Republic of Kenya
Ministry of Health

Reversing the Trends

The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya
–
NHSSP II – 2005–2010

August 2005

Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya – NHSSP II 2005–2010

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Message from the Minister for Health

Achieving the international Millennium Development Goals, as well as the targets set in Kenya's Economic Recovery Strategy, is among the strongest commitments of the Ministry of Health as a way of realizing our national vision of providing accessible, affordable and quality health care for all Kenyans, in particular the poor. It is therefore imperative to revitalize the health sector – improve service delivery, ensure community participation, and enhance cooperation, collaboration and teamwork among the various departments within the Ministry, with the districts and provinces, and with all actors having a stake in the health sector.

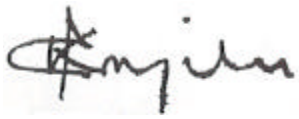
This Second National Health Sector Strategic Plan (NHSSP II) is a milestone for the Ministry, as it provides for the first time in our history a comprehensive output- and performance-oriented strategy that defines our aspirations and priorities for the coming five years. In addition, NHSSP II will be jointly reviewed and revised annually with all stakeholders and in this way MOH will arrive at "actionable" and operational annual plans (AOP). I believe that with this new Strategic Plan, the Ministry of Health has taken a major step towards achieving the general objectives contained in our national vision, the Kenyan Health Policy Framework and the ERS. Through NHSSP II, MOH will be able to reverse the downward trend of the past few years.

NHSSP II will serve several purposes besides guiding the actions and priorities of the Ministry to improve overall sector performance. This will be made visible in the indicators of the Kenya Essential Package for Health (KEPH), in the achievements of its various support services outputs, and in the implementation of the health reforms and sector-wide approach initiatives. The strategic plan will also:

- Improve the planning process within the Ministry, in particular by highlighting the need to improve coordination and decision making, eliminate duplication of activities, and use available resources more effectively and efficiently.
- Provide a platform for dialogue and partnership with all stakeholders.
- Assist the Ministry of Health in furthering the reform process.

The success of the Ministry in achieving this vision and in entrenching the important process of coordinated planning and implementation will depend on the commitment of its staff at central and peripheral levels and on all partners to use this tool for decision making. It will also depend on the quality of the annual review process that will provide us with feedback on our performance.

I request and urge all my staff to use and learn from this strategic plan, put its suggested actions into effect in the Annual Operational Plans, and in this way contribute candidly to apply its vision, objectives and actions.



Hon. Charity K. Ngilu, MP
MINISTER FOR HEALTH

August 2005

Acknowledgements

This second National Health Sector Strategic Plan (NHSSP II) is the result of a long, complex process of intensive consultations, teamwork on specific assignments, detailed studies and information gathering. The process involved clients, service providers, civil society groups, the private sector, development partners and various government stakeholders.

The Ministry of Health is very grateful to every-one who contributed, in one way or another, to the successful development of this Strategic Plan. Special thanks go to the members of the four MOH-led working groups that were tasked to review and suggest new approaches for the Essential Packages for Health, the financing of NHSSP II, the monitoring and evaluation framework, and the organizational structure. These building blocks were brought together and synthesized in NHSSP II.

Most important has been the concerted effort to involve all departments/divisions within MOH in order to ensure understanding and ownership of the new plan. The Health Sector Reform Secretariat spearheaded the coordination and shepherded the plan to completion.

The Government appreciates the financial and technical support given by the Swedish International Development Cooperation Agency (Sida), the United States Agency for International Development (USAID), the UK's Department for International Development (DFID), the World Bank, World Health Organization and the United Nations Children's Fund – amongst others. These and all of our stakeholders have been helpful and encouraging in this attempt to chart a new course for Kenya's health sector.

Finally, the Ministry expresses its appreciation to all the other individuals and institutions who contributed – and continue to contribute – towards improving the health of Kenyans and who joined us in our efforts to achieve the Millennium Development Goals and the objectives of the Economic Recovery Strategy.

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List of Abbreviations

AIA	Appropriation in aid
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
AOP	Annual operational plan
ART	Anti-retroviral therapy
BEOC	Basic emergency obstetric care
BMC	Budget Management Centre
CBO	Community-based organization
CBS	Central Bureau of Statistics
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEOC	Comprehensive emergency obstetric care
CMA	Common management arrangements
CORPs	Community owned resource persons
CPR	Contraceptive prevalence rate
CRC	Convention on the Rights of the Child
CSO	Civil society organization
DAC	Development Assistance Committee (OECD)
DHMB	District Health Management Board
DHMT	District Health Management Team
DHP	District health plan
DHSF	District Health Stakeholder Forum
DMO	District Medical Officer of Health (Head of the DHMT)
DMS	Director of Medical Services
DOTS	Directly observed treatment short course (for TB)
EBF	Exclusive breast feeding (6 months)
EPI	Expanded Programme of Immunization
ERS	Economic Recovery Strategy
ERSWEC	Economic Recovery Strategy for Wealth and Employment Creation (being the Kenyan equivalent of the PRSP; generally referred to simply as ERS)
FBO	Faith-based organization
FMS	Financial management system
FP	Family planning
GAVI	Global AIDS Vaccine Initiative
GDP	Gross domestic product
GFATM	Global Fund to Combat AIDS, TB and Malaria
GIC	Global Initiatives Committee (part of JICC)
GOK	Government of Kenya
HBC	Home-based care
HC	Health centre
HF	Health facility (= all facilities at levels 2 and 3)
HHOOP	Household out-of-pocket expenditure
HIPC	Highly indebted poor country
HIV	Human immune-deficiency virus
HMIS	Health management information system
HODs	Heads of departments
HR	Human resources
HRD	Human resource development
HRM	Human resource management
HS	Health Secretary
HSRS	Health Sector Reform Secretariat
IAVI	International AIDS Vaccine Initiative
ICC	Interagency Coordinating Committee
ICT	Information and communication technology
IMCI	Integrated management of childhood illnesses
IMF	International Monetary Fund
IMR	Infant mortality rate (the number of infant deaths per 1,000 live births)
IOP	Interim operational plan (MOH)
IPT	Intermittent prophylactic treatment (for malaria)
IT	Information technology
ITN	Insecticide treated (bed) net
IVM	Integrated vector management
JAR	Joint Annual Review (part of SWAp)
JICC	Joint Interagency Coordinating Committee
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supply Agency
KEPH	Kenya Essential Package for Health
KEPI	Kenya Expanded Programme on Immunization
KHPF	Kenya Health Policy Framework
KMA	Kenya Medical Association
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
KQM	Kenya quality model
Ksh	Kenya shilling
LLITN	Long lasting insecticide treated (bed) net

MAP	Multi-sector AIDS Programme (World Bank)
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MMR	Maternal mortality ratio (the number of maternal deaths per 100,000 live births)
MOEST	Ministry of Education, Science and Technology
MOF	Ministry of Finance
MOH	Ministry of Health
MOU	Memorandum of understanding
MPND	Ministry of Planning and National Development
MTEF	Medium-term expenditure framework
MTRH	Moi Teaching and Referral Hospital
MTR	Midterm review (of NHSSP II)
MTTP	Medium-term procurement plan
NA	Not available
NC/pp	New consultations per person
NCAPD	National Coordinating Agency for Population and Development (formerly National Council for Population and Development – part of MPND)
NDP	National Drug Policy
NEPAD	New Partnership for Africa's Development
NGO	Non-government organization
NHIF	National Health Insurance Fund
NHSSP	National Health Sector Strategic Plan
NS	Not stated
NSHIF	National Social Health Insurance Fund
OAU	Organization of African Unity
OECD	Organization for Economic Cooperation and Development
O&M	Operations and maintenance
ORS	Oral rehydration salt (or solution)
PEPFAR	President's Emergency Plan for AIDS Relief (= Bush Initiative)
PER	Public expenditure review (for health)
PHC	Primary health care
PHO	Public Health Officer
PHT	Public Health Technician
PLWHA	Person/people living with HIV/AIDS
PMO	Provincial Medical Office (Officer)
PMTCT	Prevention of mother-to-child transmission (of HIV)
PNC	Postnatal care
PPB	Pharmacy and Poisons Board
PRSP	Poverty reduction strategy paper
PS	Permanent Secretary
QA	Quality assurance
RH	Reproductive health
RHF	Rural health facilities (levels 2 and 3)
STI	Sexually transmitted infections
SWAp	Sector-wide approach (for health)
TB	Tuberculosis
TBA	Traditional birth attendant
TOR	Terms of reference
TT2	Tetanus toxoid vaccination (2 doses)
UFMR	Under-five mortality rate
UN	United Nations
UNDP	United Nations Development Programme
US$	United States dollars
VCT	Voluntary counselling and testing
VHC	Village health committee
WB	World Bank
WHO	World Health Organization
WRA	Women of reproductive age (15–49 yrs)

Executive Summary

This second National Health Sector Strategic Plan 2005–2010 (NHSSP II) intends to reverse the decline in the health status of Kenyans. The vision of the sector is of an efficient, high quality health care system that is accessible, equitable and affordable for every Kenyan household. The mission is to promote and participate in the provision of integrated and high quality curative, preventive, promotive and rehabilitative health care services for all Kenyans. The plan is further designed to contribute to the accomplishment of Kenya's Economic Recovery Strategy and the achievement of the Millennium Development Goals.

Besides a whole new approach to service delivery, NHSSP II lays out a series of supporting measures ranging from community involvement, human resources and financial management, to monitoring and evaluation, infrastructure, and institutional reforms. The indicators, targets and outputs of NHSSP II will be used as the basis for the development of annual operational plans (AOPs) and internal and external annual performance reviews.

Goal, Objectives and Principles

Reducing inequalities in health care and reversing the downward trend in health related impact and outcome indicators are the twin goals of NHSSP II. Six separate but interlinked policy objectives aim towards the realization of this goal:

- Increase equitable access to health services.
- Improve the quality and responsiveness of services in the sector.
- Improve the efficiency and effectiveness of service delivery.
- Enhance the regulatory capacity of the Ministry of Health.
- Foster partnerships in improving health and delivering services.
- Improve the financing of the health sector.

A thorough review of the experiences with Kenya's Health Policy Framework 1994–2010 and the efforts to implement NHSSP I (the first National Health Sector Strategic Plan) yielded the basic design principles that guided the development of this second strategic plan. First, service delivery will place human capital development and the human rights approach squarely at the core of its interventions. Moreover, NHSSP II shifts the emphasis from the burden of disease to the promotion of individual and community health. It does this by introducing the Kenya Essential Package for Health (KEPH), which focuses on the health needs of individuals through the six stages of the human life cycle. Finally, the strategy emphasizes strong community involvement in health care.

The Kenya Essential Package for Health

The Kenya Essential Package for Health (KEPH) integrates all health programmes into a single package focused on improving health at different stages of the human life cycle. It requires a shift in the prevailing paradigm, which is focused on service delivery. NHSSP II therefore adopts a broader approach that entails moving from the emphasis on

disease burden to the promotion of healthy life styles of individuals, with attention to the various stages in the human life cycle. In this approach health programmes centre around the different phases of human development and in this way complement each other, so that synergy and mutual reinforcement among the programmes can be achieved. Once all programmes jointly focus on a particular phase in human development, their combined outputs are expected to be better than each one could have achieved individually. KEPH distinguishes six distinct life cycle stages:

- Pregnancy, delivery and the newborn child (up to 2 weeks of age)
- Early childhood (3 weeks to 5 years)
- Late childhood (6 to 12 years)
- Adolescence (13 to 24 years)
- Adulthood (25 to 59 years)
- Elderly (60 years and over)

These phases represent various age groups or cohorts, each of which has special needs.

The KEPH approach also defines six service delivery levels:

- Level 1, the community level, is the foundation of the service delivery priorities, because it allows the community to define its own priorities so as to develop ownership and commitment to health services. Communities will be empowered with information and skills. Only in this way can real change towards healthy life styles be achieved.
- Levels 2 and 3 are, respectively, the dispensaries and the health centres and maternity/nursing homes, which will primarily handle promotive and preventive care, but also some curative services.
- Levels 4–6 are the primary, secondary and tertiary hospitals, which will focus mainly on the curative and rehabilitative aspects of the service delivery package.

Because this approach represents a drastic change in service delivery concepts, the full package will be phased in over the life of NHSSP II. During the first year, attention will be paid to the first two cohorts (pregnancy/newborn and early childhood) and for the adult age group with the following minimum interventions: safe motherhood and reproductive health; child health promotion and integrated management of childhood illnesses; malaria control; HIV/AIDS/STI and TB control; and sanitation and food safety. (Refer to Figure A.)

> Improving people's health is the whole point of improving the performance of the health sector.

> The Kenya Essential Package for Health represents a drastic change in service delivery concepts.

An example will illustrate the range of emphasis in KEPH. For the first life-cycle group, the package concentrates on the use of impregnated mosquito nets to prevent malaria, essential antenatal and postnatal care, family planning and child spacing, the use of skilled birth attendants, and general health education.

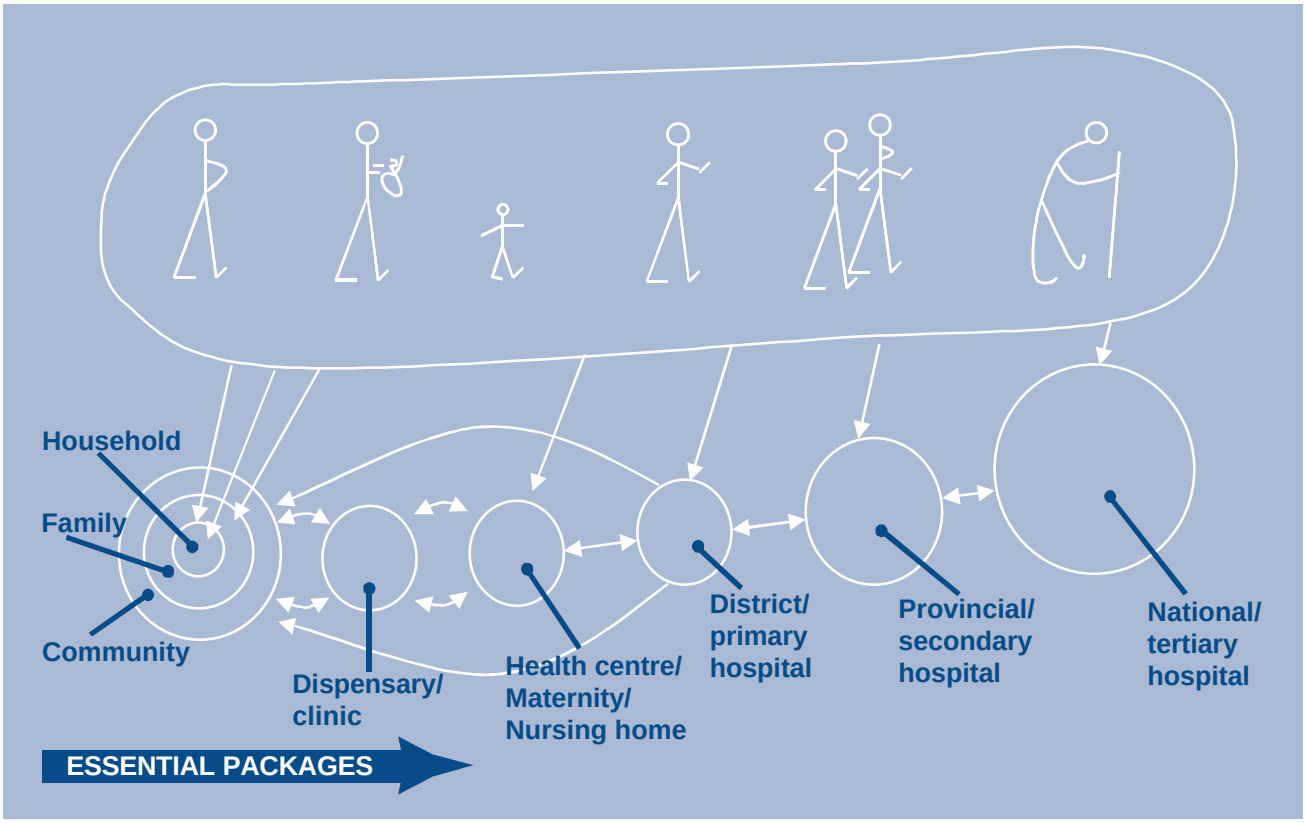
The Systems That Support KEPH

The whole point of improving the performance of the health sector is to improve people's health. Better service delivery depends greatly on support systems that function efficiently and effectively so that the necessary money, human resources, drugs commodities and other essentials reach the service providing units in a timely way. Such systems also ensure that available resources are better managed

Interface between Services and Community

The interface refers to the relationship between the community aspirations and expectations at one side and the objectives of the health services to attain greater coverage and community involvement and empowerment at the other side. Until now MOH's approach has been grounded in a "basic needs" concept that focused on primary health care activities. Because that approach has not had much impact on the health of Kenyans, NHSSP II takes a new direction – the full involvement of communities in their health care and the adoption of a human rights approach to the implementation of KEPH-related activities. The difference here is that the basic needs approach in principle helps a marginalized group to obtain access to services, while the human rights approach calls for existing resources to be shared more equitably, so that everyone has access to the same services. This entails the building of community capacity for people to understand their rights, to claim them, and to make meaningful contributions to realizing these rights.

Figure A Paradigm shift focuses attention on stages in the life cycle



Health Planning

NHSSP II sets a specific objective of strengthening district health planning in a way that focuses on the mutual responsibility of both sides – providing necessary resources on the one hand and achieving the stated targets and outputs on the other. District targets will be fully integrated into the national health system.

Financial Management

The objective of NHSSP II is to establish a robust performance-based accounting system that will enable timely disbursement of funds and timely and accurate accounting for the sector. The budget will be linked with the annual inputs through the district health plans and – to the extent possible – the expenditures with the outputs achieved (resource-based management).

Monitoring and Evaluation

The objective of the M&E support system is to assist health managers to make informed decisions and contribute to better quality planning and management. The overall thrust is to introduce performance based monitoring throughout the system that is linked to performance indicators, outputs and targets set for NHSSP II. In the meantime, all districts will be expected to adopt and use the same sector performance indicators for their daily work. Districts and programmes are expected to add other more specific indicators where needed to supervise the performance in their respective fields.

Human Resource Management and Development

People make service delivery and support systems happen. NHSSP II intends to improve the use and performance of the already available personnel, even as it increases the numbers, quality and mix of the workforce in order to address shortages. The objectives set in the human resources component involve instituting sound management principles at the central level, decentralizing certain functions where appropriate, building additional human

The basic needs approach in principle helps a marginalized group to obtain access to services, while the human rights approach calls for existing resources to be shared more equitably, so that everyone has access to the same services.

capacity in line with the health needs of the population, aligning human resource development activities with KEPH priorities, and making the development of the health sector workforce more demand driven (rather than supply driven).

Quality Assurance and Standards

The major objectives of the quality assurance support system are to ensure the development – and use by all health professionals – of clinical standards, protocols and guidelines; to strengthen patients' rights; and to revitalize and strengthen the relationships between MOH and the various professional bodies.

Commodity Supply Management

The procurement, distribution and rational use of pharmaceuticals involves a complex system of institutional, legal and policy issues that have so far managed to frustrate the original aims of the pharmaceutical reforms. The objective of the commodity supply support system under NHSSP II is to ensure that demand-driven pharmaceuticals, non-pharmaceuticals and equipment are sufficiently available, that they are used efficiently and effectively, and that they are properly accounted for through a revision of policies and strategies.

Investment and Maintenance

The objectives here are to ensure the continuous availability of care related equipment, a reliable energy supply, adequate provision of water and waste disposal tools, and the ongoing maintenance of equipment and facilities. Moreover, the transport system will be upgraded to ensure that an adequate number and type of vehicles are available and well maintained.

Communication and ICT

Communication within the health sector has different meanings. In NHSSP II the communications system will relate to channels of communication between the various levels of administrative responsibility (lines of reporting, horizontal and vertical) and medical care (communications needed for referral of emergencies). It will also refer to the information and communication technologies (ICTs) that are increasingly essential to improve and facilitate such communication. The objective here is to improve communications among the various actors operating in the health sector.

NHSSP II introduces performance-based monitoring grounded in specified and time-bound outputs for both service delivery and support systems.

Performance Monitoring

The main shift of NHSSP II is to introduce performance-based monitoring grounded in specified and time-bound outputs for both service delivery and support systems. NHSSP II sets performance indicators that will be monitored during joint annual reviews and the annual summits. These outputs are summarized in Table A. The indicators and targets have been aligned with the Economic Recovery Strategy and the Millennium Development Goals.

The Governance of NHSSP II

Until recently the primary role of MOH at the central level has been to "make things work" at provincial and district levels. Under the current health sector reforms, however, the role is increasingly to oversee, govern and facilitate the implementation of decentralization and other reforms without being involved in actual service provision. The central MOH is thus taking a "hands off, but eyes on" approach, while the provincial and district levels become increasingly involved in the daily operations of service delivery. Under NHSSP II, then, the core functions of the central MOH – policy formulation, regulation, resource allocation and performance monitoring – will be strengthened, while the provinces (supervision) and districts will be made increasingly responsible for implementation of the KEPH.

Whether at central or provincial/district level, it is clear that MOH cannot alone "reverse the trends" in the health status of Kenyans. This goal of NHSSP II can only be achieved if there is true partnership and collaboration, and regular and open coordination of all activities by all partners. This implies that joint policy responses will be required by both the public and the private sectors – and by development partners as well. The existing partnership framework, consisting among others of the Joint Interagency Coordinating Committee, various area-specific Interagency Coordinating Committees and the District Health Stakeholder Forums, will be strengthened and broadened. To

Table A Sector performance indicators and targets 2005–2015

	Indicators	NHSSP II Baseline 2004/05	AOP I Target 2005/06	ERS Target 2006/08	NHSSP II Target 2010	MDG Target 2015
Health Status	Infant mortality rate	77				25
	Under-five mortality rate	114	110	100		33
	Maternal mortality ratio	414	310	560	170	147
	% under five years underweight	22 (2003)				16,2
Service Delivery Outcomes and Outputs	% deliveries by skilled staff	42	51	70	90	90
	Basic emerg obst care (BEOC) %		60			100
	% WRA receiving FP commodities	10	20	45	60	70
	% ANC coverage (4 visits)	54	60	75	80	NS
	HIV prevalence among 15–24 pregnant women	10.6	9.2	8	6	NS
	% HIV+ under ART	20			75	NA
	% HIV+ under PMTCT (women)	10			50	NA
	TB case detection rate %	47	50		55	60
	TB cure rate %	67	70		73	75
	Malaria prevalence among 5 yrs+	30		10		NS
	% pregnant women/children sleeping under LLITN	4.4/4.7	8 / 7	50/50	60 / 60	65
	% Fully immunized under one year	57	68		90	100
	% < 1 yr immunized measles	74	84	85	94	90
	% children receiving Vit A supplement		33	-		
Access	Doctor/Population ratio (/100,000)*	15				
	Nurse/Population ratio (/100,000)*	133				
	Outpatient visits/pp/yr	0.08				NS
	Hospital admission rate/1,000 pop	NA				NS
Quality	% maternal audits/maternal deaths	0	10			NS
	Malaria inpatient case fatality %	26	20			NS
	% tracer drug availability	35	40		80	90
Efficiency	Bed occupancy rate	NA				NS
	Service output/provider (workload)	NA				NS
Financial	GOK budget (%) allocated health	6.9				12
	GOK expenditure health (US$/pp)	6.5				
	% GOK recurrent budget for health					
	% curative health	51				
	% preventive/promotive health	5				
	% rural HC and dispensary	11			15	
	% Kenyatta and Moi hospitals	18				
	% budget for drugs	12			16	

* Figures include public and private sectors and the two teaching hospitals. MOH alone has 3 doctors and 49 nurses per 100,000 population.
Ksh exchange rates (mid April 2005): 1 US$ = Ksh75.0; 1 euro = Ksh98.0
Sources: National programmes, KDHS 2003, KSPA 2004, ERS and Human Resource Mapping.

ensure the effectiveness of the framework, a comprehensive annual planning and monitoring cycle will be established that gathers and collates information and health plans from all levels and consolidates these into annual operational plans that are subsequently agreed upon by all stakeholders.

This mode of planning and management is the core of Kenya's sector-wide approach in health (SWAp). Attention to good governance, transparency in financial management and actions to address corruption in the public sector are other foundations of a viable SWAp. To make these measures functional in daily practice, NHSSP II recognizes the Three Ones as key ingredients of an operational SWAp: one plan and budget, one monitoring system, and one coordinating framework.

In order to institutionalize the Three Ones in the Kenyan context, joint annual planning, joint monitoring and evaluation, joint funding arrangements, and other common management arrangements will be designed and put into practice with inputs from all stakeholders.

Resource Requirements

Scenarios for three different levels of available resources for KEPH and non-KEPH components are estimated in this Plan. Annual plans will be made in a flexible way within the declared available resources. Most of the resources will be allocated to KEPH and the lower levels of the health care pyramid.

Sources of funding are expected to include the Government of Kenya, cost sharing, the National Social Health Insurance Fund, development partners and others. Even so, two resource gaps are identified. The first gap is the difference between the resources available and the cost of implementing the minimum KEPH. The second, larger, gap is the difference between the available resources and the cost of KEPH plus non-KEPH. These gaps can be bridged by additional allocations from the Treasury and/or donor contributions.

Under hardship conditions the gaps can be reduced by scaling down the targets of the population to be served. On the other hand, private health expenditure on KEPH is not well covered in the calculations. Moreover, some large off-budget expenditures on KEPH (e.g., support from international and bilateral health initiatives) are also not included in the figures. The actual financing gap is therefore likely to be smaller than estimated.

Figures B and C illustratethe cost allocations over the life of the plan by life-cycle cohorts and by facility levels, respectively.

Figure B: KEPH costs by life-cycle cohort: 2005–2010

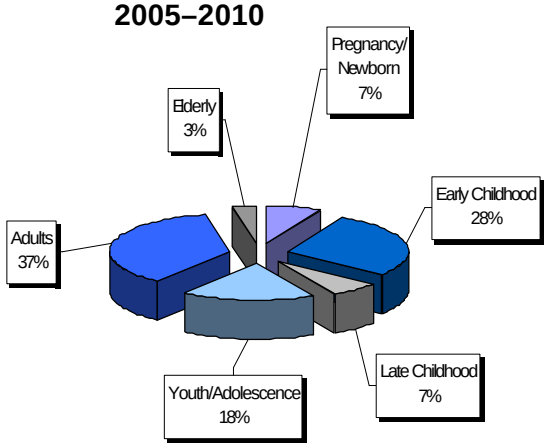
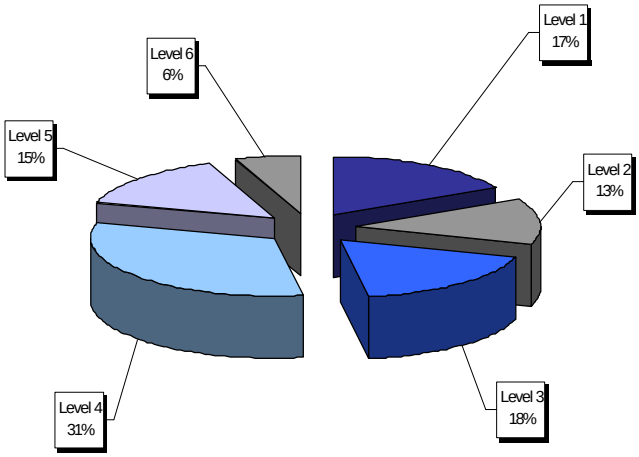


Figure C: KEPH costs by facility level: 2005–2010



1 Introduction – Kenya's Health Policy Framework 1994–2010

This second National Health Sector Strategic Plan (NHSSP II) is formulated with the aim of reversing the downward trends in health indicators observed during the implementation of the first strategic plan (NHSSP I, 1999–2004), applying the lessons learned and searching for innovative solutions.

NHSSP II will re-invigorate the Kenya Health Policy Framework (KHPF) elaborated in 1994. The health goals formulated in the KHPF underlined the need to pursue the principles of primary health care in improving the health status of the Kenyan population. The Framework set out the following strategic imperatives:

1. Ensure equitable allocation of GOK resources to reduce disparities in health status.
2. Increase cost-effectiveness and efficiency of resource allocation and use.
3. Manage population growth.
4. Enhance the regulatory role of the government in health care provision.
5. Create an enabling environment for increased private sector and community involvement in service provision and financing.
6. Increase and diversify per capita financial flows to the health sector.

These policy imperatives are still valid today. Therefore, NHSSP II will base its new strategies on the package of 15 reform measures that KHPF defined in 1994.

1.1 First Health Sector Strategic Plan, NHSSP I 1999–2004

NHSSP I re-stated the KHPF's strategic imperatives and articulated a large number of strategies and activities to continue and strengthen the reform process. These included strengthening governance; improving resource allocation; decentralizing health services and management; and shifting resources from curative to preventive and PHC services. They also specified provision of autonomy to provincial and national hospitals and enhancement of collaboration with stakeholders under a sector-wide approach.

NHSSP I was externally evaluated in September 2004 by a team of independent consultants. The most important findings are summarized below.

1.1.1 Findings of the External Evaluation of NHSSP I

The evaluation drew several conclusions. It found well focused national health policies and a reform agenda whose overriding strategies intended to improve health care delivery services and systems through efficient and effective health management systems and reform. Despite these good qualities, however, the overall implementation of NHSSP I did not manage to make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators of health and socioeconomic development as expected by the plan. The short-comings of NHSSP I may be attributed to a set of factors, most of which are inter-related, such as:

- Absence of a legislative framework to support decentralization;
- Lack of well articulated, prioritized and costed strategies;
- Inadequate consultations amongst MOH staff themselves and other key stakeholders involved in the provision of health care services;
- Lack of institutional coordination and ownership of the strategic plan leading to inadequate monitoring of activities;
- Weak management systems;
- Low personnel morale at all levels; and
- Inadequate funding and low level of resource accountability.

