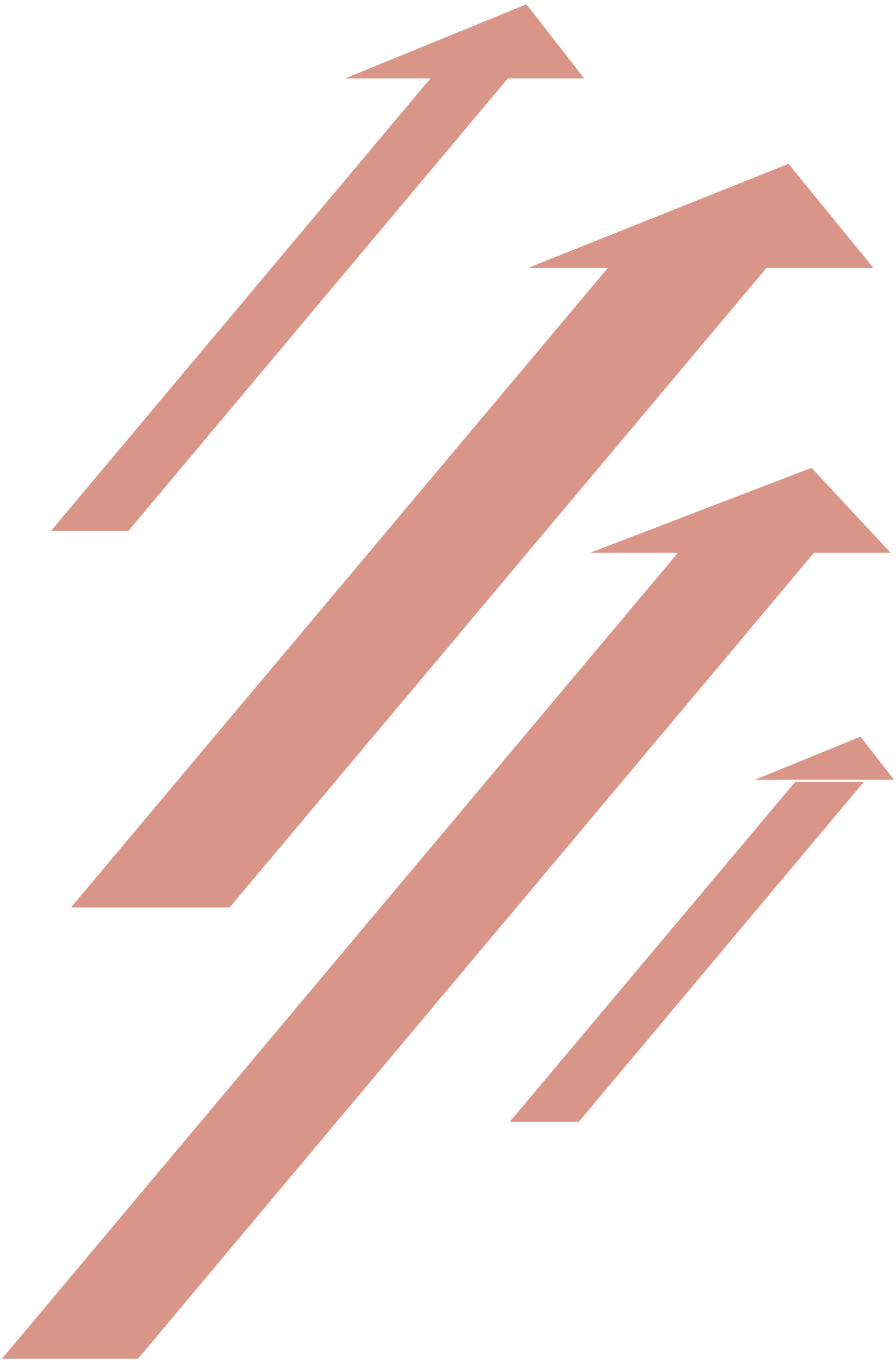
Republic of Kenya

Reversing the Trends
The Second National Health Sector Strategic Plan

NHSSP II Midterm Review Report

Ministry of Health

November 2007



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Sector Strategic Plan

NHSSP II
Midterm Review
Report

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Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya – NHSSP II Midterm Review Report

Published by: Ministry of Health
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http://www.hsrs.health.go.ke

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List of Abbreviations

AIDS	Acquired immune deficiency syndrome
AOP	Annual operational plan
BEOC	Basic essential obstetric care
CDF	Constituency Development Fund
CEOC	Comprehensive essential obstetric care
CE	Chief Economist
CFO	Chief Finance Officer
CHEW	Community Health Extension Worker
CHW	Community Health Worker
COC	Code of Conduct
CU	Community Unit
DANIDA	Danish Development Agency
DHMT	District Health management Team
DHRM	Department of Human Resource Management
DHS	Demographic and Health Survey
DMS	Director of Medical Services
DFID	Department for International Development
DP	Development partners
DRH	Division of Reproductive Health
EMS	Essential Medical Supplies
EDL	Essential drug list
GDC	German Development Cooperation
GDP	Gross domestic product
GOK	Government of Kenya
H/C&RS	Head, Curative and Rehabilitative Services
HENNET	Health Non-Governmental Organization Network
HIV	Human immuno-deficiency virus
HMIS	Health management information system
H/PPHS	Head, Preventive and Promotive Health Services
HR	Human resource
HRH	Human resource for health
HRM	Human resource management
H/SPMD	Head, Sector Planning and Monitoring Department
HSCC	Health Sector Coordinating Committee
HSSF	Health Sector Services Fund
ICC	Interagency Coordinating Committee
ICT	Information and communication technology
IDSR	Integrated Disease Surveillance and Response
IFMIS	Integrated financial management information system
IP	Implementing partner
IRT	Independent review team
ISO	International Standards Organization
IMR	Infant mortality rate
IPT	Intermittent presumptive treatment
IRT	Independent review team
ITN	Insecticide treated net
JFA	Joint Financing Agreement
JICA	Japanese International Cooperation Agency
JPWF	Joint Programme of Work and Funding
JRM	Joint Review Mission
Ksh	Kenya shilling
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KHPF	Kenya Health Policy Framework
KHSWAp	Kenya Health Sector-Wide Approach
KNBS	Kenya National Bureau of Statistics
KSPA	Kenya Service Provision Assessment
MDGs	Millennium Development Goals
MEDS	Mission for Essential Drugs Supply
MMU	Ministerial Management Unit
MOH	Ministry of Health
M&E	Monitoring and evaluation
MTEF	Medium-term expenditure framework
MTCs	Medicines and Therapeutic Committees
MTR	Midterm review
NCDs	Non-communicable diseases
NGO	Non-governmental organization
NHA	National Health Account

NHISF	National Health Insurance Fund
NHSSP II	Second National Health Sector Strategic Plan
NSHIF	National Social Health Insurance Fund
PAC	Principal Accounting Controller
PER	Public expenditure review
PETS	Public Expenditure Tracking Survey
PHMT	Provincial Health Management Team
PFM	Public financial management
PME	Performance-based monitoring and evaluation
PMIS	Procurement management information system
RBM	Results based management
RH	Reproductive health
SWAp	Sector-wide approach
SC	Service Charter
SOP	Standard operation procedure
TB	Tuberculosis
TCR	Treatment completion rate
TNA	Training needs assessment
TWG	Technical Working Group
UNFPA	United Nations Population Fund
US$	United States dollar
USG	United States government
WHO	World Health Organization
WB	World Bank

Foreword

Acknowledgements

Executive Summary

Kenya's second National Health Sector Strategic Plan (NHSSP II) defined five main objectives and ten strategic shifts that would drive its implementation over the plan period, 2005–2010. The intention was to reverse the downward slide in Kenya's health indicators and align health sector achievements with the Economic Recovery Strategy (ERS) and the Millennium Development Goals (MDGs).

As the life of the plan approached its midterm, it was necessary to review progress made towards the goals. The extent to which they are being realized is outlined in the various chapters of this report of the Midterm Review (MTR). The assessment was carried out by an independent review team and the report was developed under the leadership of the Joint Review Mission (JRM) steering committee, which provided valuable comments on the draft that were then incorporated into this version.

Among cross-cutting achievements were the articulation of a sector-wide approach (SWAp) to heath services delivery and the institution of local, district and provincial stakeholder forums. But while the MTR found significant progress in some areas, achievements in others were less impressive. Accomplishments during the first half of NHSSP II are briefly summarized below according to the five main objectives. This is followed by a selection of the major recommendations for the way forward.

NHSSP II Objectives

1. Increase equitable access to health services
2. Improve the quality and responsiveness of services
3. Foster partnerships in improving health and delivery services
4. Improve efficiency and effectiveness
5. Improve financing of the health sector

Summary of Achievements

Access

Many achievements have been made in expanding the coverage of facilities, institutionalizing the needs of clients and improving pro-poor financing. Significant among these were the implementation of the first phase of the Kenya Essential Package for Health (KEPH) and the development and roll out of the Community Strategy.

Quality

Government-wide institution of results-based management has underpinned the performance appraisal. A recent pay rise for health workers has also provided a conducive environment for reform. Many clients are more satisfied with the services.

Partnerships

Commendable planning frameworks have been developed, and the health sector is rapidly decentralizing its planning process. Commitment has been shown on all sides to substantially strengthen partnership arrangements.

Efficiency and Effectiveness

Progress is being made to enable funds to flow directly to lower level service delivery. The Health Sector Services Fund (HSSF) pilot shows that this is likely to accelerate service delivery outputs. Plans have been developed to strengthen certain health systems.

Financing

Resources have increased, and allocative efficiency has improved with more funds channelled to cost effective basic health services. Resolving bottlenecks in spending GOK funds is being addressed as a priority.

Summary of Recommendations

These are also organized according the five objectives of NHSSP II. In some cases the list of suggestions is long and they are only outlined here; details are contained in the body of the report.

Access

- Strengthen the delivery of the KEPH by accelerating implementation of the following focal areas: Safe motherhood, Community Strategy, Malaria, TB and non-communicable diseases, and developing implementation frameworks for providing services to cohorts 4 and 6.
- Address remaining barriers to equitable access through continued dialogue with the Constituency Development Fund (CDF) Committee, review of innovative service delivery mechanisms for improvement and scaling up services to remote hard-to-reach areas; recruitment and deployment of the 9,000 approved posts, and further reallocations of public funding towards pro-poor programmes.
- Make the Community Strategy more inclusive by bringing on board all interested parties and resolving issue on terms of conditions of CHWs.

Service Quality

- Strengthen systems and capacity for effective integrated support supervision and quality assurance programme at all levels.
- Accelerate the dissemination of updated clinical standards, protocols and guidelines for the KEPH including the ministerial service charter.
- Logistics chain management for essential and public health goods needs to be strengthened in GOK and PNFP facilities.
- Develop strategies for improving provider-client relationships and accountability including development of health specific charters.

Efficiency and Effectiveness

- Improve value for money by undertaking further reallocations of public funding towards pro-poor programmes especially rural health services in light of current poverty levels that justify more wavers of facility fees to alleviate financial constraints to health services access by the poor.
- Improve public financial management by implementing the Health Sector Service Fund (HSSF), enhancing collaboration with development partners, and fast tracking capacity building in financial management.
- Strengthen district health planning.
- Ensure that gender and rights sensitivity are included in training materials and planning formats and consider the establishment of a focal area at the national level to coordinate this work.
- Improve monitoring through a variety of steps to enhance the national health management information system and undertake essential health research.
- Improve public procurement by, among others, accelerating the implementation of the procurement improvement plan.
- Strengthen commodity supply management, by delineating roles and responsibilities of MOH and KEMSA, and define the role of KEMSA vis-à-vis non public actors and introducing quality assurance mechanisms.
- Enhance investment and maintenance in infrastructure , communication and transport.

Efficiency and Effectiveness

- Develop a roadmap for advancing the Kenya Health SWAp and governance structures for annual planning to be agreed and the Health Sector Coordinating Committee (HSCC) mandated to monitor its progress.
- Articulate clear benchmarks to ensure adherence by all parties to the Code of Conduct (COC) and ensure the SWAp is advanced.

Partnerships

- Formulate a public-private partnership policy framework, but give priority to addressing issues relating to private not-for-profit providers involved in direct service provision.
- Set national targets for indicators of progress on aid effectiveness per the Paris Declaration (ownership and leadership, alignment to government strategies and priorities, and mutual accountability for results and harmonization) within the NHSSP II M&E framework.

Financing

- Increase the level of health financing through improved lobbying for adherence of GOK budget projections and donor commitments.
- Improve budget management and explore mechanisms for efficient and equitable resource allocation and utilization.
- Finalize and implement a long-term health financing strategy.
- Review NHIF Act to adjust the benefit ratio; limit administrative spending; mandate expansion of the benefit package to outpatient services; change the contribution to a percentage/ratio of salary instead of fixed rates; and regulate non-benefit payments/contributions to the health sector.
- Incorporate NHIF spending/income from NHIF reimbursement into financial planning of sector and health institutions.

1. Introduction

Developed and approved for implementation in 2005, Kenya's second National Health Strategic Plan (NSSSP II, 2005–2010)[1] aimed to reverse the downward slide in the country's health indicators. The plan outlines five major strategic policy objectives: 1) increase equitable access; 2) improve service quality and responsiveness; 3) improve efficiency and effectiveness; 4) foster partnership; and 5) improve financing.

These strategic objectives are designed to be achieved through a shift of focus and commitment in the management of the health sector.

Policy Shifts in NHSSP II

NHSSP II was developed on the basis of two major principles: reversing the declining health trends and achieving the high targets set in the Economic Recovery Strategy (ERS) and the Millennium Development Goals (MDGs). If the management of the sector continued business as usual – as was the case in NHSSP I – it was recognized that the targets would not be achieved. Therefore NHSSP II focused on changing the mindset of health managers in a holistic approach to sector management, appreciating the involvement and responsibility of other actors, orientation to results rather than to processes and procedures, and utilization of flexible and learning approaches.

NHSSP II defined ten strategic shifts that would drive its implementation. As the life of the plan approached its midterm, it was necessary to review progress made in each of these areas. The extent to which they are being practised is reflected in the various chapters of this report. Progress is summarized in Table 1.1.

NHSSP II aims to keep people well, rather than simply treat disease, and to promote the involvement of communities in their own health care.

About this Report

The Plan has been carried out in the last two years through the development and implementation of Annual Operational Plans 1 and 2. One of the major strategies designed in NHSSP II has been the move towards sector wide approach, which requires a regular joint reviews and evaluations on a regular basis. In the Kenyan context, GOK is expected to organize a Midterm Review (MTR) and a final evaluation of the NHSSP II. These exercises were planned to take place before the end of the third year and during the last quarter of implementation year of NHSSP II, respectively, as per the draft of Code of Conduct (COC) and NHSSP II (page 49). All partners have jointly determined the terms of reference and the composition of the independent review team (IRT).

In view of the late schedule for the final evaluation of NHSSP II, this midterm evaluation could also serve as basis for initiating NHSSP III development process. It would be more efficient and cost effective to undertake the AOP 2 annual review and the NHSSP II MTR at the same time. According to the terms of reference (TORs), the Joint Review Mission (JRM) was to be carried out under the guidance of a Joint Government/developing partners/implementing partners Steering Committee JRM (Steering Committee). The Sector Planning and Monitoring Department would provide secretarial

[1] Ministry of Health, *Reversing the Trends – The Second National Health Sector Strategic Plan of Kenya: NHSSP II – 2005–2010*, September 2005.

Table 1.1: Progress in the realization of policy shifts in the health sector

NHSSP II plan		
From	**To**	**Current implementation status**
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.	The AOPs are institutionalized; There are still interventions being carried outside AOPs, which needs to be corrected
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.	There is significant change in management of the sector in scanning the environment and learning from experiences. The annual JRM process contributes significantly to this learning approach.
Management is based on evidence only, no risk taking.	Management is based on piloting, and managing risks and uncertainties.	There have been e pilot interventions in new policy initiatives in the last two years: Community Strategy implementation, health facility funds, demand driven EMMS procurement system, demand side financing interventions
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.	A Code of Conduct is signed on the partnership principles for the tripartite partners (government, implementing partners and development partners). Partners' interventions are increasingly included in the annual planning process. There have been three health summits that brought all stakeholders together to plan and review the performance of the sector . The DHSFs are functional in most of the districts.
Services are provided on the basis of vertically organized programmes.	Services focus on the needs of various age-groups (cohorts).	KEPH under implementation. All the services out lined in KEPH have not been introduced yet.
Focus on projects and activities.	Focus on outputs and outcomes.	Results based management and performance contracting & appraisal systems have been introduced. The Joint Programme of Work and Funding and the Joint support programme are laying the foundation for moving towards a programme approach.
Ministry alone takes responsibility.	All actors are equally responsible.	Most actors are involved in planning monitoring and monitoring process but process of responsibility for sector actions is evolving.
In setting priorities, use only criteria of technical and effective interventions.	Priority setting also includes political criteria of access to and redistribution of power and resources within the country.	Not much progress is recorded
Continue the expansion of infrastructure at all levels.	Scale up community-based interventions and link them with the referral system.	Community Strategy implementation initiated and lessons learnt to enable linking the informal structure into the formal health system
Public sector fills the poverty gap through an essential health package; pro-poor targeting, but little change.	Public sector ensures redistribution of resources and social solidarity; structural change to bring everybody on board.	Not much progress in the sector, but there are processes initiated to support the FBOs/NGOs

support. The Committee would be primarily responsible for:

- Facilitating the Joint Review planning and implementation process.
- Refining the terms of reference (TORs) for the JRM Independent consultancy team.
- Undertaking the recruitment process of the independent review team (IRT).
- Facilitating the field visits.
- Supporting the organization of the stakeholders meeting.
- Undertaking the policy dialogue.
- Developing the JRM report and presenting to the HSCC.
- Organizing the Health Review Summit.

Objective of the Midterm Review

The objectives of the NHSSP II midterm review were to obtain a comprehensive view as

- To extent the NHSPS II policies and strategies have been implemented?
- To what extent has the NHSSP II implementation contributed towards the realization of the sector objectives and targets?
- What are the challenges and constrains in implementation of the NHSSP II policies and strategies and for realizing set objectives and targets including the appropriateness and relevance, of the policies and strategies in reversing the health trends?

The JRM steering committee decided to undertake the review internally with stakeholders and to use an independent review team to verify and provide objective recommendations. The MTR process involved the development of an MTR reports by the MOH; the development of the IRT report to be an input to the stakeholders meeting; and the review of the implication of the findings of the two reports in the stakeholders' meeting that endorsed the recommendations. This report therefore has brought the additional findings of the IRT team into the original MOH report and presented the comprehensive recommendations from the whole process (MOH report, IRT comprehensive report, and the stakeholders meeting).

Methodology and Process of Development

The MOH MTR Report was developed under the leadership of the JRM steering committee. The committee has reviewed the content of the report and provided valuable comments for improvement which this version has incorporated. This document is prepared using various sources of information. The annual performance reports of AOP 1 and 2, the district health information data have been the main sources for the various sections of the report. The results of surveys for service delivery areas and systems by programmes and various review missions have also been used. The IRT individual consultants' reports, along with the recommendations of the stakeholder meeting, have enriched the content of the report.

The gaps in the information from the various sources have a negative effect on the quality of the report. The quality and reliability of the district data cannot be ascertained as data quality assurance is not fully functional. Only about 65% of the health facilities have reported for AOP 2. The systems section of the report has been consolidated from the various reviews carried out rather than a systematic reports submitted. It still remains difficult to have a comprehensive expenditure report from all the sector players. Most of the donor and implementing partner expenditures are not captured in this report.

Flow of the Report

The MTR report is structured in line with the strategic objectives of the NHSSP II. The chapters review the extent to which the sector has achieved the aims set in each objective. Chapter 2 looks into increasing equitable access to health services and the strategies implemented, and Chapter 3 explores how far the quality of services are improved and respond to the needs of clients. Chapter 4 asseses the extent to which the system related reforms are implemented to support the delivery of the defined health care services. Chapter 5 documents the progress made regarding fostering partnership. The last chapter examines the resource flows and presents how far the NHSSP targets in areas of mobilizing additional resources and in improving allocative efficiency are met.

