Reforming health systems: the role of NGOs in Decentralization – lessons from Kenya and Ethiopia

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Abstract
In an attempt to improve health sector performance, many countries across the developing world such as Chile, Colombia, Ethiopia, Ghana, Kenya, the Philippines, Tanzania, Thailand, Uganda, and Zambia have pursued a variety of health sector reforms, including decentralization. In Ethiopia and Kenya, decentralization has been touted as the key management strategy in the countries' health policies of the last two decades. One of the components the strategy seeks to address in both countries is the participation of the non-governmental organizations in helping the government to achieve stated national health objectives. Within the framework of decentralization, the extent to which the strategy has been implemented can be seen as an indicator of progress towards the health goals. The fact is that, in both Ethiopia and Kenya, health challenges are daunting. This study proposes that decentralization provides a unique opportunity for the participation of NGOs in providing health services, and that failure to integrate nonprofit players and weak inter-sectoral collaboration can hinder overall progress towards decentralization and the realization of improved health performance.

I. Introduction

Developing countries in Africa and elsewhere face severe challenges in improving health sector performance. The challenges are connected to access, efficiency and quality, calling for system reforms in the macro-organization, distribution and financing (World Bank, 1987; WHO, 2000). Since the World Health Organization (WHO) proposed decentralization as a way to empower communities to take ownership and control of their own health in 1978 (WHO, 1978), the strategy has been variously pursued in both developed and developing countries as a key management approach on the belief that it enhances efficiency in public sector performance (Milner, 1980; Saltman and Figueras, 1997).

Decentralization is regarded as the transfer of decision-making power and administrative responsibility from the central government to the periphery (Milner, 1980; Rondinelli, 1989; Bossert, 1998). According to Bossert (1998), the transfer of powers involves a range of responsibilities covering fiscal allocation, public planning, service delivery and systems management. Rooted in administrative science, decentralization has been promoted for its perceived technical, political and fiscal benefits in development planning (Conyers, 1983; World Bank, 1987, 1994; Litvack, Ahmad and Bird, 1998). By its very nature decentralization provides an excellent framework for NGOs and local communities to legitimately participate in local governance, planning and service delivery (World Bank, 1993; Grant, 2000; Kloos and Mariam, 2000). Hence, decentralizing health systems is of central interest to NGOs in many countries where they

are major players in services delivery as is the case in many African countries (Gilson et al, 1994).

Ethiopia and Kenya have pursued decentralization as a governance strategy in an effort to improve resource allocation and regional development. Both countries have significant nonprofit health actors. In such a context, decentralization cannot achieve the health goals if it ignored the participation of NGOs. This study assesses the nature of the implementation strategies in the two countries and the extent to which they have systematically accommodated or overlooked the nonprofit sector. The study will use empirical and documentary material from both countries obtained from field consultations held in June and July 2006. The study will utilize Thomas Bossert's (1998) innovative decision-space analytic model. The model provides for the analysis of decentralization as an expression of the breadth of space the lower-level entities have to make decisions over a range of health system functions. The paper also draws insights from public administration science, policy analysis and implementation studies (Rondinelli, 1981; Pressman and Wildavsky, 1984; Ostrom et al, 2002).

Literature on Decentralization in Developing Countries

"Decentralized delivery is based on the simple concept of getting resources to where they are needed" (World Bank, 2000: 127). A neoliberalist concept, decentralization has been promoted in administrative science over the last three decades for its perceived technical, political and fiscal benefits in development planning (Rondinelli, 1981; Conyers, 1983; Litvack, Ahmad and Bird, 1998; Ostrom et al, 2002; Hadington and Wilson, 2003). Furthermore, it is not only seen as an administrative/managerial exercise but part of the democratization process, hence the characterization of decentralization as an administrative and political tool for reform (Crook, 1994; World Bank, 2000; Sarker, 2006; Dauda, 2006). The most commonly used definition of decentralization is the transfer of decision-making power and administrative responsibility from the central government to the periphery (Milner, 1980; Rondinelli, 1990; Bossert, 1998). The range of decision-making powers involved covers fiscal allocation, public planning, service delivery and systems management. In his early work, Dennis Rondinelli (1981) offered a typology of four approaches to the location of authority under decentralization, which is the standard adopted by many authors in the health sector such as Mills et al (1990), Mills (1994), Saltman and Figueras (1997), Bossert and Beauvais (2002) and Management Sciences for Health (2002).

These typologies are: 1) deconcentration; 2) devolution; 3) delegation; and (4) privatization. Deconcentration is the transfer of decision-making authority to a lower *administrative* level while, in contradistinction, devolution refers to transferring decision-making to a lower *political* level. Delegation is when duties are allocated to a lower level (semi)-*autonomous* organization. While these relate to the allocation of power between different levels of government, privatization occurs with transfer of *ownership* into private hands. As discussed in major literature (Collins and Green, 1993; Mills, 1994; Smith, 1997; Bosert and Cbeauvais, 2002; Management Sciences for Health, 2002), the key objectives and benefits of decentralization in the healthcare sector can be summarized under three pillars. Firstly, decentralization can nurture dynamism in the delivery system allowing for a mix of private-public providers and services. Secondly, it

promotes pluralism by allowing civil society participation in the decision-making process and hence improves governance and accountability. Thirdly, it can enhance localized innovations and adaptations for resource mobilization and cost-consciousness in tackling local health problems. Cutting across these pillars is the assumption that decentralization can promote equity and efficiency.

