks.**

Identifying, prioritizing and allocating risk is one thing. Transferring that into a contract is another task altogether. The process requires that due consideration goes towards appreciating the link between identified risks, responsibilities across parties, rights and payment mechanisms, all of which go into the actual structuring of the contract.

### 3.5.4. Designing the PPC contract

A draft PPC contract should be developed before the transaction phase of the process (certainly before the request for proposal stage). It should define the relationship between the two parties, spell out respective rights and responsibilities, allocate risks, and provide mechanisms for addressing unforeseen occurrences/dealing with change (i.e. it must recognize uncertainty over coming years and build a mechanism to deal with that). PPC contracts must be long enough to allow costing for the entire life cycle. The draft contract sent with the RFP may be changed or may be required to remain the same, depending on project specifics.
BOX 3: PPP types and duration allowable under Kenyan law

- 1. Management contract - Private party manages and performs a specified obligation, within well-defined specifications for a period not exceeding ten years. Contracting authority retains ownership and control of all facilities and capital assets and properties.

- 2. Output performance-based contract where the private party operates, maintains and manages an infrastructure facility for a period not exceeding ten years. The contracting authority retains ownership of the facility and capital assets.

- 3. Lease - the private party pays contracting authority rent/ royalties and manages, operates and maintains facility or utilises the leased property for a period not exceeding thirty years.

- 4. Concession - contracting authority issues a contractual licence to private party to operate, maintain, rehabilitate or upgrade a facility and charge a fee while paying a concession fee to the contracting authority.

- 5. Build-Own-Operate-Transfer (and related scheme) - private party designs, constructs, finances, operates and maintains an infrastructure facility owned by the private party for a period not exceeding thirty years, after which the private party transfers the facility to the contracting authority. Periods and specific vary according to the agreement.

Box 3: PPP models and duration allowed by Kenyan law

In Kenya, the PPP Act of 2013 specifies the length of PPP contracts, with variations being linked to the nature of the partnership and level of risk transfer (Box 3). The PPP Act also specifies the minimum contractual obligations that must be included in the contract (Checklists 5 and 6).
## Checklist 5: Minimum contractual obligations (third schedule of the Kenya PPP Act of 2013)

<table>
<thead>
<tr>
<th>Obligation specified in the contract</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nature/scope of services that the parties shall carry out and the conditions for their implementation.</td>
<td></td>
</tr>
<tr>
<td>The rights of a contracting authority, the project company and where applicable, the lender, in relation to the project including step in rights of lenders.</td>
<td></td>
</tr>
<tr>
<td>A description of any property to be contributed by a party to the project agreement.</td>
<td></td>
</tr>
<tr>
<td>A description of any utilities to be provided in relation to the project</td>
<td></td>
</tr>
<tr>
<td>The ownership of the project assets, obligations of parties related to the handover and receipt of the project site.</td>
<td></td>
</tr>
<tr>
<td>The responsibility for obtaining authorizations, permits, and approvals.</td>
<td></td>
</tr>
<tr>
<td>A description of any sharing of revenue between the two parties.</td>
<td></td>
</tr>
<tr>
<td>Mutual financial obligations and their relation to the funding mechanism including the requirements relating to performance bonds and guarantees.</td>
<td></td>
</tr>
<tr>
<td>The preparation and submission of financial/other reports and doing of financial audits in relation to the project.</td>
<td></td>
</tr>
<tr>
<td>Product sale price/service availability payment on which the project is based and rules for its determination/amendment, either by an increase or decrease, as well as the indexation mechanisms to reflect inflation or changes in the interest rate, if required.</td>
<td></td>
</tr>
<tr>
<td>The means of QA and QC, supervision and administrative, financial and technical monitoring of the project.</td>
<td></td>
</tr>
<tr>
<td>The extent of the right of the contracting authority to vary the conditions of the project and other obligations imposed on private party, and the basis and mechanisms of compensation for any loss resulting from such variation order.</td>
<td></td>
</tr>
<tr>
<td>The types of insurance to be taken out on the project, and the risks of its operation or utilization, executive warranties issued in favour of the contracting authority, and provisions and procedures for their release.</td>
<td></td>
</tr>
<tr>
<td>The basis of risk allocation in respect of a change in the law, unforeseeable accidents, force majeure, or discovery of antiquities, and the resultant compensation.</td>
<td></td>
</tr>
<tr>
<td>The duration of the contract.</td>
<td></td>
</tr>
<tr>
<td>Events under which a party may terminate the contract prior to the expiry of the project agreement and the rights of the parties in relation to the termination.</td>
<td></td>
</tr>
<tr>
<td>The process of handing over project on expiry/termination of the project agreement by a party to the agreement.</td>
<td></td>
</tr>
<tr>
<td>Mechanism for dispute resolution including resolution of disputes by way of arbitration or any other amicable dispute resolution mechanism.</td>
<td></td>
</tr>
<tr>
<td>The events giving rise to compensation and the mechanisms for payment of such compensation or penalties.</td>
<td></td>
</tr>
<tr>
<td>Performance securities needed for the project, the value and renewal mechanisms.</td>
<td></td>
</tr>
<tr>
<td>Appointment of independent experts.</td>
<td></td>
</tr>
<tr>
<td>Direct agreements and lenders rights where applicable.</td>
<td></td>
</tr>
<tr>
<td>Termination and expiry of the project agreement.</td>
<td></td>
</tr>
<tr>
<td>Obligations of, undertakings and warranties by contracting parties.</td>
<td></td>
</tr>
<tr>
<td>Emergency step in by contracting authority or lenders in case of private party default.</td>
<td></td>
</tr>
<tr>
<td>The types of insurance to be taken out on the project, and the risks of its operation or utilization, executive warranties issued in favour of the contracting authority, and provisions and procedures for their release.</td>
<td></td>
</tr>
</tbody>
</table>
Checklist 6: Five sections that must be included in a PPC contract

<table>
<thead>
<tr>
<th>Factors for inclusion in contract</th>
<th>Details</th>
</tr>
</thead>
</table>
| Performance requirements (Quality and quantity) | - Specify performance targets/output requirements.  
- Specify how performance will be measured.  
- Specify consequences of deviation from target.  
- Specify role of public entity in case of failure. |
| Payment mechanisms (How the private party will be paid). | - Specify payment method, i.e. whether user fee, government payment or a blend of the two.  
- Specify penalties for different deviations. |
| Adjustment mechanisms (Handling changes). | - Specify flexibilities built-in in recognizing that PPP contracts can never be complete contracts  
- Specify the administrative processes to be followed. |
| Dispute resolution procedures (Resolving contractual disputes). | - Specify resolution options that could include mediation or conciliation, recourse to a sector regulator, judicial system, experts as arbitrators or internal arbitration. |
| Termination provisions (Handover or early termination). | - Specify contract term and handover arrangements.  
- Government may define term based on time taken for private sector to recoup investment, or the term may be included as a parameter for bidding.  
- Specify provisions for early termination, which may result from one of three reasons: default by private company, termination for public interest or early termination for unforeseen reasons (force majeure). |

Project Preparation

- The project preparation phase is primarily concerned with the feasibility study, project, project approval and contract document preparation.

- The focus of the feasibility study is defining the project’s technical specifications, legal feasibility, affordability and value-for-money, and the expected social, economic and environmental impact of the project.

- The feasibility study report is submitted to the PPP Unit at Treasury.

- The Debt Management Office MUST okay the report, based on fiscal space, before the project can get the green light from the PPP Committee.

- Based on the feasibility report, one of three decisions will be made: Proceed to the transaction phase (procurement); proceed, but through normal procurement processes (not as a PPP) or cancel the project entirely.
Risk-allocation MUST guide preparation of the contract document for the project, with two key rules: allocating risks to the party best able to prevent and/or manage them, and, allocating risks fairly, based on the nature and duration of the project.

There are five components that MUST be included in the draft PPC contract: Performance requirements (Quality and quantity), payment mechanisms (how the private party will be paid), adjustment mechanisms (handling changes), dispute resolution procedures (resolving contractual disputes) and finally, termination provisions (project handover or early termination).

**ACTIVITY:**
- Read the case titled ‘The Queen Mamohato Memorial Hospital’, and, respond to the questions below.

**CASE SYNOPSIS:**
This is a case for the Queen Mamohato memorial Hospital in Lesotho, a public private partnership project running over an initial 18-year period (2008 – 2026). The case carries unique features not characteristic of health PPPs in the sub-Saharan African region, and is meant to both demonstrate to the trainees the process and experiences with projects of that scale, and challenge them to think through alternative pathways and decisions that could have been taken to contribute to a different outcome.

**KEY DISCUSSION POINTS:**
- Government capacity to engage: Was the government capable of negotiating and delivering a contract that represents value for money? Why?
- External factors and their effect on the contract: Did the project sufficiently factor in external factors (e.g. fiscal space, complementary interventions)?
- Risk identification and assignment: Comment on risk identification and allocation for the project. Were key risks missed? Give examples. What was well-allocated? What risks were poorly allocated? What were the implications?
- Feasibility study: Comment on the feasibility study. Thoughts? In your opinion, were there components that were either omitted or perhaps not well covered?
- Benefit of hindsight: What would you have done better at the project preparation phase?
So far, the focus had been on establishment of a strong engagement process and developing of a sound project proposal. Module 4 goes a step further to look at the process of engaging the most suitable partner. The Module is guided by:

- The Kenyan Legislation
- The PPP Knowledge Lab Partnership Resources
- Other technical resources from organizations involved in supporting initiation and implementation of PPCs

**Module 4: The PPC Project Transaction Phase**

- Previous phase (PPC project preparation)
- Issuance of the RFQ (Request for Qualification)
- Formation of a prequalification committee
- Preliminary bidders meeting
- Preparation of tender documents
- Invitations sent to prequalified firms to bid
- Formation of evaluation team
- Evaluation of bids (technical proposals only)
- Winning technical bids
- Evaluation of financial proposals
- Alteration of specifications
- Awarding to winning firm or consortium
- Preparation of evaluation report, and preparing to proceed to the project implementation phase
- Next Phase (PPC Project Implementation)
4.1. Understanding the transaction phase

The transaction phase moves the proposal closer to the implementation through identifying the most suitable and competent private company to partner with. This phase can only deliver value if it is completely open and transparent.