2. Progress with Objective 1: Increasing Equitable Access

NHSSP II intends to increase equitable access to health care services by addressing obstacles to accessing health services which are classified as geographical, financial and social-cultural factors. It is assumed that breaking the barriers to accessing care would result into increased utilization of health care services. NHSSP II emphasizes the focus on the need to strengthen service delivery to ensure ill health is limited amongst the people in Kenya. This is further elaborated in the policy objective to increase in equitable access to health services. NHSSP II outlines how this is to be done, through a series of service delivery reforms, centred around a defined set of service interventions, the Kenya Essential Package for Health (KEPH.)[2]

Recap of Expectations

At the end of NHSSP I, access to health care services was found to be unequal across the country. The Kenya Service Provision Assessment Survey 2004 found that 57% of facilities could provide a basic package of child, maternal, reproductive health and HIV/AIDS services, but only 10% of clinics are able to provide 24-hour delivery services.

The MOH *Norms and Standards*[3] guideline suggests that average number of facilities per capita per level appear to be adequate, with over-availability of level 2 and level 4 facilities. The norms for facility availability are based on populations, however, and not on distance to nearest facilities, which is reported to be over 50km in some parts of the country. Even at the health centre and dispensary level, the distance factor means that adjacent populations are better served than remote villages within the catchment population, a difference that is only partially offset by outreach services. In the pastoral areas where population densities are low, average distance to a health facility is inevitably greater than in cultivated areas, even if catchment populations are identical. In the extreme case, static facilities are only infrequently accessible by nomadic populations.

Barriers to access to health care come in many shapes – financial, social, cultural and geographic. NHSSP II provided for action to improve access in all these areas.

There were also huge geographical variations in staff distribution for all cadres. For example, the distribution of nurses in 2003 ranged from 2,874 nurses per 100,000 in Central to 349 nurses per 100,000 in North Eastern province (HR Mapping Study 2003), the disparity is likewise with doctors and other cadres.

Poor health indicators were also evident in disparities depends on poverty. Income poverty was associated with poor health outcomes. Data derived from the 2003 Demographic and Health Survey[4] show that in the lowest socio-economic quintile, infant and child mortality rates were much higher (up to 50% higher) than in the richest quintile, and the incidence of moderate and severe malnutrition was almost four times greater. The financial barriers represented by user fees, which deter use of services by poorer people is a major contributor to inequality to health services.

In contrast with other countries that have defined a basic package, the focus of KEPH is not

[2] Ministry of Health, *Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya – The Kenya Essential Package for Health*, July 2007.

[3] Ministry of Health, *Norms and Standards for Health Service Delivery in Kenya*, June 2006.

[4] Central Bureau of Statistics, *Kenya Demographic and Health Survey (KDHS), Key Findings*, 2003.

on delivery of a limited set of interventions, but rather on the delivery of a comprehensive package of services aimed at keeping the population in Kenya healthy, and so able to contribute to the economic development as outlined in the Government's medium- and long-term development strategies. The KEPH emphasizes provision of services using a three-pronged approach, covering three main dimensions needed to maintain health:

- Improving lifestyles – that is, encouraging healthy behaviour.
- Preventing disease – that is, ensuring the population is able to avert avoidable diseases.
- Curing illness and rehabilitation – that is, ensuring that those who get ill are appropriately taken care of.

This KEPH approach forms the basis of the Service delivery reforms initiated with NHSSP II. While appreciating that service delivery reforms need a longer period than two years to show impact, it is important at this stage to review whether the sector is moving in the correct direction, and if appropriate policy direction is being provided to enable such movement.

The shift to the KEPH has still not taken root in the sector. Services are still largely curative. Even with the key preventive divisions, the modification of their strategies to take into consideration the need to address interventions using the KEPH philosophy has not yet fully occurred. As a result, interventions to service delivery units are still highly fragmented. This is seen even in areas that the sector has defined as priority. For example, while the sector has defined the comprehensive community approach, many programme areas are still implementing vertical community approaches. Implementation units therefore have to grapple with a comprehensive community approach, and community approaches for key programme areas like TB, integrated management of childhood illness (IMCI), maternal health, HIV, etc. This is confusing and fragmenting to implementation units.

Progress with Implementation in Line with KEPH

As the Midterm Review is based on service delivery information for the first two years of NHSSP II, without including the final six months of the actual midterm, targets are based on 40% of the overall NHSSP II targets, and not the 50% as expected. Although most of the indicators do not have both NHSSP II and MTR targets, the trend over the AOP 1 and AOP 2 periods, in most cases, is positive. In most of the indicators where there is specified target, the sector is either ahead or on target to meet the NHSSP 11 outcome targets.

The positive outcomes of the services provided in the last two years are expected to positively influence the health status, which can only be verified when the next KDHS is published. Achievements so far for each of the cohorts, based on support so far in enabling reversal of trends, are now highlighted.

Table 2.1: Status of indicators against review targets

Benchmarks for reviewing progress	Number of sector indicators that performed		
	Below target	On target	Above target
Expected on June 2007 (40%)	4	1	6
MTR target	2	0	5

Cohort 1: Pregnancy, Delivery and the Newborn

Prior to NHSSP II, the sector had seen worsening of output indicators for this cohort. Availability and use of services for this cohort was a noted weakness. Even in areas where services were available, utilization was limited by a mix of supply side (availability of staff and equipment) and demand side (socio cultural issues) issues. The services to the cohort, together with cohort 2, were priority for implementation in AOP 1, with scale up of priority interventions expected in AOP 2. But the first two years of the NHSSP II have produced a mixed picture. Performance so far has been good for two of the three results in this cohort, with poor performance for the result of "Mothers are able to have normal deliveries". Targets on WRA receiving family planning commodities and HIV-positive pregnant women receiving treatment for prevention of mother-to-child transmission of HIV (PMTCT) are more than achieved. On other hand, achievements in the area of delivery services, distribution of insecticide bed nets (ITNs) to pregnant mothers and antenatal care (ANC) services are below target (Table 2.2). This implies, much as the sector is ensuring safety in pregnancy, mothers are still at risk, as the delivery processes are still not adequate. It should be noted that most of the maternal mortality is a result of events at delivery.

As can be seen from Figures 2.1–2.3, only 80% of the expected results as of June 2007 was realized in ANC services. There is a decline in ANC provision from AOP 1 to AOP 2. While this needs to be explored further, since the four visits were introduced during AOP 1, the data on performance report of AOP 1 might have been a mixture of two and four visits, which overstate achievement at the time.

This achievement is even lower in delivery services as the sector realizes only 60% of the

Table 2.2: Achievements of targets for cohort 1

Indicators	NHSSP II baseline 2004/05	Targets Expected June 2005	Targets MTR targets	Achievement AOP 1	Achievement AOP 2	Remarks
% WRA receiving family planning commodities	10%	30%	45%	13%	43%	AT
% ANC clients (4 visits) coverage	54%	64%		56%	52%	BT
% Deliveries conducted by skilled attendant in health facilities	42%	61%		18%	37%	BT
% Newborns with low birth weight (less than 2,500 g)				2%	6%	
% HIV+ pregnant women receiving Nevirapine (PMTCT)	10%	26%		90,985	29%	AT
# LLITN distributed to pregnant women	55,000			362,345	445,497	
% ANC clients receiving IPT 2	4%			44%	40%	
# Health facilities providing basic emergency obstetric care (BEOC)	9			12	646	
# Health facilities providing comprehensive emergency obstetric care (CEOC)					203	
No. of maternal death audits					178	

Figure 2.1: ANC client coverage (4 visits), percentage

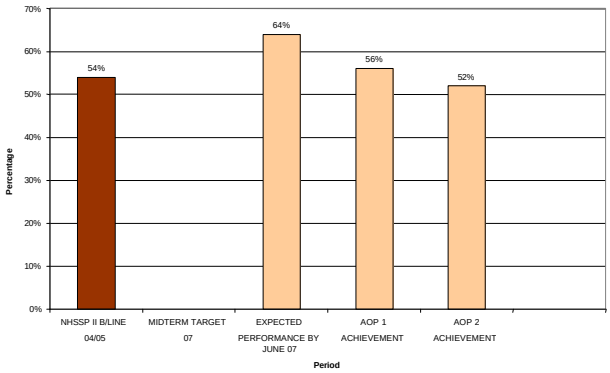
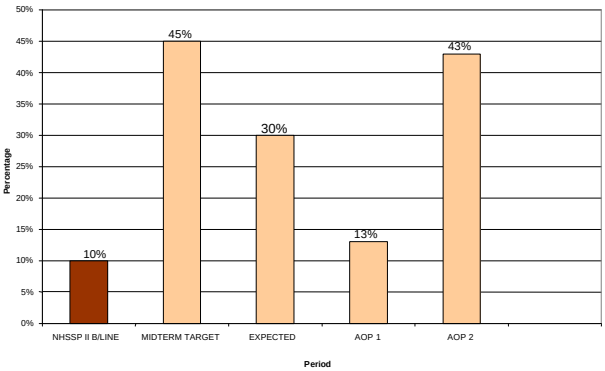


Figure 2.2: Percentage of WRA receiving family planning commodities

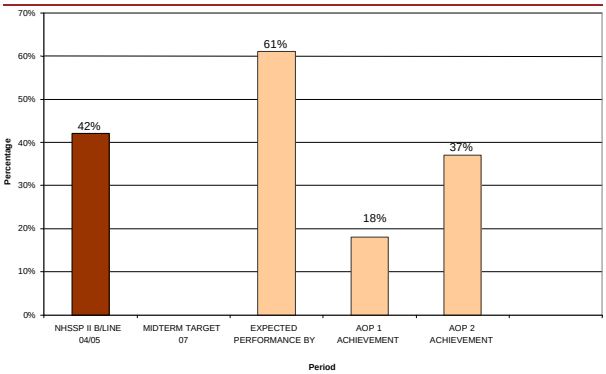


expected result. It is important to note that even though the trends represented in Figure 2.3 seem to show that the sector is performing even lower than the baseline, this is because of the different data sources used. While the baseline was based on the population based survey (KDHS 2003), the progress reported is based on routine information.

On the other hand, in the area of family planning, 96% of MTR targets and 40% more than the expected targets by June 2007 has been achieved. While the sector was able to distribute 2.8 million nets for under-five children (see next cohort) during AOP 2, this was limited to only 445,000 for pregnant women.

The sector interventions in the first two years of NHSSP II have focused on ensuring that supply-side issues are addressed. Supplies at facilities have improved to enable delivery of maternal health

Figure 2.3: Percentage of deliveries conducted by skilled attendant in health facilities



services, in line with implementation of the "Roadmap to Maternal Health"(Reference # 6). Addressing the demand-side issues, ensuring services are appropriately tailored to expectations of the communities, has been limited to a few pilot areas, particularly in Nyanza Province. Delay in roll out of the community approach in the sector has played a role in the inappropriateness with which the demand side issues are addressed.

As such, how well the progress made in this

cohort will go in reversing outcomes and impact of health of this cohort is not clear. A clear analysis of the impact of the different demand and supply side issues is needed, to guide investment in each of these that is appropriately balanced to give the appropriate impact. Interventions in the remaining years of the NHSSP II therefore need to focus both on scaling up supply side (re-open closed health facilities, improve delivery infrastructure, and train workforce), and on strengthening demand side issues through appropriate implementation of the community approach. This ensures views and input from the clients is incorporated in the delivery of services.

Cohorts 2 and 3: Early and Late Childhood

The services towards cohort 2 (early childhood) were a priority in AOP 1, with scale up expected in AOP 2 as with services for cohort 1. A series of interventions was carried out that will yield good impact for this cohort. These included push for scale up of routine immunization, child and maternal health and nutrition weeks, mass scale up of interventions to reduce malaria in children, particularly in case management (ART use), and vector control (IRS spraying), plus ITN use amongst children. Figures 2.4 and 2.5 illustrate the progress in immunization coverage.

ITN coverage has increased rapidly in Kenya since 2004. During AOP 2, close to 5 million ITNs were distributed to children under-five. The extent to which this investment has led to improvements in child survival has not been analysed through a study a dynamic cohort of approximately 3,500 children aged 1–59 months enumerated each year for two years in 72 rural clusters located in four

Figure 2.4: Children <1 year immunized against measles (%)

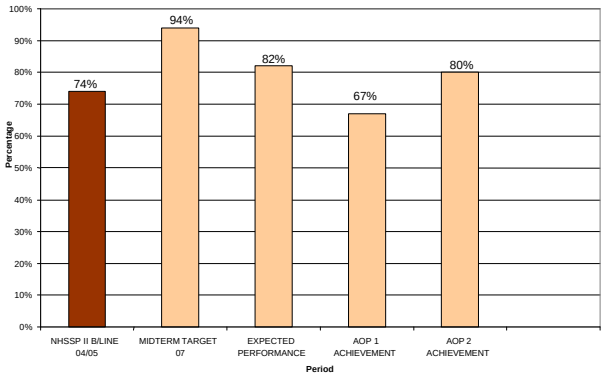


Figure 2.5: Children <1 year fully immunized (%)

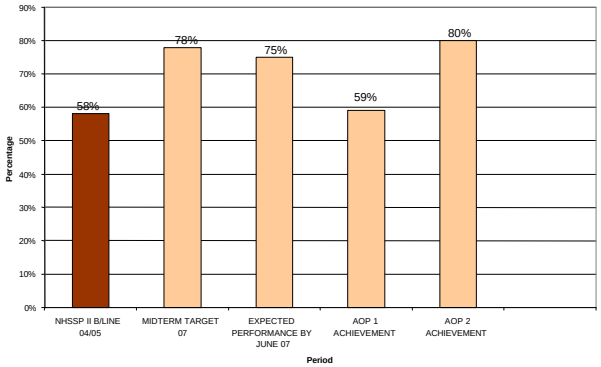


Table 2.3: Achievements of targets in cohorts 2 and 3

Indicators	NHSSP II baseline 2004/05	Targets Expected June 2005	Targets MTR targets	Achievement AOP 1	Achievement AOP 2	Remarks
% Children < 1 yr immunized against measles	74%	82%	94%	67%	80%	BT
% Children < 1 yr fully immunized	58%	75%	78%	59%	80%	AT
% Newborns receiving BCG	84%	88%		96%	99%	AT
% Children <5 attending CWC and found underweight				9%	11%	
% Children <5 attending growth monitoring services (NEW VISITS)	20%				61%	
% children <5 receiving Vit A supplement	33%	45%		15%	34%	BT
# LLITNS distributed to children under 5 yrs	250,000			1,739,675	2,773,293	
# under five years treated for malaria					2,514,504	
% of health facilities providing treatment as per IMCI guidelines	2%	10%	12%	9%	15%	AT
# Districts with community IMCI interventions					50	
Late childhood (6 to 12 years)						
% School children correctly de-wormed at least once in the planned period	25%	47%		5%	43%	BT
# Schools having adequate sanitation facilities					86,771	

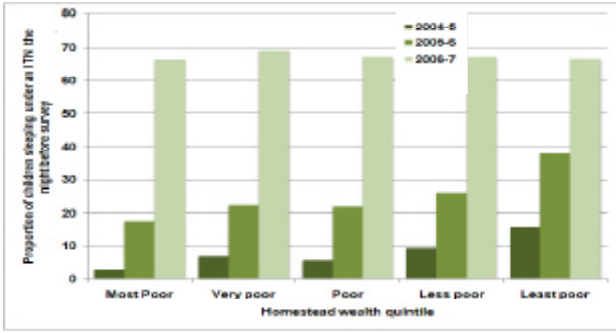
districts of Kenya. Initial indications from the ITN post mass distribution survey indicate the intervention was pro-poor, with uptake much higher amongst the poorer segments of the community. This is the segment most affected by illness, suggesting improvements in malaria morbidity and mortality. Net use increased from 7% at the first enumeration round to 67% at the last enumeration round and ITN use was associated with a 44% reduction in mortality.

In the last two years not only the coverage of ITN distribution for children under-five increased, but also the distribution of these nets have become more pro poor. as can be seen from Figure 2.6, access to nets has increased by the most poor, very poor and the poor during the three years presented. This was achieved as a result of a shift in the mode of distribution of ITNs from retail to mass free distribution which ensures universal coverage.

In 2001, 68% of the nets were distributed through subsidized retail outlets and a marginal 8% was through GOK/Mission clinics and there was no free distribution. In contrast, in 2007, about 45% of net distribution was carried out through mass distribution. The impact of this is an improved equitable distribution and use of nets by children as presented by the Lorenz curve (Figure 2.7). As can be seen from the curve, in 2004/05, distribution and utilization of nets was not equitable as the line for the year is lower than the equitable line represented by the dotted line. But the line shifts upwards reflecting the fact and become above the dotted line showing that more of the poor are sleeping under the net.

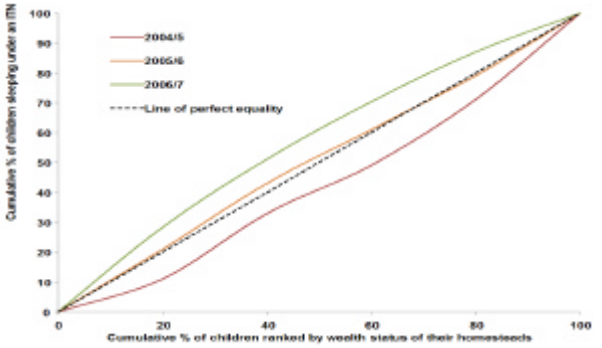
The IMCI health facility[4] survey carried out in 2006 showed the common illnesses at facilities were acute respiratory infections (ARI), malaria, and diarrhoeal diseases. Malaria is the main cause of morbidity and mortality to children, and therefore poses a major risk. Therefore, interventions in malaria control should help the country reverse trends in child and infant health.

Figure 2.6: Use of ITNs by wealth quintile following mass distribution, 2004–2007 in Kenya



[4] MOH and National Coordinating Agency for Population and Development, *IMCI Kenya – Integrated Management of Childhood Illness Health Facility Survey Report*, 2006.

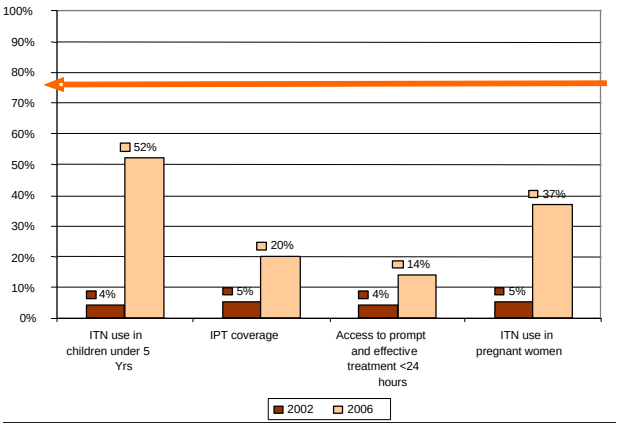
Figure 2.7: Lorenz concentration curve for children using ITNs, 2004–2007



Despite the impressive achievement in malaria control during the two years, Kenya is still far from achieving the Abuja targets (see Figure 2.8). There is need, therefore, to scale up the implementation of malaria control interventions.

Nevertheless, interventions for child health are not being addressed holistically. Different programme areas are addressing different components of child health. The immunization programme, Division of Child Health, and Division of Malaria Control are all offering key interventions for child health, which are not adequately coordinated. The KEPH concept of packaging

Figure 2.8: Progress against Abuja targets in Kenya 2001–2006



services along cohort lines for better planning and management of services are yet to be fully practiced. The sector is therefore not clear on the impact successes in selected intervention areas are having on reversing the high mortality of children. The impact of displaced mortality – from the cause of mortality being addressed to other causes of mortality – is not clear. For the sector to therefore adequately reverse poor child health outcomes, it needs to holistically address child health issues; with interventions across the major causes of child morbidity and mortality being concurrently addressed.

Cohort 4: Adolescence

Services to this cohort have been scaled up significantly during the first two years of NHSSP II, with a growing number of facilities now offering youth-friendly services – from 5 facilities in 2004/05 to 86 in June 2007. This doesn't form the full extent of expected services for the adolescent cohort, and, as noted in the AOP 2 report, the full package of services is too costly for most facilities, leading them to implement it piecemeal.