Based on such assumptions, decentralization has been strongly promoted in developing countries (Conyers, 1983; Mills, 1994; World Bank, 1997, 1994, 1987), although largely without systematic empirical evidence as to its efficacy in improving health outcomes (Collins, Green and Hunter, 1994; Roberts et al, 2003). A number of studies have shown little success of decentralization in attaining its defined goals or the overall health objectives in countries such as Zambia and Uganda (Jeppsson and Okuonzi, 2000), in causing disparities in service delivery in some East Asia countries (Campos and Hellman, 2005) and in worsening macro-economic instability in Latin America (Dilliner and Perry, 1999). One study, however, finds that the strategy can reduce infant mortality rate, to a larger degree, in low-income countries because decentralization increases the level of technical and allocative efficiency (Robalino, Picazo and Voetberg, 2001).

Research on decentralization in Ethiopia and Kenya is scanty. In the most extensive survey on fiscal, political and administrative decentralization in some 30 African countries, Ndegwa (2002) found uneven progress across the continent. Furthermore, on all the measures these countries lag far behind developed as well as developing countries in Asia and Latin America. Computed on the basis of the country having direct elections and participation in such elections, the study found that Ethiopia and Kenya scored equally among the most politically decentralized countries in the sub-continent. Using an index measuring clarity of legal framework defining roles and responsibilities for the different levels of government as well as the extent of delegation, the two countries scored moderately for administrative decentralization. On the third measure of fiscal decentralization, Ndegwa used the existence of an established formula for transfers and proportion of the public expenditures at the local level and found Kenya to be more moderately decentralized than Ethiopia where local government controls 3% of expenditures and 1.5%, respectively (ibid.).

Other studies in Ethiopia find the level of local government control of resources much higher (above 20%) (Defega, 2003) and a much deepened administrative decentralization at regional and *woreda* (district) level (Eldon and Waddington, 2007; Hadingham and Wilson, 2003). In another assessment of fiscal decentralization, Wamai (2008) found that regional governments are receiving higher transfers for recurrent health spending while at the same time increasing their revenue generation. A number of other studies on decentralization of health services in Kenya showed mixed results. The only survey of its kind, undertaken by Owino and Munga (1997) in 37 hospitals comparing decentralized and centralized zones, found that although the policy enhances facilities' effectiveness in capturing revenue, it has only a limited long-term impact in financial management. Although district-level decentralization has been a long-standing policy (Republic of Kenya (henceforth, ROK), 1994), a government assessment observed legal, institutional and managerial weaknesses as major obstacles (ROK, 1999). Oyaya and Rifkin (2003) and Wamai (2004; 2007) have also remarked that decentralization largely failed due to these factors as well as weak political will.

II. Decentralization Experiences and NGO participation in Ethiopia and Kenya

Ethiopia

Context of health reforms and decentralization

Ethiopia is one of the least developed countries in the world with low development indicators even by sub-Saharan Africa standards. 85% of the country's population of 70 million lives in the rural areas, 44% living below the national poverty line (Federal Democratic Republic of Ethiopia (henceforth FDRE), 2002: 8). National average health coverage is 64% but utilization per capita is only 0.36 (Federal Ministry of Health (henceforth FMOH), 2005: x). Following over 20 years of dictatorship under the Dergue regime, in the early 1990s a new democratic government took power and set a new environment for health policy. The new Constitution set a federal system of government comprising nine autonomous largely ethnically distinct regions and two administrative councils, which were further sub-divided into sixty two zones and 523 *woredas* (districts) (FDRE, 1998). In 1993 the government published the first health policy in 50 years setting the vision for developing the healthcare sector for the next 20 years (FDRE, 1993). Some of the aspects of this policy focus on radical reforms in the system including decentralization, expanding the primary health care system, and encouraging partnerships and the participation of private and NGO actors.

To translate the policy for implementation, the first Health Sector Development Program (HSDP-I) was launched in 1997/98. In addition, a healthcare and financing strategy was developed in the same year. Covering the first five years (1997/98–2001/02), HSDP-I put disease prevention at the centre of the sector development. The policy aimed at reorganizing the health services delivery system under decentralization. By and large, the targets set in HSDP-I were not met and a modified HSDP-II (2002/03 – 2004/05) was developed with the inclusion of NGOs in the implementation of the health package. Ethiopia is now in its third HSDP-III developed in 2005 to cover the years 2005/06-2009/10. HSDP-III stresses the strategic role of NGOs as partners in both planning and implementing healthcare delivery especially at district level and also emphasizes the need to strengthen government-NGOs collaboration (FMOH, 2005a). Decentralization and collaboration with NGOs were also strongly emphasized in the country's poverty and social economic development framework namely, the Sustainable Development and Poverty Reduction Program (SPDRP) in 2002 (FDRE, 2002).

The healthcare system in Ethiopia is characterized by some of the lowest health expenditures and poor health indicators by regional and world standards. In coverage, the healthcare system reaches only about 61 % of the population according to the *Health and Health Related Indicators* (2002/03) (FMOH, 2005b). The physician to population ratio of 29,000 is well below the WHO standard of 1:10,000. Hence, about 40% of the population does not have access to any modern health service facility. At 871 per 100,000 live births, the maternal mortality rate (MMR) is one of the highest in the world. At the same time, infant mortality rate is 96.8 per 1,000 live births, which is higher than the sub-Saharan average of 93/1,000.