In Kenya, the transaction phase is well guided under the PPP Act of 2013, the PPP Regulations of 2014 and the Public Procurement and Asset Disposal Act of 2015 (PPADA of 2015).

Key steps during the transaction phase include selecting a procurement method (guided by respective legislation); marketing the proposed collaboration project; implementing the prequalification of bidders; and managing the tender processes to identify the most qualified and best priced bidder.

**CAUTION:**

- Contracting authorities (public authorities) need to take heed of the fact that ‘Memoranda of Understanding’ (MOU) with the private sector have a limited role and cannot be a substitute for full compliance to procurement provisions. MOUs have a role, as they signify willingness to engage under certain terms. However, these are not legally-binding and should not be a mechanism for contracting out or formalizing a PPC arrangement.

4.2. Selecting the procurement method

The Kenyan legislation specifies the range of procurement models permitted (table 4). Specifically, these are covered under the Public Procurement and Asset Disposal Act (2015), the Public Private Partnership Act (2013) and the Public Private Partnership Regulations (2014). Section 91 of the PPADA (2015) specifies open tendering as the default model for procurement. Similarly, both the PPP Act (2013) and the PPP Regulations (2014) require that contracting authorities apply the principles of open tendering throughout the procurement processes. However, there may be circumstances where open tendering wouldn’t work (see section 4.7 for privately initiated investment proposals, or unsolicited proposals for instance). Under such circumstances, the PPADA (2015) provides alternative procurement methods (table 4). Special approval must be sought from the PPP Committee at Treasury whenever a contracting authority plans to use a method other than open tendering.
Table 4: Procurement methods allowable under Kenyan law

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open tender</td>
<td>A competitive bidding process that is open to all bidders. Sealed bids are opened in public and winner picked on basis of quality and price.</td>
</tr>
<tr>
<td>Restricted tendering</td>
<td>A procurement method that limits the request for tenders to suppliers who have already been pre-registered. The Kenyan laws require that the list of suppliers not be more than two years old.</td>
</tr>
<tr>
<td>Request for proposal</td>
<td>A document posted by a contracting authority, soliciting proposals from interested suppliers to be subjected to competitively evaluation. Usually includes technical and financial bids submitted concurrently.</td>
</tr>
<tr>
<td>Two-stage tendering</td>
<td>Similar to the request for proposals but has technical and financial proposals submitted one before the other, rather than simultaneously.</td>
</tr>
<tr>
<td>Design competition</td>
<td>A form of procurement where bidders compete on, and are evaluated, on innovative ideas.</td>
</tr>
<tr>
<td>Direct procurement</td>
<td>A form of procurement where the contracting authority invites a supplier directly to make a proposal for negotiation.</td>
</tr>
<tr>
<td>Request for quotation</td>
<td>A procurement method where the contracting authority requests for bids or quotes from suppliers.</td>
</tr>
<tr>
<td>Electronic reverse auction</td>
<td>A procurement method where the contracting authority spells out their requirements, and, allows suppliers to bid towards meeting their (the contracting authority’s) requirements.</td>
</tr>
<tr>
<td>Low value procurement</td>
<td>Simply refers to procurement below a certain threshold value set by a contracting authority. This varies across authorities.</td>
</tr>
<tr>
<td>Force account</td>
<td>A model for procuring private services, where the contracting authority requires the use of its resources (e.g. personnel, equipment) as part of the contractual offering.</td>
</tr>
<tr>
<td>Competitive negotiations</td>
<td>A procurement method that involves the contracting authority sending RFPs to specific suppliers only, then engaging in separate negotiations with each of the supplier until their (contracting authority’s) needs are met.</td>
</tr>
</tbody>
</table>

4.3. Supplier prequalification

The PPADA (2015) requires that prequalification be done where possible for complex goods and services. The Act specifies the requirements for the invitation for prequalification (Checklist 7). The PPP Act (2013) requires that prequalification seeks to confirm that the private party has the required financial capacity, relevant experience, and relevant expertise to undertake the project.
Checklist 7: Requirements for the invitation for prequalification

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>The name, address and contact details of the procuring entity</td>
<td></td>
</tr>
<tr>
<td>Outline of the procurement requirement, including the nature and</td>
<td></td>
</tr>
<tr>
<td>Quantity of goods, works or services</td>
<td></td>
</tr>
<tr>
<td>Location and timetable for delivery or performance of the contract</td>
<td></td>
</tr>
<tr>
<td>Statement of the key requirements and criteria to pre-qualify</td>
<td></td>
</tr>
<tr>
<td>Instructions on obtaining the pre-qualification documents, including any</td>
<td></td>
</tr>
<tr>
<td>price payable and the language of the documents; and</td>
<td></td>
</tr>
<tr>
<td>Instructions on the location and deadline for submission of</td>
<td></td>
</tr>
</tbody>
</table>

Qualified firms or consortia must meet the following requirements (checklist 8)

Checklist 8: Minimum requirements for firms to be prequalified for partnership with government

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets criteria specified in the request for qualification issued by the</td>
<td></td>
</tr>
<tr>
<td>contracting authority</td>
<td></td>
</tr>
<tr>
<td>Possesses the technical capability to undertake the project</td>
<td></td>
</tr>
<tr>
<td>Possesses the financial capacity to undertake the project</td>
<td></td>
</tr>
<tr>
<td>Has the legal capacity to enter into a project agreement with the</td>
<td></td>
</tr>
<tr>
<td>contracting authority</td>
<td></td>
</tr>
<tr>
<td>Is not insolvent, in receivership, bankrupt or in the process of being</td>
<td></td>
</tr>
<tr>
<td>wound up</td>
<td></td>
</tr>
<tr>
<td>Is not precluded by the contracting authority from entering into an</td>
<td></td>
</tr>
<tr>
<td>agreement for the purpose of undertaking the project</td>
<td></td>
</tr>
</tbody>
</table>

A prequalification committee may be established, consisting (preferably) of the relevant technical experts, along with financial and legal experts. However, it is possible for the project appraisal committee to play the same role, if the required competencies are there. The committee evaluates the bids, and may disqualify a firm if it (i) submits false, inaccurate or incomplete information in relation to its qualifications; (i) colludes, connives or is involved in any corrupt or dishonest practice; (iii) fails to meet the eligibility criteria presented in checklist 8; or (iv) contravenes the provisions of any law. Complaints are handled by the Petition Committee established under the PPP Act (2013).
Should the need arise, the contracting authority may liaise with the PPP Unit at Treasury to hold a preliminary meeting with those interested in the prequalification. Here, questions are addressed. In addition, recommendations may be given by bidders, some of which may be incorporated into the project. However, changes must not affect the prequalification criteria applied. Furthermore, changes to the project requirements must be communicated to all prequalified bidders.

4.4. Managing the tendering process

The first step is the contracting authority preparing the tender documents. The PPP Act of 2013 requires that the tender documents carry certain mandatory information (Checklist 9).

Checklist 9: Mandatory information to be included in tender documents for PPCs

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information related to the project necessary for the preparation and submission of a bid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specifications of the project including the technical and financial conditions that should be met by a bidder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specifications of the final product, level of services, performance indicators and such other requirements as the contracting authority and relevant regulatory bodies shall consider necessary including the safety, security and environment preservation requirements to be met by a bidder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic terms and conditions of the project agreement including non-negotiable conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The criteria and method to be used in evaluating a bid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The forms and documents that are required to be filled and submitted by a bidder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The value of the bid security required to be submitted by a bidder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The deadline for submission of the tender documents by a bidder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The place for submission of the tender documents by a bidder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The laws require that bidders submit technical and financial proposals separately in sealed envelopes. As a general rule, the financial bid can only be opened if the technical bid has passed the evaluation. Financial bids for firms that fail the technical evaluation must be returned unopened. Different contracting authorities may have additional rules to guide the bidding processes.

Competitive dialogue is allowed, if requisite approval is given by the PPP Committee at Treasury. Competitive dialogue refers to a process where the contracting authority engages bidders directly to discuss finer details of the technical and financial proposals. The dialogues must be transparent. Dialogue details with a bidder mustn’t be divulged to anyone outside of the discussion teams. Such dialogue may result in further changes to the project specifications (refer Module 3), or, to the prequalification criteria. Should the latter be the case
(changes to the project), another invitation for prequalification must be executed whilst maintaining those who had already been prequalified.

In cases of consortia bidding, the consortium name should be used, and evidence of all consortium partners willingness to participate included. In addition, documentation showing the person appointed to engage on behalf of the consortium must be included in the bidding documents.

4.5. Evaluation of bids

The contracting authority is required to constitute a Tender Evaluation Committee, which must have representation from the contracting authority, the node within the unit that is leading the process, the relevant regulatory authority, the PPP Unit at Treasury, and the Attorney General’s office. The Tender Evaluation Committee evaluates the technical proposals, shortlists qualified firms, invites them to the opening of the financial bids, and evaluates the bids to identify those that meet the requirements. The PPP Committee is prohibited from direct involvement in the evaluation of bids sent to the contracting authorities. At the end of the exercise, the Tender Evaluation Committee writes up a report detailing the entire process. The report should be submitted to the PPP Committee.

