Republic of Kenya

Ministry of Health

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HEALTH SECTOR WORKING GROUP REPORT

MEDIUM TERM EXPENDITURE FRAMEWORK (MTEF) FOR THE PERIOD 2014-15 to 2016-17

Monday, 11 November 2013

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LIST OF ABBREVIATIONS

ACUs	AIDS Control Units
ADB	Africa Development Bank
AIA	Appropriations in Aid
BOPA	Budget Outlook Paper
CBOs	Community Based Organizations
CDC	Centre for Disease Control
CIDA	Canadian International Development Agency
DANIDA	Danish International Development Agency
DFID	Department for International Development
FBOs	Faith Based Organizations
GDP	Gross Domestic Product
GoK	Government of Kenya
HAT	HIV/AIDs Tribunal
ICT	Information and Communication Technology
JICA	Japanese International Corporation Agency
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographical Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Agency
KIPPRA	Kenya Institute of Public Policy Research and Analysis
KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
KNH	Kenyatta National Hospital
Kshs	Kenya Shillings
MDGs	Millennium Development Goals
MPER	Ministerial Public Expenditure Review
MTEF	Medium Term Expenditure Frame Work
MTP	Medium Term Plan
MTRH	Moi Teaching and Referral Hospital
NACC	National AIDS Control Council
NGOs	Non-Governmental Organizations
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan
PEPFAR	Presidential Emergency Plan for Aids Relief
R&D	Research and Development
SAGA	Semi-Autonomous Government Agency
SWAP	Sector Wide Approach
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAMRU	US Army Medical Research Unit
WB	World Bank
WHO	World Health Organization

Executive Summary

The Health Sector comprises of the Ministry of Health and eight SAGAs namely, Kenyatta National Hospital, Moi Teaching & Referral Hospital, Kenya Medical Research Institute, Kenya Medical Supplies Agency, Kenya Medical Training College, National Health Insurance Fund, National Aids Control Council and HIV & AIDS Tribunal.

The Medium Term Expenditure Framework (MTEF) for the period 2014/15 to 2016/17 the Health Sector is guided by the Second Medium Term Plan of Vision 2030, the Kenya Health Policy 2012-2030, the health Sector Strategic Plan and the Constitution of Kenya.

The Health Sector mandate is to promote and participate in the provision of integrated and high quality curative, preventive and rehabilitative services that is equitable, responsive, accessible and accountable to Kenyans.

Autonomous and Semi Autonomous Government Agencies

There are eight Semi Autonomous Government Agencies (SAGAs) under the Ministry of Health which complement it in discharging its core functions through specialized health service delivery; medical research and training; procurement and distribution of drugs; and financing through health insurance. These SAGAs are the Kenyatta National Hospital; Moi Teaching and Referral Hospital; Kenya Medical Training College; Kenya Medical Supplies Agency, Kenya Medical Research Institute, National Hospital Insurance Fund; National AIDS Control Council and the HIV&AIDS Equity Tribunal.

Expenditure review by programmes

Budgetary allocations for the Curative Programme increased by over 40 percent between the period 2010/11 and 2012/13 financial year from Kshs. 31.6 Billion to Kshs. 45.3 Billion respectively. The budget execution ranged between 80 per cent and 95 per cent with the actual expenditures of Kshs. 25.1 Billion in 2010/11, Kshs. 29.3 Billion in 2011/12 and Kshs. 43.1 Billion in 2012/13 financial years.

In the period 2010/11 to 2012/13, preventive health programme approved budget increased form Kshs. 26 Billion to Kshs. 42.5 Billion. On the other hand, actual expenditures more than doubled from Kshs. 17 Billion in 2010/11 to Kshs. 34.3 Billion in 2012/13 financial year.

Research & Development has continued to contribute immensely to the overall achievement of National and international health goals. Key achievements within the period include tremendous increase in development partner grants. Donor funding for KEMRI has increased from Kshs. 6,657 to Kshs. 7,982 a 19% increase over the last 3 financial years.