Table 1: Demographic and health system indicators in Ethiopia

Region	Population	Health facilities*	Health personnel**		Health Expend per capita (Bir)
			Physicians	All others	
Tigray	4,223,014	487	77	5892	18.2
Afar	1,358,718	118	17	587	20.6
Amhara	18,626,047	1909	131	4964	9
Oromia	25,817,132	2670	186	7174	6.9
Somali	4,218,297	220	55	1132	8.3
Ben-Gumz	609,509	153	14	515	34.2
SNNPR	14,489,705	1866	106	4905	6.8
Gambella	240,394	73	6	324	49.9
Hareri	189,550	54	41	382	85.4
Addis A	2,887,615	616	161	1208	23.8
Dire Dawa	383,529	70	30	323	42.3
National	**73,043,510**	**8,236**	**2,453**	**45,860**	**16.8**

Source: Ethiopia Federal Ministry of Health (2005a: 29).
Notes: * Includes all hospitals, health centers, health stations, health posts and private clinics
** Includes physicians and all cadres of nurses.

Decentralization in Ethiopia entails the devolution of administrative powers and responsibilities as well as fiscal devolution up to the woreda level. Fiscal transfers of unconditional federal grants are enshrined in Article 62 of the Ethiopian Constitution. Since fiscal year 1995, block grants have been disbursed using a formula devised by the Federal Ministry of Finance and Economic Development (MOFED). Although the formula has undergone various revisions over the years, the latest being in 2007, it has maintained a core of weighted variables based on population size, level of development and level of revenue generation (FDRE, 2007). In the distinct system, MOFED allocates annual budgets downwards to regional Bureaus of Finance and Economic Development (BOFED) using this formula. In turn the BOFEDs allocate annual budgets to regional line ministries institutions and block grants to the woredas on regional equity criteria. The Woreda Councils, the highest office comprising elected officials in the woreda, is responsible for allocating budgets to the various sectors based on annual reports and work plans (Eldon and Waddington, 2007). A second wave of decentralization initiated in 2002 in the largest four regions (Amhara, Oromiya, Tigray and the SNNP) aimed at enabling woredas to take primary responsibility for the delivery of basic services with block grants being given directly to woredas starting June (African Development Fund, 2006). The highly decentralized system enables planning to occur institutionally at every administrative level with broad participation of citizens directly and through electoral representation (Hadingham and Wilson, 2003).

The role of NGOs in the health reforms and decentralization

According to Ethiopia's Ministry of Justice (MoJ), which is responsible for the registration of NGOs, there are over 3,700 local and international NGOs operating in the country. NGOs make a significant contribution to Ethiopia's health sector. The NGO healthcare system comprises over 300 health institutions in the country constituting 7%

of the 8,236 health facilities, most of which are at the primary level. They provide financing and general (curative, preventive and rehabilitative) healthcare services, HIV/AIDS and reproductive health services in clinics and through health education. According to one source citing a household welfare survey on health utilization, 3.3% of respondents reported using NGO services (Kebede, 2004). The second National Health Account reported that in 2000 the Ethiopian health NGO community contributed 10% of the national health expenditure (FMOH, 2003). A larger portion of fees paid for health services is spent in non-MOH facilities and, as one study found, cost-recovery in NGO facilities is 70% (FDRE, 1998: 7).

The decentralized structure of government requires that project implementation by NGOs is vetted through the government bureaucratic machinery. NGOs must sign tripartite agreements with the regional Disaster Prevention and Preparedness Bureaus (DPPBs) (an inter-ministerial agency), the regional Bureaus of Planning and Economic Development (BoPEDs) under the Ministry of Finance and Economic Development, and the Regional Health Bureaus (RHBs) under the Federal Ministry of Health to outline project modalities and responsibilities for the signatories (Kebede, 2004). The DPPB/BoPED and RHBs are responsible for appraising project documents before project approval and also to monitor on-going projects. NGOs are required to submit quarterly progress reports during project implementation to the DPPB/BoPED, zonal and woreda health offices. Mid-term and end-of-project evaluations are mandated to be jointly undertaken by a team comprising of representatives from the NGO, DPPB, and RHBs.

Although NGOs are expected to report their activities to the regional health authorities where they work, the reporting appears to be only haphazard. This makes accurate data hard to find. Reported data is coded and entered into the national health management information system (HMIS), where it becomes difficult to disaggregate. Two assessments of the major achievements/outputs of this study could locate were commissioned by Christian Relief and Development Association (CRDA), an umbrella agency of over about NGOs. According to one of the reports by Development Studies Association (2004), during 1997–2001, there were 360 projects implemented by NGOs in six of the country's eleven regions, of which those supported by local NGOs (223) exceeded those supported by international NGOs (137). Local NGOs were responsible for the implementation of the larger share of the health (including water, not disaggregated in this analysis) expenditure throughout the period (53%).