4.6. Negotiation phase

The contracting authority then engages in negotiation with the winner. In some instances, the second ranked bidder may also be requested by the contracting authority to extend the validity of their bid up until the negotiations with the first bidder are completed.

To engage in effective negotiation, the contracting authority is required to form a Negotiation Committee, which should be constituted of a representative of the PPP Unit at Treasury, the person from the node within the contracting authority that is responsible for the project, the transaction advisor(s) (where applicable), and any other person representing the government who may be deemed relevant, depending on the nature and content of the contract. The negotiation covers both the technical and financial aspects. However, the laws caution against negotiations resulting in increased price or in the alteration of non-negotiable terms of the project. The terms on which the bidding was done must also not be altered at the negotiation stage.

At the end of the negotiation stage, the Negotiating Committee prepares a report for the contracting authority, specifying the terms of the negotiation and resultant recommendations. The report submitted is referred to

**USE OF INNOVATION**

- The Kenyan laws prohibit contracting authorities from restricting innovation by the private partner in implementing their mandate. Innovation is encouraged with respect to financing, technology use and management of services by the private partner under a partnership arrangement.
as the ‘Project and Risk Assessment Report’. If satisfied with the contents, the Contracting Authority submits the report to the PPP Unit at Treasury, who review it, and, either sends it back to the contracting authority with some input, or, forwards it to the Debt Management Office (DMO). It is the Debt Management Office that confirms the final terms specified against what had been earlier approved at the feasibility study stage.

Once verified by both the PPP Unit and the Debt Management Office, the Project and Risk Assessment Report (carrying the project report and risk assessment report) are submitted to the PPP Committee for assessment and approval. At this stage, the Committee deliberates the reports, and gives recommendations on whether the project should be implemented as a PPP. The recommendations are forwarded to the cabinet secretary (treasury) and the cabinet secretary for the ministry of health. The two prepare a joint cabinet memorandum based on the PPP Committee’s recommendations and submit to cabinet for final approval. The exceptions are those projects that pose no contingent liabilities to the government. The law allows the respective county government to give the final approval (rather than cabinet). The PPP Committee informs the contracting authority of the outcome within a period of 30 days.

4.7. Privately Initiated Investment Proposals (Unsolicited PPCs)

There are cases where a private firm may submit a proposal to a contracting authority without express request by the latter. These are generally referred to as unsolicited PPC proposals (UPPCs). In Kenya, the PPP Act refers to these types of proposals as privately initiated investment proposals (PIIPs). The PIIPs elicit divided opinion, although there is a growing number of countries that believe they have a role (7). The main appeal around PIIPs is their potential to harness new and innovative solutions that may either not have been on the radar of the public entity, or, may be under patent and too costly for other companies to purchase and supply the contracting authority.

The private entity initiating a PIIP is expected to do all necessary pre-feasibility and feasibility studies without receiving compensation from the contracting authority or any public organ. For that reason, they circumvent challenges linked to early-stage feasibility assessments that characterize PPCs (8). Even where legal and regulatory frameworks prevent PIIPs, it is still advised that countries establish mechanisms for identifying and nurturing privately-owned high impact concepts that can deliver public good. Urgent political and community pressure may push governments into seeking PIIPs, especially from firms that already have a patented solution. It is, therefore, in the interest of governments to have in place mechanisms to deal with such arrangements should they be required. This gives them a better chance of managing the processes transparently and successfully.

Challenges with PIIPs include governance, corruption and transparency problems, lack of competition and consequent concerns over value-for-money, inadequate government capacity to manage such arrangements, diversion of public resources from planned needs (linked to the problem of corruption), and the risk that the PIIPs may not be bringing real innovations, and that they may merely be repackaging older innovations that could have been harnessed using competitive bidding.
The greatest concern with PIIPs is the absence of competition and the risks that they pose.

In Kenya, PIIPs are allowed under the following conditions: a) where urgent need for continuity of a service invalidates competitive bidding; (b) where the cost of the intellectual property is substantial, thereby making direct partnering with the originator of the innovation more feasible; (c) where there exists only one person or firm capable of undertaking the activity; (d) where the responsible Cabinet Secretary feels it would be an appropriate approach. The PPP Act (2013) stresses that a PIIP project must be affordable, demonstrate value for money, and have appropriate risk transfer arrangements.

The contracting authority is expected to follow the following steps for a PIIP: (a) prescribe clear criteria against which the outcome of negotiations will be evaluated; (b) submit the proposal to the PPP Unit at Treasury for consideration and recommendation; c) Implement recommendations given by the PPP Unit appropriately, then apply for and obtain approval from the PPP Committee before engaging in the next steps (d) following approval, engage in negotiation and award the tender in accordance with the relevant laws (PPP Act Regulations of 2014 and/or PPADA of 2015).

Innovative thinking could reduce the likelihood of engaging in a PIIP. For instance, countries like Korea and Chile have experimented turning the PIIPs into competitively tendered projects while at the same time having mechanisms for awarding fixed bonus points to the originator of the idea. Other options include introducing a ‘challenge system’, where other firms are invited to tender competing offers over a fixed period, failure to which the contract is awarded to the originator of the idea. A different approach would entail the contracting authority purchasing the concept and awarding it through an open competitive process, but this may have limitation where intellectual property costs are high.

**Transaction phase**

- The transaction phase start at the issuance of the request for qualification, and, ends with award of the contract to the winning bidder
- This is the one phase of the PPC cycle that is highly regulated. Details are provided at granular level in the three legislation (PPP Act, PPP Regulations and PPADA Act)
- Open tendering is the legally required channel. However, there are instances where restricted procedures may be applied. These are specified in law
- Negotiation may help to reshape the contract prior to award. There are rules to guide negotiation to ensure the process remains competitive throughout.
ACTIVITY:

- Read the case titled ‘The Queen Mamohato Memorial Hospital’, and, respond to the questions below.

CASE SYNOPSIS:

- This is a case for the Queen Mamohato memorial Hospital in Lesotho, a public private partnership project running over an initial 18-year period (2008 – 2026). The case carries unique features not characteristic of health PPPs in the sub-Saharan African region, and is meant to both demonstrate to the trainees the process and experiences with projects of that scale, and challenge them to think through alternative pathways and decisions that could have been taken to contribute to a different outcome.

QUESTIONS/KEY DISCUSSION POINTS:

- Government capacity to engage: Was the government capable of negotiating and delivering a contract that represents value for money? Why?

- Contract variations: The contract kept evolving throughout the period? Why? What do you think were the implications (financial, economic, political)?

- Cost escalation: There was an increase of more than 100% in expected costs. Why? How could this have been averted at the transaction phase?

Module 5:
PPC Contract Management

Module 5 covers key steps following successful award of the PPC contract to the private partner.

The module is guided by:

- The Kenyan Legislation
- The PPP Knowledge Lab Partnership Resources
- The European PPP Expertise Center (EPEC)
- Other technical resources from organizations involved in supporting initiation and implementation of PPPs
Module 5: PPC Contract Management

5.1. Understanding contract management

Contract management refers to the process of managing and administrating the collaboration or partnership, from start to the end of the contract (period typically referred to as the operational period or implementation period). Past experiences suggest that contracting authorities tend to focus more on the project preparation and procurement phases, almost as if to say that once the contract is signed, the project will run effortlessly. Yet the greatest risks lie in the implementation.

Contract management entails operations management of all aspects, which may be split into two broad categories: designing the operational management role, and performing the operational management role (9). Contract management can make or break the collaboration. It is the phase that allows the contracting authority to ensure the private partner plays its role exactly as specified in the contract, while at the same time, ensuring that they themselves (the contracting authority) play their part (any roles allocated to the contracting authority in the contract). Finally, this phase ensures that any contract changes/deviations are managed in a structured way, as per the contract.

At the heart of the contract management process is the management of risk. Because PPCs are rarely complete contracts, there must be mechanisms to handle unforeseen risk, and ensure that any arising risks are fairly distributed across parties over the lifetime of the project (which may be up to 30 years based on certain types of partnerships, according to the Kenyan laws).

The Importance of Contract Management

- To ensure private party delivers based on contract specifications. Unchecked, the private partner may deviate from agreed provisions and erode the value-for-money.
- To ensure fair allocation of risk throughout the lifetime of the project, particularly where unforeseen events occur. PPCs are rarely incomplete contracts due to the long nature of the project undertaken.
- To track performance and ensure that the contracting authority pays based on the private partner meeting agreed performance targets.
- To ensure opportunities for public expenditure savings are picked up and maximized, for instance, and that accruing benefits also reach the public sector.
- To generate lessons and identify opportunities for improvement across subsequent projects, thereby creating a virtuous cycle.

Source: European PPPs Expertise Centre

Box 4: Importance of contract management
5.2. Designing the operational management role

Two key activities characterize the stage of designing the operations management role:

- Establishing of the contracting authority’s operational management team
- Establishing of a robust and effective project governance structure

The operational management team will rely on the existence of a robust set of instruments for effective performance, including a clear and comprehensive PPC contract, a user-friendly contract management manual, an effective and easily applicable set of information management tools and a well-developed financial management model that enables the activities of the management team.

5.2.1. Establishing the operational management team

5.2.1.1. Role of the operational management team

All costs linked to human resource needs for contract management should have been factored in at the project preparation phase, particularly at the point of doing cost-benefit studies to compare with other options. The feasibility study must also include costs incurred at the contract management stage. It is recommended that persons involved at the contract management stage also have been involved at the contract negotiation phase. This allows for more pragmatism.

It is also recommended that requirements for the operational management phase be specified in the documents sent to bidders, to ensure that the winning bidder is aware of the full post-award commitments and responsibilities. In addition, the procurement team must plan to comprehensively hand over to the operational management team to ensure coherence, and guarantee that the engagement with the private party builds on a consistent platform finalized at the negotiation stage.