Prioritization of programmes and sub- programmes

The Health Sector has prioritized and ranked the programmes in order to efficiently utilize and maximize on benefits from the limited resources available to the sector. The ranking of the programmes is as follows:

1. Preventive and Promotive Health Care Services;
2. Curative Health Care Services
3. Research development & Training
4. General Administration, Planning & Support Services

Programmes and their objectives

The resource requirements of the Health Sector as captured under the three (3) programmes are guided by the sector policy commitments and the core mandates of the sub-sectors. These programmes are consistent with the strategic objectives of achieving the Kenya Vision 2030 and the Millennium Development Goals (MDGs).

The Vision 2030 has key flagship projects which the sector will execute. These projects are aimed at achieving accessibility, affordability of health services, and reduction of health inequalities and optimal utilization of health services. These resources will, therefore, target to improve access, quality and equity in the provision of health services.

Pending Bills

The sector had pending bills amounting to Kshs 6.457 Billion; a total of Kshs. 5.89 Billion was outstanding towards the end of the last financial year due to lack of liquidity. The Research and development owes the pension scheme a total of Kshs 567 million.

Allocation of Funds

As a consequence of applying the above mentioned principles, the sector will shift resources from low to high priority programmes as guided by the following criteria: Compulsory Expenditures; Existing Commitments and Ongoing Obligations; Operational Expenses; New Expenditures; and Reduction in non-priority Expenditures.

Cross sector linkages

The health sector interacts to various degrees with other sectors of the economy that contribute to its outputs/outcomes. These sectors include: Environmental Protection, Water and Natural Resources; Governance, Justice, Law and Order (GJLO); Public Administration and International Relations; Agriculture, Rural and Urban Development; Energy, Infrastructure and ICT; Education; General Economic and Commercial Affairs; National Security; and Social Protection, Culture and Recreation. Identification and harmonization of intra and inter sectoral linkages will be critical to ensure optimal utilization of limited resources.

Key among the emerging issues includes;

a. Devolution

Through the new Constitutional dispensation a two tier health service delivery system has been introduced whereby the national level deals with Health policy, National Referral Hospitals, Capacity Building and Technical Assistance to counties. On the other hand, the County Health Services will focus on County Health Facilities and Pharmacies, Ambulance Services; Promotion of Primary Health Care; licensing and control of selling of food in public places; veterinary services, cemeteries, funeral parlours and crematorium; referral removal; refuse dumps and solid waste. This scenario will need concerted efforts in restructuring

human resource management, infrastructure development and maintenance, health financing, donor funding and partnerships, among others.

Consequently relevant health sector laws, legislations, policies and regulation will be formulated to guide the devolution of health services and programme implementation.

b. Burden of Communicable and Non- Communicable diseases

Although significant progress towards containing the threat of communicable diseases has been made, the burden to the sector is still significant. This is at the backdrop of rising non-communicable diseases due to changes in life styles. Injuries (road traffic accidents) are also significant causes of death and disability. This combined double burden is projected to further increase, posing new challenges and pressure on the already fragile health care delivery system. The situation is further aggravated by the high cost of medical care for such cases and poverty (inability to pay for services rendered).

c. The Public Health Security and Bioterrorism Preparedness and Response

In the recent threats to disease outbreaks like Ebola and HN1virus and acts of terrorism have the potential of affecting health and loss of lives. These emerging trends call for additional resources allocation in order to contain, prepare and respond to such emergencies. This will entail policy and guidelines formulation, establishment of emergency centres in strategic locations in the country. To this end, Health Sector Disaster Management Policy should be developed, disseminated and implemented across the country by the two levels of governments. In addition strengthening intergovernmental consultative mechanisms to address national security threats will be given priority.

d. Quality of Health Care, Standards and Accreditation

The Constitution guarantees every Kenyan the highest attainable standards of health and the sectoral policies and guidelines must accordingly align to this requirement. The Ministry of Health has been spear-heading various initiatives to institutionalize quality management including the rolling out of Kenya Quality Model for Health (KQMS/H). These approaches need to be further strengthened in order to gradually elevate the health care systems to international levels.

Conclusions

- During the MTEF period under review, the performance of the health sector recorded mixed results although a number of systematic investment programmes were undertaken. Regarding health status, life expectancy increased from 55 years in 2009 to 62 years; Infant and Child mortality reduced from 77 per 1000 in 2003 to 56 per 1000 while maternal mortality ratio increased marginally from 414 per 100,000 births in 2003 to 488 per 100,00 births. On the other hand, HIV prevalence reduced from 7.2% in 2007 to 5.6% in 2012 and Malaria prevalence reduced from 38% in 2010 to 21% in 2012 countrywide. The positive gains could be attributed to programme interventions which were implemented.