Table 2: Contribution of NGOs to Ethiopia's health sector (2004)

Outputs	Unit	Local	International	Total
Health facilities				
• Health Posts	#	221	445	666
• Clinics	#	11	72	83
• Hospitals built/rehabilitated	#	1	20	21
Health personnel*				
• Doctors				578
• Nurses				914
Health Care/Services				
• Health education given	Persons	5,668	8,260	13,928
• Health service (outpatient)	Persons	48,710	106,947	155,657
Financing (%) **				10

Source: Development Studies Association (2004).
Notes: *Field data acquired from the MOH; ** FMOH (2003).

Decentralization in Ethiopia has opened up important avenues for health NGOs to participate in the health sector reform program. At the local district level, the woreda is the central unit coordinating planning, budgeting and implementing programs and projects. The National Capacity Building Program (NCBP) launched by the federal government in 2001 has targeted woreda governments to strengthen their implementation of block grants which have been awarded directly to them since 2002. Following publication of the NCBP, the Ministry of Capacity Building, established to oversee this program, developed a consultative document for the involvement of civil society organizations (CSOs) in the government's poverty reduction program (the SPDRP) (FDRE, 2004). NGOs and the myriad of CSOs are mandated to participate in the three pillars established under these programs, namely, democratization, delivery of services, and decentralization. The Civil Society Capacity Building Program (CSCBP), as it was called, aimed at, among other things, streamlining registration and coordination, increasing resources for CSOs, enhancing engagement with government, establishing a Civil Society Capacity Building Partnership Fund, and building CSOs capacity for service delivery and engagement with the public (ibid.). The SPDRP (2002: ix) emphasized the role of NGOs in decentralization thus:

> "[Fiscal empowerment] is a fundamental shift in the history of Ethiopia, which mandates communities through their elected councils to plan, allocate budget and implement to address their socio-economic problems. This is a key process that will unlock the energies of communities to face the challenge of poverty at its root. They will be provided with budget grant to make their own empowerment effective and complement their local resources, which for sure they will mobilize to address their own problems, by themselves."

Hadingham and Wilson (2003) have detailed the planning process at the woreda level highlighting the involvement of NGOs at the various stages. A typical planning process begins with the lower level institutions collecting information on priority needs, which is fed into the woredas development plans. NGOs are active in facilitating the first step at the *mengistawi buden* (a hamlet of 30-60 households). At second higher institutional level, the sub-*kebele* or village, NGOs assists the planning woreda

government team comprised of three persons and grassroot representatives which includes farmers, teachers and household heads. Consolidation of information is done at the *kebele* (a peasant association comprised of several villages in which officers are elected at the ballot) which is then given to the woreda (comprising 20-30 kebeles). A model woreda institutional structure typically has offices for rural development, finance and economic development, social affairs, administration and justice, and capacity building office in which health (and education) belongs.

This planning process opens up significant space for NGO participation in woredas where the institutional mechanisms are weak and in strengthening those with existing mechanisms. As Hadingham and Wilson (ibid. 20) point out, "NGOs are often involved in providing support to these consultations, either by facilitating the consultations themselves in collaboration with the DAs [development agents] or by providing training to the DAs in PRA [participatory rural appraisal] and other participatory approaches." This is in line with the mandate provided by the SPDRP and the CSCBP. The extent to which NGOs can participate in this process is also detailed in the CSCBP. Under the heading "how deep is participation?" for instance, it is mentioned that CSOs would be informed of availability of resources, be consulted about allocation of such resources, share in decision making on the resource allocation and be jointly involved in exercising control of the resources (FDRE, 2004: 9).

Kenya

Context of health reforms and decentralization

Emerging from colonial rule in 1965, the independent government set *Sessional Paper No. 10 on African Socialism and its Application to Kenya* which encumbered the government to the eradication and control of diseases and provision of equal access to health for the whole population. As the first step undertaken with the first Development Plan, a free access policy abolished the Ksh 5 co-payment operative in the colonial healthcare system until 1965. The policy proposed expanding coverage through centralizing the delivery responsibilities from the counties and municipalities to the Ministry of Health. Although centralization achieved harmonization of the system, it did not eliminate regional disparities nor reach everyone (Mwabu, 1995).

To improve government performance, the *District Focus for Rural Development* (DFRD), a sweeping cross-governmental/sector decentralization program of which health is part, was announced in 1983. Three years later in 1986, and following the 1978 WHO framework for Primary Health Care for all by Year 2000, the government published the *National Guidelines for the Implementation of Primary Health Care in Kenya* which focused on "decentralization, community participation, and inter-sectoral collaboration" (Oyaya and Rifkin, 2003: 115). The introduction of user charges in 1992 in an effort to inject money into the crumbling health facilities was a major set back in access to services (Mwabu, 1995; Collins et al, 1996). In 1994, the ongoing reform agenda was detailed in the most recent comprehensive *Kenya Health Policy Framework Paper* (1994-2010). The policy explicitly stated the underlying vision for health developments and reforms as to provide "quality health care that is acceptable, affordable and accessible to all" (ROK, 1999). To instrumentalize the health policy, the *National Health Sector Strategic Plan (NHSSP) 1999-2004* was developed belatedly in 1999 and an improved

second NHSSP for 2005-2010 was released in September 2005 (ROK, 1999; 2005). Table 3 below shows recent health indicators across the country's eight provinces.