As a result, efforts made during NHSSP I did not contribute to the improved health status of Kenyans. Rather, health indicators showed a downward trend with increases in infant and child mortality rates; declining use of health services in public facilities (in 1990 there were 0.6 new consultations per person [NC/pp], while in 1996 there were only 0.4 NC/pp); decline in doctor to population ratio during the 1990s (compared with the 1980s); and stagnating contributions from the public sector to health (from US$12/pp in 1990 to US$6/pp in 2002). In more general development terms, poverty levels were going up from 47% in 1999 to 56% in 2002.

1.1.2 Recommendations for NHSSP II

The external evaluation provided eight important suggestions and recommendations for the development of NHSSP II:

1. NHSSP II should strengthen the implementation of a sector-wide approach (SWAp) and define the resource envelope needed to implement the next plan, including a financial mobilization plan as part of a strategy that focuses on achieving specific targets and programme outputs.

2. NHSSP II should provide a specific timeframe for reviews and monitoring, as well as midterm and final evaluations, to ensure adherence to the strategic plan, based on the agreed benchmarks. M&E frameworks already developed need to be entrenched into current programmes and their respective indicators need to be harmonized and coordinated by a central unit at MOH headquarters.

3. All MOH departments should prepare individual departmental medium-term strategic plans based on the new NHSSP II targets and objectives. Furthermore, their respective divisions' operational plans and implementation need to be guided by the departmental targets and priorities. This management practice will not only facilitate integration and strengthen operational linkages amongst the MOH service delivery programmes, it will also enhance monitoring and evaluation, hence promotion of efficiency and effectiveness in health sector performance.

4. An institutional review is necessary to realign the current organizational structure and (re-)position new emerging core functions. NHSSP II should develop organizational structures with clear roles and responsibilities for each department/division. Support services should create an enabling environment and provide general backstopping. All units of policy, planning, budgeting/finance, human resource development and other support services need to link their activities directly to service delivery programmes.

5. NHSSP II should explicitly address the issue of coordination and come out with improved internal and external coordination mechanisms. This should allow for external resource negotiations and avoid the existing functional overlap of mandates between various departments.

6. A national training policy is needed to guide and integrate training and capacity building on the basis of needs. Next, a national training plan should be developed for all different cadres of staff. The provincial and district level training plans should be guided by the national training plan and reflect the national objectives.

7. A national policy for health infrastructure, equipment and waste management should be developed from the reports of national infrastructure audits and inventory records, which should be reviewed annually. Capital budgets need to have adequate provision for operation and maintenance (O&M).

8. The preparation of NHSSP II should be developed through a participatory process at all levels of MOH and stakeholders. The current working teams for the preparation of NHSSP II should invite provincial and district inputs and views through active participation of Provincial Health Management Teams (PHMTs), District Health Management Teams (DHMTs) and other stakeholders.

1.2 Reversing the Trends – The Second Health Sector Strategic Plan

Overall, the thrust of the NHSSP II is to firmly address the downward spiral of Kenya's health status. The goal of the NHSSP II therefore is to contribute to the reduction of health inequalities and to reverse the decline in the impact and outcome indicators. These health inequalities exist between urban and rural populations, between districts and provinces (compare Western Province having 68% of the population below the poverty line with Central Province at 46%).[1] They are related to gender, education and disability. The goal to reduce health inequalities can only be achieved effectively by involving the population itself in decisions on priority setting and consequently in the allocation of resources. This requires a fundamental change in the existing governance structures in order to allow such community ownership to take place.

NHSSP II recognizes that "reversing the trends" cannot be achieved by the government health sector alone. Active involvement and partnership with other stakeholders in the provision of care is needed. NHSSP II will establish a well functioning health system that relies on collaboration and partnership with all stakeholders whose policies and services have an impact on health outcomes. Health is defined here in its broad sense, as not only the absence of disease but the general mental, physical and social well-being of an individual. In this definition, the environment in which people live – including access to nutritious food, safe water, sanitation, education and social cohesion – also determines health.

The private sector is defined here to include private not-for-profit organizations (faith-based, non-government and civil society organizations) and private for-profit institutions and organizations.

The achievement of the NHSSP II outputs will need the contribution of all actors whose primary purpose is to promote, maintain or restore health. These actors are:

- The public sector, represented by MOH and other government institutions
- The private health sector (being private for-profit and private not-for-profit)
- Traditional healers, providing traditional medicine
- Individuals and households that ensure care and support for their families and the communities they live in
- Development partners

Together these actors in 2002 managed a total of 4,634 health facilities (HF). This breaks down as 75% dispensaries; 12% health centres; 5% maternity or nursing homes; 6% hospitals and 2% others. The distribution of health facilities in the country in 2002/03 is shown in Table 1.1. Registered medical personnel working in these facilities is summarized in Table 1.2.

MOH "owns" 51% of the 4,634 health facilities, while the FBO/NGO and the private for-profit sectors

[1] As poverty levels have not been assessed in North Eastern Province, the poverty values might be even higher in that province.

Table 1.1 Health institutions and hospital beds and cots by province, 2002/03

Province	Number of health institutions 2002			2003*			Total		Hospital beds and cots 2002		2003*	
	Hospitals	Health centres	Health sub-centres & disp	Hospitals	Health centres	Health sub-centres & disp	2002	2003*	Number	No per 100,000 pop	Number	No per 100,000 pop
Nairobi	56	53	376	58	54	381	485	493	4891	21.2	5,011	21.6
Central	63	86	368	65	89	372	517	526	8,191	22.4	8,314	22.9
Coast	64	40	331	64	42	334	435	440	7,687	30.6	7,998	31.4
Eastern	63	79	689	65	80	692	831	837	7,412	15.3	7,822	15.4
N/Eastern	7	11	65	8	12	68	83	88	1,707	14	1,914	14.2
Nyanza	97	114	328	98	117	333	539	548	11,922	23.1	12,545	23.2
R/Valley	98	159	1,002	100	161	1,006	1,259	1,267	12,390	16.2	12,832	16.5
Western	66	92	192	68	94	196	350	358	6,457	19.1	6,971	19.4
Total	**514**	**634**	**3,351**	**526**	**649**	**3,382**	**4,499**	**4,557**	**60,657**	**19.2**	**63,407**	**19.5**

* Provisional.
Source: MOH health management information system (2004).

Table 1.2 Registered medical personnel, 2002/03

Type of personnel	2002		2003*		In training (Number)	
	Number	No. per 100,000 population	Number	No. per 100,000 population	2002/03	2003/04*
Doctors	4,740	15.1	4,813	15.3	848	862
Dentists	761	2.6	772	2.7	169	178
Pharmacists	1,866	5.9	1,881	5.8	221	234
Pharmaceutical Technologists	1,399	4.3	1,405	4.3	155	169
Registered Nurses	9,753	31.0	9,869	33.1	1,267	1,281
Enrolled Nurses	29,094	94.6	30,212	100.2	3,882	3,940
Clinical Officers	4,778	15.2	4,804	15.7	878	891
Public Health Officers	1,174	3.3	1,216	3.6	194	215
Public Health Technicians	5,484	17.3	5,627	19.4	461	489
Total	**59,049**	**189.1**	**60,599**	**192.1**	**8,075**	**8,259**

* Provisional.
Source: MOH health management information system (2004).

together "own" the remaining 49% (data from 1998). The distribution of health facilities among these three providers is presented in Table 1.3. Information on the volume of their outpatient and inpatient services is unfortunately not known because their statistics are not (yet) included in the national HMIS.

The most important private health care providers in Kenya are:

- African Medical and Research Foundation (AMREF), which provides a broad array of services ranging from clinical care and emergency response to training and advice in health policy and systems development.
- The Christian Health Association of Kenya (CHAK), one of the largest health related NGOs in the country, covering 38% of services provided by NGOs or around 8% of all available facilities.
- The Kenya Catholic Secretariat (KCS), with 19 Catholic dioceses all over Kenya, including the sparsely populated and generally neglected districts in the northern, eastern and north eastern part of the country.
- The Family Planning Association of Kenya (FPAK), an important service provider of FP services and clinic-based reproductive health services.
- The Kenya AIDS NGO Consortium (KANCO), initiated in 1990 as a consortium of NGOs, and currently including more than 400 member organizations.
- The Kenyan Aga Khan Foundation, an international welfare NGO, which has several reputable hospitals and health facilities in Kenya.

NHSSP II defines health in its broad sense, as not only the absence of disease but the general mental, physical and social well-being of an individual. This includes the environment in which people live – with access to nutritious food, safe water, sanitation, education and social cohesion.

Table 1.3 Distribution of health facilities by type and provider, 1998

Health facility	MOH		FBO/NGO		Private		Total
	Number	%	Number	%	Number	%	
Hospital	109	50.0	67	30.7	42	19.3	**218**
Health centre	460	80.0	100	17.4	15	2.6	**575**
Dispensary	1,537	60.9	595	23.6	391	15.5	**2,523**
Nursing & maternity home	0	0.0	11	58.0	180	94.2	**191**
Health centre/Medical centre	43	0.1	72	10.2	592	83.7	**707**
Total	**2,149**	**51.0**	**845**	**20.1**	**1,220**	**29.0**	**4,214**

Source: NHSSP I, 1999–2004. MOH figures correspond with 2004 Human Resource Mapping.

2 Health Sector Priorities

The Government of Kenya (GOK) is determined to improve the access to and equity of essential health care services and to ensure that the health sector plays its essential role in the realization of the Kenyan Economic Recovery Strategy for Wealth and Employment Creation (ERSWEC, known as ERS). As a signatory of the Millennium Declaration with its internationally defined Millennium Development Goals (MDGs), Kenya has expressed its commitment to reach these targets in the remaining ten years.

The Millennium Development Goals

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce infant mortality.
5. Improve maternal health.
6. Combat HIV/AIDS, malaria and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

Kenya has incorporated these and other international goals into national targets. These will be further translated into regional and district level targets as part of the next year's annual operational plan (AOP 2) to inform and guide local priority setting and resource allocation. Recent suggestions to fast-track some of the interventions to allow tangible results in a relatively short period will be incorporated in the next AOPs.

2.1 NHSSP II as Part of ERS 2003–2007

At national level, the ERS[3] and the National Development Plan 2004–2009 together present Kenya's road map for economic recovery for the next five years. ERS is anchored in four pillars: achieving rapid economic growth in a stable macroeconomic environment; strengthening the institutions of governance; rehabilitating and expanding physical infrastructure; and investing in the poor. The ERS targets and those of the MDGs that are relevant to the Kenyan health sector are summarized in Table 2.1.

[3] The Economic Recovery Strategy for Wealth and Employment Creation (ERSWEC 2003–2007) is the Kenyan equivalent of the poverty reduction strategy papers (PRSP).

The NHSSP II is an integral part of ERS, from which it is derived. Key components of the ERS policy as it relates to the health sector include:

- Revisiting the financing of the sector: Introduce the National Social Health Insurance Fund (NSHIF) in a phased approach to eventually achieve universal coverage of free health care for the Kenyan population.
- Focusing on investments to benefit the poor: Reallocate resources towards promotive, preventive and basic health services and enlist additional capacity through partnership arrangements.
- Increasing cross-sector cooperation: For MOH, strengthen ties and collaboration across sectors in the areas of agriculture, water and sanitation, education, roads, culture and social services, etc.

Table 2.1 MDG and ERS indicators for Kenya

MDG No	Indicators	Baseline MDG 1990	Baseline NHSSP I 1999/2000	Output NHSSP I 2003	Target ERS 2006-08	Target MDG 2015
	Kenyan population (millions)	21.4		28.7	NS	NS
	MDG outcomes/outputs					
4 Child Health	Prevalence underweight children < 5 yrs	32.5	33.1	28	NS	16.2
	Reduce IMR/1000 by 2/3 between 1990 and 2015	67.7	73.7	78		25
	Reduce UFMR/1000 by 2/3 between 1990 and 2015	98.9	111.5	114	100	33
	Proportion 1 year old immunized against measles %	48	76	74	85	90
	Proportion of orphans due to AIDS	27,000	890,000	1.2 M		
5 Maternal Health	Reduce MMR by ¾ between 1990 and 2015	590	590	414	560	147
	Proportion births attended by skilled health staff %	51	NA	42	70	90
	Coverage of basic emergency obstetric care (BEOC)		24			60100
	% WRA receiving family planning commodities	-	-	10	45	70
	HIV prevalence among 15–24 yr old pregnant women	5.1	13.4	10.6	8.0	NS
6 Disease Control	Malaria prevalence of persons five yrs and above	NA		30%	10%	NA
	Malaria inpatient case fatality rate	NA		26%		NA
	Pregnant women/children <5 sleeping under ITN %	NA		4/5	50/50*	65/65
	TB case detection rate	NA		47%		60
	Treatment completion rate (TCR, smear+ cases)	75%		80%	85%	90%
7	Access to safe water (National) (%)	48	55	48	NS	74
7	Access to good sanitation (%)	84	81	50	NS	NS
8	% population with access to essential drugs	NA		35%		NA
	ERS output indicators					
	Expenditure MOH/per capita (Ksh/US$)		395/5.0	506/6.5	NS	NS
	% GOK expenditure to health sector		7.2%	6.9%	12%	
	% MOH budget allocation rural HC and dispensaries			11%	15 %	
	% budget allocation to drugs			12%	16%	
	Reduce HHOOP** expenditure out of health budget			53%	45 %	

NA = Not available; NS = Not stated.
* Western and Coast Province; ** Household out-of-pocket expenditure.
Sources: Adopted from KHPF; ERS, February 2004; NHSSP I evaluation; KDHS 1998,2003; PER 2005; MDGs Progress Report for Kenya 2003; and Kenya Service Provision Assessment Survey 2004.

- Increasing efficiency and effectiveness: For MOH, adopt a programmatic approach with all partners involved (sector wide) leading to a jointly agreed strategic plan, financing mechanisms, M&E framework, and procedures for annual sector programme review, together with a jointly agreed medium-term expenditure framework (MTEF).

- Increasing GOK funding: Increase health sector funding from the current level of 5.6% of total public expenditure to 12% by the end of the ERS period.

The ERS has outlined various specific targets to be achieved in the programme period (Table 2.2). The achievement of these targets requires a medium-term (five years) health sector strategy and detailed annual operational plans (AOPs).

2.2 International Health Initiatives

While achieving the MDGs has assumed primary importance, Kenya is signatory to a number of international development initiatives in the health sector. Some of these refer to internationally defined indicators and targets, to which the Government has expressed its commitment (Three by Five and Abuja), while some are bilateral or international funds that have been made available to the country, such as the (US) President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), and the World Bank's Multisector AIDS Program (MAP). All these contribute to the improvement of health and service delivery in Kenya. The major provisions of these initiatives are summarized in Table 2.3.

Table 2.2 ERS targets for the health sector

No	Indicator	Baseline 2002/03	Target (value)	Year
A	**Development Outcomes**			
1.1	Reduce under-five mortality rate, MDG 4	115/1000	110	2008
1.2	Reduce maternal mortality rate, MDG 5	590/100,000	560/	2008
1.3	Reduce malaria morbidity/mortality, MDG 6	30%	10%	2003/08
1.4	Reduce HIV prevalence 15–25 yrs, MDG 6	NA	Down 10%	2006
1.5	Reduce HHOOP* expenditure	53%	40 %	2008
B	**Outputs**			
2.1	Increased budget allocation for rural health facilities (MOH)	11%	15%	2006
2.2	Increased budget allocation to drugs	12% budget	16%	2006
2.3	Sessional paper on NSHIF prepared			2004
2.4	Increased prop. of fully immunized children	74%	85%	2008
2.5	Increased contraceptive prevalence rate	38%	45%	2008
2.6	Increased prop. delivering in health facilities	56%	70%	2008
2.7	Increased % population in western and coastal areas and of pregnant mothers using LLITNs	5%	50%	2008
2.8	Increased public share of health expenditure	5.6%	12%	-

* Household out-of-pocket expenditure
Adapted from the ERS, February 2004.

For some of these initiatives it is not clear to what extent their funding is within the MOH or within Treasury or within the joint management arrangements as defined in the sector-wide approach. This refers in particular to their funding modalities (off-budget) together with their management and control procedures. The AOPs will incorporate the financial contributions from these international initiatives.

2.3 The Design Principles That Informed NHSSP II

The design principles of NHSSP II are grounded in a fundamental respect for human rights and community participation and acknowledgement of what is doable during the period. The principles can be summarized as follows:

1. Shift from disease burden (curative and vertical) to a human capital development approach by focusing on health promotion and providing comprehensive support to the six different phases of the human life cycle, while at the same time stimulating a human rights approach in all interventions.

2. Scale up interventions by reorienting the emphasis from facility-based (curative) services to increased preventive and promotive community-based care through the strengthening and expansion of the role of community-owned resource persons (CORPs) and health workers at grassroots levels, and the removal of geographical and financial (user fees) barriers.

3. Strengthen ownership and community oversight by defining ownership of service delivery at district and health facility levels; strengthening district and hospital boards and health facility committees; jointly developing district health plans; supporting District Health Stakeholder Forums to monitor performance; and improving information and responsiveness to claims (patient charters, publication of fee levels, etc.).

4. Reinforce the role of the MOH by expanding geographical and financial access to services and at the same time improving their quality; reinforcing commitment to health as a human right; improving resource allocation and financial targeting to underserved and poor areas; and introducing regulatory measures to improve collaboration.

NHSSP II is grounded in a fundamental respect for human rights and community participation and acknowledgement of what is doable during the period.

Table 2.3 International health initiatives adopted by Kenya

Name	Agency	Stated objective / Target / Policy statement
MDGs	UN	Reduce by 2/3 the rate of infant and child mortality between 1990 and 2015 Cut the rate of maternal mortality by 3/4 by 2015 Attain universal access to reproductive health services by 2015 Reduce HIV infection rates by 25% among 15–24 years by 2015 Decrease TB and malaria mortality by 50% by 2010
3 by 5	WHO	Provide anti-retroviral therapy to 3 million people by 2005 globally
Abuja the	OAU	Allocate 15% of total budget to health expenditure (Kenya's is currently 8.3%, according to PER 2004) Expand ITN coverage of pregnant women and children under 5 yrs to 60% by 2006
NEPAD	OAU	GOK is committed to the principles of NEPAD and has established an office within the Ministry of Planning and National Development, linking NEPAD to poverty reduction, economic recovery and HIV/AIDS. No specific health contribution from NEPAD.
HIPC	UN	Currently the GOK is not eligible for debt relief from HIPC funds.
PEPFAR	USA	US$15 billion over five years, 55% for treatment, 15% palliative care, 20% for HIV prevention, and 10% for orphans and vulnerable children to treat 2 million and prevent 7 million new cases. Kenya is among the 14 "focus countries", with the Plan's contribution to Kenya in 2004 amounting to US$71.4 million.
GFATM/ Kenya	UN	HIV/AIDS received round 1 (NGOs: US$220,000 and US$2.6 million) and round 2 (MOF: US$36.7 million).Malaria received round 2 (MOF: $10.5 million), TB received round 2 (MOF: $81.9 million)
MAP 1–2	WB	MAP I provided US$50 million to Kenya. MAP2 is currently being implemented.
Clinton F	Private	Initiated operations in Kenya only recently.
GAVI / IAVI		Global Alliance for Vaccines and Immunization and the International HIV/AIDS Vaccine Initiative provide money through specific support programmes. Their contribution to Kenya could not be established.

5. Enhance collaboration to improve services in both the public and private sectors by joint planning and a common monitoring system; sharing of resources like information, technology, training and finance; and provision of incentives for improved collaboration (e.g., support the private sector to provide comprehensive care, immunization services, use of DOTS).

6. Initiate steps to arrive at a sector-wide approach by articulating a shared sector-wide strategy agreed by all stakeholders; jointly elaborating common management arrangements necessary for implementing and managing the sector strategy; agreeing on funding arrangements for the strategic plan; and developing a code of conduct in which MOH and stakeholders establish a long-term commitment to collaborate in implementing NHSSP II.

7. Initiate a limited number of fast-track activities to reverse the current downward trend and allow Kenya to catch up and achieve (partially) the health related MDGs. There are four fast-track activities (referred to by number elsewhere in this plan): 1) increase the number of health workers in the rural areas; 2) initiate training of community-owned resource persons (CORPs); 3) scale up introduction of insecticide treated nets (ITNs); and 4) distribute emergency delivery kits. The fast-track interventions will be reviewed and redefined annually.

8. Estimate the resources necessary to implement NHSSP II on the basis of well established unit costs for the various items of service delivery, taking the financial limitations, the MTEF ceiling and the criteria for priority setting.

2.4 The NHSSP II Development Process

NHSSP II is the result of a long and complex process of broad and intensive consultations, teamwork on specific assignments, detailed studies, and information gathering. The process involved consumers and clients, service providers, civil society groups, the private sector, development partners, and various government stakeholders.

The preparatory work was divided among four MOH working groups, tasked to review and suggest new approaches for the Essential Packages for Health, the financing of NHSSP II, the monitoring and evaluation framework, and the MOH organizational structure. These building blocks were brought together and synthesized in NHSSP II. Most important has been the concerted effort to involve all departments/divisions within MOH in order to ensure understanding and ownership of the new plan.

This process is expected to provide the basis for the development of consensus within the provincial and district health authorities at their respective levels (as part of the development of the second AOP), with other ministries (finance, education, water, agriculture, gender), with community and civil society groups, with the private sector (faith-based organizations, NGOs and for-profit providers), and with the development partners involved in and supporting the health sector.

2.5 How the Plan Is Structured

First and foremost NHSSP II will provide a framework within which more detailed annual operational plans (AOPs) for the national level, including intersector activities, can be developed. These annual sector plans will in turn provide the structure not only for district and provincial plans, but also for division and departmental plans. NHSSP II is designed to help align health strategies with the development priorities defined by the Ministry of Planning and National Development, the Public Sector Reform Secretariat, and GOK budget allocations as defined in the ERS, the MTEF and the annual public expenditure review (PER) for the health sector. Finally, the document is intended to be the basis for reaching agreement with Kenya's development partners on their financial and technical contributions and the way in which these will be managed.

The strategy unfolds as follows. After these two introductory chapters, Chapter 3 provides the vision, mission, goal and main policy objectives of the health sector, together with the MDGs/MOH performance indicators and targets. The main thrust of NHSSP II is contained in Chapter 4, which defines the Kenya Essential Package for Health (KEPH) – the health interventions together with their performance targets for the different age groups (cohorts). Chapter 5 describes the systems that support the implementation of the KEPH, in particular the interface between health services and community; health planning; and financial management, including MTEF and the planning, reporting and disbursement procedures. Monitoring and evaluation are covered here, as are human resources, standards and quality assurance, and commodity supply. Finally, the chapter deals with investment and maintenance, lines of communication, and information and communications technology (ICT) systems.

The approach to the governance of NHSSP II is found in Chapter 6. This includes the responsibilities of MOH, its core tasks and functions, and the institutional reforms necessary to achieve the plan's objectives and targets. The chapter also describes MOH's external relations with its various stakeholders and the future partnership mechanisms. It then presents in some detail the health reforms and the SWAp related activities that will be undertaken. For each of these, detailed outputs over a five-year period are included that relate to the five policy objectives of NHSSP II.

Finally, Chapter 7 discusses the financing of the sector, including cost estimates to implement the NHSSP II over the five years, with resource allocation given by year, by age group and by source of funding. The presentation estimates the "resource gap" that needs to be bridged to implement both KEPH and non-KEPH activities.

A series of annexes provide additional information and explanatory notes, including details of the governance and costing of NHSSP II.

3 Vision, Mission and Goal of NHSSP II

The vision and mission of NHSSP II are derived from the Kenya Health Policy Framework for 1994–2010. They remain valid and appropriate as a guide for NHSSP II.

Vision: An efficient and high quality health care system that is accessible, equitable and affordable for every Kenyan.

Mission: To promote and participate in the provision of integrated and high quality promotive, preventive, curative and rehabilitative health care services to all Kenyans.

NHSSP II Objectives

- Increase access to services
- Improve service quality and responsiveness
- Improve efficiency and effectiveness of services
- Enhance the regulatory capacity of MOH
- Foster partnerships
- Improve health sector financing

3.1 Policy Objectives: A Shift in Focus and Commitment

Achieving the outcomes set out by NHSSP II will require a clean break from "business as usual". MOH has therefore defined ten strategic shifts in focus and commitment that are needed if NHSSP II's aspirations of reversing the trends are to be realized (Table 3.1).

The revised focus will provide new impetus and energy to the MOH in achieving the following goal:

> The goal of NHSSP II is to reduce health inequalities and to reverse the downward trend in health related outcome and impact indicators.

This goal translates the overall vision and mission into the following set of policy objectives that are linked to the ERS and the MDGs:

- Increase equitable access to health services.
- Improve the quality and responsiveness of services in the sector.
- Improve the efficiency and effectiveness of service delivery.
- Enhance the regulatory capacity of MOH.
- Foster partnerships in improving health and delivering services.
- Improve the financing of the health sector.

The objectives are elaborated in the sections below. Key intervention areas in service delivery (the Kenya Essential Package for Health – KEPH), in support systems, and in health reforms and a sector-wide approach will provide the operational dimensions of these policy objectives. Their expected outputs are described in chapters 4, 5 and 6, respectively.

The overall sector performance indicators and targets will provide the monitoring framework for NHSSP II (Table A in the Executive Summary). The reliability of the data used in these indicators cannot

Table 3.1 Strategy shift from NHSSP I to NHSSP II

From	To
Develop and implement a single "master plan" and adhere to its implementation.	Build a system of coordination and allow annual priority setting of the intended interventions.
Ideas and solutions are fixed and can only be changed in the next period, implying one-off initiatives.	Embrace a continuous process of learning and adaptation to the changing environment, including MOH itself.
Management is based on evidence only, no risk taking.	Management is based on piloting, and managing risks and uncertainties.
Narrow and structured participation in well defined activities, little collaboration and information sharing.	Multi-stakeholder approach, continuous review of plans and interventions; solicitation of participation of all on equal basis.
Services are provided on the basis of vertically organized programmes.	Services focus on the needs of various age groups (cohorts).
Focus on projects and activities.	Focus on outputs and outcomes.
Ministry alone takes responsibility.	All actors are equally responsible.
In setting priorities, use only criteria of technical and effective interventions.	Priority setting also includes political criteria of access to and re-distribution of power and resources within the country.
Continue the expansion of infrastructure at all levels.	Scale-up community-based interventions and link them with the referral system.
Public sector fills the poverty gap through an essential health package; pro-poor targeting, but little change.	Public sector ensures re-distribution of resources and social solidarity; structural change to bring everybody on board.

be fully ascertained, however, as there is no comprehensive operational health management information system (HMIS) in the country. Targets have been defined on the basis of the ERS and the MDGs, together with preliminary assessments of what can be achieved over the five years. Their values were estimated by MOH experts in their respective fields. Experiences from other countries show that the process of target-setting is complex and full of implicit assumptions. Targets in NHSSP II will therefore be revised during the midterm review in 2007 if they are found to be unrealistic.

3.2 Increase Equitable Access

Access implies physical distance, financial outlays and socio-cultural factors. Improving access – geographically, financially and socio-culturally – is expected to increase the utilization of health care services, as the services become closer and cheaper for the client. It is assumed that increased utilization in turn will improve the health of the population.

3.2.1 Improving Geographical Access

The key underlying principle here is to bring services closer to the people. This will be accomplished in several ways. Collaboration with communities will ensure the availability of appropriate community-based services and address barriers to accessing care at the local level. The introduction of community-owned resource person schemes (training and supervising CORPs) will take into account the lessons learned from the primary health care (PHC) era. A human rights approach to service delivery will ensure ownership and a clear distinction between the rights and obligations of the clients and those of the service providers. In addition, the network of health facilities[3] will be expanded through construction and rehabilitation of facilities from public and not-for-profit sectors, with a corresponding increase in the number of health workers in facilities at these levels. Finally, the referral system between the various levels up to the primary (district) and secondary

[3] Health facilities comprise health centres, maternities and nursing homes at level 3 and dispensaries or clinics at level 2.

(provincial) hospitals will be strengthened through effective communication and (community) transport between these levels.

3.2.2 Improving Financial Access

Various measures will be taken to improve financial access to health services, specifically for the financially vulnerable and the very poor: the elderly, street children and orphans, single mothers, and patients with chronic diseases like TB, HIV/AIDS, diabetes, etc. Guidelines to identify these vulnerable groups together with an appropriate package will be developed for health facility and hospital levels that will be reimbursed by public funds. The phased introduction of the NSHIF will be prepared. Cost-recovery, cost-sharing and the 10/20 strategy (the MOH's fee structure that calls for a 10/= fee at dispensary level and 20/= at health centre level) will be reviewed and new exemption policies and practices will be proposed. Where possible, community pre-payment schemes will be initiated to support cost recovery systems in both the formal and the informal sectors.

Finally, criteria for resource allocation to regions and districts will be reviewed and the pro-poor and gender focus will be strengthened. More resources will be targeted to very poor (and dry) areas of the country, like the northern regions and Nyanza and Western Provinces. In addition, resources will be targeted to services for women and children, like reproductive health, safe motherhood activities and services for women at community level (treated bed nets and deliveries conducted by skilled birth attendants, as proposed in Chapter 4).

3.2.3 Addressing Socio-Cultural Barriers

A major factor influencing access and utilization consists of social and cultural barriers that hinder the use of health services. This holds in particular for priority groups like women and children, adolescents, the disabled (mentally and physically), and vulnerable persons. In the coming years the intention is that service provision will become humane, compassionate and dignified. Privacy for women will be ensured, even as gender awareness and understanding of the different health needs of men and women are respected. The human rights approach will be promoted in practical clinical settings and services will become more client oriented. Here, as well, there will be deliberate measures to establish youth-friendly services and even special youth clinics where possible.

A human rights approach to service delivery will ensure ownership and a clear distinction between the rights and obligations of the clients and those of the service providers.

3.3 Improve Service Quality and Responsiveness

Factors related to the achievement of this objective include the performance of health workers on the supply side, and public awareness of client rights on the demand side. These will both be addressed during the plan period.