It is generally recommended that as much as possible, the operation management team be the same for different projects under a contracting authority to allow cross-learning and enable the building of requisite expertise. The operational management team must carry the requisite knowledge, skill and expertise mix, including the following:

- **Technical**: Capacity to verify whether any infrastructure involved is developed in accordance with the contract, service specifications meet pre-agreed standards, and that operations and maintenance are adequate across the contract period.

- **Administrative**: Capacity to verify that the private partner has met their obligations in providing the required information, and that agreed rules are followed, for instance, making payments against verified performance targets.
Legal: Capacity to understand and interpret expected and unexpected changes in the legal, policy and regulatory landscape. For instance, capacity to advise on whether a change in a certain legal provision requires the private partner to be compensated.

Financial: Capacity to understand and advise on financial aspects of the project, including, where applicable, the financial impact of refinancing the project, or giving certain guarantees.

Communication: Capacity to digest the technical information and develop information and educational messages that can be well understood by the end-users.

Insurance: Capacity to engage with insurance providers where necessary or advise on the appropriateness of insurance covers needed at different stages of the project.

5.2.1.2. Contract management team composition

Team composition may vary based on the nature and scale of the project, but may include the following as key office bearers:

- A Contract Manager (CM) – responsible for the overall management of the contract. The CM serves as the head of the team, and, is the authorized representative of the contracting authority in dealing with the private partner.

- At least one Service Performance Manager (SPM) whose primary responsibility will be to oversee the monitoring of the project, ensuring service quality, and checking to confirm that the private partner is delivering as per the contract.

- An Administrator – in charge of all administrative aspects, including supporting the legal and financial aspects of the contract.

The contract management team must have persons of high integrity. However, additional safeguards must be taken to guard against the risk of conflict of interest. The risk of the private partner ‘capturing’ a team member should never be overlooked. It is recommended that the team members sign contracts obliging them to not accept employment, payments or benefits of any kind from the private partner over a certain agreed period following either the end of their contract or their employment with the contracting authority.

It is worth noting that the contract management phase needn’t be costly. The contracting authority can bring in expertise as and when needed (Box 4). Framework contracts are particularly helpful, as they allow quick engagement of needed expertise, thereby, enabling the same team to support the implementation. This removes the need to bring new teams up to speed.
Where possible, the framework contract applied at the contract management phase could be an extension of a similar contract developed during the transaction phase. The underlying theory is that the advisors contracted at the procurement stage will have an added incentive to ensure the project’s success if they knew that there was an opportunity for them to continue providing advisory services during the contract management phase.

5.2.1.3. Ensuring effectiveness of the contract management team

The contracting authority must create an environment that allows the operational management team to work effectively, and with continuity to avoid interruptions. Strategies include providing strong management support to avoid attrition, develop a clear succession plan in case staff depart, promoting team work to ensure members are well versed on what colleagues are doing, embedding knowledge transfer and capacity-building strategies, and finally, ensuring the team is well funded to enable its operations and allow members to work without fear of losing their jobs.

Knowledge Imbalance Between Contracting Authority and Private Partner

- ‘Experience shows that there is often an imbalance between the single-project focus of an Authority’s contract manager and the ability of private sector operators to capitalise on their know-how and experience across different projects. It is therefore important to facilitate as much as possible the sharing of experience among public executives in charge of operational management.’

Source: European PPPs Expertise Centre

Box 6: Knowledge imbalance and the risk to contract management
5.2.2. Defining the operational management governance

Following the formation of a contract management team, the contracting authority next needs to define a structure for coordinating activities across the multiple players involved in the execution of the contract. At this point, the authority must ask four key questions:

- Have all stakeholders linked to the project directly and indirectly been clearly identified?
- How should different stakeholders be involved in the operational management process?
- What should the decision-making process within the contracting authority look like?
- What should be done to establish and maintain a good working relationship with the private partner throughout the contract period?

5.2.2.1. Mapping stakeholders

Often considered one of the most critical activities throughout the PPC process, from identification all the way to post-award contract management. Unlike short-term procurement, PPC contracts are often incomplete, requiring a deep level of trust and understanding. For that reason, engagement and involvement of all stakeholders is key. A typical PPC will have a wide range of stakeholders (see textbox below). It is recommended that a database be kept of all stakeholders and updated regularly.

5.2.2.2. Involving stakeholders

Successful contract execution will require that stakeholder concerns, views and opinions are captured and addressed. Stakeholders will have varying interests, positions and power, depending on the project. The contract management team (and the authority as a whole) must take these into consideration, and, develop tailored messages to communicate to all and manage expectations.

HOSPITAL COLLABORATION STAKEHOLDERS

- Stakeholders will include various units and departments at the contracting authority (may be county government, parastatal or national ministry of health-MOH), the PPP Node at MOH, county health department, other relevant county departments (e.g. lands, finance, water etc), healthcare professional associations, healthcare regulatory bodies, relevant unions, training institutions, hospital staff, communities living in the area and environment groups among others.
As discussed under in Modules 1 and 2, stakeholder engagement at the contract management phase should be merely a continuation of engagement that happened throughout the PPC process. Inadequate involvement of key stakeholders is a missed opportunity, because these can help to shape the project and improve tracking and performance reporting.

It is good practice to establish mechanisms that allow direct communication and engagement between the contracting authority, the private partner and the end users (trialogue, rather than dialogue between the authority and the private partner only).

Inadequate involvement of stakeholders poses additional risks that may delay or kill the project altogether. Risks may include community members rejecting the project (the ‘not in my backyard’ effect), administrative bottlenecks (for instance, delays in licenses and approvals) or pushback from operational staff (for instance, doctors union objecting to a hospital project).

Various approaches may be used to reach different groups of stakeholders, including individual interviews, focus group discussions and surveys. To manage communication and ensure accurate message conveyance, the authority must work with experienced communications specialists. Refer back to Module 1 for more details on stakeholder engagement.

5.2.2.3. Establishing a clear decision-making structure

Public private collaboration contracts typically specify the turnaround time for key approvals and/or decisions from the contracting authority. An example may be the need to approve, within 14 days, completion of the installation and activation of a health information management system at a healthcare facility that is being operated under a collaborative arrangement. It is therefore important that a decision-making structure is established beforehand to avoid unnecessary delays.

CAUTION

- Any decision-making chains must be well integrated with the contracting authority’s existing internal structures, processes, rules and procedures to avoid conflict. Where additional rules are required, it is important that relevant departments within the authority are consulted.

For some contracting authorities, such structures may already be in existence, for instance, committees established under the procurement phase of the project, or under general management of the organizations. For others, new bodies may need to be formed. One option is taking a ‘committee-based approach’, with the establishment of a ‘Steering Committee’ for high level decisions, and a ‘Management Committee’ for more operational decisions.
5.2.2.4. Establishing good relations with the private partners

This is, perhaps, one of the trickiest areas to maneuver during the contract management phase. On one hand, there is a strong need to encourage the contract management team to develop good relations with the private partner, and, adopt an empathetic attitude across their interactions. On the other hand, close relations may lead to the private partner ‘capturing’ the contract management team, thereby reducing objectivity and integrity of the monitoring process. This then puts the entire project at risk. It is for this reason that clear rules must be defined upfront.

The PPC contract must, as much as possible, define the nature and frequency of interaction, and specify key milestones and activities that should define the agenda of the interactions. Ad hoc meetings arising from unforeseen occurrences must also be guided, for instance, defining occurrences that could trigger an ad hoc meeting, who should be represented, and what kind of decisions may be made at that level (as opposed to those that may need higher level approval).

5.2.3. The operational management tool

The early PPC phases are usually focused on getting to the financial close stage. This happens partly because of the expertise involved, particularly during the preparation and procurement phases (legal experts, financial experts, and at times, construction experts). On the downside, this often results in important aspects being overlooked, including making adequate preparations for the contract management phase. This may cause what is at times called ‘transaction myopia’, where long term benefits (implementation) are lost in favor of short-term targets (sound procurement).

The contracting authority must ensure the following factors are well factored in during the drafting of the contract and at the negotiation stages (Checklist 10). However, actual questions may vary depending on the nature and scale of the project.

Checklist 10: Factors that must be considered early to support contract management

<table>
<thead>
<tr>
<th>Factor for consideration</th>
<th>Y/N</th>
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<tbody>
<tr>
<td>Has the planning, execution and monitoring of the project been considered?</td>
<td></td>
</tr>
<tr>
<td>Have the procedures for appointment of key staff been specified?</td>
<td></td>
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<tr>
<td>Have performance objectives, measurement plans and outputs indicators been specified?</td>
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<tr>
<td>Have the planning, execution and monitoring of maintenance plans been specified?</td>
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<tr>
<td>Have payment mechanisms, performance incentives &amp; continuous improvement measures been specified?</td>
<td></td>
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<tr>
<td>Have plans for the management of refinancing opportunities, including the profit-sharing mechanism, been specified?</td>
<td></td>
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<tr>
<td>Have the information provision requirements been spelt out?</td>
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<tr>
<td>Have protocols for managing minor and major changes been developed?</td>
<td></td>
</tr>
<tr>
<td>Have the provisions for the termination of the contract been specified?</td>
<td></td>
</tr>
<tr>
<td>Have strategies for the prevention and resolution of disputes been specified?</td>
<td></td>
</tr>
</tbody>
</table>
Importantly, the payment mechanisms must be clear and unambiguous, and must be premised on performance-based principles. This is particularly important for health services, where the contracting authority often meets part or the full expense, unlike other sectors, where PPPs may have provisions for service users paying the private company directly. The payment mechanism mustn’t be excessively punitive to the private partners; excessive stringency may put the project at risk and/or encourage falsification of information. It is encouraged that both parties have a say on the performance measures prior to execution. This should be part of the negotiation process. Importantly, the process should have some flexibility in recognition of the incomplete nature of long-term partnership contracts.