Table 3: Distribution of health facilities and hospital beds by province (2002)

	Hospitals	Health Centers	Health sub-centers & dispensaries	Hospital beds and cots	
				Number	No./ 100,000 pop
Nairobi	56	53	376	4,891	21.2
Central	63	86	368	8,191	22.4
Coast	64	40	331	7,687	30.6
Eastern	63	79	689	7,412	15.3
North Eastern	7	11	65	1,707	14
Nyanza	97	114	328	11,922	23.1
Rift Valley	98	159	1,002	12,390	16.2
Western	66	92	192	6,457	19.1
Total	514	634	3,351	60,657	19.2

Source: MOH (2005)

In order to achieve the health goals, the government identified decentralization as the "key management strategy" in the reform of the health sector (Ministry of Health, 2000). The Ministry of Health (2000: 12) articulated decentralization as the "delegation of power and transfer of responsibility for planning, management, resource allocation and decision making from central level to periphery level". Continuing solidification of these aspirations, Kenya has also developed a sector-wide approach called the Health SWAp and a Joint Program of Work and Funding (JPWF) (ROK, 2006). The SWAp represents a paradigm shift from government, NGOs and private providers as 'sectors' to one where health is one holistic sector regardless of actors. The JPWF is a consensus document formulated by all stakeholders to set their project activities under a common framework that reflects the goals of the NHSSP.

Despite the reforms of the past decades, with over half of the country's population living on less than one dollar a day and lacking an insurance coverage for all, out-pocket spending has increased from 49% of total health expenditure in 1994 (ROK, 1999b) to 53.1% in 2000 and wide disparities exist in access across rural and urban areas (ROK, undated). For example, over 50% of the country's 5,000 doctors work in only a few major towns (Wang'ombe et al, 1998: 4). Reforms of the system organization have focused on decentralizing all aspects of health management and decision-making to the 71 districts established through the DFRD framework. Although the concept of decentralization has been in existence since the 1980s, development of district-based health management systems is evident only in the 1990s. The main district-level decision-making organ, the District Health Management Board (DHMB) was established in all districts in 1992 through an amendment to the *Public Health Act* (ROK, 1999). The DHMB oversees and coordinates all the lower levels of the public system.

The role of NGOs in the health reforms and decentralization

By one account, in 2003 there were over 2,600 national and international NGOs working in over 25 fields (Wamai, 2004). NGOs in Kenya operate under the 1990 legal framework known as the Non-Governmental Organizations Coordination Act. The

governmental administration is the NGO Bureau under the Office of the President. NGOs also have their umbrella agency called the NGO Council, which was mandated under the Act. The organizational scope of NGOs working in the healthcare is not widely documented and only a few studies have been done (Berman et al, 1995; Wang'ombe et al, 1998; Wamai, 2004). Reports of the national Health Management Information System (HMIS) and the National Health Accounts are pitifully infrequent and incomprehensive on data. However, the available data indicate that NGOs play a major role in providing health services to Kenyans.

Wamai (2004) gives the most extensive available account of the role of health NGOs in Kenya. Estimates of the number of NGOs providing health and medical services, both curative and preventive, vary from 14% to 50% (Wamai, 2004: 192). The scope of the NGO health system is captured in table 4 below. As shown, NGOs run 20% of the country's health facilities NGOs. These NGO facilities are spread around the country, and in some regions provide the best services. Evidence for this can be attributed to the reimbursement trends by the National Hospital Insurance Fund (NHIF) for services provided to premium holders. Accordingly, although the NGO NHIF-accredited system is significantly smaller than that of government and the private sectors in terms of number of institutions (only 15.2%) and bed capacity (18.5%), it received the largest share of reimbursements over a five year period, 1998-2003 of 29% (Wamai, 2004: 203-4). This suggests that more and more people have been utilizing the NGO system and that it has been rapidly expanding. In fact, in the 1990s the number of NGO (and private) providers increased by 36% while that of government grew by only 12% during 1994-1999 (Berman et al, 1995; ROK, 2001). In a study assessing the capacity for NGO (and private) providers in services provision during a major strike by public health nurses between July 1997 and February 1998, Wang'ombe et al (1998) found an increase in the outpatient utilization of these facilities by 8-80% in 79% of the facilities studied. Data from the 1994 *Welfare Monitoring Survey* show a high variation of 72% private (includes NGOs) utilization in urban areas compared with only 25% in the public sector (Wang'ombe et al, ibid. 3).

Table 4: Contribution of NGOs to Kenya's health sector

Outputs	No.	% of national share
Health facilities		
• Hospitals	67	30.7
• Health centers	100	17.4
• Dispensaries	595	23.6
• Nursing & Maternity homes	11	5.8
• Health clinics and medical centers	72	10.2
Total	**845**	**20**
Health Care/Services		
• Hospital beds	-	36
• Outpatient treatment	-	51
Financing*		8

Source: Wamai (2004: 201)
Notes: * Data is for period of implementation of the NHSSP-II, 2005-2010 (Republic of Kenya, 2006: 46)

In terms of healthcare financing, some reports suggest that NGOs provide up to 40% of the total estimated cost of providing health services in Kenya (ROK, 2006: 18). The first National Health Accounts (NHA) of 1994 estimated that NGOs provide 30% of the national promotive/preventive health spending (Republic of Kenya, 1999b). However, the latest (second) NHA covering 2001-2002 indicates that domestic and international NGOs contribute only 0.6% of the country's total health expenditure (THE) (ROK, undated). However, NHSSP-II estimates NGOs will contribute 8% of the financial requirement to implement the plan during 2005-2010 (ROK, 2006: 46).