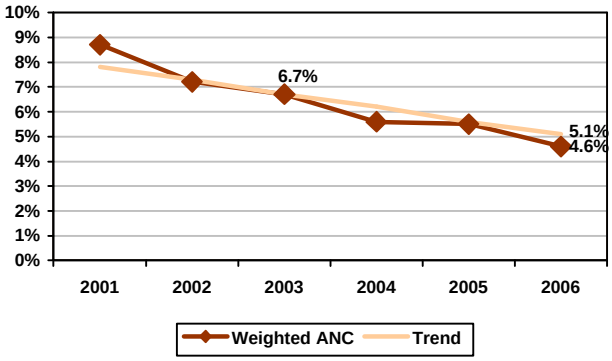
Yet, much as there has been some recognition of the need to tailor services to this cohort, interventions so far offered are not able to turn the trends in health for the adolescents. A more comprehensive but cost-effective focus on this cohort is needed.

Cohort 5: Adult/All Life Cohorts

Varied services are offered for this cohort, representing a wide scope of interventions across the sector. Services were scaled up during the first two years of NHSSP II for most of the major causes of ill health, particularly HIV/AIDS, TB and malaria. See Table 2.4.

In HIV, information is suggestive that there will be reversal of trends by the end of the NHSSP II period. HIV prevalence among adults has reduced from 6.7% in 2003 to 5.1% in 2006. The trend seen, however, had commenced prior to the NHSSP II (Figure 2.9). As such, interventions in the NHSSP II have built on those started in NHSSP I to lead to reductions seen in HIV prevalence.

Figure 2.9: Adult HIV prevalence, 2001–2006



Source: HIV/AIDS Statistics 2007.

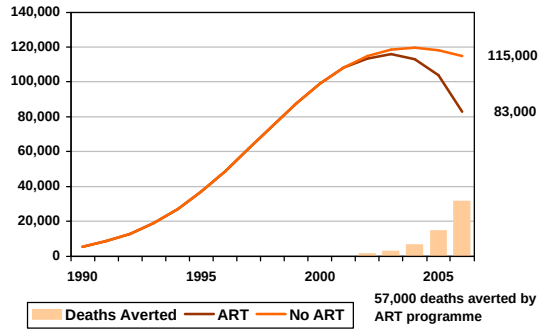
The provision of ART services have led to a significant reduction in mortality associated with HIV/AIDS (Figure 2.10). In spite of this, the number of new infections has stabilized at 55,000 per year. This implies available mass strategies are reaching their saturation point, with further reductions in incidence requiring additional interventions that are better targeted at the vulnerable populations. As with HIV, key scale up of other interventions, particularly as regards the TB and malaria were done. Scale up of TB control initiatives has markedly improved, leading to improvement in TB outcomes. The trends in TB incidence are negative, with a reduction of 9.2% between 2005 and 2006. The TB case detection rate is higher than was targeted, at over 70%. Treatment success rate is also high compared with the target, though there are still high defaulter rates. TB DOTS, and collaborative TB/HIV activities are now in place across the

Table 2.4: Achievements of targets in cohort 5

Indicators	NHSSP II baseline 2004/05	Targets Expected June 2005	Targets MTR targets	Achievement AOP 1	Achievement AOP 2	Remarks
# HIV+ patients started on ART	8,000			65,502	164,827	
# VCT Clients	200,000			474,899	780,261	
# New outpatient (curative) visits	0.08			0.4	22,572,807	
# over five years treated for malaria					4,824,691	
Malaria inpatient case fatality rate	26%				9,028	
Total # of hospital admissions					799,874	
# Condoms distributed (million)	80,000,000			43,950,000	46,122,511	
# TB cases detected	47%	50%	70%	0.331	71,177	
TB cure rate	67%	70%	82%	75%	24,133	
TB treatment completion rate (Sputum+/DOTS)	80%	83%	85%	83%	22,789	DQ
# of Districts with functional DHSF					54	
# Trained Village Health Committees (model VHC)				1,840	1,906	
Number of CHWs trained					5294	
Number of functioning community health units					129	
# Houses sprayed with IRS	2,500			443575	514714	
Total number of beds					47,555	
# Occupied bed days					5,748,034	
Total number of OPD attendance					32,974,232	

Source: Routine reports.

Figure 2.10: Estimated deaths averted because of ART scale up



Source: HIV/AIDS Statistics 2007

country, despite constraints in terms of human resources, infrastructure and financing needed to efficiently operate these interventions. These constraints are also affecting the programmatic management of multi drug resistant (MDR) TB, scaling up of community-based TB care, and other new initiatives to manage the TB burden. Impact information on malaria interventions was already highlighted in relation to children. These intervention areas saw scale up of services across the country, owing to the availability of significant partner resources that could be more targeted to the cost effective conditions within these three conditions. In addition, other non-traditional areas of interventions had services being scaled up. As such, interventions relating to management of non-communicable conditions, for example with tobacco control, were implemented in the first two years of the NHSSP II. All these interventions should affect the burden on ill health and death in this cohort.

Most of the services represent scale up of traditional interventions, as opposed to realigning scope of interventions across the KEPH services. Interventions are still provided with minimal linkages across areas representing a coordinated effort towards improving health of this cohort. As with Cohort 2, the extent of shifting morbidity and mortality, to areas not being addressed is not clear. As such, it is difficult to estimate the impact of all the interventions on overall reversal of trends for this cohort. Indications of interplay of morbidity and mortality are for example seen in the dual HIV/TB morbidity and mortality. While interventions in HIV area have reduced incidence and prevalence of the condition, the inadequacy in implementation of interventions addressing TB burden is contributing to a significant amount of morbidity and mortality even in HIV positive clients. Interventions to address both TB and HIV are now being scaled up across the country.

Some indications are pointing in the direction of improving health. Reductions in inpatient cases and deaths could indicate a reduction in severity of illness in this cohort. Further analyses are needed, to generate an appropriate package of services that need to be implemented together, to affect the health of this cohort. The present focus on the ATM set of conditions needs to be backed up with interventions in other major causes of poor health in this cohort.

Cohort 6: Elderly

The sector has not yet focused services for this cohort. Interventions received by the cohort are part of the standard services provided for the all life cohort. Interventions for appropriate ageing are planned for the different cohorts, which will affect their health when they reach this cohort. For those already in this cohort, there is need for specific services that address their health needs. As such, the sector cannot yet talk of reversing trends for this cohort. There is need to urgently review requirements for this cohort, and plan a cost effective mechanism for delivery of defined services to it.

Progress with Implementation of Strategies to Improve Access

Results to date have been achieved through a concerted effort of implementing various strategies, ranging from strengthening community interface to improving the productivity of health workers. The strategies used in the last two years, the challenges faced and actions required to strengthen the gains are described below.

Improving Geographical Access

A number of strategies addressing the geographical barriers to accessing health care were planned to be undertaken during the implementation of this strategic plan. These are described below.

Strengthening Interface between Services and Community

In 2006, the MOH approved a Community Strategy[5] that aims at directing support to promote health and to prevent ill-health in the communities. The strategy proposes empowerment of communities to adopt health life styles and strengthened linkages with the formal health sector through community heath workers which are supervised and supported by community health extension workers. To date the community implementation guidelines, key messages and training manuals for the community health extension workers and the community health workers have been developed. These management and operational guidelines and manuals lay a solid

[5] Ministry of Health, *Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE SERVICES*, April 2006.

foundation that is necessary for effective implementation and functioning of the community health interventions. Training of central, provincial and district health teams in the management of the Community Strategy has been undertaken.

Training was provided for community health extension workers and community health workers. In total, 274 CHEWS and 3,100 CHWs were trained and deployed using the new guidelines. Pilot community units have been established in Nyanza since 2006. In 2006/07 FY, a total of 129 community units were established and became functional, of which 78 are per the new guidelines. The functionality and effectiveness of these units have not been reviewed. It is necessary to learn the innovations and challenges faced in the implementation process across districts as this strategy is being implemented on 'learning by doing' basis. The implementation process is expected to move a step forward when the health systems strengthening programme supported by GAVI is implemented during AOP in selected districts.

The Community Strategy has also an inbuilt human rights approach by ensuring that level 1 services meet the needs and priorities of all cohorts and socioeconomic groups, including the "differently-abled", and strengthen the community to progressively realize their rights to access quality care and to seek accountability from facility-based health services. The human rights approach for health will be used as a tool to empower those who are not in a position to assert and defend their claim to equitable quality health care. This intention has not yet been implemented but is in the process of being rolled out. The divisional dialogue days in the pilot communities units are used a mechanism for communities to claim their rights (quality of care, waiting time and attitude of staff) for service providers.

Interface between the formal health system and the community is being strengthened through community participation in the coordination, planning, managing and monitoring of health services. A number of forums have been set up from the village to the provincial level to foster this ownership, including village health committees (VHC), Health Facility Committees (HFC), District Health Management Boards (DHMB), District Hospital Boards (DHB), Divisional and District Health Stakeholders Forum (DHSF) and Provincial Health Stakeholders Forum (PHSF). While it can be appreciated that these governance structures are well defined in the JPWF and these structures have been put in place, the degree at which these committees functions varies across communities, facilities, districts and provinces. As such, there is a need to build their capacity and understanding of their roles and responsibilities.

The implementation of the strategy to strengthen the interface between the community and the lowest level of the health system is in its early stages and has limited coverage. Even so, significant progress has been made in rolling out the Community Strategy. The ideals and principles of NHSSP II regarding the implementation of level one services was translated into operational mode through the Community Strategy document. The strategy defined what services are to be provided at the community level and the type of human resources required implementing such a service. The modality of implementation of the Community Strategy was also defined in its implementation framework.[6] These two documents provide the policy framework for the implementation. These needed to be supported by practical and user-friendly guidelines that help district and community managers in implementing the strategy. Subsequently, three implementation tools[7] were developed and used.

Providing health services to a nomadic population in vast areas with few health facilities, poor roads and limited transport from a health care delivery system designed for a sedentary population has been a challenge which is the case in the North Eastern Province and other arid and semi-arid areas in the country. MOH has therefore introduced three pilot nomadic clinic as one way of bringing basic health care services closer to the nomadic population living and moving around in the non-serviced areas of NEP. Further testing and roll out with documentation of results is required in order to determine that the sector is on the right track.

Expansion of Network of Health Facilities through Construction and Rehabilitation

The MOH's capital investment policy should focus is on rehabilitation of existing facilities, providing necessary equipment, establishing functional referral system on the basis of established norms and standards for human resources, equipment, transport and infrastructure. In the detailed Improvement Plan for Infrastructure (April 2006), there are plans to construct 169 new dispensaries, to upgrade 238 dispensaries to health centres, and to upgrade four health centres to district hospitals, with a preponderance of the new and upgraded facilities being located in remote and currently under-served areas. To this end, MOH has been allocating financial resources for maintenance and rehabilitation of health facilities and for purchasing equipment. During AOP 1, 1,668 dispensaries, 475

[6] Ministry of Health, *Community Strategy Implementation Guidelines for Managers of the Kenya Essential Package for Health at the Community Level,* March 2007.

[7] Ministry of Health, *Enhancing Community Health Systems – Partnership in Action for Health: A Manual for Training Community Health Extension Workers*; *Linking Communities with the Health System: The Kenya Essential Package for Health at Level 1 – A Manual for Training Community Health Workers*; *Key Health Messages for Level 1 of the Kenya Essential Package for Health – A Manual for Community Health Extension Workers and Community Health Workers,* March 2007.

health centres and 16 rural Health Training and Development Centres were renovated.

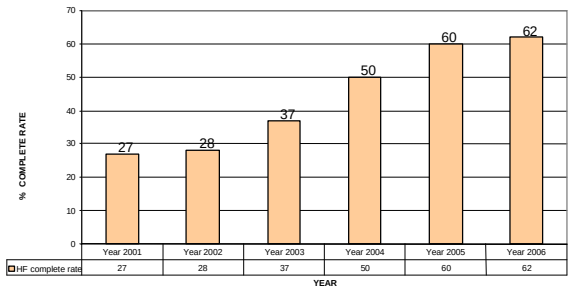
As a result of infrastructure improvements, the number of sites offering basic services have increased (Table 2.5 and Figure 2.11).

Table 2.5: Infrastructure improvements

Service expansion	2004/05	2005/06	2006/07
Basic and comprehensive OC	9%	12%	17%
Number of VCT sites	682	859	908
No of facilities offering ART	222	303	358
No of facilities using IMCI guidelines	2%	9%	22%
Facilities offering youth-friendly services	5	73	86

Source: Routine reports.

Figure 2.11: National health facility completion (%), 2001–2006



Source: HMIS.

This rational and restrained building programme is in danger of being disrupted by the uncoordinated construction of dispensaries using Constituency Development Funds, which MOH is then expected to operate. There are anecdotal reports that up to 1,600 such dispensaries have been built, not necessarily to appropriate designs and standards, or in appropriate locations – this may be determined on political grounds as opposed to rationalization of access. Currently, 300 of these CDF constructed facilities have been reopened and are functioning; in FY 2007/08, an additional 600 dispensaries will be operational.

The expansion of network of health facilities through the CDF needs to be integrated harmoniously, together with other required inputs (especially human resources, drugs, etc), to ensure efficient, equitable, effective and sustainable delivery of health care services. This can be achieved if the CDF infrastructure work is well coordinated and that the MOH is fully involved in the planning and implementation of the CDF projects. This fund can make a significant impact in terms of reversing the trends if it supports the priorities defined and agreed in district health stakeholders. The consultation initiated with the CDF Committee needs to be further strengthened and result in mechanisms on how the fund supports sector priorities and their interventions be part of the health sector overall plan and budget.

The current infrastructure norms and standards for the KEPH are based on populations and do not take into account of distances travelled by clients. Yet the 2007 Client Satisfaction Survey showed that respondents seeking outpatient services in hospitals live further away (over 13 kilometres) compared with those seeking services in health centres (7 km) or dispensaries (4 km). The overall average distance that patients/clients must travel to reach any type of facility is about 9 km. There is therefore a need to establish additional new facilities particularly in hard to reach areas.

Increase in Number of Health Workers in Facilities

The availability and comprehensiveness of health services offered at a health facility depends on the number of health workers at that facility. The JPWF estimates that approximately 427,000 health workers are needed to deliver KEPH, of which 321,000 comprise the CHWs operating at level 1 on voluntary basis. The formal human resource requirement for the sector is estimated at 106,000 against 62000 in post. This gives the formal human resource gap of 44,000. It is planned that 50% of the shortfall (22,000) will be bridged during the NHSSP II period, and priority will be given to the deployment of staff to hard-to-reach areas.

Since 2005 there has been a concerted effort to increase the number of skilled health workers available at the lower level of the health system using government funds and ear marked funds (for what is known as emergency recruitment) from foundations and global initiatives. The staff recruited through the emergency recruitment arrangements are on three-year contracts and there is agreement that the newly recruited on contracts will eventual be absorbed onto the MOH payroll. Table 2.6 shows the number of health workers recruited and deployed mainly in the public health facilities during fiscal year 2006/07. Against the target of 4,000 health workers, 3,649 have been recruited to date.

The supply of health workers appears adequate to meet the increased staffing requirements. The output from the training institutions is increasing and there are a significant number of applications for government positions.[8] Although initially the 2006 emergency recruitment process attracted a substantial number of applications (20%) from health workers employed in FBO facilities, the majority (71%) of those short-listed were in fact unemployed health workers.[9] This was achieved

[8] There were 1,876 applications received by the PSC for 150 KECHN III positions.

[9] World Bank, "Preliminary analysis of the USAID/ CAPACITY Emergency Recruitment Data", 2007.

Table 2.6: Staff recruitment 2006/07

Cadre	GOK	PEPFAR/ Capacity	Clinton Foundation	Global Fund	Total recruitment 2006/07
Enrolled C Nurses	300 (ECN III)	450	723	391	1,864
Registered Nurse		63	325	15	403
Nursing Officer	100			85	185
Clinical Officer	130	44	106	81	361
Pharm Technologists	80	36		12	128
Lab. Technologist	60	98		30	188
Social Workers				18	18
VCT counsellors				230	230
Health Records Officers					39
Accountants				80	80
Data clerks				153	153
Totals	670	591	1,154	1,093	3,649

Source: JSP 2007.

through good recruitment practices and effective controls, which also mitigated the risk of increased movement and migration within the sector and greater distribution imbalances.[10]

There will be a greater demand for education, training and development initiatives to match increased staffing levels and to equip the health workforce with new and relevant skills to deliver the KEPH. Improving the capacity of provincial and district level managers in areas such as leadership, management and supervision will also be required to enhance the delivery of the KEPH and roll out the results-based management approach. With the the Community Strategy in place, large numbers of CHEWs and CHW will be recruited who will require retooling in areas such as health interventions, supervisory support, and performance monitoring.

Policy implications: The recruitment of staff to fill vacant posts and/or meet additional requirements is dependent on the availability of funds (PE ceilings) and the number of approved posts (establishment). Any request for recruiting staff must be approved by DPM and funds should be released by Treasury. The current number of MOH established posts is 44,813 (this excludes non-public service providers), and current number of funded posts is 35,627.[11] Although there is no official recruitment freeze and the MOF is more flexible with the funding of PEs for social sector ministries, there are still tight controls on the PE budget. The sector needs to negotiate with Treasury for approval of resources to fill 9,000 workers in the approved posts.

Strengthening of Referral System between the Various Levels of the Health System

The referral system between various levels is been strengthened through improving the effectiveness of the communication and ambulance system. Usage of mobile phones for referral purposes has been introduced in health facilities. One hundred and eighteen ambulance vehicles (118) have been procured and distributed to health facilities throughout the country. The draft referral guideline been developed. There need to conclude the guidelines and initiate the implementation of the comprehensive referral services, inclusive of a sector ICT implementation plan, transport policy and maintenance policy.

Improving Financial Access

The intention to shift the allocation of resources between levels of the system in favour of levels 1–3 has a pro-poor intent and is expected to result in expanding access to the most geographically dispersed and affordable units of the provider system; the main beneficiaries being the rural population, among whom the poor are over represented

Poverty is one factor employed in weighting the distribution of funds to rural health facilities. The basic approach is to allocate funds among districts pro rata with population, weighted for poverty, AIDS incidence, female population of reproductive age, number of government facilities, child population and density. The pro-poor effect of this distribution is much weakened by the inclusion of other weighting factors, and the small proportion of the recurrent budget (just over 2%) to which it applies. The positive pro-poor effect of this formula is totally swamped by two other distributions. The first relates to the operating costs of hospitals, for which the distribution formula is heavily weighted by inpatient and outpatient numbers (reflecting the initial inequitable distribution of installed capacity). The second is that for PEs, which make up nearly 75% of total recurrent cost, the money is attached to the bodies and not to the place in which they are serving. Since the actual deployment of personnel is heavily skewed in favour of hospitals and the richer districts, this means that the overall

[10] Samuel Mwenda, "Looming human resource crisis in mission health facilities in Kenya", 2007.

[11] MOH, "Health Sector Establishment HRM Records Unit", 2006.

distribution of GOK funding is similarly skewed in favour of those areas. Revision of RAC was planned but not implemented.

Another source of inequitable access is the financial barriers represented by user fees, which deter use of services by poorer people. In theory, some mitigation of the deterrent effect of user charges is afforded by exemption and waiver policies applicable in public (and some FBO/NGO) facilities, but there is little evidence to suggest that these policies are applied as frequently as the necessity implied by the poverty statistics. In an attempt to reduce the burden of out of pocket payments at the levels 2 and 3 of the public health system, the 10/20 policy was introduced in 2004. Under-five ANC, Malaria, TB and HIV/AIDS, amongst others are exempted services. In addition, the MOH has recently introduced a policy to provide facility based delivery services.

The introduction of 10/20 had an immediate effect of increasing access but the increases were not sustained at initial levels because of the reduction in quality of care resulting from the loss in funding to finance supplementary drug and non-medical supplies, pay for support staff and pay allowances for staff outreach activities.[12] The MOH, with development partner support, is piloting direct facility funding (the Health Facility Fund – HFF[13]) in an effort to redress this loss of income to the health facilities.

MOH and development partners are also working on a number of other pilot projects to increase access through addressing financial barriers to accessing care. These include social franchising and social marketing on the supply side and patient voucher and fee waiver systems on the demand side.

