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| **Title**  Individual consultant toassess the feasibility of implementing a community-based health insurance (CBHI) in Garissa County as well as of the overall mainstreaming of NHIF membership within the NSNP. | | **Funding Code**  **SC190666** | | **Type of engagement**  Consultant  Individual Contractor | | | **Duty Station:**  Garissa and Nairobi | |
| **Purpose of Activity/Assignment:**  In the framework of the Gates foundation-sponsored “*UNICEF Country and Regional Levers to Scale and Replicate a basic package of RMNCH, social protection and Nutrition via Primary Health Systems in Eastern and Southern Africa and in West Central Africa”*, UNICEF Kenya is exploring the implementation of a Community-based Health Insurance (CBHI) in Garissa county, targeting pregnant and lactating women and focusing on Maternal, Newborn and Child Health (MNCH), as well as considering mainstreaming of the National Hospital Insurance Fund membership in the National Safety Net Programme.  The goal of this assignment is to assess the feasibility of the CBHI pilot in Garissa county, and to explore the mainstreaming of NHIF membership among beneficiaries of the NSNP. The assessment will take into account multiple aspects, notably the overall willingness and ability of community members to contribute to the CBHI and the specific health needs of pregnant and lactating women enrolled in the NSNP, in a view to ensure the CBHI enjoys broad community support and involvement, as well as to inform the benefit packages to be devised. Moreover, the consultant will be required to map relevant stakeholders, propose a design for the CBHI in close collaboration with the most relevant stakeholders, validate the design with the County Government and community representatives, as well as devise an implementation plan. | | | | | | | | |
| **Scope of Work: (see end note below)**   1. **Background and Justification**   The Constitution of Kenya guarantees all Kenyans to the right to life and the highest attainable standard of health – including quality health care services, reproductive health, emergency care, water and sanitation, food security and healthy environment. The Bill of Rights further states that equitable health care is a right to every Kenyan, including children. Further, Kenya Vision 2030 includes the attainment of a Universal Health Coverage (UHC) under the government “Big Four” agenda and the new Kenya Health Sector Strategic Plan 2018-2023 recognizes UHC as a priority. All this is in line with SDG 3 that sets multiple ambitious targets on health care provision, and also contributes to SDGs 1 and 10 on zero poverty and reduced inequalities.  Kenya has made significant progress towards achieving these commendable and ambitious goals, but further efforts are required to improve health outcomes and guarantee to each Kenyan a long and healthy life. Life expectancy was 61 years in 2017, while under-5 mortality rate was 49 per 1,000 live births in 2016 – this is a reduction from the 56/1,000 live births registered in 2013[[1]](#footnote-1), that is also linked to the introduction of maternal and child health programmes such as Linda Mama and Beyond Zero, but still represent a significant number. Immunization coverage in Kenya in 2016 was 84 per cent for DPT and 86 per for polio[[2]](#footnote-2), while skilled birth attendance was at 62 per cent in 2013[[3]](#footnote-3).  The country has a mixed health financing system, including revenues collected by national and county governments through taxes and donor funding, member contributions of the National Hospital Insurance Fund (NHIF) and of private health insurance companies, and out-of-pocket spending by citizens at points of care. Also, it is worth noting that after the 2010 devolution reform most health functions belong to the counties.  The provision of social health insurance is one of the three pillars of Kenya’s 2012 National Social Protection Policy (NSPP), together with social assistance and social security. The NHIF, housed at the Ministry of Health (MoH), works on a contributory scheme and is the primary public health insurance in Kenya. For formal sector workers membership of the NHIF is compulsory and contribution is income-rated, while enrolment is voluntary for self-employed and informal workers, who pay a flat rate.  However, health insurance coverage is quite low. Around 15% of the Kenyan population benefits from some form of health insurance[[4]](#footnote-4) - almost 90% of them under NHIF[[5]](#footnote-5) - and the others most likely covered by private schemes. Around 80% of Kenyans work in the informal sector[[6]](#footnote-6) and the optional NHIF membership remain unaffordable for many of them[[7]](#footnote-7). Furthermore, the fund only provides coverage for medical expenses excluding other indirect costs people may incur when sick, such as transport and loss of work – meaning that even those who are covered may bear significant, and something devastating, costs as a result of illness.  