The health reform process sought to involve NGOs in various ways. The *Kenya Health Policy Framework Paper* (KHPFP) emphasized a clear departure from the public healthcare system organization model by seeking to involve membership representation from NGOs at the highest level of policy making – the Central Board of Health – established in 1921 under the *Public Health Act* Cap 242 to steer the country's health development. In addition, the KHPFP sought to transfer the provision of curative services to the NGO/private sector (Oyaya and Rifkin, 2003: 115). Consequently, this objective was articulated in the first NHSSP as to "encourage the provision of essential and discretionary health services by the private sector and NGOs in underserved areas" and committed the government to "engage dialogue with the private/NGO health providers for them to take up more discretionary health packages (mainly curative)" (ROK, 1999: 11, 63).

In this framework, in addition to proposing to offer material and financial resources, the government also committed to decentralize "the licensure and certification process as well as enforcement of rules and regulations by the provinces" (ROK, 1996: viii). Since 2000, NGO/private healthcare providers have been required to obtain a certificate of registration and license from the Medical Practitioners and Dentists Board (MPDB), a specialized agency of the MOH and watchdog on all health NGO/private operators. This process has however been historically also done by the local authority in the domain of NGO/private operations: an NGO/private operator working in various locations has to secure a local license from each local authority under the criteria prevailing in the area. Recognizing the important role NGOs have in healthcare provision, then Vice President and Minister for Home Affairs observed in 2002 during the Second Conference on NGO Partnerships for Reproductive Health in Africa:

> "The importance of good governance and leadership of NGOs cannot be overemphasized. NGOs must strive to collaborate with relevant departments of government by playing roles both complementary and supplementary. Mechanisms of collaboration between NGOs, the ministries of health and other partners need to be inbuilt in all reproductive health programs. In countries where the NGO/government collaboration is strong, the impact of the activities is greater and more sustainable" (*Daily Nation*, April 30, 2002).

Early progress in realizing the KHPFP proposals for NGOs participation was in the establishment in 1997 of the Donor and NGO Coordination Division (DNCD) and the Health Sector Reform Secretariat (HSRS) in the Ministry of Health. While HSRS was successfully institutionalized in the MOH and is operational, initial steps to create an office with personnel for the DNCD failed to achieve sustainability and that organ is no longer working. In spite of this, NGOs have been involved in the development of the national health sector strategies. For instance, NGOs were represented in the Ministerial

Task Force (MTF) that had been established to steer the health reform process. The main NGO health agencies which run almost all the NGO health service system in the country – the Kenya Catholic Secretariat (KCS) and the Christian Health Association of Kenya (CHAK) – sit in top policy making agencies in the Ministry of Health. Following publication of the first NHSSP, Decentralization Action Plan (DAP) was developed in a workshop where key stakeholders including NGOs convened by the Ministry of Health identified nine priority areas for implementation, one of which is strengthening NGO-government partnerships (Wamai, 2007).

Implementation of the DAP has been slow as there is as yet no system or formally legislated structure in place governing NGO-government interactions and that supports NGOs involvement in reforms and decentralization. The most evident (but only in districts where this has taken shape) feature of the decentralization process at the district level through which NGOs are involved is the District Health Stakeholder Forum (DHSF). This institutional dynamic is meant to bring together all health actors in the districts to address health concerns and to act as a forum for participatory planning. Although the structure is working in some districts, there is no uniformity and it faces resource constrains (Wamai, 2007; Oyaya and Rifkin, 2003). There have been some efforts to strengthen this structure and NGO service delivery and collaborations at the districts mainly supported by foreign funding such as the World Bank, the Swedish International Development Cooperation Agency (SIDA), and the European Commission (Wamai, 2007).

The European Commission funded project titled District Health Services and Systems Development Program (2006-2008) was specifically designed to strengthen decentralization and participation of NGOs. Its aims were: to support integrated system of government and NGOs service delivery in selected districts in two provinces; to strengthen the collaboration between donors, NGOs and the Ministry of Health at all levels from national, provincial to district level; and to put in place transparent and accountable financing mechanisms for the government, NGOs and community based organizations (based on field consultations). According to field information, the project outlined a development budget of €9.5 million (roughly US$ 14 million) as grants to the districts and NGOs of which three large NGOs received significant amounts to implement reproductive health services. Evaluation of the projects performance meant to be conducted in 2007 was delayed but high turnover of local project managers severely affected implementation timelines and continuity.

In recent efforts to consolidate their synergies, health NGOs in 2006, have taken some steps to organize themselves nationally and have created the Health NGOs Network (HENNET) that aims to stimulate and cultivate greater collaborations with the government. The Network is also lobbying government to recommence financing them directly as had been the case in parts of the 1970s and 1980s and early 1990s (Wamai, 2004).