3.3.1 Improving Health Worker Performance

MOH will take a number of important steps to improve the performance of health workers at all levels, including developing incentive schemes to motivate better performance. The competence of service providers will be addressed through a series of training and performance management initiatives that will:

- Review and improve basic and in-service training of medical and para-medical staff in both clinical care and service management.
- Involve Kenya Medical Training College (KMTC) and other training institutions in the design of crash programmes to enhance the clinical and management skills of MOH staff in support of the KEPH, both for in-services and for continuing education.
- Elaborate a strategy and targets for integrated training for all the programmes.
- Improve supportive supervision and management at all levels.
- Enhance service quality by initiating regular clinical audits (in particular for maternal deaths) and building these into the performance management system.

Further steps to assure service quality will include a review the Kenya Quality Model (KQM) and its expansion into a national policy on quality assurance (QA), including clinical care, management support and leadership. Quality assurance strategies will be mainstreamed into the reform process, taking into

account staff motivation, staff competence, adequate resources, content and process of care, referral systems, and the active participation of client and community. Services at the secondary and tertiary levels will be reoriented to support service quality in the health facilities and to improve the performance of the referral chain.

Finally, recognizing that the human component is only part of the equation, appropriate equipment, pharmaceuticals and decent infrastructure will be provided to allow quality work.

3.3.2 Improving Responsiveness to Client Needs

The sector will take action to strengthen the demand side of the equation, so that clients are attracted to make use of the health facilities. Among other things, the plan calls for:

- Establishing and protecting client rights through the development and promulgation of a Citizens Health Charter.
- Ensuring that essential information (like fee schedules in health facilities, exemption schemes, etc., are posted publicly and visibly at all facilities.
- Ensuring that complaint procedures are in place and respected.
- Encouraging the participation of men in reproductive health services.
- Training health workers on client handling and patient centred accountability.

3.4 Improve Efficiency and Effectiveness

Value for money involves many issues of cost-effectiveness and efficiency, made possible by improved planning, management and administration. Proposals here relate to both public and private expenditure on health care.

3.4.1 Improving Value for Money

Steps here will involve the review of resource allocation criteria to make them more pro-poor and the use of poverty related information like the recently elaborated Poverty Map that targets the poor up to sub-district level.[4] The timely and regular flow of money to the districts will be ensured, while health facilities will be stimulated to undertake more outreach programmes and service providers encouraged to work at full capacity. Non-core functions will be outsourced where applicable.

> Criteria for resource allocation to regions and districts will be reviewed and the pro-poor and gender focus will be strengthened. More resources will be targeted to very poor (and dry) areas of the country, and to services for women and children.

3.4.2 Improving Planning, Management and Administration

MOH will consider the introduction of Budget Management Centres (BMC)[5] and will review the location of GOK facilities. Staff deployment will be related to levels of service outputs required (workload), including a move towards workload-based hospital allocations. Efforts will be made to avoid overlap or duplication with the private sector and other non-government facilities. Indicators and targets will be linked with those of the ERS and MDGs, with each year's annual operational plan and department/division objectives similarly linked to NHSSP II. To ensure that this all happens effectively, the lines of responsibility (and accountability) for clinical (service) and management functions will be clearly defined.

3.5 Foster Partnerships

Fostering good partnership is the main vehicle for implementing NHSSP II, as MOH recognizes that the public sector alone will not be able to provide the necessary services to all Kenyans. The targets set for NHSSP II can only be achieved if all stakeholders collaborate and coordinate their actions, in full recognition of each one's specific responsibilities.

3.5.1 Engaging in Partnerships with the Private, Not-for-Profit Sector

Civil society organizations (CSOs) have an important role in ensuring that households are well informed about good health behaviour and the need to seek

[4] MOF/Central Bureau of Statistics, 2004. Geographic Dimensions of Well-Being in Kenya: Where Are the Poor? From Districts to Locations, Volume I.

[5] Budget Management Centres (BMC) are administrative units that are accountable for the implementation, reporting and auditing of their work plans. Examples are hospitals and DHMTs. In order to become a BMC, the unit has to meet well defined eligibility criteria.

professional care in a timely way. They also participate effectively by developing and expanding public information programmes, health promotion messages (healthy life style) and information on the human rights approach to health. NHSSP II will further involve these organizations in ensuring comprehensive support for community ownership of health activities (through health facility committees and District Health Management Boards), as well as the coordination of inter-sector support for community action through District Health Stakeholder Forums.

3.5.2 Improving Partnerships between the Private and Public Sectors

The MOH will establish a well defined "window" of contact for all partnerships. It will further review the performance of the Joint Interagency Coordinating Committee (JICC) and the various ICC working groups to improve their outputs and expand their composition.

And, it will consider providing resources (financial or personnel) for not-for-profit institutions that provide good quality services and extending continuous learning programmes to non-GOK health providers.

3.5.3 Improving Inter-Sector Collaboration

Inter-sector work will be undertaken in collaboration with other ministries whose portfolios have an impact on the health of Kenyans. Collaboration with the Ministry of Education, Science and Technology, for example, would be undertaken to improve the health information in various school and teacher training curricula and the teaching of good health behaviour, initiation of a de-worming programme in primary schools, and tetanus toxoid immunization in secondary schools. Environmental sanitation and the provision of potable water will involve the Ministry of Water and Irrigation. The MOH's own National AIDS/STD Control Programme (NASCOP) will redouble efforts to work with other agencies to advocate for, support and promote policies and activities in the field of HIV/AIDS (like home-based care, school guardian programmes, theatre groups). Collaboration with the Ministry of Finance (Treasury) is, of course, essential to streamline the financial flow between the central and the district levels (to health facility level). Finally, the performance of the District Health Stakeholder Forums will be strengthened in all their functions (coordination, local priority setting, monitoring).

3.5.4 Improving Partnerships with Development Partners

With the development partners a platform has been created to agree on sector priorities, resource allocation and financing mechanisms, implementation strategies, and monitoring of progress in achieving the annual targets. In addition, Common Management Arrangements (CMA) will be elaborated to guide the planning and implementation of NHSSP II. These will establish joint procurement and reporting arrangements, a common monitoring framework, and various joint financial reporting and support modalities (common fund, others) for the strategic plan. Eventually, a code of conduct will be drafted in which the roles and responsibilities of the MOH and all its partners (NGO, development partners and private sector) are well described. MOH and development partners will jointly establish the indicators that define harmonization, alignment and mutual accountability (Paris Declaration; Annex A).

3.6 Improve Financing in the Health Sector

NHSSP II acknowledges the existing trade-off between increasing access (financial and geographical) and improving the quality of service delivery. In a financially constrained environment it will not be easy to increase access for poor people while at the same time improving service quality. NHSSP II has therefore defined priorities that will be respected over the five years of its implementation. The plan proposes a balanced approach between these objectives. Future AOPs will allow for adaptations and flexibility in the process of priority setting between access and quality.

Increased funding as part of a pro-poor agenda is essential to reach the NHSSP II performance targets. increased funding in itself is not enough, however. The following observation applies:

> Since expanded health services typically reach better-off groups rather than disadvantaged ones, poor people are unlikely to be the principal beneficiaries of efforts to accelerate progress towards the MDGs by providing additional resources to the health sector. A more plausible result of well-intended pro-poor

funding is more health improvements among privileged groups and thus an increase in poor–rich health disparities. However, such an outcome can be modified. Achieving faster progress for poor populations will need first and foremost a deliberate effort to allocate a larger share of all (financial, human, pharmaceutical) resources towards the poor, which goes beyond a simple expansion of health infrastructure or an increase in targeted activities.[6]

There are important differences in regional health indicators in Kenya. The 2003 Kenya Demographic and Health Survey, for example, showed a very high infant mortality rate (IMR) of 206/1,000 live births in Nyanza Province, while Central Province had an IMR of only 54/1,000 live births (the national average being 115). Likewise, there are large disparities in expanded programme of immunizationd(EPI) coverage (by district and by province), as shown in the maps in Figures 3.1 and 3.2. These findings are similar for other service delivery programmes, like malaria, reproductive and child health, HIV/AIDS, and TB control.

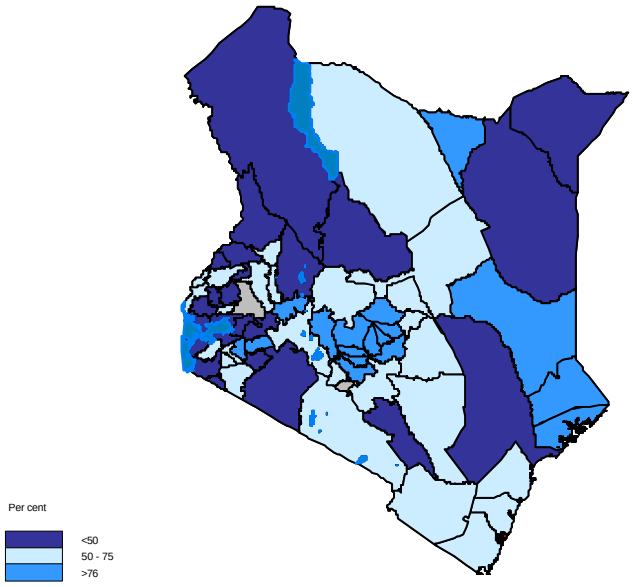
MOH will elaborate a more detailed plan to finance the health sector, once the current studies on NSHIF and the review of the 10/20 policy have been completed.

In general terms the following measures will be taken during NHSSP II:

- Improve resource allocation, utilization and accountability of funds to attract additional funding.
- Rationalize resource allocation to services with significant impact.
- Negotiate with Treasury and advocate for increased resource allocation.
- Mobilize resources from development partners and other agencies.
- Prepare the phased introduction of the planned National Social Health Insurance Fund (NSHIF) and develop appropriate regulatory and policy tools.
- Diversify resources, for example by initiating pre-payment schemes to support cost recovery systems in both the formal and the informal sectors.
- Shift resource allocations from higher levels of service delivery (hospitals) to lower levels (health centres and dispensaries).
- Shift resources from relatively well served areas to areas of extreme poverty (poverty mapping) like North Eastern Province, Nyanza Province, and the dry (and poor) northern parts of the country.
- Similarly, shift resources to arid areas and to areas with pastoralist populations and to urban slums in the major cities.
- Elaborate and implement mechanisms of common fund arrangements.

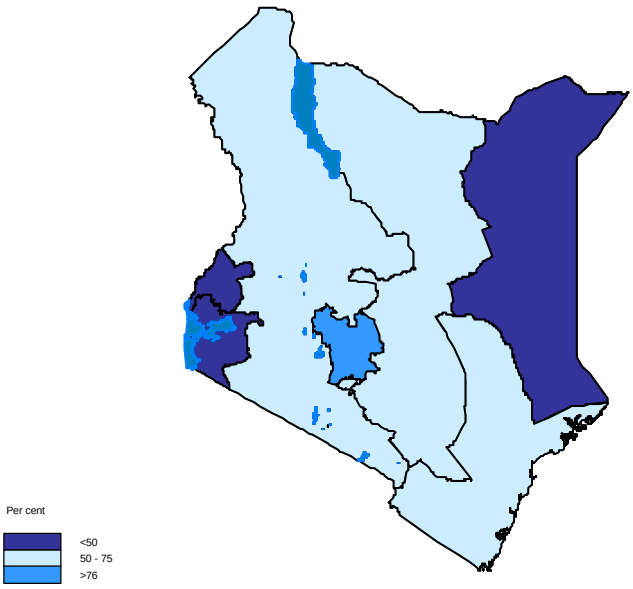
[6] David R. Gwatkin, February 2005. "How much would poor people gain from faster progress towards the Millennium Development Goals for health?", Lancet, 365: 813–7.

Figure 3.1 Proportion of children fully immunized by district, 2004



Source: Kenya MOH, KEPI, 2004.

Figure 3.2 Vaccination coverage by province, 2003 (per cent)



Source: KDHS 2003, Central Bureau of Statistics.

4 Kenya Essential Package for Health

Partners in Kenya's health sector critically reviewed the country's health service delivery system in order to devise a new strategy for making it more effective and accessible to as many people as possible. The analysis resulted in the conclusion that such an effort not only implies a need for closer and more intense collaboration among the existing essential service packages. It also requires a shift in the prevailing paradigm, which is focused on service delivery. NHSSP II therefore adopts a broader approach – a move from the emphasis on disease burden to the promotion of individual health, with attention to the various stages in the human life cycle. In this approach health programmes centre around the different phases of human development and thus complement each other, so that synergy and mutual reinforcement among the programmes can be achieved. Once all programmes jointly focus on a particular phase in human development, their combined outputs are expected to be better than each one could have achieved individually.

4.1 KEPH Philosophy and Justification

The Kenya Essential Package for Health (KEPH) represents the integration of all health programmes into a single package that focuses its interventions towards the improvement of health at different phases of the human development cycle. These phases represent various age groups or cohorts, each of which has special needs that relate to the development phase it is passing through.

4.1.1 Life-Cycle Cohorts

The KEPH approach is expected to reduce fragmentation and improve continuity of care by emphasizing the inter-connectedness of the various phases in human development. Attention during pregnancy, for example, improves the chances of a good delivery, while a well-performed delivery puts the baby in an optimal state to face the new challenges of that phase of life. This inter-connectedness equally applies to the other cohorts in human life. Each cohort needs different interventions that respond to its specific needs. The cohorts included in NHSSP II, with their various preventive and curative activities, are summarized in Table 4.1.

The KEPH Life-Cycle Cohorts

- Pregnancy and the newborn (up to 2 weeks of age)
- Early childhood (2 weeks to 5 years)
- Late childhood (6–12 years)
- Youth and adolescence (13–24 years)
- Adulthood (25–59 years)
- Elderly (60+ years)

4.1.2 Levels of Care

The KEPH approach is not limited to a definition of the target groups in terms of life-cycle cohorts. It also defines where health services will be delivered. The preventive and curative services will be provided at six levels of care. As illustrated in Figure 4.1, these are:

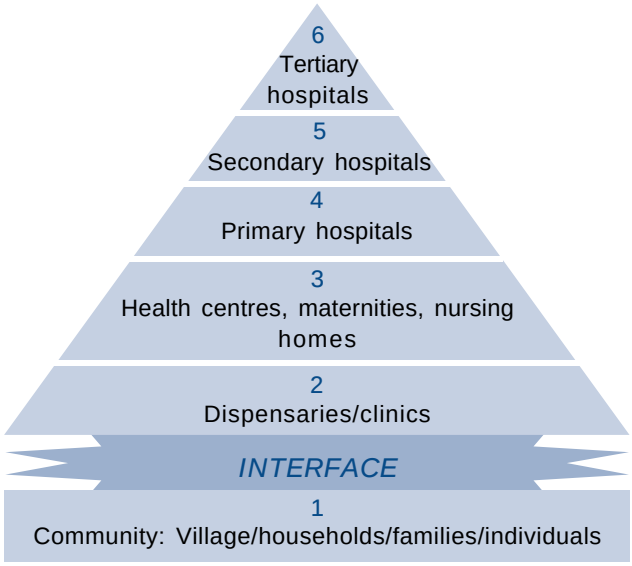
Table 4.1 Services needed during the life cycle of an individual

Life cycle cohort	Services needed	
	Promotive/Preventive	**Curative**
1. Pregnancy and the newborn (up to 2 weeks of age)	ANC and nutritional care, IPT, TT2. Use of skilled births attendants, clean delivery; BCG. PNC, breast feeding support, supplementary feeding. FP services. ITN promotion and use. IPT and indoor spraying. PMTCT/Nevirapine. Micro-nutrient supplements (iron) Hygiene, water and sanitation.	Adequate and timely referral system, partographs, transport (ambulance) system. Basic and comprehensive emergency obstetric care (BEOC). Newborn resuscitation.
2. Early childhood (2 weeks to 5 years)	Community IMCI + ITN. Appropriate nutrition, extended breast feeding; growth monitoring; EPI; provision of vitamin A/zinc. Psychological stimulation; physical/cognitive development. Exercise and recreation	Clinical IMCI. ORS for treatment of diarrhoea. Antibiotics and anti-malarial drugs. ART.
3. Late childhood (6–12 years)	Essential school health programme. Adequate nutritional care. ITN promotion and use. Exercise and recreation	Overall treatment and care. Appropriate feeding. Timely treatment of infectious and parasitic diseases.
4. Youth and adolescence (13–24 years)	TT2 in schools. RH and HIV/AIDS/STI counselling. Substance abuse counselling. Adequate nutritional care. Accident prevention. RH/FP services. Exercise and recreation	Overall treatment and care, especially for DOTS, STIs and opportunistic infections.
5. Adulthood (25–59 yrs)	Annual screening and medical examinations. Accident prevention. FP/RH services. Healthy lifestyles (exercise, recreation, nutrition, etc.)	Overall treatment and care. ART and palliative care. DOTS.
6. Elderly (60+ yrs)	Annual screening and medical examinations. Exercise and the promotion of general hygiene. Social/emotional/community support.	Access to drugs for degenerative illnesses.

- **Level 1, the community level, is the foundation of the service delivery priorities. Once the community is allowed to define its own priorities and once services are provided that support such priorities, real ownership and commitment can be expected. Important gains can be reached to reverse the downward trend in health status at the interface between the health services and the community. Village health committees (VHC) will be organized in each community through which households and individuals can participate and contribute to their own health and that of their village.**

- **Levels 2–3 (dispensaries, health centres, maternity/ nursing homes) will handle KEPH activities related predominantly to promotive and preventive care, but also various curative services.**

Figure 4.1 Levels of care in KEPH



- Levels 4–6 (primary, secondary and tertiary hospitals) will undertake mainly curative and rehabilitative activities of their service delivery package. They will address to a limited extent preventive/promotive care.

In this way, the existing vertical programmes will come together to provide services to the age groups at these various levels. Increasingly, they will cooperate and eventually merge in a common set of interventions, each directed at the various cohorts and at the level of care they are focusing on. Thus the six levels of care will deliver different intervention packages for each of the six cohorts.

This new mode of organizing service delivery calls for quite an overhaul of the existing system of health service delivery. Because it will thus not be possible to introduce everything at once, the first year of NHSSP II will focus on a limited number of interventions for the first two cohorts (pregnancy/ newborn and early childhood) and for the adult age group. The minimum KEPH interventions to be implemented during the first year are:

- Safe motherhood and reproductive health.
- Child health promotion and integrated management of childhood illnesses (IMCI).
- Malaria control.
- HIV/AIDS/STI and TB control.
- Sanitation and food safety.

Annual Operational Plan 1 (AOP 1) provides details on how the minimum KEPH will be implemented in 2005/06 and what the expected outputs should be. The implementation and inclusion of other interventions will be undertaken during subsequent years and detailed in the AOPs for those years. The full list of KEPH interventions and the time frame for their implementation is given in Annex B.

4.2 KEPH Objectives and Strategies

The objectives of the KEPH are fundamental to the overall policy objectives of NHSSP II. Specifically, KEPH intends to:

1. Increase access to health services by targeting part of its interventions at the community level and at poor deprived areas and groups (poor districts and sub-districts, pastoralists).
2. Integrate the different programmes towards the client.
3. Enhance the promotion of individual and community health.
4. Improve quality of service delivery by improving the responsiveness of health workers and changing their prevailing attitudes towards clients.

The following strategies will be used to attain these objectives:

- Revitalizing community health structures with an emphasis on prevention, health promotion and promotion of healthy life styles.
- Developing the community intervention methodology through "learning by doing", making human rights for health the basis for intervention. (Details on the proposed interventions are provided in Chapter 5.)
- Building capacity of clinical and public health workers at all levels, particularly focusing at the community level.
- Supporting and guiding FBOs and NGOs to scale up their community and preventive interventions.
- Providing relevant and culturally adapted information to the users of the health services (increasing the demand-side).
- Reducing the barriers to health care experienced by the poor and destitute through pre-payment schemes and waivers for essential services (including deliveries).
- Strengthening the referral system between the various levels.
- Harmonize the expansion in the infrastructure with the available resources (human and financial resources, etc.).

4.3 KEPH Implementation

As noted, implementation of the KEPH will follow a phased approach. The phases will include selected priority interventions (minimum KEPH) to be offered nationally and will be expanded with each successive AOP by including new priorities in a cascading manner. The complete KEPH will therefore be implemented towards the end of the plan period. Special attention will be given to the expansion of the KEPH to level 1 (community) activities that might need a different pace of implementation.

Annex B provides details of the intended timeframe for the implementation of all the KEPH programmes. It shows the cascading approach for activities (each with their indicators) that will be undertaken during AOP 1 and the subsequent AOPs for each of the programmes. Reproductive and child health, malaria, HIV/AIDS, STI, TB, environmental

health, and health promotion all start their interventions during AOP 1. Mental and dental health, rehabilitation, palliative care, and control of disease outbreaks will follow in subsequent years.

Implementation will be undertaken not only by the GOK providers, but also by NGOs, FBOs, CBOs and the private sector. MOH cannot implement the KEPH on its own and will seek the collaboration of all stakeholders.

4.4 KEPH Outputs and Annual Targets by Life-Cycle Cohort

The life-cycle approach has important implications for information and data collection systems and thus for the way health services are monitored. MOH has defined the baseline indicators and targets of the KEPH for each of the age cohorts, as discussed in the sections below. Selection of these indicators has been done on the basis of their relationship to the ERS and MDGs; the possibility of collecting them routinely through the existing MOH data collection system; and the availability of baseline and target figures. In order not to overburden the information system, the number of KEPH indicators has been kept to the essential minimum. Under the current HMIS, most data from the essential programmes are collected vertically. There is presently no central authoritative data collection point, which jeopardizes the reliability and availability of the information. For purposes of data collection, level 4 (district/primary hospitals) will be included with levels 2 and 3, as data collection is regularly conducted at this level and then reported to central MOH.

4.4.1 LIFE-CYCLE ONE: Pregnancy, Delivery and the Newborn Child

The threats that affect the pregnant mother and the newborn child during this stage of the life cycle are maternal infections, anaemia, malaria, complicated and unsupervised delivery, nutritional deficiencies, hypertension, and postpartum haemorrhage. In response to these threats, KEPH includes the following preventive and promotive activities: the use of long-lasting impregnated bed nets (LLITNs), essential antenatal (TT2 and IPT) and postnatal care, family planning and child spacing, the use of skilled birth attendants, and general health education.

At community level, deliveries conducted by skilled birth attendants[7] and the use of LLITNs by pregnant women are the most important activities that need to be monitored. At health facility level (including district/primary hospitals), indicators relate mainly to reproductive health and safe motherhood interventions. Five out of the 12 indicators are also included in the MDG Indicators (see Table 4.2 for the major indicators).

[7] MOH will decide later whether these skilled birth attendants will be "auxiliary midwives" and/or "trained traditional birth attendants". This will be part of the discussion on the PHC intervention strategy of community related KEPH interventions (salaried or voluntary CORPs).

Table 4.2 KEPH indicators for pregnancy, delivery and the newborn child

Indicators	NHSSP II baseline 2004/05	AOP 1 target 2005/06	Midterm target 2007	NHSSP II target 2010
Level 1: Community				
Deliveries conducted by skilled birth attendant **	—	—		
% Pregnant women sleeping under LLITNs **	4,4 (2003)			60
# LLITNs distributed to pregnant women	55,000	200,000		
Community DOTS activities				
Level 2, 3 and 4: Dispensary/clinic, health centre/maternity/nursing home, primary hospital				
% Pregnant women attending four ANC visits *	54	70		80
% Pregnant women receiving IPT 2x	4	20		
% Deliveries conducted by skilled health staff **	42	51		90
% WRA receiving family planning commodities **	10	20	45	60
% Newborns receiving BCG	84	90		95
% HIV+ pregnant women receiving Nevirapine *	10			50
HIV prevalence among 15–24 yr pregnant women **	10.6	9.2	8	6
# Health facilities providing basic/comprehensive emergency obstetric care (BEOC/CEOC)	9 / —	15 / —		All hospitals by level

Note: * Indicators that are also included in the list of national HMIS indicators.
** Indicators that are also part of the MDG output indicators.

4.4.2 LIFE-CYCLE TWO: Early Childhood

During this phase, the environment of the child poses constant and serious threats to health: Malaria, diarrhoeal disease, upper respiratory infections and TB, worm infestations, and malnutrition all contribute to the well documented high mortality and morbidity figures. The integrated management of childhood illnesses (IMCI) approach provides a comprehensive package with proven efficacy for this cohort. It includes a community IMCI (promotion of treated bed nets, exclusive breastfeeding up to six months, appropriate nutrition advice) and a service-related or clinical IMCI (child weighing clinics, immunization, treatment of childhood diseases, Vitamin A distribution). The KEPH indicators summarized in Table 4.3 relate to the community and health facility levels. Baseline figures are available from the 2003 Kenya Demographic and Health Survey (KDHS) for some of these indicators. Three out of eight relate to MDG indicators and targets.

4.4.3 LIFE-CYCLE THREE: Late Childhood

The challenges that affect the health of children aged 6–12 years are becoming similar to those that confront adults. However, these children are also still susceptible to malaria infections; they suffer from various worm infestations and have a relatively high risk of traumas and injuries (child labour). KEPH for this age group provides mainly school health programmes (de-worming), health education and the promotion of physical activity (sports and various social activities).

There are few indicators to be monitored, as most will be included in the overall age group, included under the adulthood package. Those that are retained relate specifically to school health programmes and to what extent these are effectively implemented. Unfortunately, few baseline figures are available. Table 4.4 illustrates.

Table 4.3 KEPH indicators for early childhood

Indicators	NHSSP II baseline 2004/05	AOP 1 target 2005/06	Midterm target 2007	NHSSP II target 2010
Level 1: Community				
% Children sleeping under LLITNs **	4.7 (2003)			60
# LLITNs distributed to children under 5 yrs	250,000	3,400,000		
% Children at 6 months on exclusive BF	13 (2003)			50
% Community IMCI interventions	-	-		
Level 2, 3 and 4: Dispensary/clinic, health centre/maternity/nursing home and primary hospital				
% Children fully immunized at 1 yr of age *	58	68	78	100
% Children < 1 yr vaccinated against measles **	74 (2003)	84	94	95
% Children receiving vitamin A (1–2 doses) *	33	-		80
% Children attending growth monitoring service **	20 (2003)			NS
% HF providing treatment as per IMCI guidelines	2	10	12	45

Note: * Indicators that are also included in the list of national HMIS indicators.
** Indicators that are also part of the MDG output indicators.

Table 4.4 KEPH indicators for late childhood

Indicators	NHSSP II baseline 2004/05	AOP 1 target 2005/06	Midterm target 2007	NHSSP II target 2010
Level 1: Community				
% School children correctly de-wormed at least once in 2005/06	25	35		80
# Districts de-worming in all schools	-	11		78 districts
% Schools having at least 3 components of the school health programmes	NA			80

4.4.4 LIFE-CYCLE FOUR: Adolescence

During adolescence, new threats to healthy development pose themselves. These particularly relate to behaviour changes, like sexuality (STI, HIV/AIDS and risk of early pregnancy), drug and substance abuse (alcohol and tobacco), and general professional development (school attendance).

KEPH will provide services specifically targeted for this age group: like the provision of RH counselling and contraceptives, voluntary counselling and testing (VCT) centres for HIV, promotion of anti-tobacco and anti-drinking habits, and the establishment of youth-friendly services within existing health facilities. The need for such centres comes from the growing realization among health professionals that messages targeted at this specific age group need to be different and adapted to their culture and life style. The adolescent age group has few KEPH indicators that need to be monitored, asshown in Table 4.5.

4.4.5 LIFE-CYCLE FIVE: All Life-Cycle Cohorts / Adulthood

The health of adults is threatened both by well-known infections like malaria, TB, STI and HIV/AIDS, and by non-communicable diseases such as heart diseases, cancer, diabetes, as well as traumas/accidents and stress – the so-called "diseases of affluence". It is for this age group that KEPH emphasizes the necessity of adopting healthy life styles: stop smoking, do exercises or sports, eat a balanced diet regularly, reduce stress, and avoid unsafe sexual encounters.

Indicators (Table 4.6) from various age groups are brought together under the adulthood category, as most KEPH services are provided for these age

Table 4.5 KEPH indicators for adolescence

Indicators	NHSSP II baseline 2004/05	AOP 1 targe 2005/06	Midterm ttarget 2007	NHSSP II target 2010
Level 2, 3, 4 and 5: Dispensary/clinic, health centre/maternity/nursing home, and primary and secondary hospitals				
# Health facilities offering youth-friendly health services	5	5	30	60

Table 4.6 KEPH indicators for all life-cycle cohorts

Indicators	NHSSP II baseline 2004/05	AOP 1 targe 2005/06	Midterm ttarget 2007	NHSSP II target 2010
Level 1: Community				
# Trained village health committees (model VHC)	-	1-2 / district		
# CORPs selected and trained	-	100		
# Houses sprayed	2,500	200,000		
# Condoms distributed (million)	80	90		
% Households implementing hygiene practices	-	25%		-
% Households with access to safe water **	48			60
% Households with adequate sanitation **	50			65
Level 2, 3 and 4: Dispensary/clinic, health centre/maternity/nursing home and primary hospital				
# New outpatient visits over the year *	0.08			
Bed occupancy rate (BOR) of hospitals *	NA			
Service output per health worker (workload) *	-			
% Health facilities with all tracer drugs available **	35	40		80
Malaria inpatient case fatality rate (level 3–4) **	26	20		
# VCT clients	200,000	NA		
# HIV+ patients starting ART	8,000	95,000		
TB case detection rate **	47	50	53	55
TB cure rate	67	70	73	75
TB treatment completion rate (Sm+/DOTS) **	80	83	85	88
Level 5 and 6: Secondary and tertiary hospitals				
% Blood collected screened for HIV	98	100		
# Regional food/bacteriological lab established	-	8		
# District aqua laboratories in place	0	80		

Note: * Indicators that are also included in the list of national HMIS indicators.
** Indicators that are also part of the MDG output indicators.

groups at the same time. In addition, two health related to inter-sector activities are summarized here, as well as three community-related activities that are undertaken as part of KEPH. Five indicators (out of the total of 16) are harmonized with MDG targets.