There is need to review pilot schemes on user/patient financing through output based aid mechanisms, to assess the feasibility for scaling up these schemes. Further work need to be undertaken on fee waiver refund schemes and on standardizing fee waiver criteria.

Addressing Social-Cultural Barriers

Increasing demand for the KEPH through removal of socio-cultural barriers will be achieved through the implementation of the Community Strategy. The Community Strategy, already developed, tends to achieve this through increased health promotion and BCC activities. The communication strategy addresses social values and attitudes that influence health seeking behaviour. FGM strategy is prepared and being implemented.

[12] Major finding of survey commissioned by MOH of the impact of introducing the 10/20 policy.

[13] MOH Position Paper on Health Facility Fund, July 2006, and Danida HSPSII Programme Document, September 2006.

Summary of the Major Recommendations

Many recommendations have come out of the MTR process from the internal review, IRT report and the stakeholders meeting. These recommendations are summarized below.

Recommendations for strengthening the roll out and delivery of the KEPH

- Accelerate implementation of the following areas of focus of the KEPH: Safe motherhood, Community Strategy, Malaria, TB and NCDs,
- Sustain ongoing service delivery interventions in the areas of focus that have performed well during the period under review.
- Develop implementation frameworks for providing services to cohorts 4 and 6.

Recommendations for addressing barriers to equitable access to health services

- Undertake a Practice and Policy review to develop appropriate policy frameworks for infrastructure, health facility plant, equipment and transport as well as for ICT including after sale maintenance policies.
- Continue dialogue with CDF Committee to ensure that the fund is supporting sector priorities and its contribution is integrated at district and national sector plans and budgets.
- Develop and implement registration guidelines, standards and regulations for the operation of health facilities with a clear separation of responsibilities of managing health facility operations or implementation of service delivery.
- Review innovative service delivery mechanisms (like the NEP nomadic clinic and others) for improvement and scaling up services to remote hard-to-reach areas
- Negotiate with Treasury to get approval of resources to fill the 9,000 approved posts, and with donors to assist in financing them.
- Finalize the referral guideline, initiate the implementation of the comprehensive referral system that is guided by an ICT and transport policies and strategies.
- Undertake further reallocations of public funding towards pro-poor programmes especially rural health services in light of current poverty levels that justify more wavers of facility fees to alleviate financial constraints to health services access by the poor.
- Expedite improved direct financing of facilities to help make good of the revenue loss from exemptions, wavers and recent abolition of fees at lower levels of care.
- Make the Community Strategy even more inclusive by bringing on board all interested parties and resolving issue on terms of conditions of CHWs.

3. Progress with Objective 2: Improving Service Quality and Responsiveness

Key elements of service quality are the performance of the service providers and the responsiveness to client needs. Efforts to improve both these areas are fundamental elements of objective 2 of NHSSP II.

Improving Health Worker Performance

Health care worker productivity is a key ingredient for improving quality of health services. Given the staffing shortages it is critical that performance and productivity of the available workforce is effectively managed and supported. A number of initiatives have been undertaken to improve health worker performance as detailed below.

The MOH has taken the first steps towards introducing and institutionalizing results-based management (RBM), a government wide public sector reform initiative, as an approach for effective implementation of the NHSSP II and its respective AOPs. Performance monitoring, performance contracting and Rapid Result Initiative are the main forms of RBM adopted by the Ministry.

Quarterly reporting and review processes have been instituted by the Permanent Secretary, in which District, Provincial and HQ performance is reviewed against AOP indicators/targets. The analysis and processing of reports is carried out by the Ministerial Management Unit (MMU), a unit set to coordinate performance monitoring of the sector, and performance review is undertaken by the Permanent Secretary's senior management team. The PS, PMOs and DMOHs are held personally accountable for performance through a system of performance contracts.

Performance contracts are a key feature of the new way of working in the Ministry of Health. All key senior staff at the central level, Medical Superintendents, PMOHs and DMOHs have performance contracts. The use of performance contracting at lower levels has the potential to improve quality of care, if such targets are appropriately expressed in these contracts.

The challenge of the RBM is to relate the results specified to resources, which will involve the development of programme budgeting. This development will depend on progress with the public financial management reform programme.

The Government has approved for implementation, a new Performance Appraisal System (PAS) for the public service. This system will support the strengthening of performance management systems at facility and individual levels. Support will be required to effectively introduce and institutionalize the PAS at all levels.

Three rounds of Rapid Results Initiative (RRI) have been undertaken to date. The priority areas for the RRI have been immunization, TB, malaria, HIV/AIDS, SWAp and reproductive health. This initiative has produced tremendous improvement in achieving results. In addition, achieving desired results, the initiative has produced the following benefits: building teamwork; improving planning and monitoring of performance; increased worker satisfaction through achieving results with the available resources. During the AOP 2 period, 12 training hospitals take on themselves to reduce the waiting time in both outpatient and emergency

The rapid results initiative has produced tremendous improvements in teamwork; planning and monitoring of performance; and worker satisfaction. A service charter introduced in 2007 recognizes the community as customers with rights and as claimants with legitimate demands on the health services.

surgical units. The effort at mid-point of the RRI programme has managed to reduce the waiting time in outpatient department by 31% and emergency surgical unit by 42%. The detail of the progress in hospital RRI is presented in Table 3.1.

Effective pay and compensation systems have been introduced to motivate health workers. The salary reviews which were effected by the Government in 2004/05 and 2005/06 have raised the average "take home" pay for senior managers in the civil service (Job Groups P, Q, R, S) by 200 – 300%, for the middle level managers (Job Groups K, L, M, N) by 100% while support staff (Job Group A–J) received on the average 70% increase.

The role of supportive supervision is being strengthened through the development and use of integrated supervision checklists; this is hampered in many districts, however, because of lack of transport. There is growing use of clinical audits, and in a number of districts Maternal Mortality Audits are being used to identify problems in the quality of care at different levels.

A secure supply of drugs and commodities is essential in the delivery of health services. There are more drugs and commodities now in the health facilities than in the past, but there needs to be a tracking system to confirm how much of the procured items reach the intended beneficiaries. Procurement of drugs and pharmaceuticals under the Procurement Consortium and by KEMSA (over the last two years) is working well. In a number of districts drug supply is moving towards a pull-system from a push-system; if effectively implemented this has potential for improving quality of care through increased supply of appropriate essential medicines and medical supplies (EMMS).

Health worker performance can be improved if the health workers are satisfied with their work environment. The MOH Health Worker Satisfaction Survey (2007) conducted to analyse the employee and work environment satisfaction among the staff of the Ministry of Health deployed in health facilities showed the following results:

- Overall, 53% of the respondents were satisfied with their jobs while 22% were neutral (neither satisfied not dissatisfied).
- Male employees were more satisfied with their jobs (59%) compared with the female employees (48%).
- Doctors/dentists are the least satisfied group of health workers as compared with other carders.
- Satisfaction was lowest among the hospital staff (42%) compared with staff in health centres and dispensaries (82%)

The reasons given for the job satisfaction were good salary (69%), job security (59%), staff development opportunities (35%), availability of supplies (34%), good management (21%) job matching with qualifications (21%).

Improving Responsiveness to Client Needs

MOH has developed and circulated the ministerial service charter for health service delivery. It is a statement of intent, defining the Ministry's mandate, commitment, duties and obligations and the customer's rights and obligations. It recognizes the community as customers with rights and as claimants with legitimate demands on the health services. This document, launched in January 2007, could serve as a human rights instrument if properly used, and should be monitored during the implementation of the NHSSP II. While it might be argued that ideally service standards should be developed in

Table 3.1: Reduction in waiting time in hospital RRI

Province	Waiting time in outpatient department (days)				Waiting time in emergency/surgical unit			
	Baseline	Target	Decrease by in 100 days	Midterm decrease	Baseline	Target	100 days	Midterm decrease
PGH KK	120	80	40		660	490	170	
PGH KSM	268	61	207	39	1125	281	844	480
PGH NKR	360	240	120	30	240	120	120	90
PGH Embu	177	150	27		360	60	300	285
PGH Nyeri	0	0	0		0	0	0	
PGH Garrisa	131	90	41	36	120	60	60	30
PGH Coast	360	240	120	105	328	224	104	219
Kisii DH	105	85	20	5	1853	1714	139	685
Machakos DH	0	0	0		0	0	0	
Meru DH	150	120	30	52	200	150	50	12
Thika DH	450	300	150	210	840	420	420	120
Kericho DH	300	180	120	120	570	180	390	270
Kitale DH	360	240	120	270	480	240	240	120
Total	2781	1786	995	867	6776	3939	2837	2311
Average	213.9231	137.3846	76.53846	66.69231	521.2308	303	218.2308	0.418684

consultation with users, not issued from the centre, this service charter will form the basis for developing health facility level charters. The challenge remaining therefore is to develop health facility specific service charters as planned by the ministry. The health facility level charters need to provide information on the services available and specific standards of care. These health facility service charters will need to be displayed publicly at the facility in order to strengthen horizontal accountability. The charters will need also to set out complaints and redress mechanisms in the event that the provider does not meet these standards In addition, it will be necessary to enhance the role of civil society in empowering communities to demand the services to which they are entitled.

The ministry has also introduced client satisfaction tools at the facility level, starting with exit surveys, to monitor whether the providers have fulfilled their service obligations as per the expectations of the clients. The results of the 2007 Client Satisfaction Survey showed that 94% of clients were satisfied with the health care services received. Most of the clients gave the following reasons for the their satisfaction for the health care received; privacy/confidentiality (91%), cleanliness of facility (90%), good altitude towards patients (86%), improved supply of medication (72%) and shorter waiting time (57%)

KEPH as a new mode of organizing service delivery may require the re-tooling of health workers and managers so that staff acquire new skills to enable them have the ability to do what is need respond to the new challenges of delivering integrated health care services. Implementation of the planned strategies of a) reviewing and improving basic and in-service training of medical and paramedical staff, b) designing to enhance the clinical and management skills of staff need to be accelerated. In addition, activities aimed at encouraging the participation of men in reproductive health services and training of health workers in client handling and patient centered accountability need to be implemented.

Summary of Major Recommendations for Improving Service Quality and Responsiveness

Among other actions, there is need to establish mechanisms for performance reward as part of PAS roll-out plans. This should include the mandate, authority, means and resources required to recognize and reward good performance as well as address and improve on specific areas of non performance. In addition, MOH and the sector should:

- Develop and implement HR development strategy to support KEPH.
- Develop the capacity of managers at all levels to effectively implement and manage the PAS.
- Strengthen systems and capacity for effective integrated support supervision and quality assurance programme at all levels.
- Accelerate the dissemination of updated clinical standards, protocols and guidelines for the KEPH including the ministerial service charter.
- Logistics chain management for essential and public health goods needs to be strengthened in GOK and PNFP facilities.
- Develop strategies for improving provider-client relationships and accountability including development of health specific charters.

4. Progress with Objective 3: Improving Efficiency and Effectiveness

Improving efficiency and effectiveness of the health sector is one of the core strategic objectives of the Second National Health Strategic Plan. The inefficiencies in various support systems have been identified and various strategies planned to be introduced in the period of the NHSSP II. The objective has two sub-objectives: improving value for money by utilizing resources in the best possible way and reengineering the processes and procedures for better management, support and administration. The overall systems focus in the strategic plan is to ensure that inputs, money, human resources, commodities, etc., get to health service units in a timely way and are used and managed well. The progress and the challenges of the last two years and the necessary actions recommended for improvement are presented below.

Improving Value for Money

Health resources (facilities, human resources and their associated operations and maintenance [O&M] budget) are not equitably distributed across the country. Rural and remote areas in particular are under resourced. The NHSSP II therefore stipulates that these the resource allocation criteria be revised to incorporate a poverty index into the allocation formula.

The resource allocation criteria currently in use were developed in 2000. District resource allocation criteria (Table 4.1) are based on existing infrastructure and other population parameters, while hospital criteria are based on bed utilization and outpatient cases. Though the district RAC provides a weight of 30% of for poverty, it is recognized that it needs to be improved if the current resource allocations are to favour underserved districts.

The wealth of evidence on the poverty profile in Kenya has improved since 2000, with the publication of the study on Geographic dimensions of poverty by KNBS. The criteria in use still do not explicitly correct to favour underserved areas. There is therefore a need to revise these allocation criteria. In doing so, lessons can be learned from the resource allocation in the CDF and other innovative mechanisms used in the country and be adapted to the condition in the health sector.

> Efficiency and effectiveness involve emphasis on value for money and the processes and procedures for better management, support and administration.

Table 4.1: District resource allocation criteria

Variables	Weight (%)
Infrastructure	15
Under five	25
Poverty levels	30
AIDS cases	5
Female population	25
Total	100

Improving Financial Management with Focus on Flow of Funds

Lessons learnt from the constraints of the pilot financial management systems under DARE/Sida, informed the NHSSP II objective of setting a robust performance based accounting system, designed to enable timely disbursement of funds, timely production of financial returns and production of timely and accurate accounts of the sector. The major outputs planned in the PFM system were:

- Strengthening the budgeting process;
- Piloting a direct flow of funds and reviewing the experiences for scaling up;
- Build capacities of the system in terms of human resources, software and skills;
- Strategy to improve financial management formulated;
- Initiating pooled funding; and
- Introducing performance based budgeting.

Achieving successful outcomes for NHHSP II and the JPWF depends on the capacity of PFM system to deliver on aggregate fiscal discipline, the strategic allocation of resources, and the efficient delivery of services on a value for money basis. It is also specifically dependent on the health sector's institutional arrangements, like budgeting, procurement, expenditure control, reporting and accounting policies and practices. Finally, it depends on its ability to respond to and adopt corrective measures to address internal and external audit findings.

Strengthening the budgeting process: As indicated in the planning section below, the linkage between annual planning and budgeting process is being strengthened through the development of "shadow/functional budget", that allows a linkage between the format of the national budget (as provided in the medium-term expenditure framework – MTEF) and the planning format (by level of intervention as provided by NHSSP II and JPWF), specifically for use in the annual plans (AOPs). The functional budget is designed to reflect On-Budget and Off-Budget contributions from the development partners and is broader than the MTEF requirements. This has allowed showing clear financing gaps by priority areas and levels of intervention to be financed from earmarked and un-earmarked resources that are projected to come from development partners. If strengthened and completed in time, it will help to develop a transparent mechanism for resource allocation in line with the priorities of NHSSP II and JPWF and result in reversing the trends. Further work is required before it serves its intended purpose, however. This includes but is not limited to the development of a resource mapping format that meets requirements of both sector planning and government budgeting processes; the willingness of constituent partners (government, development partners and NGOs) to reflect their contribution (both financial and non financial) in time; the establishment of a robust and committed working team to consolidate and consult all stakeholders on resource allocation in a transparent and participatory manner; and the setting and enforcement of a clear timetable for collecting and consolidating available resources and providing implementing units (both GOK and others) with a reasonably sound and accurate resource envelope in time for planning (reference # 17).

Direct flow of funds was one of the main strategies planned in NHSSP II to improve value for money and improve utilization of budget allocated. The MOH is committed to the establishment of Health Facility Fund in order to streamline the efficiency in the flow of funds to the lower level facilities A process of initiating direct flow of funds to health facilities using the education route was initiated in 2004. The process is still ongoing and is still on preparatory phase.

A position paper on mechanisms of the flow of funds (Reference #20) has been developed and agreed by the sector stakeholders. The is also need to revise the legal framework to make the health facility fund working, as was communicated to the MOH in 2004. However, this prerequisite was not adequately addressed and Treasury was not able to approve the proposed scheme for its implementation. Preparations to use administrative procedures have been finalized and a draft legal notice has been prepared waiting to be gazetted. Once the legal notice is gazetted, rural health facilities will become accounting units, therefore able to receive, manage and spend funds directly. Among the issues are:

- HFF recipients are only government owned facilities. Non-governmental service provider are not yet planned to participate in the HFF.
- The financial resources transferred through the HFF are rather small and it is intended to finance recurrent expenses for service delivery like, e.g., transport, consumables and salaries for support staff and common non-prescription drugs for CHW outreach services.
- Too narrow definition of activities that can be financed from HFF money.
- Resource allocation is not output based.

Until this direct flow of funds is functional budget releases to districts will continue to be rather erratic and comes from the MOH/HQ through Treasury in the form of AIEs. DMOH are not informed about their final budgets and have to operate on the basis of their quarterly AIEs as planning horizon. This will compromise the realization of the target plans in the annual plans as the emphasis will not be on planning and managing resources, but on making it possible to run the services and the hospitals. This has serious consequences with regards to budget predictability and implementation of planned activities.

The AGD, on request of the MOH, has already deployed additional staff directly at the district health office level. This officers report directly to the District Accountant. This is already an alignment that reflects the MOH and MOF understanding of the challenges of the sector. In addition, the GFATM has funded one accountant in each district health office. With the operation of HFF the need for more accountants to follow up and coordinate facility financial returns is apparent

and needs to be budgeted in the HFF capacity building budget.

The Kenya National Audit Office (KENAO), a part of the PFM reform programme, has recently been reinforced with an Act of Parliament and has been able to recruit and retain qualified staff since 2004. Nonetheless, its capacity is still constrained to about two-thirds of its staffing requirements. In addition, some of its units, such as the value for money audit units, are recent and are still developing their methodologies and manuals and testing them in practice.

The KENAO established work plans cover the risks identified, yet these are constrained by resources. The SWAp calls for a special focus on the health sector including the conduct of external audits. Such a demand cannot be met by the KENAO every year both in terms of scope and in terms of breadth of sampling.

The identified activities not delivered are: de-concentration, development of PFM reforms to assist FBOs, NGOs, not-for-profits organizations, and introduction of performance based budgeting, which looks unlikely to be implemented as MOF has announced its intention to introduce Programme Budgeting in the next fiscal year. Generally the key concerns to consider include:

- The need to re-examine its PFM system to find out why its resource absorptive capacity is declining despite all the needs in the sector and to act and reverse the declining sector financial absorptive capacity against a background of resource allocation scenarios to the health sector, that have not kept pace with the need for growth of revenue generation largely because of its low absorptive capacity;
- The need to speed up PFM reforms in the sector, for which it will be necessary to enhance consultation and collaboration with MOF to build capacity in key areas.
- The need to address the ineffectiveness of HMIS which is still unable to create linkage of the PFM to services delivery.
- The urgent need to substantially increase the minimal resource investments allocated to health infrastructure repairs and maintenance so as to improve the level and quality service delivery.

Improving Planning, Management and Administration

In this category the review looked with particular interest at the implementation of the Community Strategy, the planning system, performance monitoring – including the health information management system (HMIS) – human resources, and commodity procurement.

Community Interface

One of the strategic shifts that NHSSP II introduced has been the formalization of community services as part of the formal health service delivery system. All the policy documents since then (JPWF, AOP 2, AOP 3) put the implementation of the Community Strategy as the sector priority deservingthe first call on resources. It specifically states the need to reorient the emphasis from facility-based to community-based promotive and preventive services.

Progress in the implementation process is commendable (see details objective one). It still is at the initial stages and will face so many challenges during the scaling up. The first challenge is to bring the various types of community health workers and their mode of working according to the new mode of implementation. This requires a commitment of the central divisions of the MOH not to make community service delivery a vertical part of the system as has been the case in the past and to ensure that the various projects and programmes supported by various development partners follow the national implementation strategy. The second challenge is to ensure that community health workers are motivated through implementing various recognition and motivation mechanisms that do not necessarily have huge financial implications. The community health workers will be much more effective if they are supported by provision of commodities that are appropriate for their level.

There is ample evidence that provision of community kits to CHWs can contribute significantly to reversing the trends.[14] The draft commodity kit needs to be finalized and implemented as soon as possible. Fourth, so far the implementation has been managed by DHMTs through public health facilities. There are various implementing agencies that have interest and experience to meaningfully contribute to the scaling up process. There is thus need to work out ways the FBOs and NGOs could be involved in the implementation. Finally, as the implementation is being guided by the principle of learning by doing, there will be will be a lot of weaknesses in the strategies that require continuous follow up and adaptation.

Planning System

NHSSP II and the JPWF recognize two distinct aspects of health planning in the sector. The first relates to "development planning"; the upstream aspects of health planning covering the strategic interventions for policy positioning, planning process and regulation of stakeholder engagement and calendar. The second is the more operational aspects of planning, particularly relating to operational

[14] MDG document.

district health planning. The emphasis and details in NHSSP II are on the strengthening of operational "district health planning" but with appropriately balanced attention to "development planning".