III. Discussion and Conclusion

This study has assessed the level of NGOs participation in the decentralizing health sector in Ethiopia and Kenya. Historically, analysis of health sector development in Africa, as in most other social sectors, has focused primarily on the state action and

instruments typically ignoring the participation of non-governmental nonprofit actors. This attention to the state has long justified the expectation that government is, and must be, the central player in developing social and health policy on the continent. As a result, while NGOs are mentioned in policy documents as participants in the policy development process and as partners in realizing the plans and objectives, such mention is usually not evidenced in implementation. In other words, as demonstrated in the Ethiopia and Kenya country studies, meaningful structures for collaborations and partnerships that can facilitate achievement of national health sector objectives seem to be absent.

Decentralization in Kenya began more than a decade earlier than Ethiopia and the two countries differ in the extent of the exercise. However, neither in Kenya nor in Ethiopia have the promises of decentralization been achieved. The high reliance on foreign aid for health sector financing in both countries – 16% in both countries in 2000 – and high levels of poverty have meant that the health developments and reforms have been implemented under conditions of economic and donor-dependency constraints (Oyaya and Rifkin, 2003). While the situation seems better for Kenya, with only 6% of the share of funding needed to implement the health sector strategic plan (NHSSP-II 2005-2010) (ROK, 2006: 46), it is more challenging for Ethiopia. A World Bank study simulating different scenarios to meet the MDGs on health in Ethiopia shows that unprecedented levels of aid flow would be needed (Sundberg, Lofgren and Bourguignon, 2005). In fact, to implement HSDP-III (2005-2010) in Ethiopia, the share of external funding needed is 55.3% against the government's 34.9% (FMOH, 2005a).

The participation of NGOs in the decentralizing health sector in Ethiopia and Kenya can best be evaluated at three levels: (1) the level of engagement in the health sector in terms of their role in service provision; (2) the level of engagement with government in terms of planning, policy making and resources; and (3) the level of engagement with communities in helping them identify and represent their needs and priorities in a participatory health planning process. A summary discussion is organized along these themes.

Level of NGOs engagement in service provision in the health sector

From the data presented in tables 2 and 4, it is clear that NGOs play a significant role in providing health services in both Ethiopia and Kenya as measured by the number of health facilities NGOs run, the utilization of NGO services and financing. However, the role of NGOs is larger in Kenya than in Ethiopia. These differences may be explained by a number of historical, political and socio-economic factors. For instance, nearly all the NGO health services in Kenya are religious-based which emanates from the history of 'missionary' colonization in the country which is largely absent in Ethiopia. One major reason is that Ethiopia was under a socialist political regime for a long time that repressed NGOs; the unprecedented humanitarian emergency programs launched by NGOs and other aid agencies during the mid 1980s famine in Ethiopia helped open the space for NGOs as alternative channels to development intervention (Barrow and Jennings, 2001). In addition, Ethiopia comparatively has an overall smaller healthcare sector. Regardless of these differences, it is clear that health NGOs in both countries attract a large share of out-of-pocket (and, in Kenya, insurance) spending in terms of fees paid for services, as in many other African countries (Gilson et al, 1994). Given their large participation, it is

clear NGOs cannot be ignored in efforts to decentralize the healthcare system. In stead, decentralization should seek to ensure their full participation.

Level of NGO engagement with government in planning, policy making and resources

The level of NGO-government engagement is heavily influenced by the prevailing political climate. In Ethiopia, though NGOs have developed self-regulation mechanisms, relations remain suspicious (Development Studies Association, 2004; Gizaw, 2008) whereas in Kenya they have improved markedly after a crisis in the early 1990s during the drafting of the NGO legislation (Ndegwa, 1996; Wamai, 2004). The result for Ethiopian NGOs is that they have limited participation in formulating health policy at the national level as a study on NGOs participation in the HSDP finds (Kebede, 2004). On the other hand, in Kenya, NGOs have been more heavily involved in the process of planning the national health strategic plans as well as the HIV/AIDS policy and strategy (Wamai, 2004). Overall, both countries' health policies and strategic plans clearly take into account NGOs contribution in service provision and financing and spell the importance of their participation. Still, NGOs seem to be more strongly involved with the government in the planning process at the lower levels, which is one of the most important benefits of decentralization. At the woreda level, Ethiopian NGOs engage the local government planners in representing the communities (Hadingham and Wilson, 2003). In Kenya, NGOs are involved in district-level planning through the more formal mechanism of District Health Stakeholders Forum (DHSF) (Wamai, 2004), although the impact of this process is limited to the few districts with an active DHSF (Wamai, 2007).

There have been a number of efforts to strengthen the role of NGOs in this role in both countries, at least on paper. Governments in both countries have taken steps to incorporate NGOs in decentralization. In Ethiopia, the Ministry of Capacity Building has been proactive in developing the civil society capacity building program. In Kenya, the Decentralization Action Plan (DAP) sponsored by the Ministry of Health in 2000 included NGOs in its design. In addition, the Kenya health SWAp and the JPWF are unprecedented frameworks that incorporate NGOs in the national program of health reforms and development. While involving NGOs and strengthening their role in a decentralized healthcare system seem to be part of the health policy and overall strategy in Ethiopia and Kenya, formalization of relationships with the government remains largely nuanced.