Planning for payment schedules to be executed under the contract management phase must also consider the government budget process. For Kenya, the financial year runs from 1st July to 30th June of the following year. The budgeting process is specified under the Public Finance Management Act of 2012, the Public Finance Management Regulations of 2015 and the County Government Act of 2012.

The process carries four key stages: the formulation stage (driven by the national and county executive organs); the approval stage (driven by the legislative organs at national and county levels); the implementation stage (again, driven by the respective executive organs); and the evaluation or audit stage (undertaken by the office of the auditor general). The contracting authority must be aware of the timelines for budgeting, to ensure that commitments made are covered.

5.3. Performing the operational management role

This entails implementing the roles specified in the operation management strategy. Specifically, entails tracking performance to ensure value is delivered consistently, managing project changes (if any), preventing and managing contract disputes, and preparing for the end of the contract in order to ensure that there is continuity of service.

5.3.1. Carrying out regular reviews

Post-award contract management MUST have regular performance reviews. Two key reasons should guide the reviews: first, checking to ensure the private partner is delivering on what was agreed, and secondly, assessing the extent to which the project fits with the changing environment, and in so doing, being well prepared for any requests for renegotiation by the private partner. Another important reason is the need to identify savings (if any), and, asking that the private firm share these. The threshold for sharing arrangements may be specified in the contract to prevent disputes.

Details of the reviews will vary depending on the nature and length of the partnership. For instance, the contract may specify that full technical, financial and legal reviews be done every five years. However, additional assessments may be done as and when the need arises, for instance, following concerns or complaints from the health service users or a major change in the practice environment. The contracting authority may decide to carry out the reviews internally or may opt to get an independent evaluator. Internal capacity is a major determinant in the decision.
5.3.2. Managing project changes

Project changes may be proposed by the contracting authority or the private partner. Regardless, the former must ensure that future changes are guided through the contract. While long-term contracts tend to be incomplete (meaning, they recognize that it is not practical to foresee all scenarios), it is possible for the contracting authority to spell out the processes of managing unforeseen changes.

Any changes to the contract must be agreed, and, must be specified in an updated contract. That way, the contracting authority will always know which one is the latest version of the contract. The authority must check against Kenyan laws before agreeing to any changes. Incremental changes may morph into material changes to the original contract, which may be unlawful. Similarly, any changes must fit within the fiscal space to ensure project continuity. The Debt Management Office and the PPP Unit at Treasury must be involved where changes are material (e.g. have financial implication).

Three factors contribute to seamless project changes: maintaining good relations with the private partner, ensuring close monitoring to have the proper facts, and ensuring that the processes for renegotiation and project change procedures are specified in the primary contract.

5.3.3. Preventing and managing disputes

Collaborations, especially PPPs, tend to be incomplete, as it is never possible to foresee all occurrences over the contract period. Contextual changes may directly impact on the project and its deliverables. This may cause dispute between the partners.

Good relations and trust help to prevent disputes, as does clarity in the contract wording. However, disputes may also arise due to (political) factors external to the parties involved. Such risks must be well factored into the contract to protect the private partner. In addition, the contract must include neutral (formal) dispute resolution mechanisms. These should, ideally, include (in order of severity of disputes) dialogue, dialogue with external mediation, and arbitration and/or court proceedings. It helps to have a ‘give-and-take’ attitude when dealing with disputes.

5.3.4. Managing the closing of the project

A collaboration contract should specify the end date. However, the contract may be terminated prematurely under certain circumstances, which too, must be specified in the contract. Either way, the contracting authority must be well prepared to ensure continuity of services. The authority must ensure there are clear processes for the transfer of skills, materials or any other products.
Summary

Contract management phase

- Contract management covers the period from award to the end of service
- Entails two key components: designing the operational management role, and implementing the operational management role
- Risk management sits at the core of contract management, mainly due to the incomplete nature of PPP contracts and other long-term partnership arrangements
- Successful contract management requires that a technically sound team be formed, and, supported by project governance structure with clear decision protocols
- Implementing contract management entails tracking performance to ensure value is delivered consistently, managing project changes, preventing and managing disputes on the contract, and preparing for the end of the contract in order to ensure continuity of services.

ACTIVITY:

- Read the case titled ‘The Queen Mamohato Memorial Hospital’, and, respond to the questions below.

CASE SYNOPSIS:

- This is a case for the Queen Mamohato memorial Hospital in Lesotho, a public private partnership project running over an initial 18-year period (2008 – 2026). The case carries unique features not characteristic of health PPPs in the sub-Saharan African region, and is meant to both demonstrate to the trainees the process and experiences with projects of that scale, and challenge them to think through alternative pathways and decisions that could have been taken to contribute to a different outcome.

KEY DISCUSSION POINTS:

- Contract management? What were the major contract management challenges reported for the QMMH PPP?
- Averting the challenges: In your opinion, how could the contract management challenges have been averted at the (i) Engagement phase, (ii) project identification phase, (iii) project preparation phase and, (iv) transaction phase
- Market failure: Would you say, in the end, the resources were allocated optimally? If so, why? If not, why not?
- Benefit of hindsight: What would you have done differently if you were involved in the post-award contract management of the QMMH PPP
Appendices (cases)

CASE 1: Stakeholder Engagement in Kenya

Stakeholder Engagement: A Decade of Experiences with Kenyan Regulatory Reforms

Inadequate regulatory enforcement and low compliance caused the Kenyan Ministry of Health (MOH) to seek support from the World Bank Group to initiate a multi-stakeholder engagement process towards delivering reforms. The engagement culminated in the gazettement of the Joint Health Inspection Checklist (JHIC) in 2016 (Exhibit one). The new system sought to completely change health facility regulation, replacing the older command-and-control type of inspections with risk-based audits aimed at encouraging consistent improvement towards better outcomes.

The JHIC was a product of extensive engagement across diverse stakeholders under the leadership of the MOH. Partners included the private sector representative body, the Kenya Healthcare Federation (KHF) and the eight health regulatory agencies, namely, the Clinical Officers Council, Medical Laboratory Technicians and Technologists Board, Medical Practitioners and Dentists Board, Nursing Council of Kenya, Kenya Nutritionists and Dieticians Institute, Pharmacy and Poisons Board, Public Health Officers and Technicians Council, and the Radiation Protection Board. Technical and material support was provided by the World Bank Group.

Following gazettement of the JHIC, more engagement followed, this time, to agree on the best way of implementing the change. The engagement culminated in the signing of a multi-stakeholder pact dubbed the ‘Windsor Agreement’, which provided for the formation of a technical working group (TWG) to design an impact evaluation to test alternative ways of deploying the new system in the country. The evaluation – dubbed the ‘Kenya Patient Safety Impact Evaluation (KePSIE)’ – was to be conducted as part of a process of piloting the JHIC inspections in selected counties.

In the end, it was agreed that the KePSIE pilot be implemented in three counties, Meru, Kakamega and Kilifi. This was done between 2016 and 2018, with over 1,300 public and private healthcare facilities being covered. To date, this remains the largest trial of patient safety in a low or middle-income country. The pilot entailed developing innovative ways of measuring patient safety, and using these to compare the status quo (low inspections frequencies using unclear tools) with two different inspection models; one, intensified risk-based inspections using the JHIC, and two, similar intensified risk-based inspections, but with public disclosure of facility performance data using score cards.

The reforms and evaluation took the better part of a decade, generating important lessons. This case looks at the role of engagement, and lessons learnt, over the period, including how health systems solutions can come from systematic and deliberate collaboration – what is otherwise referred to as public private engagement. Four key lessons are shared hereunder based on the experiences.
Unpacking the reforms from an engagement perspective – the 10-year journey

Starting 2010, the MOH invited health regulatory bodies and private sector representatives to engage and find a solution to the fragmented, inefficient and corrupt facility inspection system in Kenya. The engagement culminated in a major multi-stakeholder workshop in April 2011, at which a decision was reached to combine standards from different regulatory agencies into one tool. A TWG was tasked with the job, which ended with the launch of the JHICv1 in 2012. The Checklist was gazetted under the Medical Practitioners and Dentists Act in 2012.

This marked an important milestone in Kenya. For the first time, the independent regulators would collaborate and combine resources towards ensuring facilities met the minimum safety standards.

The JHIC-v1 was tested for 12 months, at the end of which the stakeholders reconvened to discuss experiences and agree the way forward. The meeting was at the Windsor Hotel in Nairobi in 2013. Key observations included poor framing of questions in the tool, absence of objective scoring criteria causing confusion among inspectors, the absence of a process to guide post-inspection decisions, and lack of clarity on the most effective way of deploying the new system across the country.

The engagement resulted in a decision to revise the JHICv1 in order to improve the items, the scoring and the follow-up action decision support. A pact – the Windsor Agreement (see exhibit) – was signed to among other things, revise the entire checklist, develop objective scoring criteria, and develop a transparent post-inspection decision aide to allow objective follow up action. A second TWG (TWG-2) was formed, with a mandate of also drafting implementation guidelines and proposing an alternative channel for gazettment. Some regulators were unhappy with JHICv1’s gazettement under the Medical Act, saying that they feared the Medical Board had hijacked the process.

The TWG-2 engaged widely, assessing inadequacies in the JHICv1 and developing an improved tool. The result was JHICv2, along with scoring and risk-rating systems to ensure objectivity. Following engagement with legal experts, the JHICv2 was gazetted under the Public Health Act in March 2016. The regulators said they were all happy with the decision. A national stakeholder workshop was held at Windsor (dubbed ‘Windsor II’) to validate the JHICv2 resource guide.