Most citizens in Kenya – and notably the most vulnerable, that are the targeted beneficiaries of the National Safety Net Program (NSNP) – still face substantial challenges, and bear significant costs, when seeking healthcare. Out-of-pocket payments represent a high burden for many households, and especially for those in the lowest quintiles of the income distribution, who spend on average 10-15% of their budget for healthcare[[8]](#footnote-8). This results in catastrophic and impoverishing effects on families when a house member, and notably the breadwinner, falls sick. Evidence suggests that after accounting for out-of-pocket payments, the proportion of poor people increases by 2.2 percentage points in both rural and urban areas, meaning that between 1 and 1.1 million individuals are pushed into poverty due health-related expenses[[9]](#footnote-9).  To ensure access to healthcare for the most vulnerable, the NHIF initiated the Health Insurance Subsidy Program (HISP), that provides a fully subsidized health insurance to beneficiaries of the NSNP, enrolling them in a quite comprehensive scheme called Supa Cover. However, due to funding constraints, HISP could not be extended to all NSNP beneficiaries and to date covers only around 181,000 CT-OVC and 42,000 among OPCT and PwSD across the 47 counties.  Challenges in accessing health services are exacerbated by the recent Covid-19 outbreak in the country. Declared a global pandemic by the WHO, Covid-19 is rapidly spreading across all African countries, including Kenya. The disease is likely to have disastrous effects on people’s lives and the social fabric, and to substantially slow down the country’s economic growth. First, the epidemics has disruptive effects on people who fall sick, their families, and on the whole health system which may be overwhelmed and unable to respond effectively. Also, a very high number of affected people and the closure of most economic activities to prevent the spread cause a broad an acute disruption of income-generating activities. This poses serious challenges to the majority of the population and disproportionately affect informal workers and those with unstable jobs, low incomes and few savings that risk remaining with insufficient resources to sustain themselves.  ***Community-based health insurance (CBHI)***  Community-based health insurance (CBHI) is considered as an effective means to provide financial protection against the cost of illness and improving access to quality health services for those excluded from formal health insurance schemes. International evidence generally shows that CBHI has a positive impact on utilisation rates of health services and moderate positive effects on improving financial protection, with Rwanda and Ghana being the two countries in Sub-Saharan Africa that explored CBHI to the greater extent[[10]](#footnote-10).  It has also been observed that the poorest households risk to remain excluded as they cannot afford to pay premiums and, when looking at CBHIs in relation to the realization of the UHC, that they tend to stay small in size and to be quite fragmented. However, an appropriate design of CBHIs and additional government measures to cater for the most vulnerable – such as social protection interventions – and to integrate CBHIs into national systems greatly mitigate these risks.  Importantly, CBHIs tend to enhance community empowerment, can help build trust and familiarize people with the concept of insurance[[11]](#footnote-11). This also highlights that CBHIs rely on existing social capital within communities, and particularly on the solidarity and trust that let community members put together their resources for common use[[12]](#footnote-12).  UNICEF Kenya’s current country program (starting July 2018 up to June 2023) is aligned with Vision 2030 and supports the transition towards a UHC in multiple ways. In the framework of the Gates foundation-sponsored “*UNICEF Country and Regional Levers to Scale and Replicate a basic package of RMNCH, social protection and Nutrition via Primary Health Systems in Eastern and Southern Africa and in West Central Africa”*, UNICEF Kenya is exploring the implementation of a CBHI in Garissa county, targeting pregnant and lactating women and focusing on Maternal, Newborn and Child Health (MNCH), as well as consider mainstreaming of NHIF membership in the NSNP.  ***Garissa County: Snapshot of health and poverty situation***  Garissa County is located in North Eastern Kenya and has a population estimate of 868,256 in 2017[[13]](#footnote-13). Garissa is among the poorest counties in Kenya, with a 65% poverty rate, vis à vis a national average of 36%. Looking at child poverty, 129,435 children, or 66%, are multidimensionally poor, compared to an average 45% in Kenya[[14]](#footnote-14) (Figure 1). This also means that a relatively high share of the Garissa population benefits from the cash transfer programmes comprised in the NSPS (Figure 2), and overall 11,609 households are registered as beneficiaries of the NSNP[[15]](#footnote-15). Programmes currently implemented in Garissa include the Cash Transfer for Orphans and Vulnerable Children (CT-OVC), the Older Persons Cash Transfer (OPCT), the Cash Transfer for People with Severe Disabilities (PwSD-CT), the presidential bursary for orphans, the Hunger Safety Net Programme (HSNP), Food for Assets and Cash for Work.  