Achievements in Health Sector Planning at the Midterm

At midterm a bottom-up planning process has been firmly instituted in the sector, with district health plans (DHPs) now solidly rooted in the daily routine of the Kenyan health services. These plans are being consolidated, together with plans from other service units in the sector, into annual operational plans. In general, peer support and stakeholder participation in the planning process has increased,with planning guidelines annually reviewed for improvements. Training of DHMTs and stakeholders on development of DHPs was rolled out.

The Joint Annual planning has become more participatory and comprehensive from AOP 1, through to AOP 3 where all sector constituent partners have adequately contributed to, and effectively participated in its development. Additionally, while not complete, much has been attained to align the work of national vertical programmes with the NHSSP II planning process and the KEPH in AOP 2 beyond the status in AOP1.

Attempts have been made to harmonize the sector planning process with the Government budgeting process, the MTEF. Articulation of expenditure limits for respective planning units was initiated in AOP 2, and strengthened in AOP 3 development. In addition, a budget framework to link the Government budgetary structure with the Health Sector results oriented planning format were initiated in AOP 2 through a "shadow budget". This shadow budget not only provides the linkages between the planning and budgeting process, but also captures off-budget resource flows.

The results framework[15] from has been instituted in the planning process, and has now moved from a process base in AOP1 and AOP2, to a "core-function" base in AOP3. This development not only clarifies the means of how the core-functions support the delivery of services, but in addition improves the connection of how activities planned from one year to the next collectively lead to achievement of the overall expected output.

To support follow up of planned activities, the sector has used the Government-wide results based management approach to initiate Performance Contracts for top and mid level managers. These contracts are based on derivation of results as outlined in the respective AOP. These performance based contracts have enabled adequate follow up, and achievement of joint sector results.

Tools and training material for roll-out of the Community Strategy are in place though not fully implemented. In support to follow up of the planning process, quarterly supervision efforts and interaction between MOH/HQ and PMOs have now also been initiated. A client-oriented implementation process was initiated in the sector, with the intention of incorporating the gender and human rights considerations from AOP 3.

Finally, attempts have been made to consolidate planning monitoring and health information systems, with establishment of a Sector Planning and Monitoring Department, SPMD. This is constituted from the previous Health Sector Reform Secretariat, and the Health Management and Information System division.

Challenges in the Health Sector Planning at the Midterm

Adequate dissemination of the innovations in the planning process in the sector has not been adequately done. There are low overall management skills and knowledge-base at province, district and at health facility levels. There is almost complete lack of knowledge at the field level on how and why the results framework has evolved from the level of the NHSSP through the JPWF, through AOP1 and AOP 2 then onto the core-function base in AOP3. This development process has manifested more as lack at district level, of a strategic planning frameworks linked to NHSSPII and JPWF rather than the commendable innovation noted above. This may be a reflection of the low level of impact of the capacity building process.

The breadth of access to a stable and unified results framework for the development of AOPs by provinces, districts and health unit facilities, as well as the inclusiveness in participation, of the various stakeholders in the planning process and programme reviews still needs to be further strengthened. While participation is now present from all the three constituent partners in the sector, participation from within many of these constituents is not yet comprehensive enough. Government participation is limited to the Ministry of Health, without adequate input from other Government structures, and parastatals. Implementing partner participation is at present limited to Faith Based service providers, and some civil society partners operating under the Health Network NGOs (HENNET) umbrella.

Linkages between the sector planning, and budgeting processes is still not at an operational stage. Information on allocations to different planning units in the sector gets to them too late to allow for appropriate, resource-guided planning. The shadow budget, while a good initiative, is not

[15] Results framework: The logic that explains how results are to be achieved, including causal relationships and underlying assumptions. The results framework is the application of the logframe approach at a more strategic level, across an entire organization, for a country programme, a programme component within a country programme, or even a project.

adequately supported to enable it function fully. In particular roles and responsibilities for planning and budgeting need better rationalization.

The positive progress at central level in respect to improving capacity and structures for policy dialogue are not being matched or reflected at the district level. While the up-stream capacity for development planning has improved fast and tremendously, the capacity for district planning is much less spectacular and growing much more slowly. The capacity building and training for the operational district planning while commendable, is not yet comprehensive, as the capacities of the districts and provincial levels to support, and participate in the planning process is not adequately addressed. These district and Provincial officials are thus not enabled to support the field level staff plan appropriately. The lack of peer support, of human resources, of logistics and financing required to cascade the AOP skills development capacity across an ever increasing number of districts is noted to be a key challenge.

The uncertainty, and frequent modification, of indicators, together with the continuing delay in roll-out of improvement in the monitoring framework, combine with the rapid evolution of the results framework to cause what appears like frustration at the frontline planning levels in the planning efforts of district staff at the primary services output end of the system.

The year-on-year lessons learnt from implementation of the AOPs are not being effectively shared and systematically mainstreamed down to district level resulting into a rather mechanical and conceptually narrow process, the rationale of which, is much less understood downstream. This may in part be due to the slow progress with roll out of medium-term policy frameworks and plans of technical programmes, required to support districts out of this dilemma. The AOP 3 has initiated action which ought to mitigate this effect.

The separation between regulation and implementation operations of service delivery is urgently needed to improve the regulation, planning and efficiency of operations of the system. And there appears to be no initiative in place to develop a systematic operations research agenda for probing systems constraints. In addition, while gender and human rights considerations were incorporated into AOP 3, the guidelines and training materials of the health sector planning processes are not yet explicitly addressing these issues. There is currently no designated official responsible for human rights, equity and gender mainstreaming in the Ministry of Health. Yet, it is important that there is if any sustainable progress is to be expected.

Although the AOP process is gaining institutional stability and being mainstreamed into the planning cycle at all its stages, the same is not true of the JRM. The latter still appears very rushed and important thing may inadvertently fall through cracks. Again in this respect the general recommendation of the first JRM still holds. The JRM is not yet a bottom-up process as recommended. It is not based upon continuous observations made through-out the planning cycle. The rapid single point assessment approach over one week or two, with or without external consultants, does little or no justice at all, to the required assessment of the year-long planned and carefully conducted operations of the AOP. Being de-linked from the quarterly performance monitoring events renders the JRM process ineffective in contributing to the strengthening of reporting compliance of the quarterly supervision thus weakening the information base for the JRM stakeholders' forum.

Looking at the institutional capacity for management of the planning process, the capacity at the SPMD is not well matched with the workload to build and operate a suitable planning framework for the country. Key capacities, particularly in the areas of budgeting, exist the Planning Unit. Additional capacities for monitoring particularly for administrative functions exist in a different unit, the Ministerial Monitoring Unit (MMU). These need to be linked better with the SPMD for the sector planning function be more effectively coordinated, and strengthen the weak linkages between the planning, budgeting, and regular monitoring processes.

Performance Monitoring

The objective of the M&E support system articulated in NHSSP II is to assist health managers to make informed decisions and contribute to better quality planning and management. This objective is planned to be achieved by harmonizing HMIS tools to make them practical, decision oriented and performance oriented; investing in human capacity; (iii) triangulating facility- and population-based information; and stimulating operational research. The results anticipated by NHSSP at midterm were that the planning, monitoring and evaluation (PME) system would be established, functional and in use by managers for decision making for better quality planning and management of services. These results were to be achieved by: (a) revising data collection tools so as to restore functionality; (b) investing in human capacity for monitoring and evaluation; (c) conducting analysis across relevant health information databases to monitor health status and track programme performance; and (d) building operations research capacity to support NHSSP implementation and collaboration with research institutions for health development.

The focus of the effort has been towards preparation for and revision of monitoring indicators for the sector. This is three pronged, focusing on

1. Establishing a mechanism for performance monitoring for the sector
2. Strengthening coordination of routine health information system, and
3. Scaling up the Integrated Disease Surveillance and Response mechanisms.

Their linkages and expected roll out are highlighted in the sector's performance monitoring framework.

Activities to strengthen the performance monitoring mechanisms have formed a strong focus of activities during the first half of NHSSP II. Achievements in these are highlighted in the section on partnerships, but relate to adoption, and use for AOP planning and monitoring of a set of performance indicators. Reporting has consistently improved, with the reporting response greatly improved from 17 districts that did not report at all during AOP 1, to all districts reporting in AOP 2.

Regarding coordination of routine health information system, progress has been made in bringing together various users to agree a consensus set of indicators and tools. An inventory of tools has been prepared and software development has been initiated along with assessment for computer hardware acquisition to automate the HMIS. A process of harmonization of indicators was carried out over a year because of the need to reach agreement with PHMTs, DHMTs, DPs, NGOs, FBOs, and programmes on indicator list and variables associated with them. This multitude of tools have now been consolidated into 12 different registers and 6 summary reporting forms for all levels. The harmonized and agreed consensus set of tools has been costed and a draft sector monitoring and evaluation (M&E) framework and plan prepared for tabling by the Ministerial Monitoring Unit (MMU) before the sector decision makers to approve. In the meantime, preliminary self motivated work, supported by some of the partners has given the basis and foundation for consultation and agreement on a national data collection package. This nationally agreed data collection package for routine health information has been rolled out to cover a total of 23 districts in 3 provinces and over 600 health workers trained on data collection tools and their use. During AOP 2, out of the total 5,170 health facilities, 3,071 have submitted their reports, giving a completion rate of 63%.

The disease surveillance and response function has been rolled out in the country during the first half of the country. Capacity building process and package was designed, and out of the existing 78 districts in the first half of the NHSSP II, 61 had teams oriented by the end of 2007. Capacity building in the remaining districts, plus the newly created districts is planned. In addition to the capacity building, the reporting mechanism and system functions reasonably well with clear outputs and with an outbreak notification system and a bulletin. The function of disease surveillance, with previously was coordinated in the respective vertical programmes, has now been brought together in the Division of Communicable Disease Control.

Information Management

A coordinated and structured utilization of information has been initiated. Automation of information was been proposed for AOP 3, with initiation of spreadsheet applications and FTP mechanisms to ease and manage information better. Quarterly monitoring visits have been initiated between national and provincial levels, where performance monitoring information is discussed. Monthly reporting on routine health information is also being encouraged using the agreed data collection tools. A sector "Facts and Figures at a Glance" booklet was developed in 2006, and a draft annual statistical report for the last two years is under preparation. In terms of routine operations, the component for services data management (HMIS) is only nominally functioning largely to store data. It has qualified staff. The HMIS has also maintained contact with vital registration department and the central office of statistics, largely facilitated by the Health Metrics Network process. Finally, the disease surveillance information is collated using a well functioning outbreak notification system, and a bulletin. Coordination of information management function has also improved at the national level, with the performance monitoring and health information systems now managed in one department.

A lot of policy related operational research has been completed. These researches include the Annual MPERs, human resource mapping, public expenditure tracking, impact of user fees (10/20) policy, costing studies, FBO facility assessments and various other service-related surveys. These reports have come up with very useful policy findings and recommendations.

Challenges in Monitoring at the Midterm

This very slow and modest progress in rolling out the strengthening activity for the monitoring and evaluation component of the NHSSP. This has been the most constraining factor to implementation of many of the NHSSP components. Efforts to strengthen the M&E activities are not adequately guided by the strategy for strengthening M&E, as it has not yet received official endorsement of the sector. All other elements due at midterm (capacity enhancement of human resources, analytic capacity, roll out of new data collection tools and capacity for operations research), are only just initiated and far from significant progress towards midterm targets.

While the performance monitoring mechanism has been successfully initiated, there is still a high level of misunderstanding, and therefore interpre-

tation of its use, vis-à-vis the other monitoring mechanisms. There is still a strong push for additional indicators, particularly from vertical programmes, into this performance monitoring system. This has led to an annual modification of indicators used for performance monitoring, making comparisons across the years more difficult. At present, there are 71 health performance indicators, of which 43 are expected to come from the routine system with the rest from population-based surveys.

The roll out and use of the coordinated tools for HMIS is still very weak, and vertical programme reporting mechanisms are still in place. It is estimated that a nurse at the dispensary maintains about 55 registers and spends at least three person-days each month to fill reporting formats. The margin of error between the information in the registers and reports submitted can be as high as 80% and there are still gross delays in submitting reports.[16] Most indicators were defined in NHSSP II, but the need for refining them arose as there were important programmatic indicators that were missing.

The roll out of the IDSR was facilitated by support through resources for emergency activities. Resources from Government, or sector partners are not adequately channelled to support strengthening of IDSR in the country, though it remains a key area of support.

The poor logistic and financing support to the HMIS function in the sector is partly responsible for the non-performance in this results area but more so the poor support in terms of financing and technical oversight of the field level. The limited direct support, strongly complemented by support from the vertical programmes, is patchy in content and fragmented in coverage. This support from vertical programmes has tended to be tagged to the programme's specific needs, deviating attention from the comprehensive sectoral approach to management of the health information functions. Untargeted financial support has been strongest for the IDSR and performance monitoring aspects, while the HMIS coordination has largely been driven by programme resources.

Capacity to support information management by HMIS tends to be sequestrated in vertical programmes and not available for sector-wide information management development. The investment in human resources involved in the information collation is not systematically carried out. Long-term technical support for health information management is not strategically sourced or managed and so no is not able to provide effective upstream technical assistance. The available downstream technical assistance is more for administrative purposes and of little technical value.

Health system input databases (e.g., national inventories of the health workforce, national health accounts, etc.) are not collated but left with source departments without much regular triangulation of data for information generation to support policy. Performance targets are therefore not linked to resource availability in the planning process.

Supervision is irregular and rare, with fragmented responsibility for monitoring. The quality of information is quite low as a result and there are many obvious errors in results.

The impressive number of surveys with relevance to the sector is not taken full advantage of either to build human capacity or content of health sector data sets. Involvement with the census process and Demographic and Health Surveys is not strategically coordinated.

The implementation of the automation of health information management will need to be accelerated, and done comprehensively to appropriately manage the transition period. Until such integrated automation is operational, the parallel information systems that are currently functional in the MOH are likely to continue.

Finally, looking at the extent of research carried out, the extent to which these recommendations are implemented and the policy findings used for decision making is not verifiable. It is therefore necessary to put in place a mechanism providing that only relevant and informative surveys are carried out and that study findings be used effectively to inform decision making.

Human Resources

The strategic plan in its human resource section aims to optimize the use of available human resources by instituting sound management principles at the central level and decentralizing certain functions where appropriate. This objective was planned to be achieved by (a) creating an enabling working environment (norms, values, guidelines and tools); (b) aligning tasks and functions of existing work force; (c) introducing result and performance oriented contracts along with supportive capacity building measures; and (d) strengthening leadership, management and supervision accountability to enhance health workers' motivation and performance.

To address these objectives a national human resource strategic plan (2006–2010) was developed as part of JPWF. The main outputs of the HRH strategic plan are:

- Improving the planning, distribution and management of the workforce.
- Redistributing the workforce to ensure more equitable service delivery.
- Undertaking initiatives to improve institutional and health worker performance.
- Ensuring effective supervision systems.
- Improving the quality of basic and pre-service training.

[16] JDM report, page 36.

- Making appropriate use of in-service training and continuous professional development.
- Restructuring and strengthening human resource planning and management.

The strategic plan clearly stated that the human resource requirement needs to be worked out. As part of the JPWF, based on the serviced defined to be provided under KEPH, the sector developed sector norms and standards that clearly defined the services to be provided, the human resources required by cadre, and the infrastructure requirements for each level of service. These norms and standards are the standards that the health sector is aspiring to implement in the coming years. While the strategy is approved for implementation, the extent to which they are being used for deployment and redeployment of human resources cannot be ascertained. It also required further work to make it more binding for enforcement for the purpose of budgeting and establishment of any new facility by any actor in the country.

The JPWF planned to recruit 2,615 additional health workers for 2006/07 and 2007/08 and 3649 staff were employed, over 40%t more than what was planned (See section on improving access).

In addition to employing additional staff, putting in place an efficient and robust HR systems and has been one of the major strategies in NHSSP II. The current government systems for recruitment and deployment are slow, and lack of sufficiently robust controls. The current inefficiencies in the government recruitment and deployment procedures result in substantial cost and effort (spread over a number of actors) for a limited number of posts and can take several months to recruit and deploy staff. For example, of the 571 positions advertised by the Public Service Commission (PSC) in May 2006, only 230 staff had been appointed and deployed in February 2007. In contrast, the emergency recruitment process recruited and deployed 1,600 health workers in three months. This clearly shows the need to reengineer and streamline the recruitment process in the civil service in general and/or work out strategies to fast track the recruitment process for HRH.

There were also efforts to develop a database for HRH. The Integrated Personnel and Pay Database (IPPD), data from the Mapping Study, and the nursing database developed as part of the Kenya Nursing Workforce Project have improved the HR information available to plan, manage and develop the health workforce.

Although NHSSP II has outputs regarding human resource development, there has not been substantive effort in implementing the aspiration of the plan. The HRD plan is not yet in place, training needs assessment (TNA) have not been carried out and consequently training programmes have not been designed in accordance to the findings of the TNA. There is a need for improved information on pre-service training (PST), in-service training (IST) and continuing professional development (CPD) in order to assess the capacity and quality of the HRD system to meet current and future demands. Information on numbers and types of programmes, number and capacity of facilities, numbers and types of teaching staff, current and projected intakes and outputs is required to strengthen the planning and coordination of human resource development systems. This is acknowledged in the JPWF, and the HRH component of AOP 2 sets out several activities to address this issue.

In order to improve the performance of the work force, the government wide, National Performance Management Framework (NPMF) was introduced and would institutionalize the results-based management approach in the health sector as planned in NHSSP II. in addition, the Government has approved for implementation, a new Performance Appraisal System (PAS) for the Public Service. These developments will support the strengthening of performance management systems at facility and individual. Support will be required to effectively introduce and institutionalize the PAS at all levels.

These improvements in pay are attracting more health workers into the system, but it is unclear whether the improvements are sufficient to retain them and reduce attrition. The available information on external migration indicates that there are still significant numbers of health workers leaving Kenya to work overseas. The improved terms and conditions for government health workers are causing greater disparities in employment conditions for public and non-public health workers. The large number of applications for MOH jobs from health workers employed by the FBOs suggests that it there needs to be harmonization of scheme of service between the public actor and other actors.

The Mapping Study identified that there was a serious mal-distribution of staff (particularly between urban and rural areas), and NHSSP II clearly called for "policy recommendations of the human resource mapping study to be implemented and the redeployment of staff nurses and doctors to be addressed". little appears to have been achieved in this area, however. Redeployment of staff needs to be effected by a mixture of more appropriate incentives and - in the public sector - strengthened systems for deploying staff. In particular, ways of making the "hard-to-fill" posts more attractive need to be developed, and targeted not just by cadre, but also by age group, gender and other characteristics identified in studies on "push" and "pull" factors.

The HRD Unit and the Office of Continuing Professional Development (OCPD) within the MOH could have a greater role in supporting the sector to adopt a more strategic approach to HRD. They could

support the development of a HRD plan, the development of training information systems, the assessment of training needs, curricula development and the monitoring of capacity development initiatives.

The multiplicity of stakeholders involved in HRH requires robust coordinating structures and mechanisms to ensure that HRH are coordinated across the sector. The fragmentation and weak coordination of the HR function within MOH headquarters is contributing to weak and inefficient HR practices and reduces the sector's ability to maintain a strategic HR perspective. Improved collaboration and partnership with other non-government service providers is required. There is also a need to strengthen information flows and communication between MOH and DPM / PSC. Appropriate mechanism of coordination needs to be envisaged and implemented to enhance policy dialogue across the sector at both strategic and technical levels and to improve strategic oversight and coordination of HRH.

The implementation of the above strategies is quite weak for many reasons. Most of the reforms in articulated above can only performed in line with functioning civil service laws and regulations. Ministry of health, as being part of the civil service, needs to work within the overall government reforms. A meaningful change in the management of human resources for health can only achieved if there was strong engagement with the DPM. The leadership in the human resource management has not been able to steer the implementation of the strategies. The progresses recorded below have been achieved not because of attempts to systematically implement these reforms but because of fragmented efforts exerted by stakeholders.