4.4.6 LIFE-CYCLE SIX: The Elderly

The elderly suffer from various chronic conditions such as hypertension, disabilities (eyes, ears, limbs), degenerative diseases (problems with walking, backaches, etc.) and mental disorders. Although few special services are currently available for this age group, KEPH will introduce regular medical screenings, promotion of healthy life styles (exercises, sports, social activities) and access to drugs for degenerative illnesses. As no specific information for these conditions is yet available, the indicators shown in Table 4.7 are introduced.

Table 4.7 KEPH Indicators for the Elderly

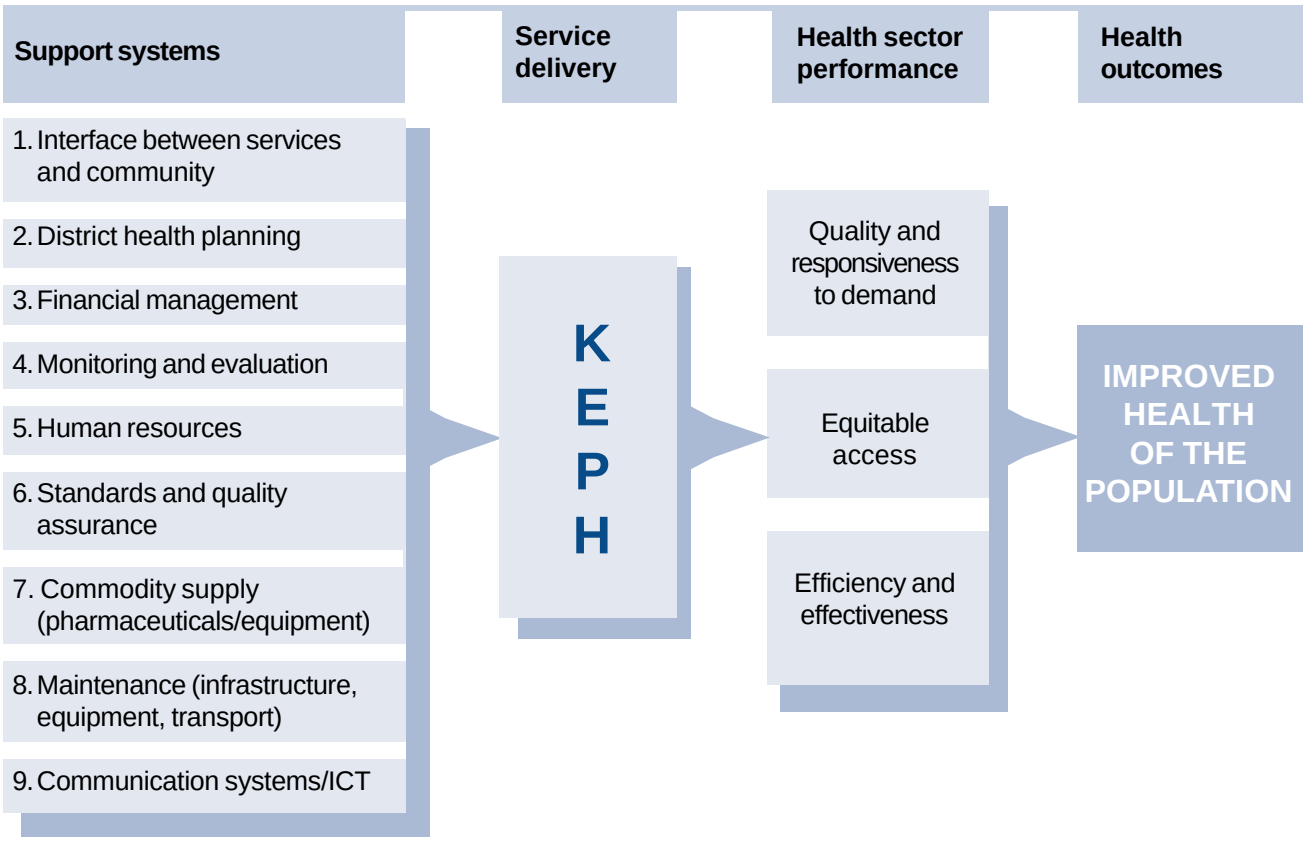
Indicators	NHSSP II baseline 2004/05	AOP 1 target 2005/06	Midterm target 2007	NHSSP II target 2010
Level 2, 3, 4, 5 and 6: Dispensary/clinic, health centre/maternity/nursing home, primary, secondary and tertiary hospitals				
% Districts with functional support systems to promote healthy life styles for the elderly	NA			20 districts
% Health facilities providing regular check-ups	NA			50% HF

5 Systems in Support of KEPH

All efforts to improve health sector performance are ultimately geared towards improving people's health. Such efforts may be directed at improving equitable access, the quality and responsiveness of the health services, the efficiency and effectiveness of interventions, or a combination of these elements that together determine the outcome of service delivery.

Service delivery objectives like those outlined in the previous chapter require strong support systems. It is these systems that get the inputs – money, human resources, drugs and commodities, etc. – to the service providing units in a timely way. They also ensure that resources are better managed (planning, financial management, M&E). This chapter discusses the various support systems and their contribution to the performance of Kenya's health sector. Figure 5.1 illustrates.

Figure 5.1 Systems to support health sector performance



The interface refers to the relation between the community aspirations and expectations at one side and the objectives of the health services to attain greater coverage and community involvement and empowerment at the other side.

5.1 Interface between Services and Community

The relationships among the various components of the service delivery system as it is implemented by the public sector and the community at village, household and individual levels are complex and not always well understood. At both perspectives, the system apparently shares the same objectives, but in reality there may be very different perceptions and concepts of what is required to attain good health. The public sector often defines health in terms of services and in terms of the absence of disease. Out in the community there may be different, multi-layered concepts of health. These may sometimes correspond to the "formal" view (as when requesting for additional infrastructure or the presence of a nurse of medical doctor), but sometimes they are clearly different from allopathic medicine (as when referring to traditional concepts to explain the origin of their sufferings).

It is this complex relationship that is referred to in this plan as the "interface". Because staff working in the public sector do not always recognize or understand the relationship between the two perspectives – or that the community view even exists – they do not solicit community participation in the implementation of health care services. The result too often is top-down decision making that lacks community involvement and ownership – and the failure of otherwise well-intended activities.

Both the horizontal and vertical relationships between the boards and committees on one side and the management structures at the other side need clarification in terms of the selection of members and their tasks, responsibilities and accountability towards each other. In a wider context, these important issues relate to questions of decentralization of service delivery and the role of local government structures. Health sector governance and management structures at various levels are illustrated in Table 5.1. They will be addressed as part of leadership outputs in Chapter 6.

In the past MOH has taken a "basic needs approach" to address and relate to the needs of the community. The primary health care activities that were part of that approach have not made much impact on the health status of the population. For the coming five years, MOH therefore intends to look afresh at its relationships with communities and move towards the adoption of a human rights approach to the implementation of KEPH-related activities. The basic needs approach in principle helps a marginalized group to obtain access to services. The human rights approach calls for existing resources to be shared more equitably, so that everyone has access to the same services. Principles of the human rights approach are:[8]

- Human rights are indivisible, universal and interdependent. As claim-holders, people not only have a right to something, they are also entitled to claim that right from those that have the duty to implement it (duty-bearers).
- Human rights imply corresponding duties and obligations. This implies that those that claim a right (the claim-holders should hold the duty-

[8] Relevant background reading on the human rights approach is given in: Urban Jonsson, 2003, Human Rights Approach to Development Programming.

Table 5.1 Governance and management structures within the health sector

Admin levels	Management	Governance	Stakeholders
National	MOH/HQ	Parliament	JICC & ICC
Province	PMO/PHMT Hospital management team	None Hospital management board	None
District	MOH/DHMT Hospital management team	DHMB HMB	DHSF
Sub-district	Hospital management team Health centre management team Dispensary management team	HMB Health centre committee Dispensary committee	
Village	CORPs	Village health committee	

bearers accountable for the realization of the right – in this case, access to health care.
- Important international rights-focused instruments with a bearing on the health sector include: the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Programme of Action of the International Conference on Population and Development.

MOH adopts the human rights approach as part of the implementation of the KEPH at the first level. This means that staff working at the levels 2 and 3 (dispensaries and health centres) and personnel working at level 4 (district/primary hospitals) need to be well prepared for such an intervention. The DHMT, DHMB and staff in the health facilities will all need special training.

The objective in this area is to revitalize the community–service delivery interface through the adoption and implementation of a human rights approach to service delivery. For that to happen, the public sector (health as well as others) has the duty to respond to these aspirations and in this way enter into a dialogue where tasks and responsibilities of both sides are defined and controlled.

The strategies the central MOH will follow are:
- Consulting the community in their different settings to respond to their aspirations and expectations.
- Adopting a learning-by-doing approach to build capacity among health staff.
- Involving other stakeholders (FBOs, NGOs, CSOs) in the development of the new primary health care interventions.
- Defining the District Health Stakeholder Forum as the platform where coordination and methodology development for the human rights approach will take place.
- Ensuring adequate resources for the implementation of these interventions.

The main outputs in the coming five years are presented in Box 5.1. More detailed outputs to be achieved in the first year are incorporated into Annual Operational Plan 1.

Box 5.1 Outputs for the services–community interface

- Lessons have been learned from Kenya (FBO, NGO, CSO) and other countries that have embarked upon the human rights approach as part of the primary health care strategy and an appropriate decision incorporated into the community strategy.
- A clear remuneration mechanism, choosing between volunteerism or remuneration of CORPs, defined before "going nationwide". Similarly, the gender of the CORPs to be selected has been defined.
- Decision made whether to use auxiliary midwives (remunerated) or trained traditional birth attendants (volunteers) as the new skilled birth attendants at community level.
- Selection criteria defined for the role of village health committees and CORPs in the national health system and the tasks and responsibilities of the VHC, the CORPs and the health workers articulated.
- MOH has drafted a viable strategy to guide the work of the Provincial Medical Officers (PMOs), the DHMTs, and in particular levels 2 and 3.
- The relationship of the CORPs with other already existing volunteers working at community level, like community-based distributors (CBDs) and traditional birth attendants (TBAs) defined.
- The relationship of the village health committees and the CORPs with the Health Facility Committees at dispensary and health centre level defined.
- Capacity building programme for health workers at levels 2 and 3 elaborated with help from the private not-for-profit sector (e.g., FBOs).
- Annual fast-track interventions defined and implemented.
- Capacity of health workers and VHCs/CORPs strengthened through specific training and improved supervision.
- Funding requirements for the implementation of the KEPH at this level secured.
- All districts have functional VHCs and CORPs.
- Primary health care activities at community levels initiated.
- Decision made whether VHCs and CORPs will be an integral part of the national health system, including having access to some essential drugs and other necessary equipment (e.g., delivery kits).

5.2 Health Planning

District health plans (DHPs) are now firmly rooted in the daily routine of Kenyan health services. Guidelines for DHPs and a training manual have been developed and are in use.

Yet districts are not yet able to prepare comprehensive plans that include the full resource envelope because the methodology is not fully adhered to: The resources are not completely community centred and most programmes still prepare their own parallel work plans with (vertical) funding of their activities.

Another deficiency is that priority and target setting is not yet defined by the national level. There exists no agreement between national (or provincial) and district health authorities that defines the expected annual outputs (or targets) or the resources the DHMTs require to achieve these outputs. Resources often arrive late in the year and the information system is still deficient. For these reasons a performance-based management agreement does yet seem feasible.

NHSSP II sets the specific objective of strengthening district health planning, with the intention of arriving at a performance-based contract to be established annually between the central and district levels. Under the plan, the mutual responsibility of both sides is acknowledged (providing necessary resources, for the one, and achieving stated targets and outputs, for the other) and district targets will become part of the national health system.

Strategies to arrive at such a situation touch different parts of the health sector. At the district level, the M&E system should be able to provide reliable indicators of the performance of the district. The available resources should be known at the beginning of the year, shared with all the stakeholders (through District Health Stakeholder Forums) and provided in time to implement the planned activities. Financial (and other) reporting should be ongoing, and supportive supervision should be regular and focused on the intended outputs. Targets should be defined by the DHMTs themselves to promote ownership, taking the national targets and the available resources into account.

At the central level, the various departments should provide the district health authorities with the necessary guidelines, targets and other relevant information and make sure that they are understood by them. The central level (including Treasury) should provide the districts with the (financial) resources on time and in the expected quantities. National programmes should provide support upon request by the districts (as expressed in their district health plan) and avoid disturbing the district activities with visits and workshops. Finally, development partners should increasingly bring their resources into a central "Health Fund" together with the funds from the MOH, so that these funds can move together and provide for the district operational costs.

The expected outputs for the coming five years are summarized in Box 5.2.

For KEPH to reach the first level, the support of the provincial and national levels is an essential condition, without which the programme cannot succeed. NHSSP II will adopt a learning-by-doing stance in developing the human rights approach for the health sector.

5.3 Financial Management

MOH has been implementing the financial management system presented in Treasury Circular 3/2000 for the last five years. The use of this system in supporting smooth operations of programmes has not been successful, however, particularly at the lower levels of management. Quarterly financial disbursements that are released to districts through Authority to Incur Expenditure (AIE) often arrive very late at the DHMT office. Statements of expenditure (SOE) from the districts arrive back at the central level even later. The delays on both sides have made it difficult to utilize the money for its intended purpose. This in turn leads to serious under-expenditure of approved budgets arising from the inherent complex accounting system (complicated and time consuming mechanisms for financial flow and too many accounting documents required). The problem has been so serious that it has defeated efforts to build capacity in the districts to adequately manage finances by providing training on the use of a computerized financial management system (FMS) and information on GOK accounting and finance procedures.

The drive to implement the KEPH framework, with its emphasis on the peripheral levels of the health system (levels 1–4), its intention to accelerate decentralization of decision making and the desire to allocate more resources to these peripheral levels, puts even more pressure on the financial management system to disburse and account for resources more efficiently than ever before.

Box 5.2 Outputs for support for district health planning

- A performance based contract signed annually between the central MOH and the District Medical Officer of Health (DMOH), linking resources required from the centre (GOK and development partners) with realistic targets set by the DHMT.
- DHMTs are responsible for deciding on their annual district targets, as they are accountable for achieving them.
- DHMTs and other stakeholders receiving relevant and adequate capacity building to undertake these planning activities.
- District targets in line with the national targets set by MOH (at the summit); they will take the expected available resources into account.
- KEPH activities at community level are part of the district health plan.
- Work plans of the various national programmes revised and brought into line with the NHSSP II planning format and with the interventions defined in the KEPH for all levels.
- Expenditure limits (ceilings) for budget preparation in place.
- District and central level managers are accountable not only for the inputs utilized but also for their expected results (outputs).
- AOP 2 developed through a bottom-up approach and submitted on time for approval and incorporation into MTEF.
- PMOs, PHMTs and HQ departments conduct regular action-oriented and meaningful supportive supervision in their districts using agreed tools.

As MOH is looking forward to introducing the sector-wide approach to programming, the financial management systems need to be revised and strengthened, not only to help ensure effective and efficient delivery of services, but also to meet the expectation of development partners. The financial management system is one of the critical elements that will definitely affect the pace of implementation of the KEPH. Nevertheless, MOH recognizes the limit to which it will be able to strengthen financial management on its own, as the financial system is to a large extent the responsibility of other ministries within the GOK (Ministry of Finance/Treasury).

The objective of the financial management system in the next five years will be to establish a robust performance-based accounting system designed to enable timely disbursement of funds, timely production of financial returns for reimbursements, and timely and accurate accounts for the sector. Technically, efforts will be made to link the budget with the annual inputs (through the DHP) and – to the extent possible – the expenditures with the outputs achieved (resource-based management).

The strategies of the Ministry of Health for achieving this are:

- Learning from best practices within the region and the country: There are experiences in Kenya and in the region with similar structures and systems that are doing well in disbursing funds downwards and reporting expenditures accurately and on time upwards. The MOH will learn and adapt these best practices to get quick results.

- Scanning the developments in the Treasury: The Treasury will undoubtedly be trying to improve the financial management of the country in the next five years. This will affect positively the efforts made in the MOH. It may at the same time result in duplication of efforts. MOH will therefore coordinate and follow up with the Treasury initiatives before embarking on its own activities.

- Building capacity (systems, hardware, software and skills): The weakness in the current financial systems relates to complicated procedures, weak ICT, and lack of adequate and skilled personnel. In addition to working towards revising the procedures and rules, MOH will therefore ensure that adequate capacity is built in the area of ICT for financial management (hardware, software) and will train health workers involved in the accounting system.

- Using short-term technical assistance: The development of a performing financial system may not be possible, given the existing capacity within MOH and probably within the government system. MOH initially will outsource the development of

M&E is defined to include the health management information system (HMIS), supportive supervision and periodic reviews.

such a system, while making sure that adequate skills transfer is made for sustainable management of the systems.

The main outputs expected in the next five years are shown in Box 5.3.

5.4 Monitoring and Evaluation

Monitoring and evaluation in the Kenyan health system is essentially based on reports from the routine HMIS, supervisory (field) visits and periodic reviews. The function of M&E (including the HMIS) is twofold: to inform policy makers about the progress towards achieving targets and meeting objectives; and to assist health managers in day-to-day decision making. The HMIS shows imperfections, as timely and comprehensive data are not available at one place in the central MOH (which should be the authoritative source for all departments to consult). In addition, the information is not performance based or output oriented as it does not yet serve decision making.

As a recent report analysing the current M&E process and HMIS stated: "currently available information is not adequately used for managerial decision making, data quality and timeliness is not optimal and there are several gaps and a great deal of overlaps in data collection by the various programmes".[9] In addition, a national M&E policy is not yet in place and the list of core indicators for use by the DHMTs has not yet been formalized and endorsed nationally.

These imperfections are serious, as they have potential to prevent the monitoring of the performance of the whole NHSSP II and AOP 1. For these reasons, MOH will address this issue as a matter of urgency. MOH sees it as a challenge to ensure that data from the operational level of service delivery

[9] MOH/HSRS, March 2004. Strengthening district level M&E and HMIS in Phase I districts – Proposal for a support package.

Box 5.3 Outputs for Financial Management Systems

- A system of direct financing to health facilities piloted in a few districts, following the MOEST route, with a restructured fund flow and more simplified accounting procedures, with due regard for proper accounting of funds that meets government and donor requirements piloted and with its results reviewed for possible replication.
- Strategy for public financial management reform developed and implemented (focusing within MOH) to assist the move towards SWAp and the establishment of a Common Fund. Stakeholders (for-profit and not-for-profit) able to access special funds for the poor (GFATM, PEPFAR).
- Pooled funding arrangements formulated, jointly appraised by stakeholders and implemented as defined in the Common Management Arrangements.
- The financial management system supports the implementation of KEPH through:
  - Establishment of basic institutional framework for sustainable financial management systems.
  - Strengthening of systems to meet national accounting and auditing requirements.
  - Development of a financial management information system that captures both the age cohort and levels of care in budgeting and expenditure reporting.
- Transparency in resource use ensured by providing information on service standards and resource allocation. Financial reports available not only to MOF and development partners but also to the public at large.
- Authority for budget execution deconcentrated and transferred to the Budget Management Centres (being DHMTs and level 4 and 5 hospitals), ultimately moving towards block grant allocation.
- Computerized financial management information system developed and functional for budget preparation, implementation, reporting and, ultimately, transactions accounting.
- The internal audit of financial operations and procedures strengthened, including the introduction of performance audits at all levels of budget execution.
- Performance-based budgeting process introduced (establishment of Budget Management Centres), linking budgets to inputs and linking outputs to expenditures with workable monitoring and accounting mechanisms.

sites (health facilities) are channelled through the appropriate pipelines (districts and provinces) towards the central level to enable monitoring of health sector performance.

The overall performance indicators and targets the MOH wants to achieve by the end of NHSSP II still need improvement to make them reliable and complete. In the meantime, it is expected that all districts – as a minimum – will adopt and use these sector performance indicators for their daily work. Districts and programmes are expected to add other more specific indicators to supervise the performance in their respective fields.

The objectives of the M&E support system are to assist health managers to make informed decisions and contribute to better quality planning and management. The strategies for achieving these objectives are fourfold, based on:

- Revising the HMIS tools required for data collection, compilation and reporting, as they relate to NHSSP and AOP, making them practical, decision oriented and performance related.
- Investing in human capacity building for M&E.
- Triangulating facility and population based information systems.
- Stimulating operational research (OR) that provides answers to service and management related questions (collaborate with research institutions).

Outputs expected from the M&E support system are summarized in Box 5.4.

Imperfections in the existing M&E system are serious, as they have potential to prevent the monitoring of the performance of the whole NHSSP II and AOP 1.

5.5 Human Resource Management and Development

Kenya suffers from an overall deficiency of human resources for the health sector. There is a shortage of health workers and glaring skills imbalances within the existing workforce. Health workers are unevenly distributed – between urban and rural areas, and between the public and private sectors. The working environment, with deficient equipment, lack of drugs and irregular supervision, saps morale and effectiveness. There is, as well, a weak knowledge base in skills and competencies. These problems are interrelated and hamper planning and service delivery.

The Ministry of Health is committed to developing its human resource base through effective policy and making strategic choices in the area of human resource management (HRM) and human resource development (HRD). A comprehensive and balanced package of measures will be developed that is expected to support the intended improvement of

Box 5.4 Outputs for Monitoring and Evaluation Systems

- National M&E policy and strategy defined and endorsed. An agreed list of core indicators for use by DHMTs and health facilities in place.
- M&E indicators are used in annual performance reports at all levels.
- An integrated set of HMIS tools (for data collection, compilation, aggregation and reporting) in line with KEPH matrix developed, with a set of guidelines on how they should be used.
- Data-sets defined to measure regional disparities (Arid Land policy) and resource allocations to enhance pro-poor interventions.
- Mechanisms designed and implemented for making managers at all levels accountable for the results that they are expected to achieve in their work plans. Tools for rewards/sanctions in place.
- Comprehensive checklists adopted by DHMTs and used in field supervision, with a standard format for supervision reports.
- Financial and M&E reporting aligned.
- Quarterly performance reports shared with all actors.
- Operational research (OR) activities undertaken that relate to relevant policy related questions to improve service delivery and management.
- A plan for automation of district health M&E systems in place; Implementation of this plan finalized.

A comprehensive, balanced package of measures for human resources management and development will be developed to support the intended improvement of health system performance.

health system performance. In this regard, MOH will work in close collaboration with the Public Sector Reform and Development Secretariat, which is spearheading the introduction of results-based management in the public sector.

The condition for the successful implementation of such a performance-based system is that both levels – national and district – feel responsible and committed to make it work. To arrive at such a situation, substantial preparatory work is needed to put the systems in place that will allow for this condition to be fulfilled.

Therefore, the prerequisites for a performance-based management system are:

- Timely availability of all known resources (finance, staff, drugs, transport, etc.).
- Reliable indicators to measure the outputs.
- Clear lines of communication and reporting.
- Trust, flexibility and transparency in the relations between the centre and the periphery, for a supportive rather than control-oriented working environment.

5.5.1 Human Resource Management

The 2004 human resource mapping and verification study[10] found, among other things, that staffing levels do not meet prevailing MOH staffing norms. Almost half of the dispensaries (47%) have just one community nurse and one or two support staff, while 3% have only support staff who are not qualified to administer drugs. Nurses were found to be overstaffed in district and provincial hospitals, while many health centres and dispensaries were acutely understaffed. An estimated total of about 2,300 nurses is available at levels 4 and 5 who could be redeployed directly to fill the existing gaps at levels 2 and 3. Similarly, there is a great disparity in staffing of doctors at district hospitals, with about half of the hospitals having fewer than six doctors (out of 12 required) and others having more than 20. The study also found that Public Health Officers (PHO) and Public Health Technicians (PHT) form a cadre of staff that appears to be severely under-utilized. MOH will revitalize these cadres and bring them together with other members of the DHMT into the intended activities at the community level.

The objective of the human resources management component is to optimize the use of available human resources by instituting sound management principles at the central level and decentralizing certain functions where appropriate.

The strategies that will be used to this effect are fourfold:

- Creating an enabling environment (norms, values, guidelines and tools) for health workers to improve their performance.
- Aligning tasks and functions of the existing workforce in relation to KEPH and existing morbidity and mortality patterns.
- Defining results-oriented, performance-based indicators that will form the basis for contracting between health managers at various levels, along with a supportive capacity building training programme.
- Strengthening leadership, management, supervision and accountability, all with a view to enhance health worker motivation and performance.

The expected human resource management outputs of NHSSP II are presented in Box 5.5.

5.5.2 Human Resource Development

MOH will take the lead in identifying the current gaps in the available workforce and in their technical competencies, as compared with the requirements derived from KEPH priorities. It will collaborate with the Ministry of Education, Science and Technology and other relevant stakeholders (national and provincial training schools, Kenya Institute of Management) in actually planning for the development of the needed capacity.

The objective of the human resources development component is to build additional human capacity in line with the health needs of the population, align human resource development

Human resource management envisages improving the use and performance of the already available workforce, while the objective of human resource development is to increase the volume, quality and mix of the workforce in order to address shortages.

[10] Ministry of Health, December 2004. Human Resource Mapping and Verification Exercise.

Box 5.5 Outputs for Human Resource Management

- Computerized staff tracking system in place and maintained by central MOH on the basis of regular reporting by all districts and provinces.
- Redeployment of staff (over- and understaffing) addressed, in particular redeployment of nurses to accelerate KEPH implementation at lower levels (fast-track 2) and redeployment of doctors to poorly staffed district hospitals.
- Policy recommendations of the human resources mapping study implemented; the suggested detailed action plan developed and implemented.
- Results-oriented performance management introduced and operational among central, provincial and district managers; performance standards and expected outputs defined and a supportive training programme is in place. Private sector expertise used.
- Comprehensive human resource management guidelines elaborated and adopted. These guidelines will include revised/rationalized staffing norms (based on workload); transparent criteria for redeployment of staff; harmonization of employment schemes between various categories of employers (GOK, NGOs, FBOs); policies to enhance staff motivation and welfare and improve staff retention; the introduction of annual staff performance appraisals; and suggestions for the introduction of a functional performance-based remuneration system with incentives and/or promotion.
- Mechanisms for making managers at all levels accountable for the results they are expected to achieve in their work plans designed and implemented, and tools for rewards/sanctions in place.

activities with KEPH priorities and make the development of the human resource more demand driven (rather than supply driven).

For this to happen, a concerted effort is required through which the various MOH departments, under the leadership of the Human Resources Department, will elaborate a comprehensive human resources development plan that provides a prioritized list of required staff for the next five years, including detailed plans on how and where these new staff will be trained and what the implementation of such a plan will cost.

Strategies to realize these objectives are:

- Deciding on recruitment and posting of additional staff to deprived and under-served areas in line with KEPH priorities at levels 1, 2 and 3.
- Advocating for decision making authority about the use of (at least part of) human resources at district level.
- Participating in curriculum development to reflect MOH needs.
- Advocating for increased resources to training institutions.
- Instituting systematic on-the-job career development mechanisms.

The expected human resources development outputs of NHSSP II are shown in Box 5.6.

Box 5.6 Outputs for Human Resource Development

- National human resources development plan elaborated and ready for presentation at Health Planning Summit 2007. This plan will take into account the specific competencies required to deliver the KEPH and will address both pre-service and in-service activities. It will specify the numbers of various categories of staff to be recruited and deployed. Targets will be set in subsequent AOPs, once the human resource development plan has been adopted.
- Training needs assessment elaborated to establish training requirements (and identify the gaps within the current training capacity) in the light of KEPH and NHSSP II (by end of 2006) and relevant curricula developed.
- Training programmes in place for junior and senior managers to strengthen leadership, management, supervision and accountability.
- Decentralization of part of the human resource development budget to districts and individual health facilities.

5.6 Quality Assurance and Standards

Kenya's health sector faces a variety of quality imperfections such as substandard health facilities, professional misconduct, quacks offering bogus services and a poorly regulated pharmaceutical subsector, amongst others. There does not yet exist a nationwide system for monitoring the quality of the health care provided. It is therefore time to review and update the Kenya Quality Model (KQM) and to introduce regular clinical audits.

The supply-side measures need to be complemented by strengthening the demand-side of the provision of care. Steps need to be taken to improve, establish and protect client rights, for example by introducing a citizen's health charter, posting treatment fees and exemption schemes in clear view in all health facilities, and ensuring that proper complaint procedures are in place and known to the public.

Moreover, according to a recent study, the performance and management of professional associations in Kenya in general is weak. There is little coordination and sharing of information among them. The legal position of the various boards and councils to undertake and effectively enforce some regulatory functions is ill-defined.[11]

The objectives of the quality assurance support system are to facilitate and support the development and use by all health professionals of clinical standards, protocols and guidelines; to strengthen patients' rights; and to revitalize and strengthen the relationships between MOH and the various professional bodies.

The strategy is to enhance and stimulate collaboration with other technical departments within MOH and with professional associations on QA issues.

The expected outputs in this area over the coming five years are shown in Box 5.7.

5.7 Commodity Supply Management

Whereas the supply of pharmaceutical and non-pharmaceutical products to faith-based organizations has been cost-effective and efficient for many years, public sector provision has been largely supply-driven and unsatisfactory. In 1997, key stakeholders proposed measures to implement the policy imperative of the Kenya Health Policy Framework 1994–2010. The main thrust of the proposed mechanism was a shift from a supply-driven to a demand-driven system. This required institutional, legal and policy related interventions. These efforts led to the creation of the Kenya Medical Supplies Agency (KEMSA) in 2001.

It was equally proposed that most supplies be centrally procured to ensure quality and economies of scale. It was envisaged that KEMSA would take over the central procurement functions currently handled by the MOH headquarters, whilst improving the logistics capacity of the supply chain. The medium-term procurement plan for health commodities (MTPP) would guide the central procurement requirements. The required reforms to procure and distribute supplies were thus expected

[11] Njoka, December 2003, The Potential Role of Professional Health Associations in the Regulation of the Private for-Profit Sector, Kenya Country Study. South Consulting, Nairobi.