Community-based organizations and community structures play a vital role in multiple aspects of life in Garissa. For instance, land is often community-owned, there are various cooperative societies, including SACCOs, as well as women groups and youth groups, and several local NGOs working at community level are active in the county[[16]](#footnote-16). Community structures are involved in the health sector through the Community Units, but also play an important role in other fields, ranging from security to management of natural resources.  Coverage and outcomes of key MNCH and nutrition indicators in Garissa perform below national averages. Maternal mortality rate is estimated is 646/100,000 live births as compared to the national average of 488/100,000 making Garissa one of the 15 highest burden counties contributing to over 60% of the national total of maternal deaths[[17]](#footnote-17). Newborn mortality rate (24/1000 live births) is above the national average (22/1000), and skilled delivery coverage and the rate of pregnant women getting the four recommended key Anti Natal Care (ANC) visits are below national values[[18]](#footnote-18). Also, Garissa county has one of the highest fertility rates in the country (5.9 compared to a 4.6 national average).  Among its activities in key social sectors, including social protection and health, and with the specific goal of improving health outcomes and financial protection, UNICEF is supporting the modelling of an innovative package including Primary Health Care (PHC) for MNCH, nutrition and social protection interventions in Garissa. The proposed approach for the PHC pilot is to use cash top ups to enable vulnerable pregnant and lactating women – that could be identified among the existing beneficiaries of the NSNP – to access MNCH and Baby Friendly Community Initiative (BFCI) services. An innovative model of CBHI shall be devised for this purpose, and cash top up will be used to pay the insurance premium. The top-ups and MNCH and BFCI services will work jointly and reinforce each other in improving health outcomes and addressing financial constraints vulnerable households may otherwise face in accessing membership of a CBHI.  The above links to the possibility of mainstreaming NHIF membership in the NSNP and to the mentioned HISP. Also, the envisioned approach entails that in the long term the CBHI will be absorbed or linked to NHIF.  To ensure effectiveness and relevance, UNICEF is seeking the support of a highly qualified individual consultant to conduct a feasibility assessment of the proposed CBHI, as well as towards the mainstreaming of the NHIF membership in the NSNP.   |  |  | | --- | --- | | Source: Kenya Social Protection Sector Review 2017  Figure 1: Map of Kenya indicating indicating poverty rates and numbers of people living in poverty by county in 2016 | Figure 2: Proportion of the population in each county in receipt of a social assistance transfer,2015/16    Source: Kenya Social Protection Sector Review 2017 | | | | | | | | | |
| 1. **Goal and Objectives**   The goal of this consultancy is to assess the feasibility of the CBHI pilot in Garissa county, and to explore the mainstreaming of NHIF membership among beneficiaries of the NSNP. The assessment will take into account multiple aspects, notably the overall willingness and ability of community members to contribute to the CBHI and the specific health needs of pregnant and lactating women enrolled in the NSNP, in a view to ensure the CBHI enjoys broad community support and involvement, as well as to inform the benefit packages to be devised. The scope of the assignment also includes the design of a proposed CBHI and the formulation of a feasible implementation, both to be developed in close collaboration with the Garissa County Government and the community representatives and to be validated with relevant stakeholders.   1. **RWP areas and UNDAF outputs covered**   This assignment contributes to UNDAF *Strategic Result Area (SRA) 1 Human Capital Development* and *SRA 2 Transformative Governance*, and particularly to *Outcome 1.2: By 2022 people in Kenya access high quality services at devolved level that are well coordinated, integrated, transparent, equitably resourced and accountable* and *Outcome 2.6: By 2022, marginalized and vulnerable people have increased access to and utilize social protection, and services for prevention and response to gender based violence and violence against children.*  The consultancy also contributes to UNICEF Country Programme Document ***Outcome 4*** *(Social inclusion): An increased number of children from the poorest & most vulnerable households benefit from shock-responsive & integrated social protection interventions, as well as from child-specific policies,* and more specifically ***Output 4.1****: Social service demand is strengthened through modelling of evidence-based linkages between social protection and social/economic sectors (including health, nutrition, protection, energy, and HIV) in select counties*, as well as to ***Outcome 1*** *(Reduced Mortality & Stunting): Increased proportions of vulnerable children, pregnant and lactating women, including adolescent girls, have equitable access to and use quality WASH, Nutrition, Health, and HIV/AIDS services to reduce their risk of mortality, preventable diseases, stunting and other forms of malnutrition, and improve their birth outcomes*.  **Activities and Tasks**  Specifically, the key task for the consultant will be:   1. **Conduct feasibility assessment of the CBHI**   The assessment will look at the feasibility of introducing a CBHI in Garissa. The analysis will take into account community-specific dynamics and will entail broad and in-depth consultations and interviews with stakeholders. These will encompass community members and community structures and organizations – notably other possible solidarity-based ones – as well as health providers, relevant institutions and stakeholders. The analysis will look at the willingness and commitment the community has towards establishing a CBHI, at the existing social capital and at the level of risk aversion of potential members, to provide suggestions on the key features that could make a CBHI likely to succeed. Moreover, the assessment will determine the main health needs of the pilot target group (i.e. pregnant and lactating women that benefit from the NSNP), in order to identify actual demand-side and non-medical barriers (e.g. transport costs) that constraint access to essential health services. The identified constraints will help inform the future benefit package the CBHI could offer to its members and that would need to include non-medical costs. The analysis will also include a desk review of national and international relevant practices. It will keep into account that in the long-term the CBHI should be absorbed – or at least closely linked – to the NHIF.   1. **Draft the design of the CBHI and map the relevant stakeholders**   Based on the feasibility assessment and on the inputs gathered from stakeholders, the consultant will draft the design features of the CBHI, possibly providing few options and highlighting their risks and advantages. The consultant will also undertake a mapping of relevant stakeholders, whose contributions will help inform the design.  The feasibility study and the design will need to be validated by the community and the Garissa county government in a dedicated workshop.   1. **Devise a plan of action for the implementation of the CBHI**   The consultant will prepare a plan of action for the implementation of the CBHI, that specifies milestones, timelines, actors involved and key actions, highlighting risks and mitigation measures as well. The plan should also foresee dissemination activities and ensure the introduction of the CBHI maintains a community-based and participatory approach throughout its phases.   1. **Work relationships**   The consultant will be responsible for the production and finalization of the deliverables and will work under UNICEF administrative and technical supervision, in close collaboration with the Garissa county government. The consultant will engage with the main health and social protection stakeholders in Garissa, and particularly with local players and relevant community structures and organizations.  The consultant will report to the Social Policy (Social Protection) Specialist in UNICEF KCO and will work in close collaboration with the Social Protection and Health teams in both UNICEF KCO and Garissa Zonal Office (ZO).  It should be also noted that:  • Payment is on satisfactory completion of deliverables duly authorized by the Supervisor of contract.  • Specific deliverables of acceptable quality must be submitted at the planned times.  • Performance will be evaluated considering quality of deliverables, consultation with stakeholders, timeliness of deliverables of and comprehensiveness of work as defined in the terms of reference.  • The consultant is expected to carry out the design process in accordance with professional communication development standards | | | | | | | | |
| **Budget Year:**  **2020** | **Requesting Section/Issuing Office:** | | | **Reasons why consultancy cannot be done by staff:** | | | | |
|  | Social Policy Section, UNICEF KCO | | | Conducting a feasibility study, as well as designing a CBHI and formulating an implementation plan are highly technical activities, that require specialized knowledge of social protection, health systems – and particularly financing and insurance schemes – as well as community-based approaches. Moreover, conducting all the activities in a short time span and producing high quality outputs represent a significant workload. | | | | |
| **Included in Annual/Rolling Workplan***:* X Yes  No, please justify: | | | | | | | | |
| **Consultant sourcing:**  National  International  Both  **Consultant selection method:**  Competitive Selection (Roster)  Competitive Selection (Advertisement/Desk Review/Interview) | | | | | | **Request for:**  X New SSA  Extension/ Amendment | | |
| **If Extension, Justification for extension:** NA | | | | | |  | | |
| **Supervisor:**  **Dr Lisa-Marie Ouedraogo-Wasi** | | | **Start Date:**  15th July 2020 | | **End Date:**  15th December 2020 | | | **Number of Days (working)**  35 |