Procurement and Commodity Supply Management

The NHSSP II stated that the EMMS and medical supplies procurement, their distribution and rational use comprise a complex system of institutional, legal and policy related matters that together frustrate attempts to respond to reform. The strategies planned in the NHSSP 2 in the area of procurement

- Institutional appreciate procedures for decentralized (demand driven commodity procurement) i.e., arrangement for regulation, procurement and distribution; and implement demand driven procurement system in 50% of districts.
- Update annually resource constrained medium term procurement plan (MTTP) to procurement of commodities.
- Ensure improvement in the availability of essential medicines and medical supplies in the sector through revision of national drug policy and Essential Drug List, strengthening EMMS supply management improve rational use of EMMS.

In the last two years the sector has spend more time in analysing the weaknesses of the procurement system and agreement on the way forward. The Government, MOH and development partners have carried out various procurement assessments and studies of the public procurement and supply chain systems and practices. The assessments indicate that there are significant risks, as the systems are inefficient and therefore fail to achieve value for money as well as associated with wastage and corrupt practices (see the procurement system improvement plan and the JSP Reports) for detailed weaknesses of the system.

The revised legal framework has (public procurement and disposal act, 2005) provided health facilities with a procurement entity status. No procurement is undertaken without fund availability. An annual procurement planning process has been introduced to guide the overall sectoral procurement resource allocation process, but it requires further refinement in terms of its link to the budget, broader participation and analysis. Procurement Review Boards and an oversight authority have been put in place. Senior procurement staff have been posted to the MOH Procurement Unit, capacity building is addressed by MOF. In short, these improvements are starting to show results. There is already a well thought out procurement and supply chain management improvement plan that is part of the JPWF; the challenge is to implement it

The "Position Paper on Procurement", December 2006 outlines the key policy decisions and actions that need to be take to institute a demand driven procurement systems with its appropriate checks and balances through a 'drawing rights' of facilities. While there is a lot of concern on the efficiency and effectiveness of the procurement process, there is very little investment from partners (with the exception of the few) in strengthening the necessary checks and balances in the system.

KEMSA has been provided with the responsibility of procuring bulk purchases since July 2006. The distribution EMMS from KEMSA has improved and every facility is receiving consignments once in a quarter. Most hospitals are now receiving EMMS on demand driven basis from KEMSA. The system of delivering vaccines to districts and to facilities appears to work well. There are more drugs now in the health facilities than in the past. An evaluation of the Kenya Medical Supplies Agency (KEMSA), September, 2006, concluded that KEMSA has developed and implemented transparent protocols but recommends that it needs to control its own finances. The evaluation report concludes

(a) that development partners are reluctant to provide support until the Government and the MOH have demonstrated that they are fully behind KEMSA, allowing it to assume authority and responsibility for its full mandate, and (b) that administrative action is rarely taken on non-compliant officials.

Despite these developments, implementation delays continue to undermine the effectiveness of the procurement system in MOH and negatively affects service delivery. Many of the NHSSP II commitments have not been delivered, mainly because of capacity constraints. In addition, MOH and development partners have, during the last two to three years, carried out procurement assessments and studies on the public procurement in the ministry and identified current problems as: 1) lack of capacity in sector ministries including MOH, 2) lack of health sector specific regulations, 3) unclear demarcation of responsibilities between MOH and organizations under e.g. KEMSA, and, between various levels of facilities in the Ministry, together with inefficiencies and ineffectiveness of the system. These problems are further compounded by the lack of concrete links between the HMIS and Procurement Management Information System (PMIS). Such a linkage would make it easy to assess and validate procurement of goods and services against service delivery. Of particular concern is the delay in updating the EDL and updating of the KNPP Policy, both of which have implications on quality of service delivery. Revision of Kenya Essential Drug List has not been done as yet, though a draft has been made and is awaiting establishment of the National Medicines and Therapeutics Committee (NMTC) by MOH. Generally, many commitments appear to have been made without due consideration of the capacity of MOH to deliver on them, but the current management (the PS), demonstrates a high degree of appreciation of what needs to be done. Despite this commitment, capacity to implement the desired reforms remains a problem. Therefore there is urgent need to rebuild credibility, and more importantly, to ensure the public gets quality goods and services, on timely basis and value for money.

There is commitment and interest both on the part of the overall government and MOH to reform procurement and supply chain management, starting with making key policy decisions in this area. While the plans are clear on what needs to be done, all sector partners need to demonstrate commitment by taking practical actions to strengthen the system rather doing on business as usual approach. DPs need to support these efforts to finance the required system strengthening efforts rather continue lamenting the weaknesses of the system. Staff interviewed at all facilities during the JRM process agreed that door-to-door delivery was a great improvement over the previous system whereby they collected supplies from higher level facilities. In terms of regularity of delivery, commodity accounting, ease of use, and supply availability the new supply transport system is a solid achievement. Among key issues and constraints identified were the poor communication and coordination between third party (development partner funded) procurement agencies and KEMSA, which is tasked with receiving, storing and distributing goods procured by other agencies. KEMSA does not receive timely notification of deliveries and future distribution schedules that would allow it to manage its core functions efficiently. Moreover, KEMSA does not recover its operational costs. Public sector clients (HFs) do not pay any handling charges for procurement, supply or distribution. There was an agreement (March 2007) for development partners to pay a 5% handling fee to KEMSA for warehouse and distribution, but to date this has not been implemented.

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.

Over the course of a 15-month period, the old Kenya National Drug Policy 1994 was subjected to intensive review by a Working Group established specifically for that purpose involving all the key stakeholders (including special input from WHO Geneva) which was supported by a special Task Force. A new, comprehensive Kenya National Pharmaceutical Policy (KNPP) 2007 was drafted to replace the old policy document and was submitted for further review at a National Consensus Meeting in August 2007. Agreed resolutions and recommendations from that meeting are being incorporated into the draft and a few outstanding issues are being addressed in order to finalize the work and prepare the document for submission through MOH Senior Management to the Cabinet for formal approval and adoption. The five year strategic plan for the pharmaceutical sector will be developed once the KNPP has been officially adopted.

Annual procurement planning has now become well established and takes place towards the end of the first quarter of each year at a special retreat involving all the concerned parties. Considerable inputs have been provided by the Division of Pharmacy in the form of assessment of kit content and performance and quantification of annual requirements for both kits and bulk (loose) items. The result of this has been greatly improved procurement planning and much improved availability of EMMS at all levels with subsequent substantial increases in out-patient attendance at many health facilities (particularly in districts now under the demand-based ("pull") supply system).

Challenges still to be tackled include the long-delayed transfer of procurement of essential medical supplies ('non-pharmaceuticals) from MOH to KEMSA and further streamlining and strengthening of the quantification and procurement process at all levels.

Following a systematic process of baseline assessment, sensitization, training, and preparation and dissemination of relevant documentation (e.g., order forms, stock cards, guidelines) the 'pull' system is now well established in two provinces (Coast and North Eastern) serving nearly 300 rural health facilities, which have to date received seven cycles of quarterly supplies. Order fill rates of up to 90% have been achieved and are averaging over 75%. Guidelines for ordering by the facilities are incorporated into the training materials and consolidated national guidelines on all aspects of EMMS management at facility level are at an advanced state of preparation. Nairobi Province (60 health facilities) was also inducted into the system in August 2007.

Strengthening drug supply management (including procurement, reception, warehousing, stock control, inspection and monitoring) received attention during the intensive training involved in preparation for introduction of the pull system. Evidence obtained in the course of regular pull system performance assessment field visits shows that there have been considerable improvements in several key areas of EMMS management at facility level (e.g., better storage conditions and arrangements, improved stock records and quantification, prompt order preparation and submission) but that serious challenges still remain to be addressed. These include: the need for regular retraining to compensate for the adverse effects of high staff turnover, the need to establish and institutionalize a pharmaceutical supportive supervision system within the DHMTs to provide continuous support to RHF staff for maintaining effective operation of the pull system.

The revision and adoption of Kenya Essential Drug List (EDL) has not been implemented as it is still awaiting the long-delayed establishment of the MOH National Medicines and Therapeutics Committee (NMTC). It is expected that this committee will be established and become operational before the end of 2007. In the meantime the list of EMMS to be supplied to RHFs and (sub-) district hospitals has been subject to continuous review and annual updating as part of the annual procurement process.

Draft guidelines for rational drug use at primary care level have been developed for three main therapeutic areas (IMCI, malaria and STIs) and used in the training of RHF staff as part of the pull system introduction. In a separate process, a draft 487 page update of the Clinical Guidelines 2002 has been prepared by an MOH working group and is currently being distributed for review and comment. A draft Kenya National Formulary for Primary Care Level which covers all EMMS used at KEPH levels 2 and 3 has been prepared and will be submitted to the NMTC once this is established for formal review and adoption. The area of medicines utilization remains a major challenge and there is continuing evidence of high levels of inappropriate use and consequent waste and therapeutic compromise. This will receive increasing attention once the required documentation is completed and ready for introduction and dissemination.

This capacity drug supply management has been significantly increased at RHF level in the pull system districts as a result of the intensive training programme involved in introduction of the system. RHFs in eight other districts in Central and Eastern Provinces have also been trained in this area in a joint/KEMSA exercise supported by one of the development partners. Drug management information tools including Standard order Forms and Stock Control Cards have been developed and distributed throughout the pull system districts and a new Prescription form is in print for testing in these districts prior to national introduction.

Guidelines on the establishment, role and effective functioning of institutional Medicines and Therapeutic Committees (MTCs) were prepared by the Division of Pharmacy and distributed to all hospitals in March 2007. Requested responses regarding to the status of these committees and related issues in the form of a structured questionnaire are being compiled analysed with a view to planning further support for their establishment and functioning. A special MTC workshop is planned for approximately 10-15 of the busiest hospitals later in 2007.

Investment and Maintenance

The NHSSP II has planned interventions on investment and maintenance in the health sector. The progress in investment for increasing access for care is well described in earlier sections and will not be repeated here, but efforts to strengthen maintenance systems have been planned, and these are reported below.

The main outputs planned are related to infrastructure and equipment as well as transport. According to NHSSP II, they are:

- Assessment of the conditions of infrastructure, equipment and transport including ambulances.
- Policies on maintenance, transport are developed and implemented.
- Capacity building in the three area in terms of human resources.
- Establishment of maintenance units at district level and community transport system.

Efforts were made to strengthen district based transport system in Coast and provinces. The transport system assessment found that there are no standard transport information systems in place, no reliable transport data, ad hoc systems of vehicle scheduling, no systematic vehicle maintenance schedules and procedures, no defined role for transport management responsibility, age of most of the fleet exceeded economic lifespan, and no accountable budgetary statements relating to transport related expenditure are available. The interventions planned to strengthen the system include:

- Put in place an information based transport management system, key performance indicators, and operational guidelines;
- Train district level transport officers to operate systems and apply guidelines;
- Provide a curriculum for training motorcycle riders and vehicle drivers in the safe driving and riding techniques, and planned preventive maintenance and procedures, and train rider and driver trainers for each district;
- Link operational costs and vehicle replacement costs to the management information system and district and provincial budgeting procedures; and
- Provide an "ideal fleet" model, disposal and purchase plan.

There are achievements recorded in strengthening the system in the Coast province. There is an information-based transport management system in place at provincial level and in each of the districts; skills and software are available for manual and computerized generation of key performance indicators. There is a District Transport Officer in post in each district – but only 3 of the 22 Transport Officers who attended had completed all three trainings, meaning that knowledge and skills of Transport Officers are variable. Vehicle scheduling procedures are now in place in each district. A number of riders and drivers have been trained to a basic level. There is no curriculum in place for on-going training because no riders and drivers with sufficient basic skills to be taken into a training of trainers programme. There is a system in place to evaluate vehicle maintenance work undertaken by private sector service providers. A partnership agreement has been drawn up between provincial MOH and Mombasa Polytechnic to train senior drivers from each district in Planned Preventive Maintenance Techniques. The system is in place to link operational and replacement costs to district and provincial budgeting procedures, although the lack of central level directives and demands for specification do not allow operational and capital transport costs to be meaningfully consolidated.[17] This experiences needs to be widely shared and their cost effectiveness reviewed and scaled up with necessary adjustments if any.

The effort at midterm may not be on track to affect the key issues being addressed in terms of halting the poor maintenance and non repair of health infrastructure due to poor planning and follow up of maintenance of the procured infrastructure, rationalizing basic technical and administrative equipment to support service delivery, including for communication, ICT and transport, to comply with defined standards and guidelines for equipment so as to match them to expected functions. This warrants a sound evaluation by the central level to decide on a way forward on the transport, equipment and health infrastructure development and management policy as well as development of a more rational human resource management policy.

Communication and ICT

NHSSP II aimed at improving the communication among various actors through development of a national communication plan or strategy, production of newsletters, the use of radio transmitters for emergency evacuation in remote facilities, establishment of functional information communication technology (ICT) networks in the headquarters and to progressively expand to provinces and districts.

The government wide ICT policy is being implemented in the Ministry of health and the policy is clear on what the health sector needs to do regarding ICT which eliminates the need to come out with a specific health ICT strategy or policy. What is required is to know what it takes (in terms of resources and time) to implement the strategy in the health sector. A TOR is drafted and an implementation plan is expected to be completed by the end of AOP 3. There is a regular newsletter being printed and distributed by the MOH. It may be necessary to improve its quality and expand its distribution list. An ICT network is functioning in Afya House and is being expanded to wide area network to include other offices and provinces.

Recommendations for Improving Efficiency and Effectiveness

To meet this NHSSP II objective action is recommended in all areas of efficiency and effectiveness: improving value for money, public financial management, efforts to strengthen development planning , monitoring, district health planning, commodity supply management, and

[17] "The Development of a District-Based Health Transport Management System, Coast and North Eastern Provinces, Kenya", January 2007.

investment and maintenance. These are itemized below.

Improving value for money

- Undertake further reallocations of public funding towards pro-poor programmes especially rural health services in light of current poverty levels that justify more wavers of facility fees to alleviate financial constraints to health services access by the poor.

Improving public financial management

- Accelerate the implementation of PFM improvement plan.
- To reverse the declining capacity to absorb finance resources, conduct an urgent evaluation of its PFM management.
- Implement the Health Sector Service Fund (HSSF).
- For MOH and development partners, enhance collaboration to reduce parallel and fragmented PFM systems in the health sector through the implementation of the JFA.
- Fast track capacity building in financial management and, for development partners, step in and help build capacity, especially in PFM for the implementation of HSSF.
- For MOH, in order to promote financial predictability, develop criteria for cost sharing waivers and provide a clear policy strategy for the health sector so as to avoid disruptive decision making.
- Strengthen data capture to ensure expenditure is consistent with the service delivery.
- Expedite increasing of benefits by NHIF to transfer efficiency gains to the contributors.

Improving the effort to strengthen district health planning

- The priority is to scale-up the roll out of the training for AOP preparation at all levels with increased peer support to districts and provinces, timely circulation of planning frameworks, expenditure ceilings, formats, and/or guidelines and tools beginning with preparations for AOP 4.
- In light of the core-functions based results framework used in AOP 3, the MOH technical departments should review their respective strategic approaches in line with the present policy and strategic directions. This should help in identifying gaps in delivery of their respective policy and strategic frameworks required to roll out their technical interventions in line with the implementation of the KEPH.
- Urgently prepare districts and provinces with management and planning skills training so as to take over the in-service AOP skills-sharpening training for more rapid, effective and wider coverage of the undertaking before the end of NHSSP II.
- Enhance the administrative and logistics support available to provinces, districts and health units to conduct more inclusive annual planning with more meaningfully participation of civil society, FBO/NGOs and other partners starting in AOP4 for the AOP5 process.
- Consider and prepare for the introduction of medium term planning frameworks for districts and provinces to set the direction for sustainable decentralized operations, especially for the maintenance of capital investments in buildings, plant and equipment.

Improving efforts to strengthen development planning

- Enhance capacity at the central level in technical planning to ensure implementation of the strategic approaches identified is maintained.
- Strengthen policy dialogue structures at sub-national level requires with the establishment of appropriate structures to improve engagement of civil society and partners in the planning and sector review processes.
- Ensure that gender and rights sensitivity are included in training materials and planning formats and consider the establishment of a focal area at the national level to coordinate this work.
- Rationalize and harmonize the planning function, and planning cycles with budgeting cycles as soon as is practical
- Restructure the MOH to make a succinctly clear distinction between monitoring of administrative support to technical implementation (by the MMU) and the separate, well differentiated functions of technical monitoring and evaluation of sector productivity (by the SPMD through the division of health information).
- In the same vein, appropriately delineate and appropriately disseminate the difference between the functions of linkage of budget management processes of the Ministry of Health (and on budget donors) with the overall Government (by the planning unit), and the separate technical results based and bottom up comprehensive sector planning and budget process based on planning and monitoring sector productivity (by the SPMD).
- Redesign and reform the JRM process to become bottom-up not just in terms of information generation, but also in information dissemination and linkage with other processes, particularly the quarterly monitoring review process. In addition, specific technical assessments in problem hot spot areas could be carried out during the year, to feed into the JRM

process as opposed to having these all done at the JRM.

Improving monitoring

- Endorse the M&E strategic roadmap to give overall comprehensive guidance to strengthening of the M&E function in the sector.
- Develop TORs for elaboration of a development roadmap for agreeing and reassigning roles and responsibilities across the sector, staffing, system design arrangements, equipping, training and financing plan. It also includes development or updating of a national health information policy and regulations and adjust any existing guidelines to comply
- Set up a national representative health information technical committee that will not only to drive this work but give technical oversight to ensuring the M&E strategic framework is implemented in a comprehensive and participatory manner.
- Establish a focal point on health research as a first step towards building capacity for essential health research policy development, operations research and collaboration with research institutions for health improvements.

Improving public procurement

- Accelerate the implementation of the procurement improvement plan
- Delineate procurement responsibilities between the ministry PU and other procurement organization including KEMSA.
- Establish the various committees currently pending(NMTC).
- Complete the new comprehensive pharmaceutical policy.
- Urgently embark on capacity building in procurement and accountability.

Strengthening commodity supply management

- Delineate roles and responsibilities of MOH and KEMSA, and define the role of KEMSA vis-à-vis non public actors like MEDS.
- Demonstrate support KEMSA by articulating clear plan and schedule for transferring the balance of its EMMS procurement and eventually medical equipment to KEMSA.
- Implement 5% of handling charges for all commodities procured by third parties and distributed through KEMSA.
- For KESMA, provide information to health facilities the unspent portion of their quarterly drawing rights and roll it over to the next quarter
- Increase the resources allocated to the procurement of commodities that goes to the health facilities.
- Review the impact of 10/20 policy on FBO and NGO facilities and consider grants to allow these facilities to drawing rights from KEMSA.
- Build capacity at all levels.
- Finalize the revision of National Pharmaceutical sector strategic plan.
- Revise Essential medicines list.
- Scale up demand driven supply system.
- Introduce quality assurance mechanism (including regular audit) for commodities and supplies.

Enhancing investment and maintenance

- Strengthen the strategic framework to guide investment in infrastructure , communication and transport.
- Develop an ICT implementation plan to guide investment in the health sector.
- Improve financing of maintenance of infrastructure, health facility plant, equipment and transport to ensure the sound state of their operation.
- A communication and transport strategy should be developed to improve and rationalize support to referral
- Develop the capacity for maintenance.

5. Progress with Objective 4: Fostering Partnership

In its aspiration to reverse the observed downwards spiral of the health indexes, NHSSPII recognizes that to effectively do so, there is need to involve all sector players and the population at large in decision making. The Plan's intention is to 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.

One of the four sector priorities provided for in the Joint Programme of Work and Funding is the strengthening of sector stewardship and partnerships with all stakeholders by ensuring clarity of roles and responsibility in a rationalized organizational setting and instituting joint planning, funding and monitoring arrangements. The mechanism for putting this into operation is a programme to review and reform existing common arrangements (CMAs) with all stakeholders to conform to an agreed SWAp and other international declarations or agreements. These consultations would inform the signing of a Code of Conduct and subsequently a Joint Funding Arrangement.

Joint Planning and Priority Setting

Functional planning calendar: In line with the strategic plan, a formal planning and monitoring system and calendar has been introduced and functional in the last two years. Most of the stakeholders are part of the process. Moreover, there are still development and implementing partners that are planning and budgeting on project mode and outside the agreed time frame. The follow up and reporting of adherence to the COC principles will assist in providing incentive for better alignment if the results are widely shared to ensure that there is also peer pressure among these actors.