Box 5.7 Outputs for Quality Assurance and Standards

- Clinical standards, protocols and guidelines in the country developed and disseminated among all professional health workers.
- Guidelines in the area of KEPH interventions elaborated for all levels and for each age group.
- Patient referral guidelines developed, implemented and adhered to in all health facilities in the country.
- Patient rights defined.
- A Citizen's Health Charter, treatment fees and other important operational information posted in all health facilities.
- Roles and responsibilities of boards (DHMBs, Health Facility Committees) and councils strengthened.
- Public Health Act reviewed (last review dates from 1986), including registration, accreditation, inspection, and control of public and private health providers.
- Health laws and other regulatory mechanisms updated and gaps for future action identified; the health sector coordination framework formalized in a new law.
- Professional bodies strengthened to contribute towards professionalism and ethics, as well as the enforcement of standards and regulations.

to progress in tandem with the necessary capacity building for all public sector facilities and districts to plan, manage, use and monitor their requirements, on the basis of a given resource envelope. This fits entirely with the intended demand-driven approach that is part of the decentralization process.

To accomplish this, MOH began to scale up its move towards a demand-oriented procurement system at the district level. Guidelines and training manuals have been developed and the system could be rolled out slowly. Attention is still needed for setting up – at district levels – the basic structures for purchasing and quantification, stock control and warehousing, and inspection.

The procurement of pharmaceuticals at central level, their distribution and rational use, comprise a complex system of institutional, legal and policy related matters that together frustrate attempts to respond to the original aims of the pharmaceutical reforms. This prompted MOH to commission a comprehensive study of the functioning of the Kenyan pharmaceutical drug sector.[12] MOH awaits the summary report before it will make some of the necessary decisions.

The objective of the commodity supply support system is to ensure that commodities (pharmaceuticals, non-pharmaceuticals and equipment) are sufficiently available (as per the standards laid down in medical procedures and guidelines), that they are used efficiently and effectively, and that they are properly accounted for.

The strategies to achieve this will be:

- Entrusting local managers (of individual health institutions and districts) with the responsibility of ensuring availability, proper use and accountability, while strengthening their technical and managerial capacity to do so.
- Instituting appropriate procedures for decentralized (demand driven) procurement, including quantification of requirements, costing, budgeting, purchasing, warehousing, stock management, promotion of rational use and accounting.
- Updating annually a resource constrained medium-term procurement plan (MTPP) to guide the procurement of commodities.

The expected outputs for the coming five years are presented in Box 5.8.

Box 5.8 Outputs for Commodity Supply Management

- Institutional arrangements for regulation, procurement and distribution in the pharmaceutical sector, focusing on MOH involvement in policy, planning, finance and monitoring, reviewed, with special attention given to transparency and accountability in the area of procurement and financial reporting.
- National Drug Policy (NDP) reviewed, updated and adopted.
- Five-year strategic plan for the pharmaceutical sector produced.
- Medium-term procurement plan revised and updated annually.
- ICT framework in place that links the functions of finance, audit and procurement.
- Districts' demand-driven procurement plans implemented in more than 50% of the districts; guidelines for decentralized procurement in place.
- Drug supply management strengthened (including procurement, reception, warehousing, stock control, inspection and monitoring).
- The Kenya Essential Drug List (EDL) reviewed, updated and adopted.
- Guidelines for rational drug use developed and used in more than 50% of health facilities.
- Capacity for drug supply management strengthened, including the use of a drug management information system at lower levels.
- Guidelines on the role of therapeutic committees produced.
- Pharmacy and Poisons Board (with the National Quality Control Laboratory and an Inspectorate of Medicines and Pharmacy) serves as a National Drug Regulatory Agency.
- Tasks/functions of MOH and regulatory bodies de-linked.
- KEMSA competes with and complements other supply channels.

5.8 Investment and Maintenance

The utilization of health services depends to a large extent on the availability of skilled and competent human resources, the cleanliness of the facility, and the availability of drugs and diagnostic medical equipment. The physical infrastructure in some regions of the country has a

[12] Studies were conducted on national drug policy; access and institutional capacity; quality assurance and sustainability of the medical supplies sub-sector; and rational drug use and logistics management. A summary report will be produced on the strategic approach to reform this aspect of the health sector.

coverage of one facility per 50–200 km, thereby adversely affecting geographical and financial access to basic health care, especially in regions that already have poor health indexes. Increasing access to and affordability of health services necessarily requires investment in infrastructure, equipment, maintenance and transport.

5.8.1 Infrastructure and Equipment

The many years of neglect caused by budgetary insufficiencies has reduced most facilities to a sorry state that requires rehabilitation before a maintenance programme can be instituted. Some of Kenya's health facilities lack adequate premises for priority interventions, such as delivery rooms, maternity, laboratories, theatres, etc. Public health technicians who were trained to maintain physical infrastructure are not used for that purpose.

Similarly, because of low budgetary allocations to health, the few available resources have been fully charged to pharmaceutical and non-pharmaceutical commodities. As a result, equipment has not been replaced for a long period, compromising the quality of care provided. Staff skilled in maintenance are rarely available at the district levels and below. Where they exist, they are not supported by the necessary tools, consumables or financial resources. General maintenance capacity has therefore been eroded over the years. Keeping the health infrastructure and the equipment in good condition would undoubtedly change the public's perception of good quality care and this in turn would encourage people to use the available health services.

The objective of the maintenance system is to support the provision of good and adequate health services through the continuous availability of care related equipment, a reliable energy supply, adequate provision of water and waste disposal tools, and the preventive maintenance of available physical infrastructure.

The outputs of the investment and maintenance system by the end of NHSSP II are detailed in Box 5.9.

5.8.2 Transport

Transport in the health sector is vital for its smooth operation. Transport includes first and foremost ambulance services that provide first aid and emergency medical care to patients who need to be treated in a secondary or tertiary health facility. It also enables the transportation of supplies and materials/commodities needed in the districts. Here, often ambulances are used because no proper vehicles are available. Finally, transport (vehicles, motorcycles or bicycles) is needed in the districts and by the hospitals for their supervisory functions: supervising the implementation of the various programmes, taking staff to facilities that have no access to radio or other means of communication, or bringing staff to the communities where programmes are being implemented.

The overriding weakness of the public health sector's transport system is the absence of a realistic maintenance plan and the recurrent funds required to keep the transport fleet operational. This weakness has serious impact on the implementation of a variety

Box 5.9 Outputs for Investment and Maintenance Systems

- The condition of physical infrastructure and equipment inventoried to provide the elements for the elaboration of a MOH rehabilitation and maintenance plan, its organization, and the allocation of resources.
- Maintenance policy and operational guidelines for different levels developed and being implemented.
- Planned preventive maintenance (periodic inspection, maintenance and analysis of maintenance related data) promoted to minimize or prevent wear and tear, breakdowns of equipment, and rundown of buildings.
- Staff using the equipment are adequately trained on how to handle and undertake preventive maintenance to avoid user-induced breakdowns.
- Medical equipment needs assessment and drug needs assessment finalized.
- Maintenance capacity (primary and secondary level workshops) at appropriate levels (district/province) established with adequate machinery, hand tools and basic consumables.
- Each district has at least one qualified maintenance officer (with capacity to undertake maintenance needs assessment, keep records).
- Adequate resources allocated in the annual budgets for preventive and curative maintenance. MOH will decide on a maintenance rate, being a percentage of the acquisition value.

of existing programmes, like KEPI, outreach activities, or the reproductive health and TB programmes.

The objective of a transport system is to ensure the availability and maintenance of an adequate number and type of transport facilities that can be maintained financially.

Strategies to be adopted in NHSSP II for the establishment of a national transport policy are:

- Increasing the operations and maintenance budget lines (O&M) specifically for the maintenance of the transport facilities.
- Providing districts with new means of transport based on their needs.

Expected outputs over the coming five-year period are listed in Box 5.10.

Box 5.10 Outputs for Maintenance of Transport

- National transport inventory finalized by the middle of 2006.
- Transport needs assessment conducted by end of 2006.
- A National Transport Policy, including procedures and funding for maintenance, adopted by end of 2007.
- Specific measures proposed to strengthen a community-based transport system (bicycles and motorbikes) and emergency referrals.
- Requirements to initiate a national ambulance service inventoried, and if considered viable, implemented in Nairobi and Eldoret.
- District transport inventory ready in 50% of the districts, together with a maintenance plan for the fleet and capacity of district staff

5.9 Communication and ICT

Communication within the health sector has different meanings. In NHSSP II it will relate to the range of communication channels that exist between the various levels of administrative responsibility (lines of reporting, horizontal and vertical) and medical care (communications needed for referral of emergencies). It will also refer to the information and communication technologies (ICTs) that are becoming increasingly essential to improve and facilitate such communication.

The various lines of reporting as well as requests for emergency referrals (from health centres to hospitals) are not often considered a system in its own right and indeed the separate elements of communication could also be grouped to some extent under the other support systems discussed earlier. There are advantages to bringing them together as one system that defines the effectiveness of the communication in the health sector. By looking at communication as a system, its imperfections and bottlenecks become clearer. In fact, much of the frustration and misunderstanding that have affected the sector could have been avoided if clear and appropriate guidelines had been in place to define how to conduct communication with the various institutions around us.

The objective of this support system is to improve communications among the various actors operating in the health sector.

The most important outputs envisaged for the coming year are shown in Box 5.11.

Box 5.11 Outputs for Communication Systems and ICT

- Lines of reporting between horizontally and vertically placed actors reviewed.
- A national communication plan/strategy has been defined.
- Periodic health bulletin/newsletter produced regularly by MOH and distributed to all facilities.
- Most remote facilities using radio transmitters for emergency evacuations.
- ICT network within the central MOH established.
- ICT requirements for the health sector inventoried and costed.
- ICT policy implemented in MOH; tools and guidelines for use drafted.
- ICT network expanded to provincial and district levels, All districts (DHMT and hospitals) have access to email with central MOH.
- Access to ICT experience/expertise assured (contracted from outside).
- District communication/referral strategy defined in two districts per province.

6 Governance of NHSSP II

This chapter addresses the actors involved in governing the health sector (MOH and stakeholders), what needs to be governed (health reforms and the sector-wide approach) and – to a limited extent – how it will be done.

The tasks and responsibilities of the Ministry of Health are many: it articulates policy, licenses and deploys personnel, sets standards and regulations, controls budgets, and advocates for increased resources. Ultimately, the Ministry is responsible for shaping the nature of the health system and the delivery of a sector-wide programme. This responsibility is not carried by MOH alone. It involves many other players, within and outside government.

6.1 Ministry of Health Responsibilities

Within the Kenyan health sector, the responsibility of the Ministry of Health in essence is to:

- Establish the health policy framework: This includes: issuing annual strategic direction and planning guidelines for itself and for other stakeholders (with budget ceilings based on MTEF); and ensuring that budgeting and resource allocation reflect national priorities. It also involves monitoring and controlling the performance of the health care providers in the public sector (DHMTs, and primary, secondary and tertiary hospitals). Besides these, MOH regulates the providers in the private sector (private for-profit and the not-for profit health providers like FBOs, NGOs and traditional practitioners).

- Ensure quality of service delivery: In NHSSP II specifically, the MOH has taken steps to initiate the KEPH and monitor its implementation. In addition, systems are being set up to produce practical and achievable annual operational plans (AOPs) and annual progress reports. MOH will also structure and define the mechanisms for regular coordination and collaboration with all stakeholders.

- Enforce regulation and control of the health sector: This includes reviewing the overall legal framework, and setting standards and guidelines to ensure quality of service delivery and overall performance. It also entails the enforcement of the legal framework, standards and regulations, including the provision of relevant information to the public.

While the past role of the central MOH has always been quite operational and geared to "make things work" at the periphery, under the current health reforms, the role of GOK and the central MOH will increasingly be to oversee, govern and facilitate the implementation of the reforms without becoming operationally involved in service provision. Increasingly the central MOH will take a "hands off, but eyes on" approach, while the provincial and district levels become more and more involved in the daily operations of service delivery. Table 6.1 summarizes the situation.

Table 6.1 Governance responsibilities at the different levels of MOH

Levels	Responsibilities / Functions
Senior management of MOH at national level	Formulating policy, developing strategic plans, setting priorities Budgeting, allocating resources Regulating, setting standards, formulating guidelines Monitoring performance and adherence to the planning cycle Mobilizing resources Coordinating with all (internal and external) partners Training health staff (pre-service)
Departments/Divisions Central MOH	Translating policies into strategic objectives and action plans for service delivery (KEPH) and for support services
Provinces (PMO)	Developing and implementing provincial operational plans in health care delivery Supervising and supporting districts Monitoring and evaluating activities Coordinating with other programmes and stakeholders (development partners, NGOs, etc.) Mobilizing resources and networking
Districts (DHMTs)	Delivering services in all district health facilities (levels 1–4) Developing and implementing district health plans (DHPs) Supervising and controlling the implementation of DHPs at health facility and dispensary levels (M&E) Coordinating and collaborating through District Health Stakeholder Forums (DHMB, FBOs, NGOs, CSOs, development partners) Mobilizing resources (private sector, DHSF, DHMB) Training and developing capacity (in-service) Maintaining quality control and adherence to guidelines

MOH is currently strengthening community oversight and ownership through District Health Management Boards and Health Facility Committees at the various levels. These bodies are expected to play an essential role in the implementation of the KEPH, the management of available resources and the setting of local priorities. Their responsibilities are often not fully understood, however, resulting in their limited involvement and ownership of the peripheral health facilities. An overview of the complex and interrelated governance and management structures at all levels of the health sector is given in Annex C.

6.1.1 Decentralization

The MOH has made substantial efforts to put into operation and reinforce the decentralization of decision making towards the peripheral health services, and in particular the reinforcement of a viable district health system, capable of managing all health activities at that level. For this, MOH has invested human resources, finance and technical assistance to make such a decentralized health system work. Some noteworthy achievements have been observed: Many districts have improved their planning and monitoring capacity. Financial resources arrive earlier, are better used and reporting is improving. Some districts are capable of calculating their own needs for drugs and other commodities, and, in general, management, leadership and commitment to improve the health situation are clearly present.

> Central MOH will take a "hands off, but eyes on" approach, while the provincial and district levels become more and more involved in the daily operations of service delivery.

Frustrations continue to be observed, however, with the lack of real responsibility for human resource management and the late arrival of too few financial resources, compounded by slow decision making and insufficient guidance by central MOH. Continuous interruptions by central visits, workshops and other interference disturb the work flow, and coordination among the various district programmes is lacking.

The working group on the restructuring of MOH acknowledges that little has been achieved during the last years to accelerate decentralization. Several reasons are cited for this. For one, MOH remains centralized in its operations, with weak administrative

linkages among the central MOH, the PMOs and the DHMBs. Moreover, the linkages within the Ministry itself appear quite ineffective. The report of the working group concludes: It is evident that decentralization within MOH operations has achieved limited success. It is furthermore a long and tedious process that is only partly controlled by MOH.

6.1.2 Public Sector Reform and the Health Sector

According to the Public Sector Reform and Development Secretariat in the Office of the President, all public service reform initiatives are to ensure that the objectives of the Economic Recovery Strategy will be achieved and in the process the country will progressively achieve the MDGs. The Secretariat has defined the following important approaches and principles:

- Establish public sector values, ethics and managerial competencies.
- Mainstream public management accountability framework at all levels (including introduction of a results-based management performance system).
- Re-establish cohesive governance and leadership capacity for transforming public service.
- Review organizational management systems and practices.

All ministries including MOH are called upon to review and undertake strategic rationalization and restructuring of their respective operations, aiming to:

- Cut operating costs.
- Improve quality and efficiency of service provision.
- Enhance organizational competitiveness.
- Strengthen institutional and leadership capacity building.

The main components of the public sector reform agenda for MOH include a review of the mission, vision and policy objectives and the revision of the institutional framework. They also involve reassessment of core functions and service delivery mechanisms; strategic partnerships; and governance parameters. Financial and human resource management get a critical look, while the confidence and satisfaction of clients in relation to the commitment of the staff comes to the fore.

While reviewing these aspects, consideration should also be given to regulatory functions, the delegation of authority, capacity building programmes, community participation, and applied or operational research (OR). The reform agenda also insists that the Public Sector Reform Secretariat be informed about the direction and efficiency of the MOH reform process.

The development of NHSSP II has enabled MOH to act on virtually all of these components of the reform agenda. The Ministry has initiated an in-depth review of all its operations, from a thorough review of its vision, mission and policy objectives to the introduction of performance-based accountability. The plan calls for a restructuring of service delivery system (through KEPH) and a review of its institutional framework. Furthermore, NHSSP II is firmly aligned with the ERS objectives, even as it redefines the content of the health reforms and the partnerships with all stakeholders (SWAp).

Rationale for Restructuring MOH

Spurred by the reform agenda, MOH undertook an internal review of its institutional framework because:

- The external evaluation of NHSSP I and the working group on restructuring MOH had highlighted some important limitations related to the internal coordination of the Ministry (ill-defined responsibilities and relationships at the apex of MOH). These limitations stood in the way of the effective implementation of NHSSP II .
- The adoption of KEPH and the renewed emphasis on health promotion and community interventions necessitated different ways of collaboration between departments and divisions within MOH. In particular, it implied a move away from providing services through the various (vertical) programmes towards an integrated and continuous service delivery to age cohorts.
- Finally, the general move towards results-based management and making service providers accountable for their work necessitated a review of the existing lines of communication and reporting.

Currently, MOH has almost finalized a thorough review of its institutional structure in order to redefine the central tasks and responsibilities of the various departments. The following criteria define the Ministry's new organizational approach:

- Functionality: The structure should allow for functional clusters of responsibility to permit a coordinated and focused approach to the delivery of KEPH.

- Decentralization: The structure should promote coordinated interventions at district levels and below: the community (level 1) largely involved in preventive activities; the dispensary and health centre (levels 2 and 3) working on both preventive and curative care; and the hospitals (district and regional) moving to more preventive plus curative and rehabilitative care (see Table 6.2).

Table 6.2 Expertise by level of service and intensity

		Promotive & preventive	Curative & rehabilitative
Level 1:	Community health services	+++++	++
Levels 2+3:	Primary health services	++++	+++
Levels 4+5:	Referral hospitals (public)	++	++++
Level 6:	Teaching hospitals	+	++++

- Complementarity: The proposed structure should allow for a coordinated and effective system of support to all the service delivery needs. For example, the provision of pharmaceuticals, the financial management systems and the monitoring of the implementation of the NHSSP II should become transparent and mutually reinforcing.
- Management: The new structure should respond to generally accepted principles of management, like clear lines of reporting and accountability, well defined responsibilities and a fair distribution of tasks among the various units.

Proposed New MOH Structure

Although changes in the proposed structure may still be made, senior management of MOH haves drafted the essential responsibilities and functions to be addressed in the plan period. The proposed structure will be made operational by adding the following elements during the first year:

- Descriptions of core functions of the various departments and sections.
- Details of job descriptions and scopes of work, together with the required competencies (experience, expertise and skills) of the respective officers in these functions (for departments, divisions and sections).
- Confirmation of lines of reporting and accountability.
- Financial implications (salaries, selection process, training, capacity building).

Once these elements have been incorporated, a comprehensive and phased plan for restructuring MOH can be finalized and endorsed. The plan will include the critical postings to be filled in the first years, the legal framework needed to formalize the restructuring process and the expected costs of implementing the restructuring.

The position of Health Secretary is proposed. The Health Secretary will report to the Permanent Secretary and be responsible for all activities related to service provision. This responsibility will include:

- Health promotion and prevention (with responsibility for levels 1–3 of KEPH) and for all essential programmes (malaria, reproductive health, child health, HIV/AIDS, TB; health promotion, nutrition, environmental health, non-communicable diseases).
- Curative and rehabilitative care by all primary and secondary hospitals (special attention to levels 4-5 KEPH).
- Health systems, including human resources development and management; planning, HMIS (including ICT) and M&E, infrastructure, equipment and transport; commodity management; and external relations.
- Quality management (responsibility for standards and inspection) and legal services.

The key functions under the direct responsibility of the Permanent Secretary will be:

- Planning and policy development, which includes policy development and review; coordination and M&E; health sector reforms; operational research; and public relations and communication.
- A Coordinating Office for Finance and Administration, including finance, public accounts, personnel administration and management, procurement and supplies, and IT support.
- A Liaison Office to relate with the various parastatals and the regulatory boards and councils operating in the health sector
- Internal auditing related functions of the MOH.

6.2 MOH and Partnerships

The objective of NHSSP II, reversing the trends in health outcomes, can only be achieved if there is a synergy in action and regular and open coordination of all activities by all partners. This

implies that joint policy responses will be required by both the public and the private sectors. The following measures will be taken to strengthen such collaboration in the next five years:

- Engage in joint planning.
- Establish collaborative regulation and develop jointly agreed explicit rules.
- Encourage informal relationships.
- Share resources, share information and share technology.
- Reinforce quality in both public and private sectors and use community to benchmark facilities: giving good facilities special benefits and promoting competition where it acts to root out poor quality providers.
- Develop common financing tools to discourage segmentation, avail incentives to the private sector to provide comprehensive care and subsidize community insurance for the poor.

Sincere and strong partnership cannot be developed overnight. MOH recognizes the need for all stakeholders to re-think their intention to collaborate and eventually to negotiate openly on new modalities of cooperation. Consensus has to be reached to arrive at new and simple modalities of operations through a give and take process. This process should be gradual, as it needs to be built on trust, transparency and accountability among all participants. MOH is convinced that in the long run, results and outputs will improve once there is collaboration and sharing of information. Table 6.3 provides some examples of possible gains and losses from such partnership arrangements.

6.2.1 Parastatal Organizations

There are six parastatal organizations under MOH, all being semi-autonomous institutions (state corporations) governed by a Board of Management (BOM). The BOM is generally composed of a group of 8–15 senior persons representing the public sector (Ministry of Health and other ministries), private sector and other interested parties. A Chief Executive Officer (CEO) together with a management team is responsible for daily management and implementation of the institutions' strategic plans. Most of the corporations receive part of their annual financial requirements from GOK (Ministry of Finance) and have to raise the other part themselves through cost-sharing or from other sources (development partners, donations, NGOs, their clients/students). (Refer to Table 6.4 for an overview of some of the features of the MOH parastatals.)

All parastatals recently finalized five-year strategic plans for 2005–2010 defining the future direction of their service provision that will contribute to the improved performance of the sector (e.g., specialized care, training, research). The Chair of the BOM of each of the parastatals will enter into a performance contract with the Government of Kenya, represented by the Permanent Secretary of the MOH. These performance contracts will, on one hand, define the contribution GOK is expected to make to their operations (within MTEF ceiling) and, on the other hand, describe the services and outputs that the parastatals have to deliver each year.

MOH will expect the parastatals to pursue the following outputs to improve their operations and performance:

Table 6.3 Gains and losses in partnership arrangements

	GOK / MOH	Development partners	FBOs / NGOs
What can be gained from partnerships	Will have predictable resources from development partners, who will support agreed priorities / align resources. Reporting will be harmonized (lower transaction costs).	Have opportunity to participate in policy and priority setting, strengthen synergy, and avoid duplications. Independent JAR will provide information on sector performance.	Can negotiate financial support and sharing of staff in peripheral services, leading to improved services.
What can be lost when going into partnerships	Will no longer decide on policies and priorities alone. Resource allocations will need to be negotiated on the basis of explicit priorities. Will be accountable to all stakeholders on deliverables.	Resources would reflect the agreed MOH priorities. Will have to give up individual reporting and accounting requirements.	Potential loss of autonomy through interference in internal policies and decision making.

Table 6.4 Features of parastatal organizations

Parastatal	Founded	Corporation status date	Mandate	Features
KNH	1901	April 1987 (Legal Notice 109)	Provide specialized care, training and research	Beds: 1800 Staff: 4,955 Doctors: 270 IPD: 2,000/d
MTRH	1917	June 1998 (Legal Notice 78)	Provide specialized care, training and research	Beds: 500 Staff: 2,054 Doctors: 92 IPD: 100/d
KMTC	1927	1994 (Legal Notice 14)	Train middle level health professionals	Colleges: 25 Staff: 600 Stud: 6,000 Courses: 50
KEMRI	1979	April 1979 (Science & Tech Act 79)	Conduct multi-sector health research	Staff: 1535 Scientists: 200 Research sites: 7
KEMSA	2001	*Strategic plan was not yet ready at the time of finalizing NHSSP II*		
NHIF	1966	1998 (Act 9)	Provide quality social health insurance	Members: 1.5M Staff: NA Outlets: 23

Key: KNH = Kenyatta National Hospital; MTRH = Moi Teaching and Referral Hospital; KMTC = Kenya Medical Training College; KEMRI = Kenya Medical Research Institute; KEMSA = Kenya Medical Supply Agency; NHIF = National Hospital Insurance Fund.

Source: Strategic plans of the respective parastatals.

- Become client centred and responsive to the needs of the population. The two referral hospitals should become centres of excellence in patient care and training of medical professionals. They should become truly referral in their operations. KEMRI should strengthen its operational research work, responding to priorities of the sector, while KEMSA and KMTC should re-direct their operations to become demand driven and strengthen their core business towards KEPH implementation (community/district-related work).
- Become cost-effective, adopting private sector management principles, such as results-based management, with a flexible and lean structure and increasingly trying to de-link their operations and funding from the public sector.
- Search for alternative financial sources and move towards full cost-recovery of their operations in order to become financially self-sustainable.

6.2.2 Stakeholders

Stakeholders in the health sector are many. They range from other ministries, many having a direct bearing on the health of Kenyans, to institutions, the private sector including non-government organizations, professional associations, and development partners. Even practitioners of traditional medicine are increasingly recognized as legitimate partners in health service delivery.

Ministries and Institutions

MOH will strengthen its relations with other ministries and institutions, as mentioned earlier in this plan, and in this way strengthen and intensify its inter-sector work. In particular in the water and sanitation sector, fruitful collaboration is expected with the Ministry of Water and Irrigation as part of KEPH implementation (joint hygiene and health promotion messages). In the education sector, special attention will be given to the expansion of school health programmes for primary (de-worming programmes) and secondary schools (two tetanus toxoid immunizations and counselling on reproductive health and substance abuse). Collaboration will be strengthened with relevant research institutions in the country to develop operational research (OR) programmes that are relevant to MOH policy development. MOH will therefore review its research agenda and define new research priorities in line with KEPH and the renewed emphasis on health reforms and SWAp. Research should become a regular tool for policy makers' review of MOH achievement of the ERS and MDGs.

Ministry of Local Government

This ministry is perhaps a special case, as it is a co-implementer of health service delivery. In all major towns and cities of the country, health services are provided by the city/municipal councils (MOH has

delegated this responsibility to the Ministry of Local Government), complemented by the private sector. It is estimated that city/municipal councils provide health care to some 15–20% of the population. Work relationships between MOH and the council authorities in general are good and cordial, with regular sharing of information and resources. Over the last three decades, however, local authority revenue collection has progressively diminished, affecting the delivery of social services including health care. The limited resources have resulted in allocations to key priorities that in most cases did not include health, with an almost corresponding deterioration of the quality of health care. MOH is addressing this issue in consultation with the Ministry of Local Government through a number of strategies, key of which has been the establishment of the Nairobi Health Board to provide guidance and oversight in a coordinated manner. First experiences are already encouraging. It is envisaged that if this model succeeds in addressing the constraints councils experience, it will be rolled out to other urban areas.

Regulatory Bodies (Boards and Councils)

The regulatory bodies (for example the Pharmacy and Poison Board and the Medical Practitioners and Dentists Board) are semi-independent institutions that operate under an Act of Parliament. These bodies perform important service related regulatory functions on behalf of the Ministry of Health: the definition of professional standards; the establishment of codes of conduct; and the licensing of facilities, training institutions and professional workers. From their work, they often generate considerable revenues that finance their operations. However, the legal position of the various boards and councils does not allow them to undertake effective regulatory functions. Under NHSSP II, MOH will strengthen the capacity of these regulatory bodies, aiming for outputs like harmonization of the legal framework of the regulatory bodies and the development of strategic plans.

Professional Associations

Various professional associations represent the interests of specific professional groups, including doctors, dentists, nurses, physiotherapists and others. They are independent and are mainly involved in welfare related activities for their members. According to a recent study, the performance and management of professional associations in general is weak. There is little coordination and sharing of information among them. If requested, MOH will consider working with these associations with the aim of strengthening their inputs to and support for the health sector.

The Private Sector (for-Profit and Not-for-Profit)

Whether for-profit or not-for-profit, the private sector is really only partially co-opted for health development. In the past years, collaboration between MOH and the private sector has been irregular and not productive. Even NHSSP I 1999–2004 recognized the need to improve collaboration in order to:

- Facilitate regular consultative meetings between MOH and private providers.
- Second critical personnel by the MOH to private providers.
- Facilitate acquisition of GOK owned land by private providers to develop health facilities in under-served areas as a step to improve equity.
- Rent out under-utilized facilities to private providers, on the condition that they cushion vulnerable groups from the high cost of health care.
- Facilitate waivers of taxes/duty on drugs and medical supplies.

Available information shows that much expertise and many resources are available from the private sector at national and district levels. These could provide significant support to central MOH, as well as provincial and district health authorities, in expanding quality care to remote and underprivileged populations. In particular, the experiences of FBOs, NGOs and CSOs in working with the community are an asset for the implementation of the KEPH at grassroots level. Learning from these experiences will help to build capacity among health workers and will thus facilitate the proposed "learning by doing" approach. The District Health Stakeholder Forums seem to be the platform where such collaboration should be promoted.

MOH will also stimulate other innovative mechanisms for involving the private sector. Among others this will involve linking the National TB Control Programme with private for-profit specialists and including the private sector in work related to the expanded programme for immunization (EPI). It may also entail expanding HIV/AIDS work to private practitioners in the cities and to the communities in the rural areas. Finally, by stimulating outsourcing and subcontracting of non-core services (e.g., laundry services, provision of food, laboratory services, etc.) to

the private sector, MOH will attempt to improve the efficiency and quality of the services and thus reduce costs. Public–private partnership seems an excellent mechanism to stimulate such collaboration.