- Despite the above gains, resource allocation to the sector stagnated at 4.6% of the National Budget falling far short of the requirements to meet the increasing demand and rising cost of health services. This situation is aggravated by the high population growth rate of 2.7% and fertility rate 4.7%. In addition, allocative inefficiency has been identified as one of the major causes of poor performance. During 2014/15 planning period the sector, plans to further deepen implementations of priority programmes aligned to MTPII. Efforts will be made to ensure progressive realization of rights to health as envisioned in the Constitution.

- The sector will continue to build capacities of county governments and provide the necessary technical support to enable counties effectively execute the functions assigned under the Fourth Schedule. In addition the sector will continue to strengthen the National referral hospital to be able to provide the critical backstopping to the counties with regards to specialized health services. All these National Government functions will require significant financial inputs.

- In implementing the sector priority programmes the sector will be guided by the health policy and the Medium Term Plan II.

- Although the proportion on budgetary allocation to the sector from the government's total budget has remained relatively constant at 4.5%, far below the Abuja targets of 15%, absolute terms show a steady rise. However, the per capita expenditure on health is currently at US$42 adequate to achieve MDGs. This discrepancy emphasizes the need to strengthen efficiency processes within the sector. Progress towards universal coverage is still far as the current coverage rate by NHIF stands at 5%. This needs to be increased to above 30% in the next MTEF period.

- Investment in improvement of infrastructure amounted to Kshs 7.4 billion in 2012/2103 including Kshs 5.6 billion from development partners. Priority areas where these were invested included Renal equipment for level 5 Hospitals, Ambulances for health facilities, Cancer Treatment equipment for KNH and rehabilitation of level 5 and 4 Hospitals[1].

- Adequate, motivated and equitably distributed human resources for health still remain a critical input for effective health care system. During the period under review 700 medical officers were recruited and the number of trainees admitted to KMTC increased 4,957 in 2009 to over 7,000 in 2012

- Service delivery in the health sector was improved over the period through strengthened referral system and communication across all levels of the healthcare, enhanced periodic supportive supervision to hospitals, and provision of human resources for health to faith based hospitals in order to complement government efforts and strengthened training in Health Systems.

- At the end of the financial year 2012/2013, the sector had pending bills amounting to Kshs 6,457 million.

- During the period under review the health sector maintained and strengthened partnerships mechanisms with all the health sector actors, the government, development partners and the implementing partners. The partnership mechanisms like Inter-agency

[1]Which are the hospitals

Coordinating Committees (ICC) continue to play an important role in programme policy formulation and implementation in curative, preventive, promotive health, social protection and research and development areas.

- The health sector will continue to strengthen inter sectoral linkages under the umbrella of social determinants to enhance achievement of health goals. The social determinants literacy levels, employment and poverty levels, globalization, urbanization and housing conditions, national security, environmental and occupational hazards, good infrastructure, fundamental human rights, promotion of health tourism among others.
- In the recent past threats to disease outbreaks like Ebola and HN1virus and acts of terrorism have the potential of disrupting health and more often loss of lives. This calls for additional resource allocation in order to support containment, preparation and response to such emergencies. In addition, new policy and guidelines will need to be formulated as well as establishment of emergency centres in strategic locations in the country. To this end, Health Sector Disaster Management Policy should be developed, disseminated and implemented across the country by the two levels of governments. Further, strengthening the intergovernmental consultative mechanisms to address national security threats will be given priority.

Recommendations

This MTEF review process brings to a close the specific analyses of the sector performance based on the two ministries with their constituent semi-autonomous government authorities. In addition, the creation of the two levels of government with clearly distinct functions as well as the establishment of the devolved governments will therefore greatly informed the recommendations regarding the issues to be addressed during the next planning period. This is due to the fact that health care delivery has substantively been devolved to the county governments.