> Building stronger partnerships and strengthening stewardship involves ensuring the clarity of stakeholder roles and responsibilities in a rationalized organizational setting characterized by joint planning, funding and monitoring arrangements.

Several strategies were proposed to implement this component which has been implemented to varied degrees. Three annual operational plans (AOPs) have been developed and utilized during the period of the current NHSSP. The first AOP was developed in tandem with NHSSP II on the basis of contributions of mainly national public sector players and hence had limited participation, ownership and awareness. The Plan was not launched because the launch of NHSSP II occurred six months (29 March 2006) after the JICC approval in September 2005. Non the less, the plan became the key guide for the national interventions to lay the foundation for design of SWAp, which was expedited through the government-wide RRI. The second AOP was developed in tandem with Joint Programme of Work and Funding (JPWF) based on inputs of SWAp RRI groups that formulated documents addressing priority areas on KEPH and KEPH support system as well as the contribution of district and provincial plans that was developed through a bottom up approach.

The key principles of developing both the second AOP and the JPWF were a product of a consultative forum of key sector stakeholders held in October 2005.[18] Key amongst the principles for AOP 2 development was for the Ministry to initiate a process for a bottom-up planning process. This being the first attempt of country wide bottom-up planning through involvement of districts in determining

[18] Kenya Health SWAp Concept Paper, 2005, www.hsrs.health.go.ke

their planned outputs and interventions for each priority areas and established targets, the outcome was very encouraging. In total, 78 (including 39 final ones) district health plans and 5 provincial plans were submitted and included in AOP 2. This progress was not without challenges, such as the inclusion of individual facilities, private sector, district governance structures and department/ division wide participation. A major constraint during the development of AOP 2 was the limited link between the plan and the funds through MTEF and funds outside the printed estimates. This challenge notwithstanding, AOP 2 became the basis of the PS's performance contracts and those of the cascaded contracts.

The challenges faced in developing the second AOP informed the process and design of the third AOP. The sector decision that AOP 3 needed to be developed on the basis of the MTEF in turn posed two significant challenges:

- It delayed the district, provincial and national planning and the required quality control (support only started end-March after declaration of the resource envelope in mid-March) and operations allocations for DHMT and national divisions/programmes were not concluded at the time of conclusion of the plan; and
- The alignment of priorities and objectives of NHSSP II and JPWF were not necessarily aligned with the budget structure under the MTEF and failed to reflect the overall resource flow that is coming to the sector.

These constraints and challenges have provided an opportunity for the sector to critically examine the structure of the MTEF and agree on an functional budget that has been called a "shadow budget" to enable the sector to factor a functional structure and include all on and out of budget funds. Further, this experience has justified the need to start the planning process in first quarter rather than in the third quarter as has been the process to determine the available resources for all levels from the different sources to better inform resource-based planning. As explained in the planning section, however, there is lot of preparatory work to be completed by government, implementation and development partners for the effectiveness of the functional budget.

The participation of implementing units in the planning process has increased substantially during the last three years (from AOP 1 to AOP 2 and now during AOP 3 preparations). In AOP 3 there is now full compliance by all districts, provinces and national programmes/divisions to an agreed standard format and adherence to a consolidated planning process. In terms of participation, what remains is the inclusion of levels 5 and 6 (provincial and national hospitals) in the planning process.

These experiences will be invaluable for the development of AOP 4 and improvement of the general planning process. AOP 3 planned strengthening of the district governance structures will further enhance stakeholder participation in joint planning at the lowest level of care-community.

The government-wide initiative of performance contracts and performance appraisal systems, which have been institutionalized and are at formative stages, have been valuable instruments for institutionalizing AOP 2 to inform the indicators and targets that are then utilized for generating and negotiating performance contracts. This equally will in future be strengthened by the current performance appraisal system in the public sector that requires each individual to be appraised every six months on key outputs drawn from the AOP.

There are still challenges that sector should improve further in the area of planning:

- Ensuring that the quality of plans at all levels (by facilities, districts, provinces, divisions, implementing agencies and development partners) have improved and interlinked to support each other. Significant activity is still being implemented not only outside the budget but also outside the mainstream annual plan.
- Ensuring the predictability of resources from all sources and linking them to the strategic objectives and priorities of the sector. There is a need for a transparent resource allocation mechanism to ensure that allocative efficiency is achieved.

The quality and scope of sector-wide planning has been consistently and systematically improved as a result of the strengthening of the sector coordination mechanisms, key of which is the establishment of the Health Sector Coordinating Committee (HSCC)[19] which now occupies its policy leadership role from the third quarter of AOP 2 augmented by the improved stewardship role of the Ministry of Health. The HSCC establishment is a key milestone in institutionalizing the Kenya Health SWAp (KHSWAp) as it is expected to not only coordinate joint planning and monitoring but to also steer the establishment and strengthening of the sector coordination structures and mechanisms including reforming the ICCs and District Health Stakeholder Forums (DHSF).

NHSSP II provided for an annual Health Planning Summit that serves as the zenith of the planning process for the following year, where the key dissemination and launch of the sector plan is conducted. Two Planning Summits have been held, in June 2006 and 2007, that have helped to increase ownership and awareness of the AOPs across the sector. Some districts are report as having launched their AOPs (which are the District Health Plans)

[19] Health Sector Coordinating Committee (HSCC) TORs (approved), www.hsrs.health.go.ke

in their districts after the June 2007 national launch. The launches have been held in June rather than the desired May because of lateness in the preparation of the AOP, which hopefully will be corrected through initiation of the process in the first quarter of the year.

Joint Monitoring

NHSSP II recognized joint monitoring as one of the critical pillars of the KHSWAp and hence proposed an annual Health Review Summit in November as the zenith of a review process where the sector performance is disseminated and the report is launched. It also proposed the strengthening of a uniform health management information system for the sector.

The performance monitoring system aimed at supporting the health managers through providing accurate and timely evidences for decision making. During the time of NHSSP II, there are positive developments in this area. These include the introduction of result based management, the introduction of quarterly performance report and the production of annual reports.

The result based management systems introduced particularly the rapid results initiative have fast tracked the implementation of some of areas. It helped to speed up the development of SWAp processes. It also assisted in improving service delivery at district levels: ART, immunization are best examples in this regard. The main innovation of the RRI initiative is defining goals, millstones and actions steps and conducting close follow up by the top management on the realization of the set targets. The lessons leant in the RRI initiative, if scaled up to the regular quarterly reviews to ensure the realization of the implementation of AOP targets, it will positively contribute to reversing the trends.

Performance reports, JRM and the annual health summits: One of the cornerstones of SWAp is the institutionalization of common monitoring mechanism to reduce the over elaborate and repetitive project based implementation reviews carried out by individual projects and programmes

For the first time, the MOH released a comprehensive Health Sector Performance report that reviewed the achievements, constraints and challenges during the first year (2005/06) of the current five-years plan period, against the objectives and the targets that had been set in AOP 1. In spite of its limitations, as outlined in the report and commented by independent of consultants, it has provided the platform for future policy dialogues.

The most important outcome of the first performance report was the ranking of the district performance, though the methodology needs to be refined, to create a sense of result orientation (delivered services per unit of input) or value for money and a feedback mechanism. The exercise resulted in a ranking of 61 districts (out of 78) and the selection and acknowledgement of the best performing district in each of the eight provinces The best performing districts at provincial and national levels were acknowledged. Similarly, the best performing districts in the first nationwide rapid results initiative were also identified and documented. This has created a sense of competition for recognition and improved the reporting rate as non reporting districts are classified last in ranking. Some districts did discuss their performance with their stakeholders afterwards.

The joint review mission carried out by the independent consultants created a forum where the weaknesses in the implementation of planned activities and actions to improve them are openly discussed by sector partners agreed and taken forward for the ongoing and next AOPs. The independent consultant provided valuable inputs for improving the various areas of the work plan. There were lessons learnt in the planning and management of future JRMs (preparation, length of time, support required, etc) from the fist experience. The joint review mission of 2007 is expected to review the extent to which the recommendations of the JRM 2006 have been implemented.

The results of the performance report and the JRM mission was discussed in the JRM meeting in October 2006 where major forward looking actions were agreed. As per the planning cycle adopted by stakeholders, the first review health summit was conducted in a one-day meeting on 30 November 2006, in Nairobi, attended by delegates from almost all the actors that have a stake in the health sector in Kenya (district health management teams from all over the country, senior officials from the MOH, civil society representatives, senior government officials, the donor community, the MOH reiterated its intentions and achievements in reforming the health sector and gave a rather detailed insight into what had been achieved so far. The health planning (June) and monitoring (November) summits are now firmly instituted. The way the summit conducts its business could be strengthened further.

The reports are prepared at high transaction cost, as there is as yet no single custodian of information in the Ministry

Pooling of Funds

A Code of Conduct signed by key partners to the sector forms the base for designing an agreed fund, in tandem with the Joint Funding Agreement development, which would provide the guide for the day-to-day management of resources. Consultations by the different partners are on-going that will inform the design.

Stewardship, Leadership

Strategies for strengthening governance and management, overall health legislation, regulation and law enforcement systems, and partnerships with stakeholders were all part of NHSSP II. These aims supported the restructuring of the sector in order to improve servide delivery.

Several consultations on the restructuring have been conducted and are still going on. In addition, under the leadership of MOH, and in close collaboration of the development and implementing partners, members of the sector developed and signed the Code of Conduct (COC). Development and implementing partners will be required to buy into the health sector programme of work and plans.

Governance and management structures are being strengthened. The key focus is on aligning the existing structure to KEPH. A stewardship and coordination structure[20] was developed as a framework whose details are being developed to initiate implementation. The governance structure framework[21] was further developed to link the formal and informal delivery health delivery structures up to the household level. Draft governance tools have been revised to make them compliant to KEPH and their utilization will occur from Q2 of AOP 3.

Health service provision in the city of Nairobi has been reorganized through the establishment in 2003 of one Health Management Board and eight Districts, each with its own DHMT. PMO Nairobi is the Chief Executive Officer (CEO) of the Board. MOH has also strengthened the services through the provision of Doctors, Nurses and Public Health Technicians. These health districts are currently being linked to the three newly constituted administrative districts. At the moment, these 8 districts are severely constrained by inadequate and dilapidated infrastructure.

The MOH is fostering greater ownership of health services by communities through a number of strategies. One is through popular participation in the coordination, planning, managing and monitoring of health services. A number of forums have been set up from the village to the provincial level to foster this ownership, including village health committees (VHC), Health Facility Committees (HFC), District Health Management Boards (DHMB), District Hospital Boards (DHB) and the District Health Stakeholders Forum (DHSF). Not all these committees are fully functional and there is a need to provide continuing support to build their capacity and understanding of their roles and responsibilities. The MOH is increasing ownership of the health services through empowerment of the community and the individuals it serves. It has also developed a Service Charter, which was launched by His Excellency, the President Hon. Mwai Kibaki on 22 January 2007. The Service Charter recognizes the community as customers with rights and as claimants with legitimate demands on the health service. Cascading service charters to the health facility level will be an enormous challenge, but is a key deliverable in most performance contracts.

As for legislation reviewed and gaps identified, no progress has been made in delivery of this output. Consultations are ongoing to fast-track the process.

Dialogue dialogue with private-not-for profit has been systematic and encouraging through their incorporation as a third major partner to the signed Code of Conduct, which now forms the framework of partnership. The Kenya Episcopal Conference Catholic Secretariat (KEC-CS) and Christian Health Association of Kenya (CHAK) coordinate the bulk of not-for-profit non-government health care providers. Following high level meetings in September 2006, these bodies have re-opened discussions with MOH to suggest modalities for future collaboration, including the re-instatement of a financial grant to church health facilities; secondment of doctors and nurses; support in kind through provision of drugs, medical supplies, equipment and ambulances, and the revision and updating of the legal policy framework to govern this collaboration.

This dialogue was greatly improved by the establishment of a network for the NGOs and FBOs in health to facilitate effective dialogue within the sector. The challenge is to facilitate a similar network to enable engagement with the private-for-profit sector whose initial dialogue was initiated in Q4 of AOP 2 and is expected to be further depended in AOP 3.

Formal partnership arrangements are routine: Having designed the KHSWAp during 2005/06, focus during AOP 2 was on development of the SWAp instruments from the first quarter (Q1). An agreed draft COC[22] was concluded by AOP2 in the third quarter and agreed that a key partner – the Ministry of Finance – would countersign the instrument and facilitate the signing of the other partners. The COC was signed on 2 August 2007 at the Treasury by the Permanent Secretaries of the Ministry of Health and Ministry of Finance and 11 sector partners. The Ministry of Finance will coordinate the completion Joint Funding Agreement (JFA) development from AOP 3 Q1 to guide effective system development for quality service deliver.

[20] Ministry of Health, *Joint Programme of Work and Funding for the Kenya Health Sector 2006–2010*, pp 54–5, www.hsrs.health.go.ke

[21] Ministry of Health, *Community Strategy Implementation Framework*, 2006, www.hsrs.health.go.ke

[22] Kenya Health SWAp: Code of Conduct, 2007, www.hsrs.health.go.ke

Recommendations to Improve Collaboration and Partnership

Considrable progress has been made towards this objective, but improvement is needed in some areas, as itemized below. Issues of efficiency, equity and effectiveness are addressed under objectives one and three.

- Develop a roadmap for advancing the Kenya Health SWAp and governance structures for annual planning to be agreed and HSCC mandated to monitor its progress.
- Articulate clear benchmarks to ensure adherence by all parties to the COC and ensure the SWAp is advanced.
- Formulate a public-private partnership policy framework, but give priority to addressing issues relating to private not-for-profit providers involved in direct service provision.
- Set national targets for indicators of progress on aid effectiveness per the Paris Declaration (ownership and leadership, alignment to government strategies and priorities as well as systems, mutual accountability for results and harmonization) within the NHSSP II M&E framework and to inform the KJAS results matrix.

6. Progress with Objective 5: Improving Financing of the Health Sector

One of the targets set out in the Economic Recovery Strategy was to achieve a 5% reduction in poverty by 2007. Health was given prominence in the ERS and was seen as an important contributor to the efforts to reduce poverty, as well as overall economic growth and development. The ERS noted that the system of charging fees for services had resulted in up to 40% of the poor not seeking care because they were unable to pay. At the same time, the plan noted that apart from barriers because of charges for services, the poor state of health infrastructure and shortages of essential drugs, among other factors, further contributed to the unavailability and low population coverage of health services. Consequently, introduction of NSHIF, rehabilitation of health facilities, and adequate supply of drugs in health facilities were singled out in the strategy as important measures to improve the availability of health services and therefore coverage and access.

In addition to defining health care access indicators, the ERS also set targets related to financing for health care, and committed to increase: public sector per capita expenditure on health from US$6.5 to US$10 by 2007; allocation for drugs and medical supplies to 16% of the health budget; and overall GOK funding on health from 5.5% of total public expenditures to 12% between 2003 and 2013.

Developed in this context and introduced soon after the launch of the ERS, NHSSP II planned to achieve the following resource-related objectives:

- To improve the availability of more resources for health in a sustainable and equitable manner
- Review health financing mechanisms specifically to introduce NSHIF to gradually achieve Universal population coverage
- Reorient and re-focus public investments for health care provision to benefit the poor more by reallocation of resources towards promotive, preventive and basic health services

Several methods of financing health services are available, including taxation, user fees, donor funds and health insurance. These methods have become increasingly important funding mechanisms for funding health services in the country, but they should reflect both the cost of service provision and the population's ability to pay. Government resources fall short of Kenya's commitment to spend 15% of total budget on health, as agreed in the Abuja Declaration, thus reducing the sector's ability to ensure and adequate level of service provision to the population.

Assumptions

Achieving increased financing for health was linked to a set of inter-related events and decisions at the macroeconomic and government-wide level, health sector-specific decisions as well as health-related initiatives at the international level.

The ERS projections indicated that Kenya would achieve the following macroeconomic indicators:

- GDP growth rate of: 1.2% in 2002; 1.9% in 2003; and reaching 4.3% in 2006/07 period;
- Reduction in poverty by 5%; and
- Improved economic management for example a lowering of the wage bill.

Achieving these targets would result in increased GOK spending on health through the allocation of additional resources, and also through better management of the wage bill to create spending flexibility to allow increased allocation of available resources to previously under funded but critical inputs for service delivery.

Increased Government Allocations to Health

The government through its budget outlook paper (BOPA) and budget strategy paper (BSP) 2003–2007/08 committed to gradually increase health spending to facilitate greater access to better quality health care by improving the provision of drugs, more staff training, etc.

The spending ceilings were set to change as follows:

- Sector ceiling for health as a percentage of total GOK was to grow from 8.62% in 2004/05 to 9.90% in 2005/06, 10.30% in 2006/07, and 10.67% in 2007/08.
- Ministerial ceiling, on the other hand, was to grow as a ratio of government expenditures: 7.66% in 2004/05, 9.09% in 2005/06 and 9.32% in 2006/07.

These projections meant that public expenditure on health would grow both absolutely and in proportion to GDP and overall government expenditures, as well as in per capita terms.

Rise in User-Fee Revenues (Public Health Facilities)

Revenues from user fees were kept modest to reflect the trend in revenue yield reported by GOK health facilities, and also on projections from the strategic plans of Kenyatta National Hospital (KNH) and Moi Teaching and Referral Hospital (MTRH).

Rise in Bilateral and Multilateral Financial Assistance

The revenue yield from external resources (donor assistance) was calculated using the 2002 National Health Account (NHA) estimates of donor funding on health in Kenya, and adjusted to reflect the expected pattern of external funding as depicted in the analysis by the External Resources Department (ERD) at the Treasury as well as to reflect potential growth in funding resulting from the new global initiatives for health.

In the base case scenario, public expenditures were expected to increase as a proportion of GOK and reach a level of 8.6% in 2005/06, and rise to 10.7% in 2007/08. Funding streams based on this scenario are summarized in Table 6.1. A second scenario assumed an increased level of external resources and a higher level of GOK allocation on health at levels commensurate with the goal of reaching the ERS target of 12% as a share of total government expenditure (Table 6.2).

Table 6.1: Scenario 1 projected funding on health (million Ksh)

Funding source	2005/06	2006/07	2007/08	2008/09	2009/10
GOK	26,384	34,014	39,585	45,384	52,835
User fees	2,729	3,152	3,648	4,233	4,923
Donor	4,910	5,277	2,703	2,716	2,869
NSHIF	0	0	11,515	11,611	15,138
Total all sources	34,023	42,443	57,451	63,944	75,765

Table 6.2: Scenario 2: projected funding on health

Funding source	2005/06	2006/07	2007/08	2008/09	2009/10
GOK	34,635	40,203	45,217	50,606	56,611
User fees	2,729	3,152	3,648	4,233	4,923
Donor	4,910	5,277	2,703	2,716	2,869
NSHIF	0	0	11,515	11,611	15,138
Total all sources	42,274	48,632	63,082	69,166	79,541

Analysis of Performance

There has been an increase in nominal aggregate and per capita public spending on health for both approved and actual expenditures during the last two years Approved allocations increased by 52% between 2004/05 and 2006/07; and annually by 26% between 2004/05 and 2005/06, and about 20% from 2005/06 to 2006/07.

Table 6.3 summarizes the trend in public spending on health. The increased spending is reflected in the rise in per capita spending in both allocations and actual spending. The level of per capita public spending on health increased from US$8.7 in 2004/05 to US$14.5 in 2006/07 in the case of approved budget, and from US$7.6 in 2004/05 to US$10.0 in the case of actual expenditures.

Table 6.3: Trend in public expenditures on health

	2004/05	2005/06	2006/07
Approved budget*	21,977	27,832	33,526
Approved US$ per capita	8.7	10.8	14.5
Share of total government expenditure (%)	7.24	7.27	7.27
Share of GDP (%)	1.71	1.78	1.91
Actual expenditure*	19,158.40	20,636.00	23,178.00
Actual US$ per capita	7.6	8.0	10.0
Share of total government expenditure (%)	6.31	5.39	5.02
Share of GDP (%)	1.49	1.32	1.32
$/Ksh exchange rate	77.3	77.3	68
Population projections (in millions)	32.8	33.4	34

*Ksh million)

The share of GOK spending on health remained lower than the anticipated levels during the period 2004/05 and 2006/07, the allocations (in absolute terms) appeared to match the level of resource yield projected for this period. For example, public spending on health was projected to reach Kh34.023 billion in 2005/06 and Ksh42.443 billion in 2006/07 under enhanced allocations to health as proportion of GOK expenditures.