Then came the most important part: how to implement the new system. More engagement led to the decision to roll-out the system via a pilot, and conduct an impact evaluation alongside it. The evaluation would help in deciding the frequency of inspections, who should carry out the inspections (i.e. teams or solo inspectors), whether and how the new risk-based approach would work in guiding inspector decisions, and finally, whether a e-version of the resource guide would increase efficiency.

Stakeholders engaged included counties and the Council of Governors, as well as private sector representatives. Three counties were picked for the pilot, Meru, Kilifi and Kakamega. The pilot would entail doing inspections of varying frequency and displaying performance score cards at facilities in some randomly selected markets.
The evaluation would use a randomized trial design to assess impact. The three counties were selected by the Council of Governors and county health officials.

The pilot - dubbed the Kenya Patient safety Impact Evaluation (KePSIE) was implemented in 2017 and 2018. Facilities inspected using the JHICv2 reported significant improvement in compliance compared to those in the control arm. Early findings were shared through a workshop in 2019, and the decision to support nationwide scale-up ratified (preparations presently ongoing). This marked the end of a decade of learning from continuous engagement. Four key pieces of advice are shared hereunder.

**One: Engage early and engage often**

Health services were devolved under the 2010 Constitution. Popular opinion is that the transfer of the health function was hurried, creating confusion on roles to be played by the two levels of government. While the Constitution provided for a three-year transition, political pressure resulted in most functions being transferred within a year. The confusion affected all key health sector actors, including the development community, who struggled to understand how to engage the two levels.

Unfortunately, this is the time when the regulatory reforms work was starting. Recognizing the confusion, the partnership driving the reforms made a deliberate effort of engage counties, most of who were still in the formative stages. As early as 2012/2013, the MOH’s Department of Standards and Regulation (DSRS ) was in contact with county governments, engaging them through various forums and workshops. The Council of Governors and counties were subsequently involved in the Windsor meeting that ratified the JHICv2, thereby creating ownership early. Yet, the MOH would have been forgiven for not making the effort, considering regulation is mainly a national function.

For the pilot, an intergovernmental, multisectoral engagement platform - the KePSIE Taskforce (KTF) – was formed, drawing membership from the two levels of government and private sector. Besides promoting ownership, KTF contributed to the design and implementation of the pilot. Its vast experience allowed the pilot to build on a detailed understanding of the national and county contexts, which was helpful, given the operational risks posed by the political nature of regulation.

Additional benefits of engagement were seen later in the pilot. For instance, out of 10 officers deployed to do inspections for 12 months in the three pilot counties, five were seconded by county governments. More tellingly, two of the five were seconded by counties other than those benefitting directly from the pilot (Mombasa and Nairobi). Yet the counties paid the staff salaries throughout. In another example, one of the pilot counties (Meru) gave a vehicle for inspections, yet, under the KePSIE partnership agreement, the national MOH was to provide a vehicle for each of the counties. The Meru vehicle replaced one of the MOH vehicles that had developed major mechanical problems.

The goodwill was suggestive of a shared purpose built through continuous engagement. All actors trusted the process, knowing that the pilot would provide evidence to help strengthen patient safety.
**Two: Engage group representation rather than individuals, wherever possible**

A major challenge of public-private engagement is dealing with the fragmented private sector in Kenya. Conservative estimates put the number of private health facilities at over six thousand, and private pharmacies at more than fifteen thousand in Kenya. In the absence of representation organs, it is virtually impossible to meaningfully engage with such large number of providers.

The Kenya Healthcare Federation (KHF) provided a novel solution. The KHF is an association that brings together private sector organizations and groups. While this has improved engagement, inadequacies remain at sub-national level, where the majority of health-related activities happen.

For the regulatory reforms work, counties nominated private sector actors of their choice, who they felt played an important role in their respective counties. Not having a standardized approach caused huge variations in the level of engagement, ranging from strong partners who engaged throughout to relatively disinterested ones who showed up occasionally and had minimal engagement.

Similar challenges exist with respect to community engagement. While counties have made effort to strengthen community engagement, most struggle to sustain this, resulting in what often looks like tokenism, involvement for purposes of rubber-stamping decisions. Proper engagement calls for more than sharing information and asking for a vote; it requires that communities understand issues deeply, and that they are involved in the entire continuum of decision-making and execution.

**Three: Leverage policy champions for higher impact**

Engagement efforts can be frustrating where there is information asymmetry or lack of interest. This is common in technical areas like health. Simplifying messages has been shown to help.

However, experience shows that it may not always be possible to get all groups equally interested. There is bound to variation in the level of interest. Some won’t be bothered regardless of the level of effort to engage. In such instances, policy champions can play an important role.

For the regulatory reforms work, the Medical Practitioners and Dentists Board (MPDB, now Council) and the Nursing Council of Kenya emerged at strong champions from the start. They were more actively involved, especially in mobilizing their counterparts to participate, and providing resources such as meeting rooms. The MPDB allowed the JHICv1 to be gazetted under its Act. In addition, they offered to manage logistics during the KePSIE pilot inspections.

Caution must nonetheless be exercised with champions. They may be viewed suspiciously by others. For instance, the MPDB’s willingness to gazette the JHICv1 was interpreted as an effort to hijack the process and subjugate the other regulators. In response, the TWG gazetted the JHICv2 under a more neutral law. Engagement can contribute to ‘capture’ in certain circumstances, for instance, where one stakeholder is excessively involved or provides the bulk of funding for engagement activities. Public authorities must balance between encouraging engagement and preventing capture.
Four: Provide evidence and information to strengthen engagement

Engagement works most times. However, there will be times when some actors drop off. The key to keeping stakeholders engaged is ensuring is to keep all constituencies interested enough. One way of is through providing additional evidence where needed in order to guide discussions. This is particularly helpful where those engaging have different levels of expertise.

The regulatory reforms processes did just that. As a matter of fact, the entire impact evaluation was predicated on the need to provide evidence to inform stakeholders on the best course of action.

One point where evidence was generated to inform discussions was during the development of JHICv2. One of the core mandates of the TWG was to develop a scoring mechanism for the checklist. Two main options were available to the stakeholders:

- First, an all-or-none scoring model where facilities would either score zero or 100% based on whether they met all criteria under a standard. As an example, a facility that had all five mandatory infection prevention and control supplies would score 5/5, which equals 100%, while another facility that had four of the five criteria (e.g. had water, but no soap etc) would score 0/5 = zero).

- Second, an equal weighted scoring, where individual items under respective sections would have marks equally distributed. For the example above, the facility that had four of the five criteria would score 4/5 or 80%, as opposed to 0/5, as was the case for all-or-none-scoring).

The stakeholders could not agree between the all-or-none and the equal-weighted option. Those favouring the former argued that the JHICv2 carried the very minimum standards for safety, and that facilities needed to meet all criteria under a standard. The latter group argued that such scoring would be punitive, adding that equal weighting would promote gradual improvement.

At that point, a decision was reached to test the two options. A small study was done at 43 facilities in Nairobi and the three neighbouring counties of Machakos, Kiambu and Kajiado. The aim was to understand the implications of applying the two models. The results indicated that adoption of the all-or-none model would result in a recommendation to sanction/close 74% of all facilities, many being public. On the other hand, only 16% would be sanctioned under equal weighted scoring.

Armed with the information, the stakeholder engaged in a more discussion and unanimously adopted the equal-weighted scoring. They felt that it would be politically untenable to sanction 74% of Kenyan facilities. Instead, they preferred that equal weighting be used to show facilities where they were doing well, where they were doing badly, and how they can improve over time. This example demonstrates the value of supporting engagement through evidence-generation.
Conclusion

Implementing major reforms requires strong political support, often achieved through early, continuous and well-informed engagement. Collaboration between the public and private sectors requires deliberate effort towards effective engagement, as opposed to tokenism.

Exhibits

Exhibit 1: The Windsor Agreement

Windsor Agreement

October 9, 2013

Kenya has embarked on an ambitious health inspections reform program to improve patient safety and quality of health care. Since 2012, patient safety has been assessed through the use of the Joint Health Inspections Checklist developed by an inclusive group of public and private stakeholders and implemented by the professional boards and councils. The World Bank Group has continued to facilitate the process and provide technical assistance.

A two-day stakeholder workshop was held in Nairobi on October 8th and 9th 2013 to discuss next steps in improving patient safety in Kenya.

We the undersigned:

1. Reaffirm our commitment to joint health inspections.
2. Renew our commitment to complete this inspections reform process.
3. Agree that there are multiple models through which health inspections can be conducted and that an evaluation will be conducted to provide evidence of the impact of these models on patient safety and quality of health care.
4. Agree that a joint World Bank-IFC team, as a neutral third-party, will conduct the evaluation, while we take full responsibility for the implementation of the different models.
5. Have appointed a Technical Working Group (TWG) led by the Ministry of Health through the Directorate of Health Standards, Quality Assurance and Regulation to spearhead the process and adhere to the attached implementation roadmap (from October 9 – 2013 to December 15, 2015). The TWG members are mandated to act on behalf of their respective agencies.

The World Bank Group agrees:

a. Continue facilitating the inspections reform process and providing technical assistance.
b. Provide funding for evaluating different models of inspections and their impact on patient safety.
c. Complete the design of the models to be evaluated, provide assistance to set up an information system to capture the results of inspections, facilitate the implementation of the models, collect and analyze the data to assess their impact on both patient safety and quality of care.