CSOs and community-based groups are another group of not-for-profit health providers. They often consist of local initiatives that respond to a felt need, being a small maternity or dispensary, the hiring of a night guard or ticket collector, or the arrangement of transport facilities (bicycle or motorbike) in case of emergency situations. Their source of income is most often local contributions among those interested, or money from cost-sharing. As the CSOs are widespread and in addition represent active members of society with proven interest in contributing to the improvement of their health, they should be invited to participate in the implementation of KEPH in their societies.

Traditional Practitioners and Traditional Medicine

In Africa, 80% of people rely on traditional medicine because of its accessibility, sustainability, affordability and cultural status. A recent workshop[13] discussed new ways to incorporate traditional medicine into the health system. The workshop called for establishment of policy and legislation, quality assurance and standardization, capacity building, protection of intellectual property rights, and the halting of loss of biodiversity. It also recommended the development of a national policy on traditional medicine and the exploration of possibilities of initiating commercial production of traditional plants for medical use.

Development Partners

Development partners constitute a rather heterogeneous group with a variety of objectives, interventions, technical and reporting requirements, and funding modalities. Some intend to support the SWAp and participate in funding, whereas others prefer to continue their "off-budget" support for projects in specific areas or targeted to special population groups.

In general, coordination between MOH and the development partners is improving because of the recently established health sector coordination framework. MOH intends to strengthen that framework and would like to harmonize the different modes of cooperation with its development partners. International initiatives, including Rome 2003 and the March 2005 Paris Declaration[14] by the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) provide an important foundation for doing so (see indicators of Paris Declaration in Annex A).

Many development partners and recipient countries, including Kenya, have agreed and are committed to:

- Simplifying procedures and systems (like common performance indicators).
- Harmonizing their procedures (make them the same or similar).
- Aligning procedures with national systems and informing the country in a timely way of intended aid flows/contributions.
- Aligning with government budget cycles and disbursements.
- Sharing information and being more transparent.
- Untying aid or at least using a common conditionality framework.
- Strengthening local capacity and supporting government leadership in aid coordination.
- Using existing coordination structures, such as participating in joint annual reviews.
- Relying on budget support (sector earmarked or direct budget support).
- Relying on SWAp and engaging in collective and open forms of dialogue between each other and with the national governments.

MOH together with its development partners will pursue the realization of these commitments during the elaboration of the Common Management Arrangements (CMA).

6.2.3 Partnership Mechanisms

A year ago MOH presented its health sector coordination framework, which has been revised and adopted by all stakeholders. Under NHSSP II, this framework will be strengthened and broadened. The coordination framework consists of the following:

1. The Joint Interagency Coordinating Committee (JICC), chaired by the Minister, is composed of GOK representatives and representatives of missions of major stakeholders and the private sector (to a

[13] NCPD, June 2004, "Traditional Medicine, HIV/AIDS, Research and Sustainable Development in Kenya: A report of an inter-sectoral workshop", School of Monetary Studies, Nairobi.

[14] In March 2005, the High Level Forum adopted the "Paris Declaration on Aid Effectiveness", in which indicators and targets for ownership, alignment, harmonization and mutual accountability have been brought together. (See Annex A.)

The Kenyan agenda for health sector reforms integrates new developments, aspirations and challenges and identifies the implications for health sector management at the level of MOH and its partners.

maximum of 20). JICC will provide policy guidance on strategic issues of NHSSP II, including harmonization of planning and M&E. It will also coordinate resource mobilization and allocation.

2. The Global Initiatives Committee (GIC), chaired by the PS, is a subcommittee of JICC. It will respond to the three diseases of poverty (HIV/AIDS, malaria and TB) and other priority interventions, funded by the Global Fund (GFATM) and other global initiatives. GIC is responsible for resource mobilization, technical oversight and monitoring the implementation of Global Fund activities. The composition of the GIC is similar to that of the JICC, with a slightly higher representation by technicians from the three programmes.

3. The Interagency Coordinating Committees (ICCs) will guide and review overall programme management and funding (appropriation in aid, in particular) for respective areas. There will be an ICC for HIV/AIDS (chaired by NACC), one for malaria and TB, and another for reproductive health and child health, including KEPI (all chaired by the Health Secretary). Other ICCs will have responsibility for health systems and for community health services. The ICC for systems is expected to give special attention to issues of integration and systems development. The composition of these ICCs still needs to be formalized, and the various ICCs will develop terms of reference for their specific tasks and responsibilities. Programmes of the MOH and the development partners will be equally represented in the ICCs, with members selected on the basis of their experience and expertise in the subject.

4. The District Health Stakeholder Forum (DHSF), under the leadership of the DHMB chair, is meant to strengthen collaboration among all stakeholders in a district and to provide a platform for discussion and dialogue on health related issues. The DHSF should review the district health plan, as proposed by the DHMT, and coordinate the various interventions and contributions from all stakeholders. Governance and management relationships among the DHSF, the DHMT and the DHMB are shown in Annex C.

6.3 Health Reforms under NHSSP II

Part three of Kenya's Health Policy Framework (KHPF 1994) is entitled "The Agenda for Reform". It lists a series of reform measures, some of which have been fulfilled over the past decade while others remain on the agenda. Important new developments – both at the global level and on the African continent – have taken the stage since the KHPF saw the light of day. Other changes have occurred within Kenya itself. It seems therefore justified to update the Kenyan agenda for health sector reforms by integrating these new developments, aspirations and challenges and identifying the implications for health sector management at the level of MOH and its partners.

6.3.1 The Reform Process

NHSSP II defines health sector reform along the lines proposed by the Pan American Health Organization (PAHO) in 1997:

> Health sector reform is a process directed at introducing substantive changes in the health sector structures and functions to improve equity in benefits, administrative efficiency and effectiveness of actions, thereby defining the strategic direction of the sector to meet the health needs of the population. It is an intensified phase of health system transformation, implemented at a particular time (time-bound) and defined by the particular situations that justify it and will make it viable.[15]

Important here is the word "process", as it refers to a sequence of decisions and actions that need to be taken over a specific period. For Kenyan health reforms this means that the outputs of NHSSP II and the decisions that need to be made will be realized within a well-defined implementation period. The definition is also important as it indicates that Kenya's health sector reforms basically aim to achieve the policy objectives detailed in Chapter 3 of this strategic plan.[16]

Attainment of these objectives is the ultimate responsibility of the senior management of MOH.

[15] PAHO, 1997, Cooperation of the Pan American Health Organization (PAHO) in the Health Sector Reform Processes, Washington, D.C. Quoted in PAHO, December 2003, "Maximizing quality of care through health sector reform: The role of quality assurance strategies", page 1.
[16] The objectives are: increase access; improve quality; improve efficiency and effectiveness; foster partnerships; and improve financing of the sector. The outputs to improve quality were presented in Chapter 5; the outputs to improve financing will be presented in Chapter 7.

And as part of performance-based management, senior responsibles in the Ministry will increasingly be accountable for the implementation of the various outputs. The following distinction has been made:

- The outputs of the intended reforms will relate directly to these broad policy objectives and will thus fall under senior management, being the directors of departments and higher levels of responsibility.
- The outputs defined under the strengthening of health support systems (Chapter 5) will ultimately become the responsibility of division heads and other managers within MOH at central and provincial levels.
- The outputs and targets related to the implementation of the KEPH (Chapter 4) will be the responsibility of the district health managers (DMOHs) together.

6.3.2 Outputs

The annual operating plan for the first year of NHSSP II (AOP 1) will define in more detail not only the outputs to be realized but also the timeframe (quarterly) and the department responsible for their implementation, thus making the AOP an actionable as well as an operational plan. In general, the outputs detailed below for leadership, access, efficiency and effectiveness will be expected.

Leadership Outputs

- Review of structure, tasks and lines of authority of MOH is finalized and implemented in function of the intended health reforms.
- Governance and management structures that define ownership, selection and technical responsibility through boards/committees and the management team, respectively, are defined, strengthened and made functional (as part of deconcentration/devolution options, in line with the constitutional review).
- Individual annual departmental plans for all MOH departments are in place, with departmental targets, indicators and priorities harmonized with the NHSSP II and linked to ERS and MDG targets. Divisions within these departments will do the same.
- The overall health legislation, regulation and law-enforcement system has been reviewed and gaps identified, and a plan adopted to address the gaps.
- The relationships between MOH and the private sector are reviewed and redefined. Formal public–private partnership agreements for subcontracting, outsourcing and other arrangements are a matter of routine (by end 2007).
- The Health Sector Coordination Framework will be fully operational by end 2005; quarterly meetings of the ICCs (with pre-established agenda) and JICC will take place; annually defined outputs for each ICC will take into account the planning cycle presented at the end of this chapter.

Outputs for Equitable Access

- Areas with limited geographical access are defined (mid 2006) and a five-year investment plan for infrastructure development and operations and maintenance (O&M) will have been developed and adopted (end 2006). The plan will take limited access and poverty criteria into account and include all public and private health facilities.
- To address financial access, the current MOH budget allocation criteria have been reviewed based on KEPH output and general poverty indicators (before February 2006). This will enable targeted budget allocations nationwide.
- Regional disparities in health status are analysed and an action plan developed and made available (redeployment of staff, targeted finance, attention to supplies/drugs). Similarly, specific groups (pastoralists, urban slum dwellers) will be targeted for focused interventions and support (before February 2006).
- The resource gap to reach the (very) poor is defined on the basis of an agreed set of criteria, together with a package of care that is responsive to the needs of this group. Funding of this resource gap will be identified from national and external resources. Detailed plans are ready for implementation by 2007.
- Public funding for health will have increased, as prescribed by ERS targets.
- As for socio-cultural access, public services are more accountable and client oriented, and client demand is stronger (complaint procedures). A plan to improve socio-cultural access is developed before the end of 2006.

Efficiency Outputs

- Costing of the AOPs is undertaken on a regular basis as part of the overall planning of MOH, along with specific efficiency studies such as the introduction of NSHIF, costing of the FBO contribution to service delivery, and the direct use (expenditure) of funds by districts and sub-districts.

- A proposal to introduce Budget Management Centres as decentralized units for management and resource utilization is finalized and approved (by end 2006), including eligibility criteria.
- Appropriate policy and implementation tools for a National Social Health Insurance Fund (NSHIF) are developed (by mid 2007), with implementation initiated on the basis of an agreed, detailed master plan (by mid 2008).
- Provincial and national levels programmes and training activities are aligned with district initiatives and district health plans (DHPs).
- Internal auditing and accounting are undertaken annually.

Effectiveness Outputs

- Redeployment of available human resources is finalized (mid 2006).
- A National Training Plan and a National Plan for Human Resource Development are finalized and adopted (end 2006 and mid 2006, respectively) with special emphasis on district capacity building targeted to the four levels of KEPH.
- Interventions by national programmes (supervision, training, workshops) are aligned with the district health plans
- Results-oriented performance management has been introduced and is operational between central, provincial and district managers; performance standards and expected outputs to be achieved have been defined and a supportive training programme is in place.
- A uniform performance-based health management information system (HMIS) is in place (before mid 2007), agreed by all department heads, PMOs and stakeholders. There is one authoritative source for all M&E indicators (by mid 2006).The harmonization of this system with the various indicators of ERS/MDGs//NHSSP/AOPs/Departments/Divisions/Districts is agreed and adopted before end 2006. Inputs (staff, money drugs) are related to outputs/outcomes (mid 2007).
- Norms and standards on ethics and quality of care in medical practice are defined and documented (end 2007). Compliance with these norms by professionals is promoted by professional organizations and taught in training schools (continuous).
- Relevant laws (Public Health Act, National Drug Policy) are reviewed and adapted (mid 2007), and mechanisms for law enforcement are known, gazetted/published and accessible to the public (mid 2008).

The Three *1*'s of Planning and Management

- **1** plan and budget
- **1** monitoring system
- **1** coordinating framework

6.3.3 Timeline for Achieving Health Reform Outputs

A six-monthly timeline for achieving the various outputs is presented in Table 6.5. Joint annual reviews of progress in implementing NHSSP II will be conducted, while a midterm review (MTR) should take place before the November 2007 Summit. This timing will facilitate the provision of strategic input into the AOP for 2008/09 and advice on the way forward for a new policy framework for the Kenyan health sector.

6.4 Sector-Wide Approach in Health (SWAp)

Although far from completing the road towards a SWAp, Kenya has already been taken some important steps. There is a single sector policy (the KHPF), this second strategic plan is under way, and an MTEF has been adopted along with the ERS and annual public expenditure reviews (PERs). These are all important prerequisites to continue building a government-led and sustained partnership with the various stakeholders. Attention to good governance, transparency in financial management and actions to address corruption in the public sector are other foundations of a viable SWAp. Platforms such as the JICC and ICCs – as part of the new health sector coordination framework – are essential elements to build and strengthen the existing partnerships between the public sector, the private sector and the development partners.

The sector-wide approach calls for a single sector policy, a single strategy and a single expenditure framework, under government leadership, that is supported by all significant funding for the sector. It also incorporates greater reliance on government's own financial management and accountability systems.

Table 6.5 Outputs and timeline for the implementation of health reforms

Year	2005	2006		2007		2008		2009		2010	
Semester	II	I	II	I	II	I	II	I	II	I	II
Outputs											
Leadership											
1. Review of MOH structure finalized and implemented	•			•							
Governance & mgmt structures strengthened		•									
2. Departments, divisions and districts make annual plans		•		•		•		•		•	
3. Legislation reviewed and gaps identified			•		•						
4. Dialogue with private sector reviewed/initiated		•									
Formal partnership arrangements are routine					•						
6. JICC and ICCs fully operational	•										
Equity											
1. Areas with limited access defined		•									
Five-year investment plan adopted			•								
2. Budget allocation criteria reviewed on poverty		•									
3. Action plan to address regional disparities ready; targeting under-served groups being done			•								
4. Resource gap defined, funding identified and interventions initiated			•	•	•						
5. Funding for health increased each year per ERS		•		•		•		•		•	
6. Plan to improve socio-cultural access ready			•								
Efficiency											
1. Costing of AOPs done regularly		•		•		•		•		•	
2. Preparations for introducing BMCs initiated		•									
3. Introductory plan for NSHIF reviewed and updated		•	•								
Implementation plan ready							•				
4. Annual auditing and accounting undertaken	•		•		•		•		•		•
Effectiveness											
1. Human resources re-deployed		•									
2. National training plan ready	•		•								
National human resources development plan ready	•			•							
3. National programmes and training activities aligned with DHPs		•		•		•		•		•	
4. Results-oriented performance management operational between managers at different levels		•		•							
5. Uniform HMIS in place; M&E system harmonized and Inputs relate to outputs	•	•	•	•							
6. Norms on ethics defined and updated			•								
7. Inventory of relevant laws initiated	•			•							
Steps taken to create public awareness of health rights		•				•					
Annual reviews					•						
Planning Summit to adopt new AOP (May)		•		•		•		•		•	
Review Summit to review existing AOP (Nov)			•		•		•		•		•
Midterm review (MTR)					•						

These measures in themselves are not sufficient to guarantee a viable sector-wide approach, however. They need to be made operational and to become functional in daily practice. Recently the "Three Ones" have been recognized as key ingredients of an operational SWAp. In order to apply the Three Ones in Kenya, far-reaching decisions need to be made. These decisions are:

1. One plan and budget: Initiation of a process of joint annual planning (next AOPs) and budgeting under the leadership of the MOH together with the main stakeholders in the sector.

2. One monitoring system: Initiation of joint monitoring of progress in achieving targets and outputs, as well as joint periodic reviews of overall

programme performance, based on jointly agreed indicators. This implies harmonization of reporting procedures (both financial and technical) between GOK and development partners.

3. One coordinating framework: Strengthening the performance and capacity of the existing health sector coordination framework to jointly agree on the future direction of the sector and to jointly agree on the decisions that need to be made to ensure the effective implementation of the policy objectives.

In order to institutionalize the Three Ones in the Kenyan context, joint annual planning, joint M&E, pooled funding and Common Management Arrangements will need to be elaborated and put into practice with inputs from all stakeholders. Against that background, the steps that need to be taken jointly on the road towards a sector-wide approach for Kenya's health sector are detailed below. They should be considered to be "joint outputs".

6.4.1 Joint Annual Planning and Review Cycle

NHSSP II sets out a comprehensive, inclusive, and ultimately bottom-up cycle for planning and review of all levels of activity in the sector. The cycle is described in detail in the paragraphs that follow, and illustrated in Figure 6.1.

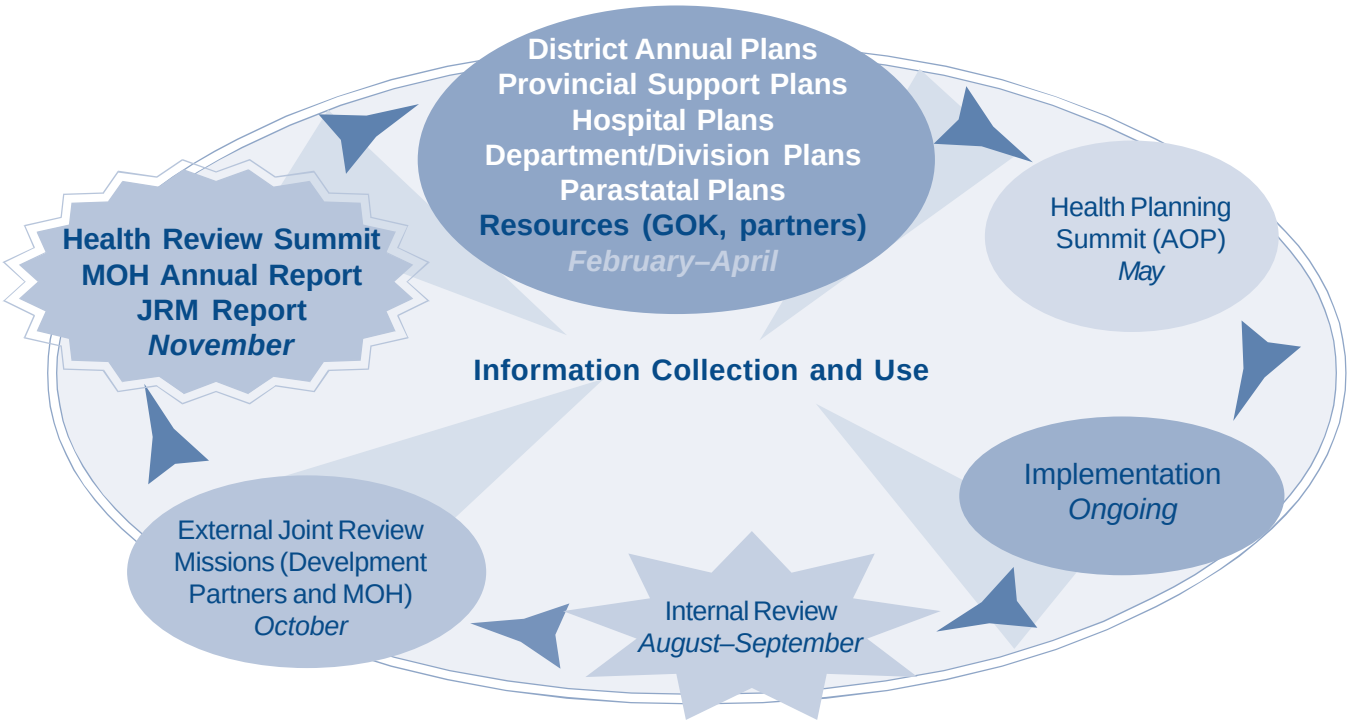
Planning for Each New AOP

In December each year, MOH will elaborate planning guidelines for the next fiscal year that summarize the results of discussion and decisions at the Health Summit in November and the content and priorities that will guide the elaboration of the next AOP. With the publication of the PER in January, MOH/MOF will then determine criteria for priority setting as part of the pro-poor policy and the financial ceilings that will define the overall resource envelope. Planning proper for the next AOP will then begin in February. This will be a bottom-up process, starting with the district health plans (DHP) and the plans drafted by the divisions that manage and support various components of the KEHP.

This process will be coordinated by the PMO offices (for their respective districts) and by department heads (for their respective divisions), using the planning guidelines and financial ceilings provided earlier.

Plans at those levels should be ready by the beginning of April each year to enable the MOH to elaborate and present a comprehensive AOP for the whole sector for endorsement by the stakeholders during the Health Planning Summit in May each year. The JICC and ICCs are expected to play an active role in both the content and the process of preparations for the Summit meeting. In this way, a bottom-up AOP will be finalized and distributed to all stakeholders in June, culminating in the signing of

Figure 6.1 Annual NHSSP II planning and monitoring cycle



The existing HMIS will be performance based, decision and action oriented, and the single authoritative source of data capture and use at national level.

performance agreements between central MOH, provinces and districts (the responsibles in the various Budget Management Centres). Final revisions may be made in July to align the real allocated budgets to the BMC.

Review of Existing AOP

The AOP review process will start in August each year, just after the finalization of the next year's AOP. Districts and divisions will prepare short annual reports – according to an established format – of the work undertaken during the year. These reports are expected to be short, highlighting what was achieved against what was planned (inputs versus outputs) and comparing performance data against targets, including the constraints experienced in the implementation of the plans. These annual reports will be compiled and presented and discussed at the District Health Stakeholders Forum (in the presence of all district actors) and at the provincial level with the provincial and national stakeholders. The annual reports by the central divisions will be discussed at departmental level.

All these reports will then be consolidated at provincial and departmental level by the PMO and the Heads of Department, respectively, and submitted to the Director of Medical Services (DMS) in mid September. On the basis of these reports, the DMS will elaborate the full MOH Annual Progress Report before the end of September. This report will constitute important input in the Joint Annual Review (JAR) that will take place in October. Preparations for the JAR (terms of reference, composition of the team, special studies, funding) will begin in July by the JICC/ICCs. The JAR report and the MOH Annual Progress Report will be presented at the Annual Review Summit in November each year.

During this Summit, priorities for the next year will be identified and commitments from all parties will be sealed in a jointly signed memorandum of understanding. At the halfway point in the implementation of NHSSP II a more thorough and detailed Midterm Review (MTR) will be undertaken, during which the relevance and appropriateness of the NHSSP II itself, including its indicators and targets will be reviewed.

6.4.2 Joint Monitoring of Performance

Joint annual reviews and joint meetings take place in all countries that work under a SWAp mode. In Kenya, the MOH intends to initiate the biannual meetings alluded to above: the Joint Annual Review Summit (in November) will serve to discuss the performance results of the sector with all the stakeholders. The Joint Annual Planning Summit (in May) will be the basis for discussion and adoption of the next AOP, which will include the conclusions and recommendations of the previous JAR. The performance indicators and targets set for NHSSP II (presented in Table A) will provide the monitoring framework for NHSSP II operations, together with the expected outputs to be achieved for the KEPH (Chapter 4), the support services (Chapter 5), and the health reforms and SWAp. This framework will be reviewed as part of the Midterm Review at the end of 2007.

The timeliness and reliability of the HMIS will to a large extent determine the capacity to monitor the performance of the sector. MOH envisages strengthening its information system by making the existing HMIS performance based, decision and action oriented, and the single authoritative source of data capture and use at national level.

MOH will organize regular (quarterly or monthly) meetings in between the official biannual meetings to discuss progress in implementing the AOP. This is expected to be particularly necessary during the first year of the SWAp, when many of the practical procedures and collaboration mechanisms may not be clear. The JICC and the ICC working groups will spearhead these discussions, since they already represent the various stakeholders and have been created by the GOK for that very purpose. It is expected that, as the review procedures between the SWAp partners improve, the need for separate evaluations will reduce or that such evaluations will be planned prior to or as part of the Joint Annual Review, so that the results easily feed into the November Summit meeting.

6.4.3 Harmonization of Funding Arrangements

There are various ways in which the external funds can be managed under a SWAp modality. A recent inventory of experiences lists the following alternatives:

- Programme funds are managed by each donor in separate accounts.
- Donor funds are pooled in a single account that is

managed by one donor agency (as with funds for operational costs in the regions of Mozambique).
- Pooled funds are managed by MOH or MOF in one or more separate accounts, which can be either district baskets (as in Tanzania), a national drug basket (as in Mozambique) or a single national health fund that is kept separate from the regular MOH account (like the Ghana Health Fund).
- The overall sector budget is supported. Funds are held by MOH in an ordinary account, without any earmarking (e.g., Fundo Géral in Mozambique).
- Targeted budget support is provided, for which funds are held by MOF in an ordinary account but under a separate budget line (e.g., Uganda's Poverty Action Fund).
- Direct budget support (DBS) is provided, with funds held by MOF in an ordinary account without any earmarking (not even for health).

Whichever modality is chosen, the release of funds takes place on the basis of reported progress against plans and budgets, as outlined in periodic (e.g., quarterly) financial performance reports. First quarter funds are normally disbursed automatically, while subsequent disbursements are made upon approval of reports. In line with SWAp principles, the MOF, MOH and development partners must give their approval before any funds can be released. This can be done, for example, through a special basket financing committee (at national, provincial or even district level). In addition, the possibility of pooled funding for technical assistance could be considered as another step towards more comprehensive pooled funding modalities.

Since Kenya has relatively little experience with such funding modalities, a joint consultation process is required, based on a review of the options given above, with an analysis of the possible constraints in implementing these SWAp modalities. Visits to a limited number of countries where such funding arrangements are performing satisfactorily may be considered. This process of consultation will be finalized by the middle of 2006, after which a joint decision is expected on the way forward. Next to the joint funding mechanisms, special attention needs to be given to the management of "off-budget" funds that follow different procedures and often complicate priority setting and control and targeting of resources.

The release of funds will take place on the basis of reported progress against plans and budgets, as outlined in periodic (e.g., quarterly) financial performance reports, and in line with SWAp principles, the MOF, MOH and development partners must give their approval before any funds can be released.

6.4.4 Common Management Arrangements (CMA)

It is expected that Government leadership will increase once SWAp procedures start to be implemented. MOH (or the MOF/MPND) will chair all meetings, in particular the biannual review meetings with stakeholders and most of the working group meetings. A capacity building programme to prepare government officials for their new roles may be solicited. As part of the harmonization exercise, the MOH will appoint a small technical working group that will be tasked to elaborate a draft version of Common Management Arrangements (CMA) to be presented to and adopted by all stakeholders at the next Summit. The CMAs will define:
- Institutional and coordination arrangements for all levels and for all the partners/stakeholders.
- Planning and budgeting procedures.
- Tendering mechanisms and financial disbursements to the sector.
- Financial control and audit activities.
- Procurement and logistic arrangements.
- The performance monitoring system.
- The annual planning and budgeting cycle, including the monitoring process.

The technical working group will be small and output oriented. It will be composed of representatives from all stakeholders, mandated by their agencies to elaborate and propose such SWAp related procedures. The group will be chaired by MOH.

As a follow-up to the 2003 Rome Declaration, in March 2005 the High Level Forum issued the Paris Declaration on Aid Effectiveness, which will form the basis for the elaboration of the CMA. The Paris Declaration brings together practical and relevant indicators of progress (with their targets for 2010), meant to monitor ownership, alignment, harmonization and mutual accountability (see Annex A.)

Eventually the SWAp process in Kenya will yield a code of conduct that defines the roles and responsibilities of the partners and their internal relationships. At the end of each Summit, joint minutes will be drafted, while at the end of the

Planning Summit in May the contributions from MOH and development partners will be captured and formalized in a memorandum of understanding.

6.4.6 Timeline for Achieving SWAp Outputs

The various outputs described above are summarized in the implementation framework presented in Table 6.6. The framework allows for a biannual review of achievements that should be detailed at the quarterly level in the various AOPs.

The annual planning and monitoring cycle is summarized on a monthly basis in Table 6.7. Review (July–December) and planning (January–June) periods are clearly distinguished.

The roles of the partners in implementing the NHSSP II over time (and as part of the planning and monitoring cycle) are summarized in Table 6.8, which shows when the inputs of the various stakeholders in the annual planning process are expected.

Table 6.6 Outputs and timeline for the implementation of the SWAp

Year	2005	2006		2007		2008		2009		2010	
Semester	II	I	II	I	II	I	II	I	II	I	II
Joint planning and priority setting											
1. Priorities for next AOP defined		X		X		X		X		X	
Development partners' contributions in MOU		X		X		X		X		X	
2. Performance agreements signed with depts and districts		X		X		X		X		X	
3. JICC and ICC preparations for both Summits in place		X	X	X	X	X	X	X	X	X	X
4. MOH Annual Progress Report available on time	X	X		X		X		X		X	
5. Joint Annual Review on time	X	X		X		X		X		X	
Joint monitoring											
1. Uniform HMIS in place		X									
2. JICC and ICCs operational	X										
Pooling of funds											
1. Options for pooling of funds reviewed and decision made		X									
2. Pooled funding initiated				X							
Harmonization of reporting procedures											
1. CMA elaborated, discussed and endorsed	X	X									
2. Code of conduct drafted			X								

Table 6.7 Annual planning and monitoring cycle for NHSSP II

Quarter	Month	Planning action	Monitoring / Approval
II	**June**	Finalize and distribute AOP. Sign performance contracts. Present Budget to Parliament (by Minister of Finance).	PS/MOH MOF
Review		*The planning/review cycle starts again*	
III	**July**	Revise district health plans (DHP) to meet budget allocated by MOF.	PS/MOH approves revised budgets.
	August	Elaborate and present short district and division Annual Report (activities/outputs vs plans/ constraints) at district & PMO level and at dept levels.	Reports from DHMT consolidated by PMO, Reports from Divisions consolidated by Depts
	September	Consolidate district and division reports (by PMO and HODs). Submit provincial and departmental Annual Reports by mid September. Prepare MOH/HQ Annual Progress Report by end September.	DMS/HS coordinates and supervises the process. PMO and HODs submit their contributions to DMS/HS mid September.
Review			
IV	**October**	Conduct Joint Annual Review (JAR) of current AOP, based on annual progress report, specific studies and findings from JAR.	JICC to draft terms of reference and prepare JAR, starting in July.
	November	Convene Annual Review Summit to discuss report/findings of JAR. Review policy implications from JAR for next AOP. Sign MOU between MOH and development partners.	JICC/ICCs to prepare agenda and negotiate decisions/contributions from all actors.
	December	For MOH, provide national planning guidelines/ priorities for the next fiscal year to all provinces/ districts and central departments/divisions.	National guidelines to be coordinated by DMS/HS.
Planning			
I	**January**	Finalize health PER (external) and communicate ceiling to all.	MOF to provide budget ceiling on basis of MTEF.
	February	At district and division levels, prepare next year's AOP with MOH guidelines and budget ceilings from MOF.	Provinces/Departments lead the process based on guidelines/ceilings.
	March	At province and department levels, consolidate district and division plans into provincial and department plans.	DMS/HS coordinates with HODs at HQ and PMOs for districts.
Planning			
II	**April**	Finalize next year's AOP and match to resource envelope (by HODs and PMO).	DMS/HS coordinates with HODs at HQ and PMO for districts.
	May	Review and approve the next year's AOP (by Annual Planning Summit).	All ICCs comment on the national programmes.
	June	Finalize and distribute AOP. Sign performance contracts. Formalize contributions from development partners. Present Budget to Parliament (by Minister of Finance).	PS/MOH PS/MOH with BMC PS/MOH or PS/MOF MOF
Review		*The planning/review cycle starts again*	
	July	Revise district health plans (DHPs) to meet budget allocated by MOF.	PS/MOH approves revised budgets.