In order to sustain the gains made and improve on the sector performance under the devolved system of government the following are the recommendations for consideration:

- The national government to support the counties in defining cost effective interventions for implementation at the county levels taking into consideration the national priorities as elaborated through flagship projects contained in the Medium Term Plan II and the Kenya Health Sector Strategic Plan, 2013-2017. This process should not compromise the county priorities outlined in the County Integrated Development Plans.
- The national and county governments to establish and strengthen mechanisms for consultation and collaboration with a view to progressively and effectively address the challenges of healthcare especially financing and human resources as well as *other health care issues* of national and county governments interest in order to accelerate realization of rights to health through universal health coverage. These will include implementation of joint programmes like free maternal services

- Strengthen the *capacity* of the health sector to anticipate, prepare, respond and contain national disasters, calamities and emergencies including bioterrorism by developing clear policies, strategies and enhancing additional funding for response. To this end, Health Sector Disaster Management Policy should be developed, disseminated and implemented.
- Strengthen the capacity of the national to effectively provide leading role in closely monitoring implementation of health programmes in consultation with the county governments with a view to learning lessons to inform development of strategies and guidelines critical for improvement of services. The monitoring framework to reflect not only service delivery outcomes but also budgetary allocation by county governments to the health sector.
- The national and county governments taking cognizance of the inadequate budgetary allocation from both national and county treasuries, the two levels of government must consider other alternatives of mobilizing additional resources including establishing systems and mechanisms for implementing health projects through Public private Partnerships
- At the national level, there is a need for continued effective coordination of health subsectors and the health SAGAs to leverage on their competitive advantage to facilitate rapid realization of the sector objectives during the 2013/14 to 2016/17 MTEF.
- In the financial year 2012/13 the sector reported pending bills amounting to Kshs 5,891 million, made up of Kshs 3,786 million for recurrent and Kshs 2,104million for development budget. These bills have remained pending primarily due to lack of provision or liquidity at National Treasury and delay in overall implementation of the budget due to stringent procedures on release of funds. It is therefore critical that the national and county governments agree on the modalities of addressing these liabilities during the transition period and putting systems and mechanisms to minimize recurrence.

In the recent past the country has witnessed the potential disease outbreaks like Ebola and HN1virus and acts of terrorism which lead to loss of lives. These emerging trends call for additional resources allocation in order to contain, prepare and respond to such emergencies. It is also important to formulate policies, and operational guidelines, and establish emergency centres in strategic locations in the country. To this end, Health Sector Disaster Management Policy should be developed, disseminated and implemented.

1 CHAPTER ONE: INTRODUCTION

This Health Sector Working Group (SWG) paper for MTEF period 2014/15-2016/17 presents an analysis of the Sector performance, achievements and the resource requirements for the period 2014/15-2016/17. The Health Sector comprises of the Ministry of Health and eight SAGAs namely, Kenyatta National Hospital, Moi Teaching & Referral Hospital, Kenya Medical Research Institute, Kenya Medical Supplies Agency, Kenya Medical Training College, National Health Insurance Fund, National Aids Control Council and HIV & AIDS Tribunal. The main purpose of the report is to provide policy makers, donor agencies and other stakeholders with information they need to make appropriate policies and funding decisions.

1.1 Background

The Medium Term Expenditure Framework (MTEF) for the period 2014/15 to 2016/17 the Health Sector is guided by the Second Medium Term Plan of Vision 2030, the Kenya Health Policy 2012-2030, the health Sector Strategic Plan and the Constitution of Kenya.

The Government long term economic blue print, Vision 2030 and its Second Medium Term Plan 2012-2017 has deliberately committed to undertake development processes aimed at making Kenya a globally competitive middle income country. Under the Social Pillar, the Government has committed to improve the quality of life for all Kenyans by ensuring Equitable, Affordable and Quality Health Care of the Highest Standard. In doing so the Health Sector has prioritized key projects that need to be implemented to support realization of the goal of the vision. The sector priority projects are:

1. Scale up of Community Health High Impact Interventions.
2. Enhance the capacity and improve access to referral systems.
3. Rehabilitation/upgrading of infrastructure and equipment for level 4 facilities.
4. Healthcare subsidies for social health protection.
5. Re-engineering Human Resource for Health
6. Establish and equip 58 facilities to e- health hubs both in the county and national facilities.
7. Mainstreaming research and development in health
8. Health and Medical tourism.
9. Enhancing uptake of locally derived natural health products into national healthcare.
10. Modernization of national referral hospitals.