Signed:

[Signatures of various entities and individuals involved in the project]
Exhibit 2: The Gazette Notice for the JHICv2

SPECIAL ISSUE 1713
Kenya Gazette Supplement No. 31 21st March, 2016

(Legislative Supplement No. 25)

LEGAL NOTICE NO. 46

THE PUBLIC HEALTH ACT
(Cap. 242)

IN EXERCISE of powers conferred by section 153 of the Public Health Act, the Cabinet Secretary for Health makes the following Rules:—

THE PUBLIC HEALTH (CHECKLIST FORMS) RULES, 2016

1. These Rules may be cited as the Public Health (Checklist Forms) Rules, 2016.

2. An authorized person visiting and inspecting any premises under section 153(1) of the Act shall use the checklist Forms provided for—

   (a) in case of facilities with outpatient services, under Form I; and
   
   (b) in case of facilities with in-patient services, under Form II,

   specified in the Schedule to these Rules.

3. An authorized person may send the checklist Forms to the facilities at least two weeks prior to inspection and the facilities shall fill and return the same to the relevant regulatory bodies.

4. The checklist Forms specified in the Schedule to these Rules shall be used for both pre-registration and post-registration purposes.

5. For the purposes of these Rules, “authorized person” means a person authorized by the Director of Medical Services under section 153 (2) of the Act to visit and inspect any premises specified under section 153 (1) of the Act.
Exhibit 3: Comparing all-or-none scoring with equal weighting scoring

Figure 1: Graphs showing facility performance for all-or-none versus equal weighted scoring

Figure 2: Health facility performance based on all-or-none versus equal weighted scoring
AUTHORS’ NOTE: Based on figure two, 74% of inspected facilities would have attained a score of grade D, meaning they would have to face sanctions for poor regulatory performance. On the other hand, only 16% of facilities would face sanctions if equal-weighted scoring were applied. This information enriched stakeholder engagement, allowing them to make a well-informed decision. That resulted in the new Kenyan health facility inspection system adopting the equal-weighted scoring. It would not have been politically feasible to pick an option that required 74% of Kenyan facilities to be shut down.

Exhibit 4: Pictures taken during some of the engagement activities during the regulatory reforms

Photo 1: An engagement panel with MOH, regulators, counties, private sector representation and World Bank team discussing the joint health inspection checklist (Year, 2014).

Photo 2: The Director of Medical Services and representatives for the counties, private sector and World Bank at the official launch of the JHICv2 (Year, 2016).
CASE 2: The Queen Mamohato Memorial Hospital, Lesotho

MASERU, LESOTHO (2020)

Background

Lerato Thabiso sat in her office on the fourth floor of the imposing Moseto Building in the Hlabeng-Sa-Likhama valley of Maseru. She could see Maloti Mountains from a distance, and only just noticed the mild spring drizzle pattering against her office window. Snap! She needed to leave before traffic piled up. The afternoon had been a busy one. She had spent most of it finalizing a report in preparation for a high-level meeting coming up later in the spring.

For the past two months, Lerato had been leading a strategic review of the Queen Mamohato Memorial Hospital (QMMH), a contentious multi-million Dollar hospital network public-private partnership (PPP) project, the first for Lesotho, and indeed, the first of its kind in sub-Saharan Africa. Her assignment was clear - examine the project in detail in order to inform a visiting Kenyan delegation on whether they should consider taking a similar approach with their national referral hospital.

The assignment was exciting. She had learnt a lot, and yet, she still wasn’t quite sure how to answer the one question she was certain would come - is the PPP a success? She could feel the weight of responsibility on her shoulders, knowing that her answers would have some bearing on the decision that the Kenyans would take. And for the umpteenth time, she found herself asking the question: How can one project have so many positives and negatives at the same time?

Her mind wondered back to the edifying experience she had had over the past eight weeks.

The problem

The time was ripe for change. At the time the conversation on a possible PPP started, Lesotho’s health services were in a mess. The Country’s two million inhabitants were fully reliant on the then ageing and dilapidated Queen Elizabeth II Hospital, which had served the country for more than 100 years. By the late 90s and early 2000s, the Country had almost no capacity to provide specialized services. Residents were sent to South Africa for simple procedures, and, often had to meet the costs. And the health indicators reflected that. The second-highest HIV prevalence and the highest TB incidence in the world, along with a 74% HIV/TB co-infection rate. One in nine children died before their fifth birthday. Between 1990 and 2008, Lesotho’s average life expectancy had dropped from 60 to under 48 years.

The government implemented health reforms in early 2000s, including investment in primary health and refurbishing the Queen Elizabeth II Hospital – tripling its budget in the process. Nothing doing. The frustration was evident. The public was restless. New ideas were needed. Badly.

This case was prepared by Dr Francis Wafula as a basis for discussion rather than to illustrate effective or ineffective handling of the Queen Mamohato Memorial Hospital PPP. It’s role is to complement training on public private collaboration in health in Kenya. The case is not intended to serve as an authoritative source of information on the PPP. Information came from a variety of secondary sources, including commissioned reports, publicly available media reports and the Lesotho government line ministry websites (treasury and MOH). No part of this case may be reproduced, stored in a retrieval system, used in a spreadsheet, or transmitted in any form or by any means – electronic, mechanical, photocopying, recording, or otherwise, without permission.
And so, in 2005, the government approached the World Bank Group’s International Finance Corporation (IFC) to advise on whether, and how, a PPP arrangement might help improve the situation. Discussions led to the decision to establish a modern hospital to replace the archaic Queen Elizabeth Hospital, with IFC providing transaction advisory services. Under the contract, a private partner or consortium would deliver a 425-bed capacity referral hospital, supported by primary healthcare facilities, which would altogether form a network to provide service coverage to more than 25% of Lesotho’s population.

The PPP contract was prepared and competitive procurement processes undertaken. Netcare - a South African private hospital network – won the tender. Following the award, Netcare formed a consortium with local firms under the company name ‘Tsepong’. An 18-year design, build, part-finance and operate contract was signed between the Kingdom of Lesotho’s Ministry of Health (MoH) and Tsepong in October of 2008.

The contract

The contract gave Tsepong two and sixteen years for construction and operation respectively. At the start of the project, the scope included building and operating the hospital, building and operating an adjacent gateway clinic, and refurbishing and re-equipping three ‘filter’ clinics in the Qoaling, Mabote and Likotsi suburbs of Maseru. The clinics were to support the referral system and minimize congestion at the main hospital.

It was agreed that capital financing be split between the government (34% and Tsepong 66%). At the ‘Request for Qualification (RFQ’) stage, the projected capital cost had been US$ 36 million. The figure changed following the award of the contract to Tsepong, when more services were added to the contract, including MRI, neonatal ICU, laparoscopy and neurosurgery, as well as the gateway clinic and refurbishment of one additional filter clinic. As a consequence, the capital outlay increased from US$ 36 million to US$ 84 million, a 133% increase. This resulted in the government’s capital contribution increasing from US$ 12.3 million to US$ 28.8 million.

Aside from providing transaction advice, the World Bank gave a grant of US$ 6.25 million to provide bridge funding for the design and operation of the filter clinics between 2009 to 2012.

The other major point for consideration was how to pay Tsepong. Lesotho public hospitals did not levy user charges, except for select services. User fee was, therefore, not a payment option. This also fits in well with the equity goal of health systems globally. The contract proposed an annual unitary fee to Tsepong to cover for costs and a return to debt and equity. At the RFQ stage, the contract specified the annual fee to be US$ 13 million. However, as more services were added after the award, the annual unitary fee shot up to US$ 18.4 million. The contract emphasized that no new user fees were to be introduced, and that any fees collected from chargeable services would go directly to the MoH.
The PPP contract was specific on patient volumes: Tsepong were to treat up to 20,000 inpatients and 310,000 outpatients per year, and, earn an annual unitary fee of US$ 18 million in exchange. Provisions were made for any additional patients. The Hospital would charge US$ 4.1 and US$ 684 for every additional outpatient and inpatient treatment provided respectively. The charges would be levied at the end of each year as a top up on the unitary fee.

A unique addition to the contract was mandatory attainment of international accreditation. The Hospital needed to meet international quality standards or risk contract termination. This requirement is not typical of public hospitals; in sub-Saharan Africa (SSA), patient safety and quality matters are deemphasized in favor of financial inclusion and geographic access.

The operation and performance of facilities

The facilities opened at different times. The three refurbished clinics commenced operations in May 2010. The main hospital and gateway clinic opened officially in October 2011, just over two years from the signing of the contract and commencement of construction.

The Hospital obtained accreditation from the Council for Health Service Accreditation of Southern Africa (COHSASA), a respected authority on matters of patient safety and quality, in 2013. It became the first hospital in Sub-Saharan Africa (outside of South Africa) to obtain COHSASA accreditation, scoring 93%, a figure way above the minimum score of 80%. The Hospital was reaccredited in 2019.

The hospital operated as a multi-specialty facility, providing the general outpatient services, emergency services, inpatient services and specialized services. However, some key services were still unavailable at the start, forcing the Hospital to refer patients to South Africa. Omitted services included transplants, joint replacements, dialysis, planned cardiac surgery, obstetrics and gynecology, plastic surgery, dentistry, chemotherapy and radiotherapy. Some of the services have since been introduced, including obstetrics and gynecology, dentistry, as well as some additional surgical services.

Boston University did an evaluation of the entire hospital and clinics, comparing 2007 baseline data (before the PPP) and 2012 data. The network had expanded service coverage, with a 30% increase in the number of patients served per day. Findings included a 45% increase in deliveries, a 10% reduction in maternal deaths, a 65% drop in pediatric pneumonia deaths and a 20 percent point increase in low birthweight survival. Lesotho’s maternal mortality ration reduced from 1,155 to 1,024 between 2009 and 2014, a drop partly attributed to the QMMH. Improved operations were reported; for instance, availing of selected laboratory results within one hour of the test, and having nearly all patients triaged within five minutes of arriving at facility. Finally, facility cleanliness indicators improved, lowering hospital-acquired infection rates. A complementary economic evaluation reported that in comparison with the previous facilities, the new network was 22% more cost efficient on a per patient basis.
Contract management

PPP contract management capacity is generally low in Lesotho. In 2015, for instance, there were only two full-time officers overseeing outsourced projects, which represented 52% of the government’s health budget. Yet, contract variations are common in PPP contracts due to their incomplete nature.