Table 6.8 Inputs from MOH and stakeholders in the planning cycle

MOH and partners	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN
MOH / PS+DMS			AOP agreed & finalized		XX ANNUAL PLANNING SUMMIT NEXT AOP XX	Allocations signed					XXX ANNUAL REVIEW SUMMIT CURRENT AOP XXX	Planning guidelines	
MOH – other ministries	Health PER & MTEF ceilings announced												
MOH / Departments			AOP synthesized				TORs/ JAR		Annual Progress Report				
MOH / Divisions		Preparation of next Division AOP						Report on current division AOP					
Referral hospitals	As per strategic plan					As per strategic plan							
Secondary hospitals	Preparation of next hospital AOP							Reports on current hospital AOP					
PMOs	Int. AOP Review												
DHMTs/ DHMBs		Preparation of next district and hospital AOP						Reports on current district and hospital AOP					
District hospitals													
Development partners (JICC/ICCs)		MOH/partner consultations on respective contributions (baskets, etc.)					TOR/ Joint Annual Review		Annual financial development partner reports				
Private not-for-profit organizations													
Private-for-profit sector								Reports on inputs/outputs					
Regulatory bodies	As per strategic plan					As per strategic plan							

7 Financing the Health Sector

Adequate resources are key to the sustainable provision of health services. Kenya's health policy framework of 1994 identified several methods for financing health services, including taxation, user fees, donor funds and health insurance. These methods have become increasingly important for funding health services in the country, but they should reflect both the cost of service provision and the population's ability to pay. In the non-government sector, health services are financed primarily through revenue collected from fees and insurance premiums charged to service users. These fees and premiums are a trade-off between the costs of service provision and the ability of the clients to pay for the services.

Information on costs of health service delivery is scarce in Kenya. This chapter presents estimated costs of providing a broad range of health services in the country, with emphasis on the KEPH. The costs are based on data derived from published documents and from a representative sample of government and non-government health facilities, using an internationally accepted costing methodology. Technical details on the methodology used to arrive at the cost estimates presented in the first part of this chapter are provided in Annex D.[17] In the second part, the estimated costs are compared with the available resources. In this way, the resource gaps in financing the health services at the various levels can be identified. The information on costs, resource envelopes and resource gaps will assist stakeholders, including beneficiary communities, to develop realistic annual health budgets, without which annual operational plans cannot be designed or implemented effectively.

7.1 Current Financing Trends, Policies and Expenditure

Over the past decade, real financial allocations to the public sector have declined or remained constant. Reviews of public expenditures and budgets in Kenya show that total health spending constitutes 8.6% of total government expenditure and that recurrent expenditures have been consistently higher than development expenditures, both in absolute terms and as a percentage of the GDP. The per capita total health spending stands at about Ksh500 (or US$6.2), showing that health spending remains far below the WHO recommended level of US$34 per capita. It also falls short of the GOK commitment to spend 15% of the total budget on health, as agreed in the Abuja Declaration. The under-financing of the health sector has thus reduced the sector's ability to ensure an adequate level of service provision to the population.

GOK funds the health sector through budgetary allocations to MOH and related government departments. Tax revenues as sources of health finance are unreliable, however, because macroeconomic conditions such as poor growth, national debt and inflation often affect allocations to health. Manifestations of the health budget shortfalls are the widespread lack of adequate drugs and pharmaceuticals, staff shortages, and poor maintenance of equipment, transport and facilities.

Over the past two decades, GOK has pursued a policy of cost-sharing to bridge the gap between actual

[17] The method used to arrive at the cost estimates and the financing gap of NHSSP II is quite different from the one used to budget AOP 1 (details in Annex D).

budgets and the level of resources needed to fund public health sector activities. The revenue from the cost-sharing programme has continued to grow in absolute terms and as a percentage of the recurrent government budget. In 2003/04, cost sharing contributed over 8% of the recurrent expenditure and about 21% of the non-wage recurrent budget of the MOH. Because of the worsening poverty situation in the country, however, MOH has changed its cost-sharing policy and replaced it with the "10/20 policy", thus reducing this source of income.

Against the background of limitations in implementing the system of waivers and exemptions – which are administratively complex and reduce income even further – the cost-sharing programme has become a barrier to service utilization by the poor. As an alternative, the government plans to implement the National Social Health Insurance Fund (NSHIF) in the coming years to ensure that basic health services are equitably available to all Kenyans. According to the Kenya Medium-Term Strategy Paper 2005/6–2007/8, plans are under way to improve the health infrastructure and establish institutions and systems to effectively manage the NSHIF. Contributions to NSHIF will be mandatory for everyone, but the government will meet the needs of the indigent population that is not capable of paying their contributions (National Social Health Insurance Bill, 2004). The NSHIF will be implemented in phases and will be rolled over to the entire population at a pace consistent with government's ability to raise fiscal resources to cover the insurance premiums of the indigent population.

The health budget allocation has continued to be skewed in favour of tertiary and secondary care facilities, which absorb 70% of the health expenditure. Yet most of the primary care units, being the first line of contact with the population, provide the bulk of health services and are cost-effective in dealing with most disease conditions prevalent in communities. Expenditures on health personnel and emoluments are high, relative to money spent on drugs, pharmaceuticals, and other medical inputs such as equipment and supplies. After accounting for about 50% of the budget for personnel spending, 30% of the recurrent budget is left for drugs and medical supplies, 11% for operations and maintenance (O&M) at the facility level, and 10% for other recurrent expenses.

The limited funding available has been used largely to finance curative care, with less attention paid to the preventive and promotive health needs of the population. Curative expenditure constitutes more than 48% of the total MOH budget. This expenditure pattern is inequitable and ineffective and needs to be changed.

For the first year of NHSSP II – 2005/06 – the total cost of KEPH is about Ksh65 billion. About 70% of the KEPH expenditure goes to salaries, drugs and medical supplies.

GOK works closely with development partners to raise money for the health sector. Donor contributions to the health sector have been on the increase, rising from 8% of the health budget in 1994/95 to 16% in fiscal year 2001/02 according to the latest National Health Accounts. In some years, donor contributions accounted for over 90% of the MOH development budget.

In summary, the Ministry of Health Public Expenditure Review (PER 2005) reported that the flow of funding to health facilities, especially at the primary care level, is poor. There are leakages amounting to 22% of the user fee revenue collected. The PER advised allocating more resources to community-based facilities where health resources have been shown to be most effective in dealing with prevailing disease conditions and in improving people's health.

7.2 Costs of Implementing NHSSP II

Table 7.1 shows the annual costs of KEPH for its key interventions for the first year of NHSSP II, 2005/06. The total cost of KEPH for this period is about Ksh65 billion. The costs of all the essential elements of KEPH are given in the table, including administration and support costs. The sum of columns 1 to 4 is the total variable cost, i.e., the part of the overall cost that varies with the level of service provision. For example, as more nurses are employed or as more drugs are bought, the variable cost increases. The sum of columns 5 and 6 is the total fixed cost, i.e., the part of the overall cost that does not increase as the service level increases.

The fixed cost includes outlay on management, the health management information system, and monitoring and evaluation, items that must be paid for irrespective of whether a low or high volume of service is provided. The bottom row of Table 7.1 shows that about 70% of expenditure on KEPH goes to salaries, drugs and medical supplies.

Annex E provides details of disaggregated costs for the various interventions shown in Table 7.1. It also

Table 7.1 Cost of KEPH by intervention 2005/06 (Ksh millions)

Cost categories/ Interventions	Salaries (1)	Drugs and supplies (2)	Lab tests/ other investigations (3)	Bed and meals (4)	Allocated overhead (5)	M&E (6)	Total annual cost (7)
Reproductive health	6,487	2,058	950	1,155	1,598	533	12,781
Child health / IMCI	6,150	1,496	98	2,534	1,542	514	12,333
EPI	951	1,490	-	-	366	122	2,930
Malaria control	3,644	1,846	338	908	1,011	337	8,085
HIV/AIDS	1,183	7,499	2,130	561	1,706	569	13,649
STI control	1,220	660	618	-	375	125	2,998
TB control	968	332	100	595	299	100	2,394
Environmental health	2,057	2,522	-	-	687	229	5,494
Mental health	57	46	-	10	17	6	136
Dental health	303	412	-	-	107	36	858
Health promotion	22	1,720	-	-	51	16	1,809
Rehabilitation	486	419	-	64	145	48	1,162
Palliative care	185	53	-	-	36	12	285
Total	23,712	20,554	4,235	5,828	7,939	2,645	64,914
Per cent of total cost (all interventions)	37%	32%	6%	9%	12%	4%	100%
Per cent of total cost (without HIV/AIDS interventions)	44%	26%	4%	10%	12%	4%	100%

provides a summary of variable and fixed costs. The sum of variable and fixed costs is equal to the overall cost of the interventions shown in the last column. Once the population in need and the targets are defined, the fixed and variable costs can be used to compute the total cost of KEPH in a given year.

The fixed and variable costs vary over time owing to changes in prices of inputs. These inflationary changes are taken into account in computing annual costs of KEPH for each year of NHSSP II. Table 7.2 depicts the total cost of KEPH for the period 2005–2010. It shows that for the whole plan period, KEPH will cost Ksh410.3 billion, with an annual average of about Ksh82 billion.

The overall cost of health care consists of KEPH and non-KEPH related expenditure. Non-KEPH expenditure relates, for example, to overall administration and the costs for the two referral hospitals. Table 7.2 shows that the overall cost of the NHSSP II (being KEPH and non-KEPH together) is about Ksh586 billion, or approximately Ksh117 billion per year. These two costs are calculated on the assumption that KEPH costs represent 70% of the total. This is in line with the experiences of many

Table 7.2 Total cost of KEPH for key interventions 2005–2010 (Ksh million)

Intervention	FY2005/06	FY2006/07	FY2007/08	FY2008/09	FY2009/10	2005–2010
Reproductive health	12,781	16,094	18,052	20,160	23,671	90,758
Child health/IMCI	12,333	12,991	13,678	14,396	15,145	68,543
EPI	2,930	3,117	3,316	3,527	3,752	16,640
Malaria control	8,085	8,613	9,926	10,782	11,682	49,087
HIV/AIDS	13,649	15,668	18,537	19,508	21,865	89,226
STI control	2,998	3,225	3,469	3,730	4,010	17,432
TB control	2,394	2,523	2,661	2,807	2,961	13,346
Environmental health	5,494	6,178	6,763	7,398	8,087	33,920
Mental health	136	181	241	373	440	1,370
Dental health	858	1,105	1,200	1,303	1,396	5,861
Health promotion	1,809	2,363	425	454	484	5,535
Rehabilitation	1,162	1,877	2,636	3,442	4,297	13,413
Palliative care	285	611	980	1,398	1,868	5,142
Total (KEPH)	64,914	74,544	81,882	89,276	99,660	410,275
Total (KEPH + non- KEPH)	92,734	106,491	116,974	127,537	142,371	586,109
Per capita US$ (KEPH)	25.8	28.8	30.7	32.5	35.2	
Per capita US$ (KEPH + non-KEPH)	36.9	41.2	43.8	46.4	50.22	

Cost estimates find major gaps between the known available resources and the cost of KEPH plus non-KEPH. These gaps can be bridged or financed by additional allocations from the Treasury and/or donor contributions. Under hardship conditions the gaps can be reduced by scaling down the targets of the population to be served.

developing countries, which have shown that the essential health package accounts for about 70% of the overall health costs.

Table 7.3 presents the cost of KEPH by level of the health system for the period 2005–2010. Level 1 (community) and the levels 2–4 (dispensary, health centre and district/primary hospital) are the levels of key interest for KEPH. As shown in the table, the bulk of KEPH resources will be spent at these levels.

Table 7.2 showed conventional financial allocations for the various key interventions of KEPH, which are essentially vertical programmes. Table 7.4 presents KEPH costs by life-cycle cohort for the period 2005–2010. The table shows that each year, nearly 60% of KEPH cost is devoted to improving the health of the 0–24 age group. A substantial amount of resources are devoted to adult health.

7.3 Financing Scenarios

Figures 7.1 and 7.2 show two scenarios for the cost of implementing the NHSSP II with the existing level of resources (bottom line), the cost of implementing the minimum KEPH (middle line), and the cost of implementing KEPH and non-KEPH interventions. Annex F provides detailed information on the various sources of finance (GOK, cost sharing, NSHIF, development partners, among others) that will support the implementation of NHSSP II. Unless the amount of resources indicated by the middle line is available, the minimum KEPH cannot be implemented.

Thus two resource gaps are shown in the figures. The first gap is the difference between the available resources and the cost of implementing the minimum KEPH. The second gap is the difference between the available resources and the cost of KEPH plus non-KEPH. These gaps can be bridged or financed by

Table 7.3 Annual cost of KEPH by level of services, 2005–2010 (Ksh million)

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	National
Fiscal year 2005/06							
Wage	2,446	2,680	3,717	9,049	4,119	1,700	**23,712**
Non-wage	9,793	5,943	7,493	10,850	5,056	2,066	**41,201**
Total	12,239	8,624	11,211	19,898	9,175	3,766	**64,914**
Proportion of total	19%	13%	17%	31%	14%	6%	100%
Fiscal year 2006/07							
Wage	2,694	2,914	4,319	10,815	4,932	1,981	**27,655**
Non-wage	11,301	6,558	8,406	12,418	5,832	2,374	**46,889**
Total	13,995	9,472	12,725	23,233	10,763	4,355	**74,544**
Proportion of total	19%	13%	17%	31%	14%	6%	100%
Fiscal year 2007/08							
Wage	2,974	3,141	4,816	11,792	5,368	2,146	**30,236**
Non-wage	10,642	7,330	9,578	14,448	6,865	2,782	**51,646**
Total	13,616	10,471	14,394	26,240	12,233	4,928	**81,882**
Proportion of total	17%	13%	18%	32%	15%	6%	100%
Fiscal year 2008/09							
Wage	3,277	3,388	5,391	12,980	5,897	2,344	**33,277**
Non-wage	11,642	7,904	10,437	15,596	7,410	3,012	**55,999**
Total	14,919	11,292	15,828	28,575	13,307	5,355	**89,276**
Proportion of total	17%	13%	18%	32%	15%	6%	100%
Fiscal year 2009/10							
Wage	3,603	3,669	6,086	14,587	6,628	2,612	**37,185**
Non-wage	12,785	8,682	11,614	17,575	8,409	3,411	**62,475**
Total	16,388	12,351	17,700	32,161	15,037	6,022	**99,660**
Proportion of total	16%	12%	18%	32%	15%	6%	100%

Table 7.4 Annual cost of KEPH by life-cycle cohort, 2005–2010 (Ksh million)

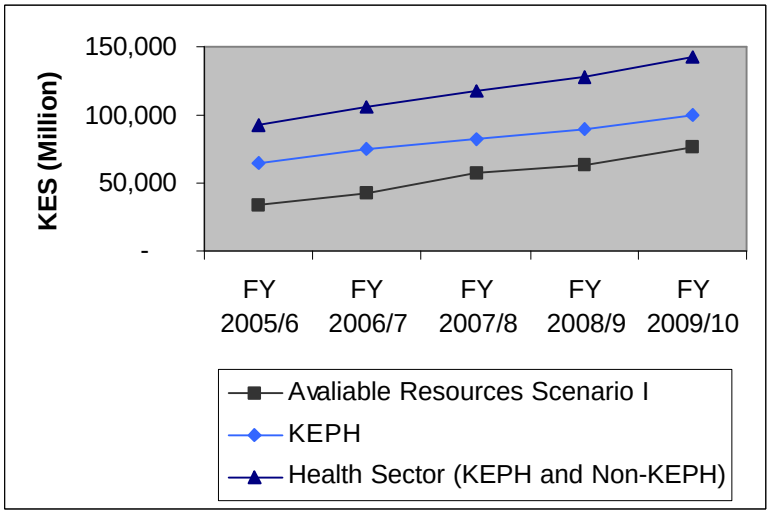
	Pregnancy/ Newborn	Early childhood	Late childhood	Youth/ Adolesc-ence	Adults	Elderly	Total
Fiscal year 2005/06							
Wage	1,701	7,824	2,050	4,347	7,215	576	**23,712**
Non-wage	2,550	12,182	2,301	6,878	15,805	1,485	**41,201**
Total	4,251	20,005	4,352	11,225	23,020	2,060	**64,914**
Proportion of total	7%	31%	7%	17%	35%	3%	100%
Fiscal year 2006/07							
Wage	2,294	8,325	2,253	5,243	8,851	688	**27,655**
Non-wage	3,011	13,181	2,783	7,993	18,144	1,777	**46,889**
Total	5,305	21,505	5,036	13,236	26,995	2,466	**74,544**
Proportion of total	7%	29%	7%	18%	36%	3%	100%
Fiscal year 2007/08							
Wage	2,395	8,870	2,570	5,766	9,832	803	**30,236**
Non-wage	3,684	14,144	2,812	8,917	20,104	1,984	**51,646**
Total	6,079	23,014	5,383	14,684	29,936	2,787	**81,882**
Proportion of total	7%	28%	7%	18%	37%	3%	100%
Fiscal year 2008/09							
Wage	2,666	9,435	2,859	6,423	10,979	915	**33,277**
Non-wage	4,176	15,200	3,160	9,757	21,512	2,195	**55,999**
Total	6,842	24,635	6,018	16,180	32,490	3,110	**89,276**
Proportion of total	8%	28%	7%	18%	36%	3%	100%
Fiscal year 2009/2010							
Wage	3,154	10,032	3,158	7,308	12,500	1,033	**37,185**
Non-wage	4,888	16,331	3,576	11,007	24,148	2,525	**62,475**
Total	8,042	26,363	6,734	18,315	36,648	3,558	**99,660**
Proportion of total	8%	26%	7%	18%	37%	4%	100%

additional allocations from the Treasury and/or donor contributions. Under hardship conditions the gaps can be reduced by scaling down the targets of the population to be served. It should be noted that the resource gap shown in the figures is overstated because private health expenditure on KEPH is not well covered in the calculations. There are also some large off-budget expenditures on KEPH that are not included in the figures (Global Fund Round V, PEPFAR, etc.). The actual financing gap is therefore likely to be smaller than depicted here.

The following assumptions have been made in drawing up Figures 7.1 and 7.2:

- Government financing is based on the Kenya Medium-Term Budget Strategy Paper 2005/06 to 2007/08 Projections. Scenario 1 (Figure 7.1), the baseline or status quo situation, provides for an increase in the share of resources to the health sector from 8.6% in 2005/06 to 10.7% in 2007/08, while Scenario 2 (Figure 7.2), the alternative or best case scenario, is based on the availability of additional donor support. The projections for FY 2008/09 and FY 2009/10 are based on past trends, with the latter target being

Figure 7.1 Health care financing – Scenario 1



the attainment of the ERS target of 12% of total government expenditure.

- Private sector financing is projected on the basis of National Health Accounting expenditures in FY 2001/02, adjusted for the growth in the private sector in the preceding years.
- Grants from development partners have been included on the basis of the MTEF draft budget donor commitment list provided by the External Resources Department, Ministry of Finance, and the draft budget estimates for recurrent and development expenditure.
- The resources for the HIV/AIDS/TB and malaria programmes by the Global Fund have been committed and signed for the first two years. While the next tranches for malaria are more certain and have been committed, those for HIV/AIDS/TB will be provided on the basis of the success of the Government's proposal to the Global Fund (Round V) and achievement of certain performance criteria. Additional bilateral and multilateral support for TB estimated at US$8.9 million is included and is apportioned equally for the first two years. The funds are specifically from USAID, CDC, WHO, GDF and CIDA/KNCV.
- The resources from the NSHIF are assumed to come in during year two of NHSSP II. MOH projections of anticipated contributions have been used.
- The cost-sharing funds for government facilities have been included, on the basis of their increase in the past four years. For the referral hospitals, the projections are based on their strategic plans for 2005–2010.

Finally, the financing scenarios assume relative constant and rising contributions from GOK to the health sector as reiterated in the latest Medium-Term Budget Strategy Paper. Annexes G and H show health budgets for the NHSSP II period as percentages of gross domestic product (GDP) and GOK budgets. The tables depict the financial risks the health sector faces from changes in GDP or the government budget that are outside the control of MOH. Past fluctuations in GDP and public budgets should be considered when predicting health budgets based on previous allocations. Risks associated with non-availability of funds to finance activities at a given level can be assessed by examining the reliability of the potential sources of funds for that level. The detailed projections of available resources for NHSSP II implementation in both scenarios show the magnitude of the health sector under-funding, and specifically for the provision of KEPH.

Other ways to close the financing gap at least to some extent are to reduce costs and use the available money more efficiently. Figure 7.3 shows the importance of personnel and drugs in the provision of KEPH. Effective and efficient utilization of these inputs, including their deployment/procurement and distribution, can go a long way in closing the gaps indicated in Figures 7.1 and 7.2.

Figure 7.2 Health care financing – Scenario 2

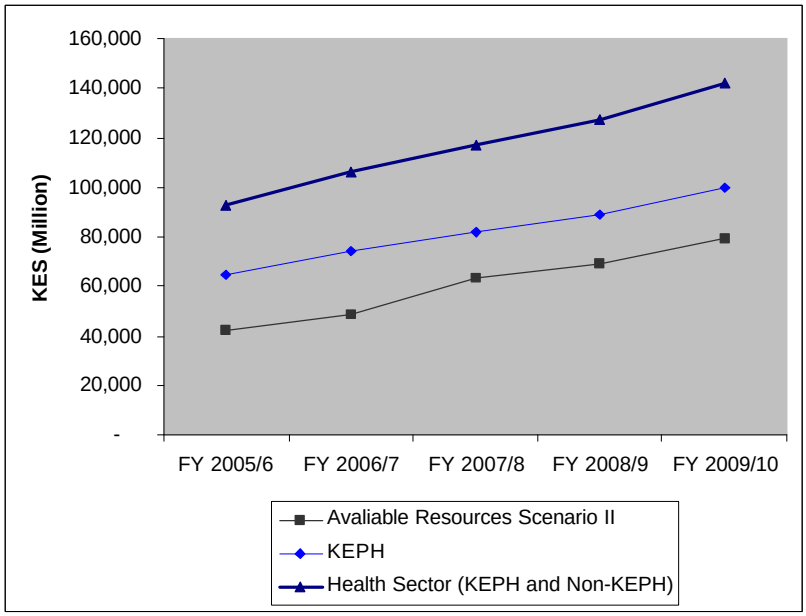
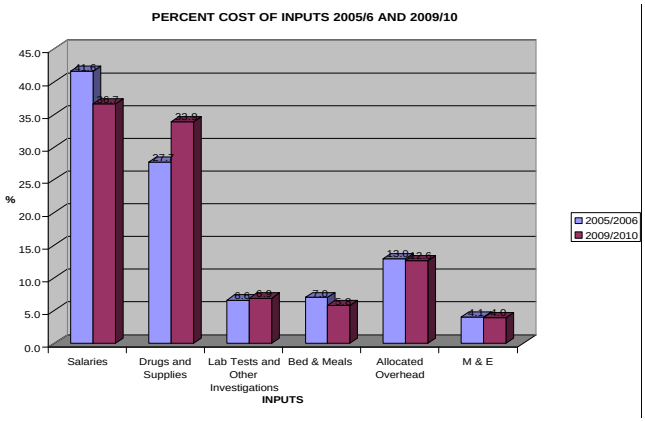


Figure 7.3 Relative shares of key inputs in KEPH costs, 2005–2010



7.5 Outputs in Health Care Financing

In conclusion, the Kenyan health sector is grossly under-funded at present. Estimates of the cost of KEPH show that the available resources are insufficient to enable MOH to meet ERS objectives and the health-related MDGs, to which the Government is a signatory. Moreover, even if additional health resources are made available, they will have little impact on health if current patterns of health spending are continued. In addition to more resources for the health sector, there is urgent need to use them in a more cost-effective way. There is particular need to increase allocations to community-based services and to preventive and promotive health services. Resource allocations according to the life cycle of the population will help address many of previous problems of inefficiencies and inequities in the health sector. NHSSP II intends to make these changes.

Box 7.1 summarizes the major health care financing outputs MOH has defined for the coming years.

Box 7.1 Outputs for Health Care Financing

- Plans elaborated that outline the preparation of a feasible national social health insurance programme for the country.
- Efficiency studies carried out and health care financing policy guidelines reviewed on the basis of new and/or emerging needs and priorities.
- Revenue collection and accountability by public hospitals/facilities improved, including strengthened NHIF claiming (through computerization and review of operational manuals).
- Secondary and tertiary referral hospitals supported to undertake costing of their interventions based on KEPH priorities.
- Financial management skills of middle level health care managers strengthened through tailor made courses in planning, budgeting and priority setting.

References and Documents Consulted

Cassels, A. 1997. A Guide to Sector Wide Approaches for Health Development: Concepts, Issues and Working Arrangements. WHO,/ARA/1997.12. WHO, DANIDA, DFID and EU, December.

CBS. 2003. Kenya Demographic and Health Survey (KDHS), Key Findings. Nairobi: Central Bureau of Statistics.

Overseas Development Institute (ODI), Centre for Aid and Public Expenditure (CAPE), London.

Gazette Supplement No 29 (Bills No 10), Bills 2004. The National Social Health Insurance Fund Bill 2004, page 365.

Gazette Supplement No 95 (Acts No 8), Acts 2001. The Children Act, 2001, page 493.

Ghana MOH. 2001. The Second Health Sector Five-Year Programme of Work (POW) 2002–2006. SWAp II. Partnerships for Health: Bridging the Inequalities Gap. Accra, Ghana: Ministry of Health, November.

Ghana MOH. 2001. "Common Management Arrangements for the Implementation of the POW II (CMA II)". First draft. Accra, Ghana: Ministry of Health, November.

Gwatkin, David R. 2005. "How much would poor people gain from faster progress towards the Millennium Development Goals for health?", Lancet, 365(February): 813–7.

Health Economic and Development Consortium (HEDC). 2004. "Evaluation of the National Health Sector Strategic Plan for 1999–2004". Draft report, September.

Jonsson, U. 2003. Human Rights Approach to Development Programming. UNICEF.

Kioko, U. and G. Mwabu. 2004. "The NHSSP 2005–2010: Health care financing needs and mechanisms", 2nd draft. Report submitted by the POLICY Project, August.

MOH. November 1994. Kenya's Health Policy Framework 1994–2010. Nairobi: Government Printer.

MOH. 1999. The National Health Sector Strategic Plan: 1999–2004. Nairobi: Government Printer.

MOH. 2003. "Public Expenditure Review (PER) Report". Ministry of Health, Nairobi.

MOH. February–May 2003. "Mid-Term Procurement Plan for Health Commodities, Fiscal Year 2003/04 to 2005/06". Ministry of Health, Nairobi.

MOH. October 2003. Needs Assessment for Health Sector's Monitoring and Evaluation System Study. Ministry of Health, Nairobi.

MOH. 2004. "Public Expenditure Review (PER) Report". Ministry of Health, Nairobi.

MOH. March 2004. "Strengthening District level M&E and HMIS in Phase 1 Districts: Proposal for a Support Package". Ministry of Health, Nairobi.

MOH. April 2004. Health Sector Coordination. Workshop presentations, Serena Beach Hotel, Mombasa. Ministry of Health, Nairobi.

MOH. June 2004. "Report on an Inter-Sectoral Workshop on Traditional Medicine, HIV/AIDS, Research and Sustainable Development in Kenya". Ministry of Health, Nairobi.

MOH. August 2004. "Interim Operational Plan 2004–2005 (IOP)". Ministry of Health, Nairobi.

MOH. August 2004. "Medium-Term Procurement Plan for Health Commodities, Fiscal Year 2003/04 to 2005/06". Ministry of Health, Nairobi.

MOH. November 2004. "Kenya Essential Package for Health (KEPH)", draft 001. Ministry of Health, Nairobi.

MOH. December 2004. "Human Resource Mapping and Verification Exercise". Ministry of Health, Nairobi.

MOH. Undated. Structure of the Health Sector (Working Group 1). Ministry of Health, Nairobi.

MPND. 2000. Interim Poverty Reduction Strategy Paper 2000–2003. Nairobi: Ministry of Planning and National Development.

MPND. 2003. Economic Recovery Strategy for Wealth and Employment Creation 2003–2007 (ERSWEC). Nairobi: Government Printing Office.

MPND. February 2004. "Investment Programme for the Economic Recovery Strategy for Wealth and Employment Creation 2003–2007" (Revised). Ministry of Planning and National Development, Nairobi.

MPND. November 2004a. "MDGs: Needs Assessment Report for Kenya: Child Health (Goal 4); Maternal Health (Goal 5) and Health Systems". Report prepared by Population Studies and Research Institute, University of Nairobi.