Under the Constitution, Kenyans have the right to life and the highest attainable standard of health, which includes the right to quality health care services, reproductive health, emergency care, clean, safe and adequate water for all Kenyans, reasonable standards of sanitation, food of acceptable quality and a clean healthy environment.[2] The role of the national government is to provide stewardship in the formulation of health policies and strategic direction, setting standards, national referral services and provide leadership in research for health. On the other hand, the counties will progressively be responsible for the provision of healthcare services to the public. The proposed structure of the new County Health Services is to organize delivery around three levels of health care i.e.: (i) community level, (ii) primary care, and (iii) primary referral services.[3] Community level care refers to organizing health education and sensitization of the community, while primary care and

[2] Kenya Constitution 2010
[3] Implementation of the Constitution in the health sector, 2011

referral services refer to service provision through dispensaries, health centres', and maternity homes.[4]

In this regard significant resources will be required to support implementation of change management within the sector and specifically progressive improvement of counties to effectively provide equitable, affordable and quality health care. The general level of funding to public health sector has increased. However, the overall allocations (recurrent and development) have been on average accounted for 7 percent of total Government allocations, which is just about half of the Abuja target of 15%. It is important, therefore, that National Treasury provides adequate funds for health services delivery in line with Vision 2030 and MDGs.

1.2 Health Sector Vision and Mission

(a) Vision

"A globally competitive, healthy and productive nation."

(a) Mission

To deliberately build progressive, responsive and sustainable technologically-driven, evidence-based and client-centred health system for accelerated attainment of highest standard of health to all Kenyans.

Mandate

To deliberately build progressive, responsive and sustainable technologically-driven, evidence-based and client-centred health system for accelerated attainment of the highest standard of health to all Kenyans

1.3 Strategic goals and Objectives of the Sector

The following policy objectives aim towards the realization of the Health Sector Vision:

Eliminate communicable conditions: This is to be achieved through reducing the burden of communicable diseases, till they are not of major public health concern.

Halt, and reverse the rising burden of non-communicable conditions. This is to be achieved by ensuring clear strategies for implementation to address all the identified non communicable conditions in the country.

Reduce the burden of violence and injuries. This is to be achieved by directly putting in place specific strategies in collaboration with stakeholders in other sectors that address each of the causes of injuries and violence at the time.

Provide essential health care. These shall be medical services that are affordable, equitable, accessible and responsive to client needs.

Minimize exposure to health risk factors. This aims at strengthening the health promoting interventions, which address risk factors to health, plus facilitating use of products and services that lead to healthy behaviour in the population.

[4]There are three types of health facilities: hospitals, health centres and dispensaries (including mobile clinics), with the latter being largely the first contact for people seeking medical care. The rural poor rarely use hospitals and depend largely on health centers, dispensaries and mission facilities though hospitals also serve as primary healthcare institutions for many in the respective catchment areas (See Republic of Kenya, 2006).

Strengthen collaboration with other sectors. This aims to adopt a 'Health in all Policies' approach, which ensures the Health Sector interacts with and influences design implementation and monitoring processes in all health related sector actions.

1.4 Health Sector mandate

The Health Sector mandate is to promote and participate in the provision of integrated and high quality curative, preventive and rehabilitative services that is equitable, responsive, accessible and accountable to Kenyans.

1.5 Autonomous and Semi Autonomous Government Agencies

There are eight Semi Autonomous Government Agencies (SAGAs) under the Ministry of Health which complement it in discharging its core functions through specialized health service delivery; medical research and training; procurement and distribution of drugs; and financing through health insurance. These SAGAs are the Kenyatta National Hospital; Moi Teaching and Referral Hospital; Kenya Medical Training College; Kenya Medical Supplies Agency, Kenya Medical Research Institute, National Hospital Insurance Fund; National AIDS Control Council and the HIV&AIDS Equity Tribunal.

1.5.1 Kenyatta National Hospital

The Mandate of KNH is to receive and treat patients on referral for specialized care from other hospitals and health institutions within and outside Kenya; provide facilities for medical education for the University of Nairobi and for research by directly or indirectly cooperating with other health institutions within and outside Kenya; provide facilities for education and training in nursing and other health and allied professions and participate in national planning and policy formulation.