There were concerns raised over the government’s capacity to manage the contract and ensure value-for-money. Perhaps in recognition of the inadequate contract management capacity, the contract was structured such that whoever won would have to obtain accreditation. Obtaining COHSASA accreditation helped guarantee compliance to international patient safety and quality standards, thereby ensuring Tsepong was, at the very least, causing no harm to the patients. However, service quality is only one aspect of contract management. Less focus went to the other important aspects, including managing and/or responding to demand variations, controlling/managing order variations and controlling/managing government spending in light of limited budgetary allocation.

Increased demand

Improving health facilities and services was always going to trigger increased demand, more so, in Lesotho, where there was already a large unmet demand for hospital care. To guard against excessive use of specialized services, the government partnered with the Millennium Challenge Corp (MCC) to refurbish and improve primary health facilities across the country. Unfortunately, that didn’t happen in good time. That contributed to excessive use of the new hospital network. As late as 2018, peripheral facilities still lacked specialists and vital supplies, despite the MCC-supported infrastructure improvement program being in place.

The result, excessive crowding at the QMMH facilities, especially the Hospital.

The Hospital ended up serving a much larger number of patients, sending a good proportion away without offering complete care. Between 2017 and 2018, for instance, media reports talked of non-emergency patients receiving limited outpatient care (for stabilization) and thereafter being sent to peripheral facilities for further care. Uptake of services previously unavailable to the poor was particularly high. In 2018, for instance, the hospital reported receiving 5-10 botched abortion cases each day. To put this in context, abortion is illegal in Lesotho, forcing those wishing to terminate pregnancies to do so using the black market. Consequently, professional staff time was diverted from more appropriate needs. The five gynecologists employed at QMMH were said to have been spending up to two-thirds of their time doing evacuations. Prior to the PPP, evacuations could not be done in Lesotho, resulting in poor maternal outcomes, particularly among those who could not afford to get the services in South Africa. Such factors were not well factored in at the contract preparation phase.
The PPP contract was specific on patient volumes: Tsepong were to treat up to 20,000 inpatients and 310,000 outpatients per year, and, earn an annual unitary fee of US$ 18 million in exchange. However, by 2015, roughly 27,000 inpatients and 350,000 outpatients were being treated each year. The surge was attributed to weak gate-keeping mechanisms and a strong preference among communities for services offered at the hospital. It was estimated that each year, up to 70% of all cases treated at QMMH had bypassed primary health facilities. Cases that could not be handled at QMMH were referred to South Africa, although there was no clear mechanism on how that should be done.

**Unplanned order variations**

Order variations were a constant feature of the QMMH Network contract. They started prior to the signing of the contract and continued to the contract management phase. Variations included addition of infrastructure and services. Infrastructure variations included addition of one filter clinic and residential facilities for hospital staff. Services previously unavailable were also added, including obstetrics and gynecology, dentistry, blood cross matching, patient transport and neurosurgery among others. All additions triggered unplanned adjustments to the costs of operation and maintenance.

It is worth noting that prior to the PPP, the Kingdom of Lesotho health system did not have the capability of providing specialized services. Patients were referred to Bloemfontein in South Africa. There was a strong need for specialized services at the country’s main referral hospital. However, concerns were raised over the manner in which additional services were added over time, and whether such post hoc adjustments could deliver value for money.

**Budgetary strain on the government**

The QMMH network has been consuming roughly one-third of the national budget for health. Between 2012 and 2015, the network consumed an average of 35% of the country’s health budget. This was within the upper limit of 37% stipulated in the PPP contract guided by historical spending (35-37% of health budget was spent on comparable services between 1995-2005, a decade before the PPP).

While the unitary fee continued rising through to 2019, the amount represented a drop in the percent of the entire health budget. For instance, in the 2018/19 budget, the network consumed US$ 50.4 million of the US$ 180 million health budget, equating to 28% of the national allocation.

Besides expanded services and demand, there have been concerns raised over what has been termed as ‘unclear inflation adjustments’ by the Tsepong Company. The argument is that increased demand and range of services cannot on their own, explain the ten-year rise in the unitary fee. The fee rose from US$ 18,429,591 agreed at signing to US$ 50,400,173 allocated for 2019, a 173% increase. Inflation-adjustment problems have mainly been as a result of disagreement on the base price to use (Lesotho did not have a medical inflation indicator, forcing them to use South Africa’s).
A quick check through the financing structure revealed that Tsepong was funded through corporate financing arrangements with the Development Bank of Southern Africa (DBSA), levying an annual interest of between 11.65% and 13.10%. Lerato found this disturbing, especially when compared to the government’s borrowing rate of 0.6%.

“Was it really wise to enter into a PPP funded through corporate financing at such a high interest rates, when the government could have borrowed at as low as 0.6% to do the same work?”, Lerato had asked herself. No wonder penalties for delayed government payments to Tsepong were staggering!

She was thinking of the additional interest levied by Tsepong due to massive delays in government paying the unitary fee as per the contract. While Tsepong had deferred earlier penalties, the problem was far from over. This appeared to be a problem that was not going away soon.

It is the continued increase in the payments to Tsepong that had triggered public unrest in recent years. For instance, members of the public complained of lack of qualified personnel in 2017 protests, prompting the Hospital management to respond. In their response, they pointed out that QMMH employed nearly 45% of all doctors in the country (84 doctors and 24 specialists), and that it remained the only facility to have attained COHSASA accreditation. The management noted that they were serving 30% more clients than projected, and that although that had overstretched the facility, they posted good healthcare outcomes.

The decision

And suddenly, it was all very clear. Lerato knew exactly how she was going to approach the discussions with the Kenyan delegation. Or rather, she knew how she was going to turn this around to allow for a more open and frank conversation on the real benefits and dangers of undertaking such a project. They needed to know. It wasn’t just a matter of ‘yes, let’s do it’, or ‘No, let’s pull the plug’.

She was smiling to herself when locked the heavy mahogany office door and walked towards the lifts.
Exhibit 1: Capital and operations costs for the QMMH Network

Capital expenditure (CAPEX)

<table>
<thead>
<tr>
<th>Item</th>
<th>% share</th>
<th>Projected cost (US$)</th>
<th>Actual spend (US$)</th>
<th>Variance (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project capital</td>
<td>100</td>
<td>36,051,625.93</td>
<td>84,000,288.41</td>
<td>47,948,662.48</td>
</tr>
<tr>
<td>Public contribution</td>
<td>34</td>
<td>12,257,552.82</td>
<td>28,841,300.74</td>
<td>16,583,747.93</td>
</tr>
<tr>
<td>Private contribution</td>
<td>66</td>
<td>23,794,073.11</td>
<td>55,158,987.67</td>
<td>31,364,914.56</td>
</tr>
</tbody>
</table>

Operating expenditure (OPEX) – incurred as a unitary fee

<table>
<thead>
<tr>
<th>Operating costs (unitary fee)</th>
<th>Value (US$)</th>
<th>Variance from pre-contract value of US$ 13,007,427 (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contract signing unitary fee (2011)</td>
<td>13,007,427</td>
<td>0</td>
</tr>
<tr>
<td>Post contract signing unitary fee (2011)</td>
<td>18,429,591</td>
<td>5,422,164.54</td>
</tr>
<tr>
<td>Year 2013/14 unitary fee</td>
<td>31,682,169</td>
<td>18,674,742.23</td>
</tr>
<tr>
<td>Year 2018/19 unitary fee</td>
<td>50,400,173</td>
<td>37,392,746.41</td>
</tr>
</tbody>
</table>

Exhibit 2: Selected performance indicators for the QMMH (data from multiple sources)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reported change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient volume</td>
<td>30% increase in patients served per day</td>
</tr>
<tr>
<td>Triage</td>
<td>Over 90% patients triaged within 5 minutes of arriving at the facility</td>
</tr>
<tr>
<td>Deliveries</td>
<td>45% increase in deliveries</td>
</tr>
<tr>
<td>Pediatric pneumonia</td>
<td>65% reduction in pediatric pneumonia deaths</td>
</tr>
<tr>
<td>Low-birth weight</td>
<td>20 percentage point improvement in survival of low-birth weight babies</td>
</tr>
<tr>
<td>Maternal deaths</td>
<td>10% reduction in facility maternal deaths</td>
</tr>
<tr>
<td>Mortality rate</td>
<td>41% reduction in health facility deaths</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>22% increase in satisfaction scores</td>
</tr>
<tr>
<td>Operations cost</td>
<td>22% reduction in per patient cost</td>
</tr>
<tr>
<td>Accreditation</td>
<td>93% assessment score attained to obtain COHSASA accreditation (80% was the minimum score needed for accreditation). First hospital in Africa outside of South Africa to get the accreditation. Hospital got re-accredited after 4 years.</td>
</tr>
</tbody>
</table>
Exhibit 3: Queen Mamohato Memorial Hospital
Bibliography


Southern Africa Development Community (2012) SADC PPP Studies: Lesotho New Referral Hospital


World Bank Group (2013) Implementation completion and results report on a grant in the amount of $6.25 million to the Kingdom of Lesotho for a new hospital PPP project

World Bank (2018) Public Expenditure Review for the Kingdom of Lesotho: Improving expenditure efficiency for inclusive development and growth

Additional data sources

Kingdom of Lesotho Ministry of Finance Website accessed March 2020

Tsepong Hospital social media pages

Various Lesotho electronic and print media sources reporting on Tsepong between years 2008 and 2020.
References