As Table 6.4 shows, the current levels of budgetary allocations are not too far off the projections, accounting for up to 80% of the projected resource yield, at least in 2005/06 (under a higher GOK allocations and a scenario of modest user fees and donor contributions).

Table 6.4: Estimated available resources vs. projected flows

	2005/06	2006/07
Projections (scenario 1)	34,023	42,443
Projections (scenario 2)	42,274	48,632
Available budgetary (allocations)	27,832	33,526
Available resources (all sources)	42,074	46,619

Because of macroeconomic factors, and the government's intention to limit its expenditures to a manage level of GDP, it is unlikely that substantial increases in budgetary resources allocations to health can be expected.

Per capita health spending

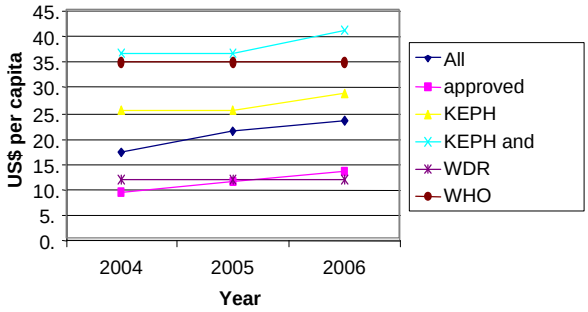
Mobilizing and coordinating the use of all available resources, including off budget support, would improve the financing of the sector. Such coordination would have placed nominal per capita spending on health at US$17.6, US$21.5 and US$23.7, respectively, in 2004/05, 2005/06 and 2006/07, and made spending in the sector close to reaching the required per capita expenditures for providing KEPH services.

Trends in per capita expenditures are summarized inTable 6.5 and illustrated in Figure 6.1.

Table 6.5: Per capita health spending in Kenya compared with selected benchmarks (US$)

	2004/05	2005/06	2006/07
All sources	17.6	21.6	23.7
approved budgetary only	9.57	11.9	14
KEPH requirement	25.8	25.8	28.8
KEPH and Non-KEPH	36.9	36.9	41.2
WDR 1993	12	12	12
WHO 2000	35	35	35

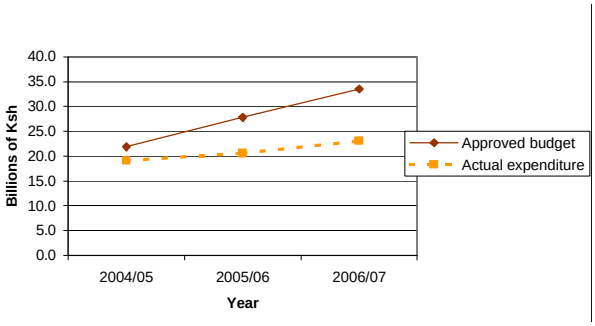
Figure 6.1: Per capita spending on health against selected benchmarks



Actual Expenditures Compared with Approved Budgets

Approved budgets constitute a road map for the spending in a given financial year. Actual expenditures reports released every year reveal the true allocations and their applications in implementing planned activities. A review of expenditures during 2004/05 and 2006/07 reveals that the variance between aggregate approved budget and actual spending is decreasing in percentage terms from 87% in 2004/05, to 74% in 2005/06, and to 69% in 2006/07 (see Figure 6.2 for the trend).

Figure 6.2: Approved and actual expenditures compared



Issues in Public Spending on Health

More importantly, the low level of spending shows that little progress is being made towards meeting the government's own expenditure targets, which were set to increase from 7.66% in 2004/05 to 9.32% of total government expenditures in 2006/07. These low levels mean that public spending will not only stay below the ERS target of 12% of total government spending, but also

not approach the 15% commitment reached at Abuja, as well as other international spending benchmarks – US$35 (recommended by WHO).

Budgeting and expenditure reforms – involving the use of budget ceilings were introduced to help achieve fiscal discipline, which links expenditures to macro-economic forecasts – GDP, inflation, balance of payments, revenues, and aggregate levels of expenditures. The BOPA 2007 has applied this fiscal management framework in setting out the projections for health sector expenditure scenario for the period 2007/08 to 2010. The level of MOH expenditure was expected to increase from Ksh35.0 billion in 2006/07, to KShs.38.9 billion in 2007/08 to Ksh43.1 billion in 2008/09, and reach Ksh53.0 billion in 2009/10.

In general, it appears that decisions regarding expenditure allocations to health are influenced largely by decisions and factors outside the sector. As part of the overall strategies to improve health financing, the sector has implemented the following strategies to influence the allocation of resource for the sector.

- ***Developing quality sector plans:*** The overall allocation of resources are being done according to how the ministries or sector plans respond to the ERS objectives in particular, in relation to core poverty programmes. The role of health in poverty reduction is well recognized. As such what the ministry needs to do is to promote its strategic plan and show its core poverty reduction programmes. The AOPs developed annually offer the best opportunity to identify areas for negotiating for enhanced allocations to the sector, especially if it is able to identify priority areas for spending in the sector.
- ***Accurate and comprehensive costing of sector plans:*** This can provide invaluable information for lobbying for additional or new funding to the sector.
- ***MPER process:*** Here the intention is to strengthen dialogue and coordination with MOF and partners. Immediate options available to the MOH include the use of the MTEF and sector hearings, as well as the use of MPERs to document spending and areas that require additional or new funding.
- ***Overall sector financing strategy:*** This is an ongoing effort.

These approaches need to be actively used for influencing additional resources from the central government (MOF, other government offices) and parliamentarians. Several multilateral and bilateral donors (IDA, DFID, US government agencies, DANIDA, Sida, GTZ-GDC, JICA, UNFPA, UNICEF, UNDP, AfDB, etc.) have shown commitment to support the activities and developments in the health sector in Kenya. An analysis conducted in early 2007 to document current year and future financial commitments by some of the key bilateral and multi-lateral partners in the health sector revealed that a cumulative total of Ksh51.6 billion in on- and off-budget support would be available to the health sector between 2006/07 and 2009/10 period. Traditionally categorized as development budget, much donor support is used on items that are recurrent in nature – drugs, personnel, operations and maintenance – and more so on core poverty and public health interventions such as malaria control, HIV/AIDS, immunization, reproductive health, etc.

Even though external resources are an important part of the overall financing especially of key public interventions, inability to predict future flows of external resources makes planning of service delivery difficult and uncertain. Additionally, external resources are prone to shifts in focus – some times emanating at the international level, it creates insecurity in the financing of key health inputs. The health sector in Kenya has experienced these difficulties, and increasingly the government is taking decision not to factor donor resources as part its annual budget since the mismatch between donor pledges and commitments has led to the variances in budget and actual expenditures reported at the end of government financial year.

As evident in how forthcoming most donors were with information on their planned contribution to the sector, this is becoming a lesser issue in Kenya. This stems from the on-going inclusive arrangements under the SWAp framework, and the Paris Declaration on Aid Effectiveness. Regardless, existence of a large amount of resources off-budget remains a challenge to monitor the utilization of these resources.

External aid flows can impinge on the sector's fiscal space and present a challenge to the achievement of fiscal management goals of the government. A good example is the use of donor aid to support the hiring of health personnel in some cadres to address the shortages. As a result, the MOH will be forced to seek additional funding to absorb these personnel upon the expiry of their contracts following the lapse of donor support. The use of these funds to sustain these additional staff impinges on funding for other activities.

Alternative and Innovative Financing Mechanisms

Clearly, additional approaches are needed to indentifying resources to finance health care in Kenya. The approaches range from a fresh look at existing sources, like user fees and NHIF, to the adoption and adaptation of novel mechanisms for generating funds

User Fees

The system of user fees for health care was introduced in the public sector in Kenya in 1989 against the background of decline in budgetary allocations to health resulting from the drop in overall government expenditures experienced at the time. The drop and low budgetary allocations to health resulted in lack of essential supplies for provision of care and manifested in non-availability and poor quality services.

Though modest, the revenues from user fees have formed an important source of discretionary expenditures in public health facilities. In its early phase, revenues from user fees accounted for up to 37% non-staff expenditures in provincial hospitals, and about 20% at lower hospitals, and 21% in health centres.

More recently, user fee revenues collected in public hospitals have increased, although in a modest way, and are helping to finance gaps in resource requirements in public health facilities. Within individual health facilities, user fee revenues are significant and form an important source of discretionary spending for O&M, and sometimes became an important source of expenditures for essential medical supplies because of both the under-allocation centrally for these items, and the inflexibility in the management of the MOH budget at the local levels (10/20 Policy Review Report, 2005).

Recent data on the programme show some growth in the amount of revenues collected and reported by MOH health facilities. Analysis done as part of the MPER-Health 2006 reported that these revenues accounted for up to 7.4% of MOH recurrent expenditures for 2005/06.

It appears that there is some role for user fees as a mechanism for health financing in Kenya. Realizing its full potential is curtailed, largely because of the lack of third party payment for the cost of waivers and exemptions instituted to protect and guarantee access by the needy. As a result, the fee levels were kept low, thereby undermining its revenue generating potential, and consequently its ability to support increased provision and availability of quality services.

The success or failure of the scheme in Kenya is a question for debate. As in all health systems, a system of paying for services – such as introducing user fees for health – regardless of the level of fees charged, has been a source of motivation for staff by bestowing them with discretionary expenditure decisions, as well as creating a mechanism for pricing of health services, which is a foundation for developing and expanding pre-payment schemes, i.e., health insurance, etc.[23]

National Social Health Insurance Fund

The MOH has increased its efforts to find an affordable, equitable, effective and efficient health financing system. In view of the stalled process of the NSHIF and in line with the vision 2030 of the Government, the MOH has established a working group which is developing a health financing strategy for the next decades.

Social Health Insurance is considered as one possibility but all other possible combination of financing systems are also reconsidered.

Presently, Kenya has the oldest social health insurance in sub-Saharan Africa The National Hospital Insurance Fund (NHIF) has been operating for more than 40 years and covers the formal sector against cost of admission treatment. While in previous years the benefits of NHIF were quite limited and members still had to pay considerable amounts for admission treatment, this has changed recently. Over the last 3–4 years, the services of NHIF have been improved drastically in order to make the impact of the insurance coverage felt to the members.

Meanwhile, NHIF is collecting contributions from its members up to the equivalent of 20% of the Health Ministries' recurrent budget allocation. Even so, the ratio between the revenue collected and the benefits paid for members' treatment is 40–50%, still far below international standards.

Among the issues to consider here are:

- NHIF contribution to the health sector not covered in MOH planning.
- Contributions from members of NHIF is not equitable as it comprises of fixed rates and not percentages.
- Surplus from NHIF used erratically to subsidize public health services.
- NHIF benefit ratio too low by all standards.
- Untapped capacity in NHIF for output based health financing, contracting especially with private sector and quality management/ improvement.

Other Financing Mechanisms

The MOH is further testing various tools for health care financing in order to learn from their impact on service provision, quality development and improvement of access. Alternative exemption mechanisms and identification tools for the poor are also piloted in various districts.

A so-called "output-based aid" (OBA) approach tries to establish the impact of a voucher system that provides the target group with access to reproductive health services. Identified poor women (target group) can purchase vouchers for family planning, antenatal care and delivery or gender

[23] World Bank, *Health Financing Revisited*, 2006.

based violence (e.g., rape) at a highly subsidized rate and request the services from selected accredited service providers. The hospitals, health centres and dispensaries receive the actual payment for the services from a financial management agent upon submission of the vouchers at a previously agreed rate.

All reports from the three districts and two urban slums in Nairobi where the programme has been operating for almost two years indicate that the utilization of reproductive health services by the target group has increased dramatically. Financial flow to both government and non-government health service providers is smooth and effective.

Furthermore, the MOH is testing a system of "social franchising" where selected private health service provider are supported and trained the provision of good quality long term contraceptive methods which in turn is provided at a subsidized rate.

Issues to consider in this approach include:

- OBA implementation still under Ministry of Planning.
- Results of revision of pilots not widely known.
- Limitation of pilots to reproductive health.

Improving the Allocative Efficiency

One of the objectives of the NHSSP II therefore is to reorient and focus public investments for health care provision to benefit the poor more by reallocation of resources towards promotive and preventive services, and basic health services. The MOH has made positive steps in reorienting its budget and expenditures to support the policy objectives of making the budgeting and financing of health care pro-poor.

As shown in tables 6.6 and 6.7, there has been a gradual reduction of the budget allocated to curative health as a proportion of the total MOH recurrent budget. The level reduced from 45.9% of actual expenditures in 2004/05 to 38.1% in 2005/06, representing a 20% reduction below the previous year expenditures.

Table 6.6: Trends in expenditures as percentage of total MOH budget

Function or service	2002/03 *Actual*	2003/04 *Actual*	2004/05 *Actual*	2005/06 *Actual*
Curative	50.8	48.5	45.9	38.1
Preventive/promotive	5.3	5.8	9	17.4
Rural health services	10.6	13	13.1	17.8
KNH	15.2	14.7	13.9	13
MTRH	2.7	2.8	2.4	2.6

Table 6.7: Distribution of MOH recurrent budget allocation by economic categories (percentage)

Categories	2004/05 Approved estimates	2005/06 Approved estimates	2006/07 Approved estimates
Salaries & wages	51.2	54.3	49.4
Grants	9.1		7.3
Drugs	11.3	11.5	15.2
O&M	10.1	10.7	11.9
KNH	15.2	14.9	13.4
MTRH	2.6	3.7	3.3

On the other hand, preventive and promotive services and rural health services have received increased allocations between 2004/05 and 2006/07 period. Similarly, allocations for drugs have increased to about 15% of the total MOH recurrent budget, up from 11% level in 2004/05.

Reallocation of resources by levels of care was another objective of NHSSP II. In particular, it was envisaged that more resources would be allocated to lower levels – levels 1 to 4 – consistent with the KEPH framework. Table 6.8 shows that District and rural health services have been allocated the largest share of the total resources, mainly human resources and infrastructure. Although the allocations for drugs and other supplies were concentrated at the national level, it reflects the centralized system of procurement of these items, rather than the fact that they are being consumed

Table 6.8: 2006/07 MOH budget (gross) disaggregated by levels (Ksh million)

Level	Salaries & wages	O&M	Drugs & supplies	Infra. & equipment	Grants & transfers	Total	% of total
Central/National	1,049.40	1,048.70	5,575.20	10	0	7,683.50	24.3
Provincial	2,796.10	198.8	256.9	230.5	0	3,482.40	11.0
District Health Services	5,940.90	1,066.70	564	980.2	0	8,552.00	27.0
Rural Health Services	759.8	697.4	1,958.90	2,408.40	0	5,824.50	18.4
KNH	0	0	0		2,858.00	2,858.00	9.0
MTRH	0	0	0		714	714	2.3
KMTC	0	0	0	60	592.7	652.7	2.1
KEMRI	0	0	0	624	852.2	1,476.20	4.7
KEMSA	0	119.8	114	108	0	341.8	1.1
Total	10,546.40	3,131.50	8,469.20	4,421.10	5,017.00	31,585.40	100.0

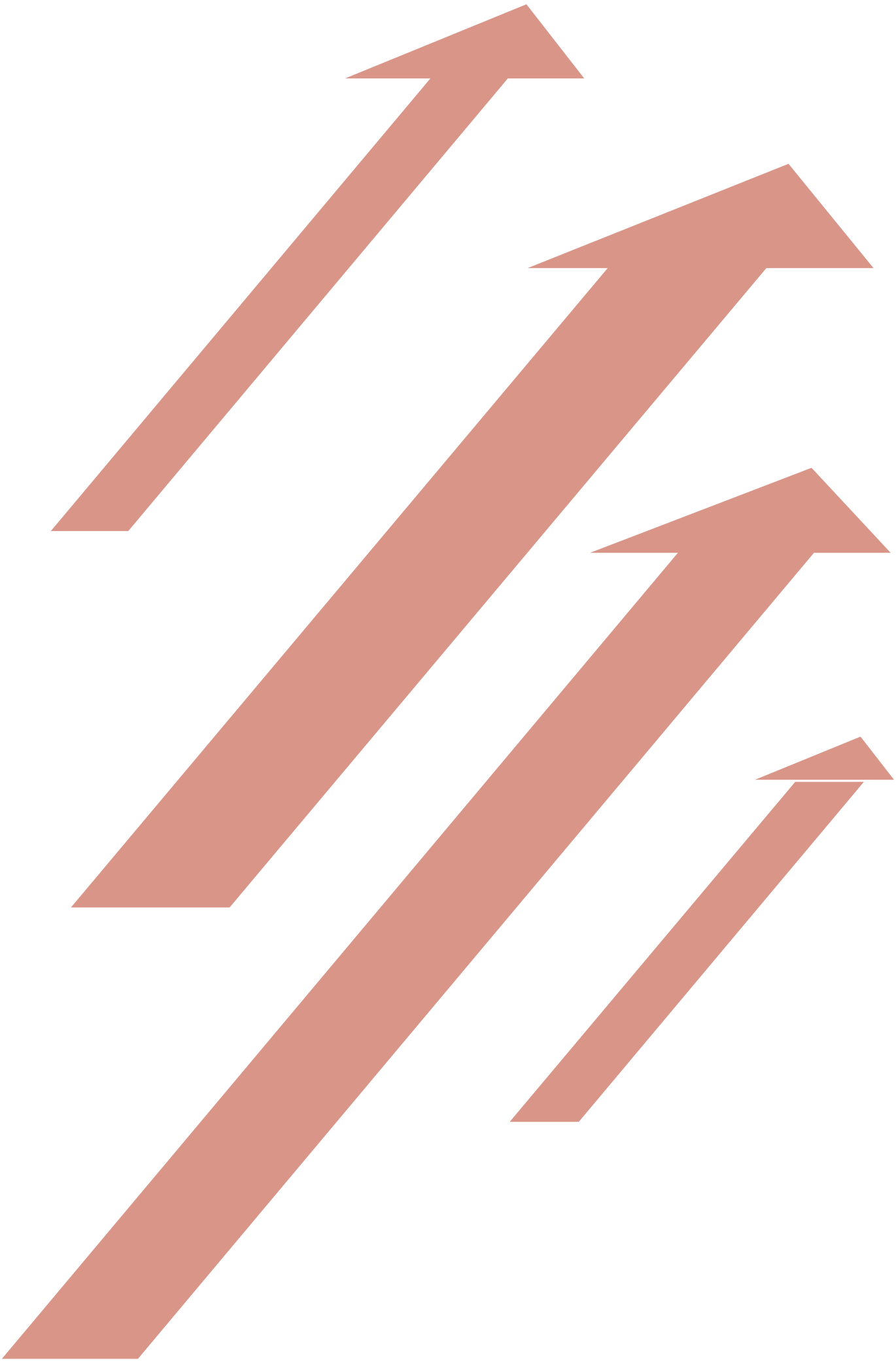
at the centre. It also reflects the fact that the central level still retains a lot of processing responsibility and power.

Recommendations to Improve the Financing of the Sector

In an atmosphere of high population growth, widespread poverty and diminished financial resources for health, greater attention needs to be given both to finding new sources of funds or ensuring the precision tuning of allocations of existing funds. Among others, the following steps are needed:

- Increase the level of health financing through improved lobbying for adherence of GOK budget projections and donor commitments.
- Improve budget management and explore mechanisms for efficient and equitable resource allocation and utilization.
- Finalize and implement a long-term health financing strategy.
- Review NHIF Act to adjust the benefit ratio to a minimum of 80%; limit administrative spending; mandate expansion of the benefit package to outpatient services; change the contribution to a percentage/ratio of salary instead of fixed rates; and regulate non-benefit payments/contributions to the health sector.
- Incorporate NHIF spending/income from NHIF reimbursement into financial planning of sector and health institutions.
- Plan for use of NHIF experience and capacity in contracting, payment of providers/ reimbursement for delivered KEPH services and quality management.
- Transfer OBA to Ministry of Health.

References



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