1.5.2 Moi Teaching and Referral Hospital

The mandate of MT&RH is to receive patients on referral from other hospitals and institutions within and outside the country for specialized health care; provide facilities for medical education for Moi University, and for research in collaboration with other health institutions; provide facilities for education and training in nursing and other health and allied professions.

1.5.3 Kenya Medical Training College

KMTC is mandated to provide facilities for education in health manpower personnel training; facilitate the development and expansion of opportunities for Kenyans for continuing education in various disciplines of medical training; provide consultancy and technical advice in health related training and research; empower health trainers with the capacity to conduct research, develop usable and relevant health learning materials, and manage health-related training institutions; and provide guidance and leadership for the establishment of constituent training centers and facilities.

1.5.4 Kenya Medical Supplies Agency

KEMSA is mandated to procure, offer for sale and supply medicine and medical supplies; establish warehouse facilities for storage, packaging and sale of medicine and medical supplies to health institutions; conduct analysis of medicine and medical supplies to

determine their suitability; advice consumers and health providers on cost effective use of medicine.

1.5.5 National Hospital Insurance Fund

The mandate of the NHIF is to provide accessible, affordable, sustainable and quality social health insurance through effective and efficient utilization of resources to the satisfaction of contributors. The core activities of NHIF include registering and receiving contributions; processing payments to the accredited health providers; carry out regular internal accreditation of health facilities and contracting health care providers as agents to facilitate the Health Insurance Scheme

1.5.6 Kenya Medical Research Institute

Mandate of KEMRI includes; conducting research aimed at providing solutions for the reduction of the infectious, parasitic and non-infectious diseases and other causes of ill-health in Kenya;

- To provide leadership in research for Health;
- To promote and sustain excellence in research for health;
- To strengthen principles of Good Corporate Governance;
- To disseminate and translate research findings for evidence-based policy formulation and implementation;
- To strengthen research partnerships and collaborations with other stakeholders.

1.5.7 National AIDS Control Council

NACC is a national coordinating authority for HIV and AIDS and her mandate includes: - Provision of policy and a strategic framework; Mobilization and coordination of resources; Prevention of HIV transmission; and Coordination of care and support for those infected and affected by HIV and AIDS.
The overriding mandate of NACC is to coordinate the multi-sectoral response to HIV and AIDS in Kenya as defined in the legal notice No. 170 of 1999. NACC is committed to provide the leadership and coordination that will ensure that the Kenyan Society is free from HIV and AIDS and its negative impact.

1.5.8 HIV&AIDS Equity Tribunal

The jurisdiction and mandate of the Tribunal is stipulated in Section 26 and 27 of The HIV&AIDS Prevention and Control Act. The law specifically provides for the Tribunal to have jurisdiction;

- To hear and determine complaints arising out of any breach of the provisions of this act,
- To hear and determine any matter or appeal as may be made to it pursuant to the provisions of this act and
- To perform such other functions as may be conferred upon it by this act or by any other written law being in force.

1.6 Role of Sector Stakeholders

The Health Sector has a wide range of stakeholders with interests in the operational processes and outcomes. Some of the stakeholders who play important roles in the Sector include the following:

(i) The National Treasury plays a major role as a stakeholder by providing the budgetary support for investments, operations and maintenance of the Sector's ministries besides the remuneration of all employees within the Sector;

(ii) The Ministry of Planning and Devolution plays a crucial role in coordination in planning, policy formulation and tracking of results in the sector. It also provides the relevant schemes of service for career development under the directorate of Public Service Management.

(iii) Development Partners play a critical role in providing financial support for various programmes within the sector;

(iv) Parliament, Universities, NGOs, FBOs in the Health Sector and the private sector also play crucial roles in augmenting sector funding ;

(v) County governments. The Counties will focus on County Health Facilities and Pharmacies, Ambulance Services; Promotion of primary Health Care; licensing and control selling of food in public places; veterinary services, cemeteries, funeral parlours and crematorium; referral removal; refuse dumps and solid waste.

(vi) Kenya National Bureau of Statistics (KNBS) and Kenya Institute of Public Policy Research and Analysis (KIPPRA); conduct surveys and provide information for planning purposes.