According to Tom Bossert's (1998) 'decision space' model, decentralization demands that roles and responsibilities of the various levels in the center and the periphery be well defined. Although this was already done in both countries for the government levels, lack of capacity and resources together with possible lack of political will remain key challenges. On the other hand, clarity on the roles and responsibilities for NGOs has not been clearly established: for example, responsibility for NGOs to deliver specified services for a specified geographical area or population group under the decentralized structure. One result in Ethiopia is a case where drugs imported for free delivery went to waste due to disagreements between NGOs and the government (Dejene, 2003: 4). Likewise, no formal or legal structures have been established whereby NGOs have a mandate to secure government financing; in Kenya a discussion is ongoing. Lacking much government support, NGO health services rely on user-fees and donations

in both countries (FDRE, 1998; Wamai, 2004). This is in contrast with other countries in the continent such as Malawi and Ghana where salaries of all staff of health services run by churches is covered by the government (Gilson et al, 1994: 16). Nevertheless, it is known that in Kenya NGO health providers do get a secondment of staff from the Ministry of Health (Wamai, 2004: 209). However, this process is still centralized as staff can only be authorized at the MOH headquarters.

Level of NGOs engagement with the community

As already discussed, NGOs are involved in delivering health services to communities in both countries. Here we discuss their engagement with communities in the decentralized planning processes. Official international development cooperation has long legitimized the participation of NGOs in a people-to-people led local development approach (Overseas Development Institute, 1995; Fowler, 1998). In addition, poverty reduction programs that are conditionality for foreign aid – such as the World Bank's aid facility the Poverty Reduction Strategy Paper and the UN Millennium Development Goals – demand participation of NGOs. Within this context, decentralized governance offers an appropriate framework for the participation of NGOs and local communities and provides formal institutional legitimacy for this engagement (Grant, 2000). Decentralization is a pro-poor policy because it can stimulate bottom-up participation providing opportunities for local communities to participate in governance (World Bank, 2000: 77). However, for this process to occur it has to be demand-driven and NGOs can play an important role in organizing, capacity-building and channeling this demand. Such civic education and capacity building, however, is not a task exclusive to health NGOs but can be done by NGOs working in other sectors.

In both countries, NGOs help communities to participate in the planning processes such as in the Poverty Reduction Strategy Papers cycles. The woreda planning process in Ethiopia follows a series of stages wherein NGOs are involved especially at the lowest levels, the *mengistawi buden* and sub-*kebele*. The NGOs become a vital link between the households and communities and the government team (Hadingham and Wilson, 2003: 17-20) whereby community inputs are channeled at least in part through NGOs. In Kenya, the District Health Stakeholders Forum (DHSF) mechanism is the most direct way in which communities can work with NGOs to ensure their voices are heard in the district planning process. While the DHSF meetings are open to anyone working in the health field, NGOs are represented in the various committees making up the formal DHSFs (Wamai, 2007). In the Forum NGOs can act as voices of the communities in which they serve. Even so, the extent to which this is the case in practice is arguable since health services-oriented NGOs may often be looking only after their own turf (Grant, 2000).

Importantly, a comparative advantage of NGOs is that they often provide health services in rural and marginalized areas. However, such services if dependent on user fees may be unsustainable. As such, it is imperative that NGOs engage with the local communities at the grassroots in order to give them voice through meaningful representation and in seeking ways to solve their health challenges.

Conclusion

Decentralization has been a cornerstone of state transformation and service delivery in Ethiopia and Kenya as in many other developing countries. In both countries, decentralization is a framework of shifting national development from the state to a shared responsibility with the civil society and the private sector. This is clear in both Ethiopia's SPDRP and Kenya's Health Policy Framework. The most effective entry level for NGO interventions is at the community level. The participation of NGOs demanded by the health and poverty agenda at national – and international levels such as the Millennium Development Goals – requires decentralized governance. A decentralized service delivery model provides an excellent avenue for NGOs to be more actively and directly involved. Importantly, where decentralization is institutionalized in the legal and policy structures of a country, it legitimates government-NGO collaboration and engenders democratic governance in addressing health and poverty challenges. This, however, does not mean that such collaborations then become automatic or easy as shown by these country cases.

Several observations can be made on the quality and capability of NGOs in Ethiopia and Kenya that limits their impact on decentralization. The most important of these is the lack of legal or policy mandate coupled by a lack of government funding to the NGO sector. This may result in the various levels of government (central, regional and local) to see NGOs not as equal partners even while acknowledging their importance. As a result, both sides may be reluctant to engage in collaboration if there is no mutual trust and real or perceived benefits. Furthermore, this renders such collaborations at best temporary and thus without guarantees in a climate of ever changing personnel and policies. In addition, because NGO health facilities depend on user fees for income, they are mostly geographically concentrated in urban areas – and primarily the capital cities of Addis Ababa in Ethiopia and Nairobi in Kenya – and the relatively developed areas, to attract revenue. Thus marginalized and poor rural areas may not have substantial NGO representation to participate in district level systems decentralization.

Furthermore, in spite of their apparent passion for, and commitment to, local communities and social development, NGOs, even within the same sector are hardly united or organized into strong alliances. This can pose serious challenges to true representation and having an active and strong voice for the community. Because of the multiplicity of the stakeholders, to achieve the desired results coordination among the stakeholders is imperative (Moore et al, 1998). Yet the lack of collective efforts and political influence from aid agencies reduces their impact and role in improving health (Bate and Tren, undated) and on decentralization. Overall, besides duplication of efforts leading to wastage of scarce resources, lack of meaningful collaboration among NGOs and between government and NGOs inhibits the overall progress towards decentralization and the realization of improved health performance.

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