MPND. November 2004b. "MDGs: Needs Assessment Report for Kenya: Combat HIV/AIDS, Malaria and Tuberculosis (Goal 6)". Ministry of Planning and National Development, Nairobi.

MPND and CBS. 2003. Geographic Dimensions of Well-Being in Kenya: Where Are the Poor? From districts to locations, Vol. I. Nairobi: Ministry of Planning and National Development, Central Bureau of Statistics.

MPND and CBS. 2004. Economic Survey 2004. Nairobi: Ministry of Planning and National Development, Central Bureau of Statistics (health related pages 39–41).

MPND and UNDP. 2003. Millennium Development Goals (MDGs), Progress Report for Kenya 2003. Nairobi: Ministry of Planning and National Development, Central Bureau of Statistics.

Nandakumar, F. December 1998. Costing the Basic Benefits Package in Egypt. Technical Report No. 32. Partners for Health Reform Project. Bethesda, Maryland: Abt Associates.

NCAPD, MOH and CBS. March 2005. "Kenya Service Provision Assessment Survey 2004". Preliminary report. Ministry of Planning and National Development, Nairobi.

NCPD and Ministry of Health. 2003. Adolescent Reproductive Health and Development Policy. Nairobi: National Council for Population and Development and Ministry of Health, Division of Reproductive Health.

Njoka, J.M. December 2003. "The potential role of professional health associations in the regulation of the private for-profit sector". Report of the Kenya Country Study. Institute of Development Studies, Nairobi.

OECD/DAC. 2003. Harmonizing Donor Practices for Effective Aid Delivery. DAC Guidelines and Reference Series, Good Practice Papers. Paris: Organization for Economic Cooperation and Development.

PAHO. December 2003. Maximizing Quality of Care through Health Sector Reform: The Role of Quality Assurance Strategies. Washington, D.C.: Pan American Health Organization.

Republic of Kenya. Undated. Keynote address on "MOH restructuring for efficient and effective service delivery", by Mr. Joyce Nyamweya Nyakeya, Secretary, Public Sector Reform and Development Secretariat, Office of the President, Cabinet Office, Harambee House, Nairobi.

Schleimann, F., U. Enemark and J. Byskov. April 2003. Development Assistance to the Health Sector – A Danish Prspective: A Framework for Support to the Health Sector in a SWAp Context". A DANIDA publication

Sida. July 2003. "Mapping of Sector Wide approaches in Health". Institute for Health Sector Development, London, UK, for Swedish International Development Cooperation Agency.

UNDP. 2003. Getting Serious about Meeting the MDGs: A Comprehensive Development Framework (CDF) Progress Report. UN Millennium Project, United Nations Development Programme.

UNDP. 2005. Investing in Development: A Practical Plan to Achieve the Millennium Development Goals. "Overview". UN Millennium Project, United Nations Development Programme.

UNDP. January 2005. Who's Got the Power? Transforming Health Systems to Improve the Lives of Women and Children. Task Force on Child Health and Maternal Health. UN Millennium Project, United Nations Development Programme.

Annex A

Indicators of Progress* in MOH–Development Partners Collaboration (Paris Declaration)

Ownership	**Target for 2010**
1. *Partners have operational development strategies* – Number of countries with national development strategies (including PRSP) that have clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets	**At least 75%** of partners countries
Alignment	**Targets for 2010**
2. *Reliable country systems – Number of partner countries that have* procurement and public financial management systems that either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these	Target for improvement to be set by September 2005
3. *Aid flows are aligned on national priorities* – Per cent of aid flows to the government sector that is reported on partners' national budgets	**85%**** of aid flows reported on budgets
4. *Strengthened capacity by coordinated support* – Per cent of donor capacity development support provided through coordinated programmes consistent with partners' national development strategies.	Target for improvement to be set by September 2005
5. *Use of country systems* – Per cent of donors and of aid flows that use partner country procurement and/or public financial management systems in partner countries, which either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these	Target for improvement to be set by September 2005
6. *Strengthened capacity by avoiding parallel implementation structures* – Number of parallel project implementation units per country	Target for improvement to be set by September 2005
7. *Aid is more predictable* – Per cent of aid disbursements released according to agreed schedules in annual or multi-year frameworks	**At least 75%**** of such aid released on schedule
8. *Aid is untied* – Per cent of bilateral aid that is untied	Continued progress
Harmonization	**Targets for 2010**
9. *Use of common arrangements or procedures* – Percent of aid provided as programme-based approaches	**At least 25%****
10. *Encourage shared analysis* – Per cent of (a) field missions and/or (b) country analytic work, including diagnostic reviews that are joint	Target for improvement to be set by September 2005
Managing for Results	**Target for 2010**
11. *Results-oriented frameworks* – Number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programmes	**75%**** of partner countries
Mutual Accountability	**Target for 2010**
12. *Mutual accountability* – Number of partner countries that undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness including those in this Declaration	Target for improvement to be set by September 2005

* To be measured nationally and monitored internationally.
**These figures will be confirmed or amended by September 2005.

Annex B

KEPH Implementation Timeframe

Area of intervention	Outputs	Indicators	Year of implementation				
			1	2	3	4	5
Reproductive Health							
AOP 1 Expansion	Demand for skilled delivery increased	% increase of deliveries by skilled health workers					
	Community-based distributors of contraceptives in 5 districts	% of new districts with CBD programmes					
	Provision of basic and comprehensive obstetric care increased	% of facilities offering BEOC/CEOC					
		% drop in case fatality ratio for pregnancy related complications					
	Availability of family planning commodities at health facilities improved	% of facilities reporting no stock-outs in at least 3 methods					
		% of WRA receiving family planning in health facilities					
	Deliveries by skilled attendant and utilization of FP services increased from --- to --- in five years	% of deliveries by skilled attendant					
		% of WRA using FP					
Adolescent health	Youth-friendly services in 10 districts established	No. of districts with youth-friendly services established.					
Screening of breast and cervical cancers	Infrastructure for cervical and breast cancer screening, treatment and palliative care improved at all levels of health care	No. and type of equipment procured					
	Health providers at all levels of health care trained to provide cervical and breast cancer screening and treatment services	No. of trained health workers					
Gender and reproductive health	Post rape services in 10 districts established	No. of districts having established post rape services					
Management of common gynaecological conditions	Quality of management of common gynaecological condition improved	No. of patients with uterine fibroids managed appropriately					

Continued

Area of intervention	Outputs	Indicators	Year of implementation				
			1	2	3	4	5
Child Health, IMCI & KEPI							
AOP 1 Expansion	Case management of childhood diseases impairment and disabilities improved	% of facilities treating childhood diseases as per IMCI guidelines					
		% decrease in case fatality rates for ARI					
		% fully immunized children at 1 year					
		% children with disabilities managed appropriately					
		% <5 years attending growth monitoring clinics					
	Biannual de-worming of school going children commenced	% of school going (primary) children de-wormed at least once in the planned period					
Screening of disabilities / impairments	Quality of care of children with disabilities improved	% of children in six districts with enhanced sensations					
Nutrition support services	ART centres offering nutritional support to HIV+ clients	No of ART centres equipped to offer nutritional support					
	80% of hospitals offering therapeutic feeds	No. of hospitals offering therapeutic feeds					
Nutrition supplementation	At least 10 districts have adequate stocks of nutritional supplements for malnourished inpatient children	No. of facilities with no stock-outs of nutritional supplements					
Micronutrient deficiencies	50% of children <5 in at least 40 districts receive at least 1 dose of vitamin A in 1 yr	% of children < 5 yrs in at least 40 districts receiving at least 1 dose of vitamin A in 1 yr					
	60% of pregnant women in at least 40 districts receive at least 1 course of folic acid and iron	% of pregnant women in at least 40 districts receiving at least 1 course of folic acid and iron					
Malaria Control							
Integrated vector management	60% of under-fives and pregnant women sleep under LLITNs/ITNs	No. LLITNs distributed to children under 5 and pregnant women					
Management of severe malaria	80% of patients admitted with severe malaria receive correct treatment	No. of patients with severe malaria receiving correct treatment					
Strengthened malaria diagnosis	60% of patients with clinical malaria obtain parasitological diagnosis	No. of patients with parasitological diagnosis of malaria					
	Malaria case management improved	% of facilities reporting no stock-out of 1st line anti-malaria drugs					

Continued

Area of intervention	Outputs	Indicators	Year of implementation				
			1	2	3	4	5
HIV/AIDS, STI & TB Control							
Expansion of AOP 1 activities							
Home-based care and nutritional support	Clinical management and nursing care strengthened and available at all levels	Reduction in the number of medical complications related to HIV/AIDS					
	Social support mechanisms in place	No. of infected persons receiving support					
	Guidelines and measures to prevent the spread of opportunistic and HIV infections developed and implemented	Reduction in cross infection					
	Strengthened institutional capacity for the provision of continuum of care and support	No. of districts with adequate institutional capacity to provide continuum of care					
Opportunistic infections	Management of opportunistic infections strengthened at all levels	Improved health status of people living with HIV/AIDS					
Environmental Health							
Expansion of AOP 1							
Food safety and quality management	Reduced cases of food borne diseases	No. of cases of food-borne diseases					
	8 regional food laboratories established	No. of regional food laboratories established					
	80 Parqua laboratories established	No. of Parqua laboratories established					
	One central referral laboratory established						
	Sampling materials/equipment procured and made available	No. of sampling equipment and materials procured					
	Sampling system established						
Sanitation and water quality management	Sanitation policy printed and disseminated to the districts	No. of districts having sanitation policy					
	Samples analysed at the districts and provinces	No. of samples taken and analysed					
	Staff deployed to handle the district and provincial laboratories	No. of laboratories meeting staff norms					
	Demonstrations conducted at the community on Phast (water & sanitation)	No. of demonstrations conducted					
	Appropriate technology transfer trainings conducted	No. of trainings conducted					
	Harmonization of staff deployment						
Pollution control	At least 80 supervisory visits made to all districts per month	No. of supervisory visits undertaken					
	Inventory of pollution sources taken in 80 districts	No. of pollution services identified					
	Pollution monitoring equipment made available	No. of pollution equipment procured					

Continued

Area of intervention	Outputs	Indicators	Year of implementation				
			1	2	3	4	5
Occupational health	Provision and adoption of occupational health guidelines required in all work places	No. of industries that adopt and display guidelines					
	Training of 5 TOTs in occupational health done in each district	No. of TOTs trained in occupational health					
	Inventory of the workplaces that have past history of reported illnesses followed and inventory taken	No. of reported cases of injuries and illnesses from specific workplaces					
	Basic training in occupational health & safety conducted for workers in selected places	No. of trainings conducted					
	Staff to manage the laboratories made available	No. of staff employed in each laboratory					
	Reagents and kits made available	No. of laboratories with reagents and kits					
Mental Health							
Community mental health support	At least one CORP in each village trained in the identification, referral and follow-up of mentally ill in 10 districts	No. of CORPs trained in each district					
Management of mental illness	All hospitals integrate mental health into their services	No. of hospitals offering integrated services including mental health					
Dental Health							
Community dental health support	At least one CORP in each village trained in oral health in at least 20 districts per year	No. of CORPs trained in oral health in each district					
Youth related activities	Number of DMFT in the school going children (6–12 yrs) reduced by 50%	Level of DMFT among the school going children (6–12) yrs					
Health Promotion							
AOP 1 Expansion	Health promoting family practices improved	% of fully immunized children at 1 year					
		% of under-fives attending clinic for growth monitoring					
	Demand for skilled delivery increased	% Increase of deliveries by skilled health workers					
	Community-based distributors of contraceptives in 5 districts	% of new districts with CBD programmes					
	60% of households sprayed in epidemic prone districts	% of households sprayed					
		No. of villages with at least one spray team					

Continued

Area of intervention	Outputs	Indicators	Year of implementation				
			1	2	3	4	5
Community capacity building	Community participation for health action strengthened	No. of districts with 1 model health promoting village					
		No. of formed and trained village health committees					
		No. of community health workers trained					
		No. of health workers with knowledge on old age disabilities.					
		Availability of training package for community health committees					
	Policy environment to support community participation for health action improved	Formulation and adoption of policy guidelines for the formation of community participation structures (e.g., village health committees)					
Promotion of healthy life styles	Health literacy improved	Percentage of people who know how to prevent malaria, HIV/AIDS, water-borne diseases (KDHS)					
		No./types of communication materials distributed to allow for appropriate health seeking behaviour					
		No. of health facilities provided with equipment to support patient education					
	Adoption of health promoting practices by families/house-holds increased	Percentage of people who smoke (KDHS)					
		LLITN coverage rate					
		Contraceptive prevalence rate					
Youth-friendly centres	Youth access to preventive, promotive and curative services improved	No. of districts with at least one model youth-friendly clinic					
		No. of clients visiting youth-friend centres					
Health education	Patient health literacy improved	No. of health facilities with patient health information centres					
		No./types of health information materials produced and distributed at health information centres					

Continued

Area of intervention	Outputs	Indicators	Year of implementation				
			1	2	3	4	5
Rehabilitation							
General rehabilitation of population at large	Screening and management of people with disabilities and impairments improved	% of people with serious disabilities and impairments identified and screened					
		% of people with serious disabilities and impairments managed in the community and health facilities					
Control of Communicable Disease							
Integrated disease surveillance and response (IDSR) data management and feedback	Strengthened data management capacity and feedback mechanism at district and national level	Proportion districts submitting surveillance reports on time to the national level					
		No. of feedback epidemiological bulletins produced and sent out					
Epidemic preparedness	Increased capacity for timely response to epidemics at district hospital level	Proportion of priority diseases that have current trend analysis (line graph) at the district level					
		Proportion of suspected outbreaks of epidemic prone diseases notified to the provincial and national level within 2 days of surpassing the alert threshold reported					
		Proportion of confirmed outbreaks with recommended response					
		Case fatality rate for each epidemic prone disease					
Laboratory capacity to confirm priority communicable diseases	Confirmation of priority communicable diseases at district level	Proportion of outbreaks of epidemic-prone diseases with laboratory confirmation results					
IDSR training and support supervision	IDSR rolled out to all districts and quarterly support supervisions carried out	No. of districts trained in IDSR					
		No. of support supervisions undertaken					
Operational research	Operational research carried out to answer the unanswered questions on disease outbreak	No. of operational research studies carried out and documented					

Continued

Area of intervention	Outputs	Indicators	Year of implementation				
			1	2	3	4	5
Blood Safety							
Blood screening	100% of blood screened for HIV	% of blood screened for HIV					
Blood collection	80% of blood collected from voluntary blood donors	% of blood units collected from voluntary donors					
Blood transfusion management	Management Board gazetted	Gazette notice					
Blood use	All level 5 & 6 facilities implement blood use guidelines	No. hospitals fully implementing blood use guidelines					
Blood collection	100% blood collected from voluntary blood donors	% of blood units collected from voluntary donors					
Blood use	50% of level 4 hospitals implementing blood use guidelines						
Construction of RBTC	One extra RBTC constructed	Centre operational					
Blood use	100% level 4 hospitals implementing blood use guidelines	% of level 4 hospitals implementing blood use guidelines					

Annex C

Governance and Management Structures in the Health Sector by Level

Administrative structures	Health sector			Multi-sector			Political structures
	Management structures	**Governance structures**	**Stakeholder forums**	**Ministry of Planning & National Development**	**Ministry of Local Government**	**National AIDS Control Council**	
National	Ministry of Health HQ – senior management team	Parliamentary Committee on Health	Joint Inter-agency Coordination Committee + various ICCs	Ministry of Planning & National Development	Ministry of Local Government	NACC	Parliament
	Hospital management team	Hospital management board					
Provincial	PHMT	None	None				Constituency
	Hospital management team	Hospital management board					
District	DHMT	DHMB	District Health Stakeholder Forum	DDC	County council	CACC	
	Hospital management team	Hospital management board					
Sub-district	Hospital management team	HMB		Division DC	Local councillors		
	Hospital management team	Hospital management board		Location DC			Ward
	Hospital management team	Hospital management board		Sub-location DC			
Village		Village health committee		Village DC			

Annex D
Methodology of Costing KEPH

The objective of costing NHSSP II was to make a realistic estimate of the financing requirements for the Kenya Essential Package for Health (KEPH), including also the non-KEPH component. In developing the approach, the MOH together with the costing team took the following steps:

1. Identified the goals and objectives the MOH wanted to meet in terms of reducing mortality and morbidity and improving the health of the population.
2. Linked these goals to MDGs and the goals of PRSP and ERS
3. Identified a number of key health interventions to be provided under each health sector goal or objective.
4. Through discussions with the costing team, broke down each programme into a set of discrete interventions.
5. For each intervention, established targets over the five-year period 2005–2010.

Costing Approach

The costing approach adopted builds on international cost studies* tailored to Kenyan needs. It combines the basic principles of cost functions with an input–output analysis of health interventions to estimate resource needs and budgets for the health sector as a whole. The methodology relies on population-based, as opposed to facility-based, data on costs of service provision. Thus the costs and budgets obtained with the method relate to the health needs of the whole population.

From a costing perspective, health managers must produce quantities of health outputs or services at a given cost using a specific intervention. The outputs require inputs of labour, drugs, supplies and medical equipment, along with overheads such as supervision and systems support. Each input has a cost associated with it. Once the quantities of inputs are known for each intervention, the inputs are multiplied by their respective unit costs to obtain the total cost of an intervention. Summing up the cost of all interventions that are needed to produce a particular service gives the cost of service provision.

> The computer model used for estimating NHSSP II cost fosters dialogue among stakeholders, and allows cost and budget analyses to be carried out across different regions, sub-sectors, health system levels, population groups and life-cycle cohorts.

Computation Method

A computer-based algorithm is used to obtain the costs of KEPH and non-KEPH components. The challenge in the costing exercise is in defining and computing unit costs of outputs and services. The costing algorithm used is transparent and flexible (because it allows changing costs by altering the underlying assumptions). It fosters dialogue among stakeholders, and allows cost and budget analyses to be carried out across different regions, sub-sectors and health system levels, as well as population groups and life-cycle cohorts. The algorithm can be used to simulate budgetary effects of various financing scenarios.

Since KEPH is based on a life-cycle approach to

* F. Nandakumar, December 1998, "Costing the basic benefits package in Egypt", Technical Report No. 32, Partners for Health Reform Project, Bethesda, Maryland, Abt Associates.

human capital development, and is delivered through a decentralized health system, the costs of interventions were computed by:

- Classifying the population by age groups for each of the five years of the strategic plan: The demographic figures used were drawn from the recent population census and adjusted to suit the age groups in KEPH.

- Phasing in targets: For each intervention, both current targets and levels of service were specified. For example, if for a given intervention, the current population coverage is 10% and the target coverage at the end of five years is 70%, assumptions were made as to how to get from 10% to 70% during these years.

- Specifying, for each intervention:
  - Prevalence or incidence rates of health conditions.
  - Number of illness episodes per person per year.
  - Per cent of episodes needing inpatient admissions.
  - Number of episodes needing outpatient contacts.
  - Number of outpatient visits per episode.
  - Average length of stay by inpatient admission.

- Further specifying for each intervention:
  - Per cent of admissions or visits by level at which service is provided. KEPH stipulates service provision at the community, dispensary/clinic, health centre/maternity or nursing home, primary hospital, secondary hospital, and tertiary hospital levels.
  - Category of service provider at each level. KEPH stipulates three categories of providers: public facility, faith-based or NGO, private facility.
  - Salaries for each type of employee by level of facility and by type of provider. Nineteen categories of employees were used and salaries included all employment benefits.
  - Protocols for various forms of medical treatments.
  - Unit costs of drugs, laboratory tests and X-rays, including overheads.
  - Time input expended by those delivering the service under each intervention by level of facility and type of provider.

The computer-based algorithm for calculating costs was run under the assumptions listed above and produced the following results:

- For each intervention:
  - Full-time equivalent (FTE) staff by type of employee, by level of facility and by type of provider.
  - Annual cost of drugs, laboratory tests and X-rays, by level of facility and type of provider
- The number of FTE employees needed to provide adequate services to each of the age groups at each stage of a life cycle.
- Number of employees needed by level of facility and type of provider.
- Annual salaries by level of facility and type of provider.
- Estimate of population size of age group in a life cycle.
- Total cost of KEPH broken down by main input categories, interventions, health system levels and population life-cycle cohorts.

The computer-based algorithm to compute KEPH costs can be used for other cost estimations as needed. The assumptions underlying the algorithm were generated through a process of discussions with stakeholders, especially the KEPH team at the Ministry of Health, and through a thorough review of secondary material and data sources. Since in Kenya data are not generally available according to the cost categories stipulated in KEPH, it is important to appreciate the necessity of assumptions in cost calculations.

Annex E

Cost of KEPH by Targets, 2005–2010 (KSh Millions)

Cost category	Salaries	Drugs & supplies	Lab tests & other investi-gations	Bed & meals	Allocated overhead	M&E	Total annual cost
FY 2005/06							
Malaria control	3,644	1,846	338	908	1,011	337	8,085
Environmental / public health	2,057	2,522	-	-	687	229	5,494
Health promotion	22	1,720	-	-	51	16	1,809
TB control	968	332	100	595	299	100	2,394
STI control	1,220	660	618	-	375	125	2,998
EPI	951	1,490	-	-	366	122	2,930
Rehabilitation	486	419	-	64	145	48	1,162
Palliative care	185	53	-	-	36	12	285
IMCI	6,150	1,496	98	2,534	1,542	514	12,333
HIV/AIDS	1,183	7,499	2,130	561	1,706	569	13,649
Mental health	57	46	-	10	17	6	136
Dental health	303	412	-	-	107	36	858
Reproductive health	6,487	2,058	950	1,155	1,598	533	12,781
Total	**23,712**	**20,554**	**4,235**	**5,828**	**7,939**	**2,645**	**64,914**
FY 2006/07							
Malaria control	3,779	2,084	343	972	1,077	359	8,613
Environmental / public health	2,253	2,895	-	-	772	257	6,178
Health promotion	23	2,271	-	-	52	17	2,363
TB control	1,035	356	107	606	315	105	2,523
STI control	1,313	710	665	-	403	134	3,225
EPI	1,008	1,589	-	-	390	130	3,117
Rehabilitation	753	743	-	68	235	78	1,877
Palliative care	395	114	-	-	76	25	611
IMCI	6,482	1,574	103	2,667	1,624	541	12,991
HIV/AIDS	1,462	8,356	2,593	646	1,958	653	15,668
Mental health	78	59	-	14	23	8	181
Dental health	325	442	-	153	138	46	1,105
Reproductive health	8,750	2,169	1,076	1,416	2,012	671	16,094
Total	**27,655**	**23,361**	**4,887**	**6,541**	**9,075**	**3,025**	**74,544**

Cost category	Salaries	Drugs & supplies	Lab tests & other investi-gations	Bed & meals	Allocated overhead	M&E	Total annual cost
FY 2007/08							
Malaria control	4,174	2,671	387	1,039	1,241	414	9,926
Environmental / public health	2,467	3,169	-	-	845	282	6,763
Health promotion	24	331	-	-	53	18	425
TB control	1,106	381	114	617	333	111	2,661
STI control	1,412	763	716	-	434	145	3,469
EPI	1,068	1,695	-	-	414	138	3,316
Rehabilitation	1,037	1,087	-	73	329	110	2,636
Palliative care	634	182	-	-	123	41	980
IMCI	6,829	1,656	109	2,805	1,710	570	13,678
HIV/AIDS	1,894	9,879	3,235	439	2,317	772	18,537
Mental health	103	79	-	18	30	10	241
Dental health	353	480	-	167	150	50	1,200
Reproductive health	9,136	2,993	1,275	1,640	2,256	752	18,052
Total	**30,236**	**25,367**	**5,835**	**6,797**	**10,235**	**3,412**	**81,882**
FY 2008/09							
Malaria control	4,465	2,995	414	1,111	1,348	449	10,782
Environmental / public health	2,698	3,467	-	-	925	308	7,398
Health promotion	25	353	-	-	57	19	454
TB control	1,182	408	122	627	351	117	2,807
STI control	1,518	821	770	-	466	155	3,730
EPI	1,132	1,807	-	-	441	147	3,527
Rehabilitation	1,339	1,451	-	78	430	143	3,442
Palliative care	905	260	-	-	175	58	1,398
IMCI	7,192	1,741	114	2,949	1,799	600	14,396
HIV/AIDS	2,105	0,135	3,606	410	2,439	813	19,508
Mental health	162	121	-	28	47	16	373
Dental health	384	521	-	181	163	54	1,303
Reproductive health	10,170	3,237	1,571	1,822	2,520	840	20,160
Total	**33,277**	**27,317**	**6,597**	**7,207**	**11,160**	**3,720**	**89,276**
FY 2009/10							
Malaria control	4,776	3,328	443	1,188	1,460	487	11,682
Environmental / public health	2,950	3,790	-	-	1,011	337	8,087
Health promotion	26	377	-	-	61	20	484
TB control	1,262	437	130	638	370	123	2,961
STI control	1,632	882	827	-	501	167	4,010
EPI	1,199	1,927	-	-	469	156	3,752
Rehabilitation	1,661	1,837	-	83	537	179	4,297
Palliative care	1,209	348	-	-	234	78	1,868
IMCI	7,572	1,830	120	3,099	1,893	631	15,145
HIV/AIDS	2,269	1,491	4,031	430	2,733	911	21,865
Mental health	187	146	-	33	55	18	440
Dental health	412	558	-	194	175	58	1,396
Reproductive health	12,029	3,846	1,708	2,143	2,959	986	23,671
Total	**37,185**	**30,797**	**7,259**	**7,809**	**12,457**	**4,152**	**99,660**

Annex F

Sources and Types of Funding for NHSSP II 2005–2010 (Ksh Millions)

Available resources	FY 2005/6	FY 2006/7	FY 2007/8	FY 2008/9	FY 2009/10
Government					
Financing Scenario 1 (status quo)	26,384.5	34,014.6	39,585.8	45,364.1	52,835.5
Financing Scenario 2 (best case)	34,634.7	40,203.2	45,216.7	50,605.5	56,610.9
Cost sharing					
Government facilities	1,632.0	1,958.4	2,350.1	2,820.1	3,384.1
KNH	825.0	907.5	998.3	1,098.1	1,207.9
MTRH	272.5	286.1	300.4	315.5	331.2
National Social Health Insurance Fund (NSHIF)	0.0	0.0	11,514.6	11,611.4	15,138.2
Global Fund					
Malaria	3,558.5	2,628.8	2,703.4	2,716.2	2,869.2
HIV/AIDS	527.2	1,824.0	n/a	n/a	n/a
TB (incl. other bilateral/ multilateral support)	825.0	825.0	n/a	n/a.	n/a
Available resources					
Scenario 1	34,024.7	42,444.4	57,452.6	63,925.4	75,766.1
Scenario 2	42,274.9	48,633.0	63,083.5	69,166.9	79,541.5
Overall costs					
KEPH	64,914.0	74,544.0	81,882.0	89,276.0	99,660.0
Health sector (KEPH and Non-KEPH)	92,734.3	106,491.4	116,974.3	127,537.1	142,371.4
KEPH financing gap					
Scenario 1	-30,889.3	-32,099.6	-24,429.4	-25,350.6	-23,893.9
Scenario 2	-22,639.1	-25,911.0	-18,798.5	-20,109.1	-20,118.5
Health sector financing gap					
Scenario 1	-58,709.60	-64,047.04	-59,521.68	-63,611.74	-66,605.32
Scenario 2	-50,459.38	-57,858.45	-53,890.75	-58,370.29	-62,829.93

Annex G

Annual Ministry of Health Expenditures, 2000–2005 (Ksh Millions)

	2000/01	2001/02	2002/03	2003/04	2004/05
Recurrent	11,041	12,715	14,405	15,438	15,952
Development	1,032	2,519	945	1,003	7,659
Total	12,072	15,234	15,351	16,441	23,611
Per capita Ksh	395.49	488.44	481.97	506.05	712.67
Per capita US$	5.05	6.28	6.29	6.52	9.10
Ministry of Health expenditure (gross) as % of total government					
Recurrent	7.67	8.23	8.69	7.76	7.22
Development	4.49	17.18	5.12	2.77	8.83
Total	7.23	9.01	8.33	6.99	7.67
Ministry of Health expenditure (gross) as % of GDP					
Recurrent	1.32	1.38	1.40	1.41	1.29
Development	0.12	0.27	0.09	0.09	0.62
Total	1.44	1.65	1.49	1.51	1.91

Source: Ministry of Health Draft Public Expenditure Review 2005.

Annex H

Annual Ministry of Health Recurrent Expenditures by Sub-Vote, 2000–2004 (Ksh Millions)

	Sub-Vote	2000/01 Actual	2001/02 Actual	2002/03 Actual	2003/04 Actual
110	General Admin. Planning	700.7	587.0	714.8	760.4
	Total as % total MOH	6.3	4.6	5.0	4.9
111	Curative Health	6,080.9	6,758.6	7,677.6	7,768.0
	Total as % total MOH	55.1	53.2	53.3	50.3
112	Preventive and Promotive	874.4	665.2	632.2	863.6
	Total as % total MOH	7.9	5.2	4.4	5.6
113	Rural Health Services	1,121.4	1,378.1	1,436.4	1,687.6
	Total as % total MOH	10.2	10.8	10.0	10.9
114	Health Training and Research	884.2	1,060.2	1,161.8	1,459.8
	Total as % total MOH	8.0	8.3	8.1	9.5
116	Medical Supplies Unit	29.6	48.3	34.2	32.0
	Total as % total MOH	0.3	0.4	0.2	0.2
117	Kenyatta National Hospital	1,349.6	1,865.2	2,327.0	2,409.0
	Total as % total MOH	12.2	14.7	16.2	15.6
118	Moi Teaching and Referral Hospital	0.0	352.3	421.5	458.1
	Total as % total MOH	0.0	2.8	2.9	3.0
	Total MoH	11,040.8	12,714.9	14,405.4	15,438.5
	Total as % total MOH	100.0	100.0	100.0	100.0

Source: Ministry of Health Draft Public Expenditure Review 2005.

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NHSSP II – 2005–2010

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Health Sector Reform Secretariat