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| **Work Assignment Overview** | | | |
| Tasks/Milestone: | Deliverables/Outputs: | Timeline | Estimate Budget |
| Inception Report including Desk Review (5 days) | | 31 July | 20% |
| Draft Feasibility Questionnaire and Assessment Tools (5 days) | | 31 August | 15% |
| Draft Feasibility Study including Plan of Action for the Implementation (15 days) | | 15 October | 25% |
| Validation Workshop with the Community and the Government of Garissa (5 days) | | 30 October | 10% |
| Final Feasibility Study as approved by the Government of Garissa, inclusive of an endorsed Plan of Action (5 days) | | 15 December | 30% |
| **Estimated Consultancy fee** |  |  |  |
| Travel International (if applicable) | NA |  |  |
| Travel Local (please include travel plan) |  |  |  |
| DSA (if applicable) |  |  |  |
| **Total estimated consultancy costs[[19]](#endnote-1)** |  |  |  |
| **Minimum Qualifications required:** | **Knowledge/Expertise/Skills required:** | | |
| Bachelors X Masters  PhD  Other  Enter Disciplines  Including but not limited to Public Health, Economics, Health Economics, Public Policy, or other | The consultant should have:   * A Master’s degree or equivalent in Public Health, Economics, Social Sciences or similar, a PhD in Health Financing would be an asset * Minimum of 5-8 years of relevant experience in health care financing and social protection in sub-Saharan Africa, especially in cash programming and community engagement and coordination * Experience working in ASAL areas, especially in Kenya and extensively understand the contexts of the target counties * The consultant should be familiar with the local context in the targeted county and should be fluent in Kiswahili. Knowledge of any other relevant local languages will be considered as an advantage * Experience working with national and county/district governments * Demonstrated ability for coordination of a complex group of stakeholders and government representatives * Demonstrated qualitative and quantitative data collection and analytical writing skills, excellent report writing skills * Proven ability to: (i) handle multiple tasks under pressure with short deadlines; (ii) ability to work independently, seeking guidance on complex issues; and (iii) excellent interpersonal skills, proven team orientation and the ability to work across unit boundaries. | | |
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| **Administrative details:**  Visa assistance required:  Transportation arranged by the office: | Home Based  Office Based:  If office based, seating arrangement identified:  IT and Communication equipment required:  Internet access required: | | |
| **Request Authorised by Section Head** | **Request Verified by HR:** | | |
| Lisa-Marie Ouedraogo-Wasi, Chief of Social Policy (OiC) | Alexandra Gusarova, Human Ressources Manager | | |
| *Approval of Deputy Representative, Programmes (if Programme)*  Jean Lokenga, Deputy Representative Programmes  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Representative (in case of single sourcing/or if not listed in Annual Workplan)*    *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | |
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1. Kenya National Bureau of Statistics (2017), Statistical Abstract [↑](#footnote-ref-1)
2. Kenya National Bureau of Statistics (2018), Economic Survey [↑](#footnote-ref-2)
3. Kenya National Bureau of Statistics (2014), Kenya Demographic and Health Survey [↑](#footnote-ref-3)
4. Kenya National Bureau of Statistics (2018), Kenya Integrated Household Budget Survey [↑](#footnote-ref-4)
5. 2013 Kenya Household Health Expenditure and Utilisation Survey [↑](#footnote-ref-5)
6. Kenya National Bureau of Statistics, 2014 [↑](#footnote-ref-6)
7. KEMRI Wellcome trust, Examining National Hospital Insurance Fund reforms in Kenya, 2018 [↑](#footnote-ref-7)
8. Salari, Di Giorgio, Ilinca, et al. The catastrophic and impoverishing effects of out-of-pocket healthcare

   payments in Kenya, 2018. BMJ Global Health 2019 [↑](#footnote-ref-8)
9. Ibidem [↑](#footnote-ref-9)
10. [↑](#footnote-ref-10)
11. [↑](#footnote-ref-11)
12. [↑](#footnote-ref-12)
13. Second Garissa County Integrated Development Plan 2018-2022 [↑](#footnote-ref-13)
14. UNICEF-KNBS, Multidimensional poverty report 2017 [↑](#footnote-ref-14)
15. <http://mis.socialprotection.go.ke:20307/Public/Map> [↑](#footnote-ref-15)
16. Second Garissa County Integrated Development Plan 2018-2022 [↑](#footnote-ref-16)
17. District Health Information System 2 (DHIS 2) and 2009 census [↑](#footnote-ref-17)
18. Ibidem [↑](#footnote-ref-18)
19. Costs indicated are estimated. Final rate shall follow the “best value for money” principle, i.e., achieving the desired outcome at the lowest possible fee. Consultants will be asked to stipulate all-inclusive fees, including lump sum travel and subsistence costs, as applicable.

    Payment of professional fees will be based on submission of agreed deliverables. UNICEF reserves the right to withhold payment in case the deliverables submitted are not up to the required standard or in case of delays in submitting the deliverables on the part of the consultant. [↑](#endnote-ref-1)