(vii) Other stakeholders are the Ministry of Environment, Water and Natural Resources, Ministry of Transport and Infrastructure and Ministry of Education.

(viii) International collaboration on matters of public health is a critical component in driving the process forward in prevention of diseases, sharing and partnering on public health best practices. Towards this effect Health Sector collaborates with WHO, CDC and other international bodies whose mandates is to contain, research, or disseminate findings on health matters. At local level the Sector collaborates with Public universities and research bodies in order to generate public health knowledge for benefit of the country. Other international key stakeholders in include UNICEF, UNFPA, DANIDA, GIZ, ADB, JICA, Italy, France, USAMRU (US Army Medical Research Unit)World Bank, among others.

(ix) Households, and communities have a role in resource mobilization and management of the sector programmes at all levels of care.

2 CHAPER TWO: PERFORMANCE EXPENDITURE REVIEW 2010/11 – 2012/13

This chapter examines performance expenditure review for the 2010/11 to 2012/13 period for the health sector. It provides an analysis of the resources that were allocated to the health sector from both the national treasury as well as Development Partners. Further, the section illustrates the budget execution of the financial resources.

2.1 Performance of Sector Programmes –delivery of outputs

2.1.1 Curative Programme

The curative programme is mandated to ensure availability of medical care and improve lives through responding to health care needs of the population in Kenya. It oversaw the operations of the National referral hospitals (Level IV), Provincial General Hospitals (Level V), and District and sub-district hospitals Level IV).
Kenya is likely to achieve some MDGs related to health[5]. Overall, most health indicators showed positive change, although there were some that still need more focus like Maternal Health. The following section provides details of achievements;

2.1.1.1 Health Care Financing:

Budgetary allocations for the Curative Programme increased by over 40 percent between the period 2010/11 and 2012/13 financial year from Kshs. 31.6 Billion to Kshs. 45.3 Billion respectively. The budget execution ranged between 80 per cent and 95 per cent with the actual expenditures of Kshs. 25.1 Billion in 2010/11, Kshs. 29.3 Billion in 2011/12 and Kshs. 43.1 Billion in 2012/13 financial years. A number of reforms and policy measures also been undertaken to address health financing which included:

i) In January 2012 the Government rolled out a comprehensive medical scheme for Civil Servants, teachers and the Police through the National Hospital Insurance Fund. In order to address some of the outstanding issues in the Draft Healthcare Financing Strategy, an independent review of the strategy was undertaken in March 2012. Review of the National Hospital Insurance Fund (NHIF) Act in order that the NHIF can play a leading role in social health insurance with a view to attaining universal health coverage;

ii) Total number of dependants plus members covered through National Hospital Insurance Fund (NHIF) increased from 4 Million in 2007 to 12.3 Million in 2012. NHIF has seen an increment in the informal sector membership from less than 0.2 million in 2005 to 0.8 million in 2012.

iii) User fees (cost-sharing revenue) continue to be an important source of financing health services in hospitals, especially in supplementing the operation and maintenance (O&M) funding. Cost-sharing revenue collections increased from Kshs. 3.17 Billion in 2010/11 to Kshs. 3.6 Billion in 2012/13 financial year. User fees are

[5] Republic of Kenya, MDG Report, 2012

intended to be an additional source of financing for operational expenses in hospitals to fill the gaps in recurrent expenditure.

2.1.1.2 Health Infrastructure

Overall, the programme implemented a total of 115 projects funded by the Government at an estimated cost of **KShs 1.8 billion** in the 2012/2013 financial year. In addition, eight major projects were implemented through funding from Development Partners at an estimated cost of **KShs 5.6 billion**. Further;

a) Referral facilities were equipped with renal equipment's (Coast PGH, Rift Valley PGH and Nyanza PGH)
b) KNH acquired an Endoscopy Machine at KShs 20.5 Million and a cancer equipment (Linear Accelerator) is being procured at a cost of Kshs. 300 Million.
c) The programmes upgraded 47 Level 4 and 5 hospitals and rehabilitated others to increase equity and access;
d) Supply of ambulances through N.H.I.F to six health facilities countrywide including fully equipped boat ambulances to Lamu and Kisumu counties

2.1.1.3 Health Workforce

The programme has strengthened its staff complement through recruitment of key health workers while other health workers were promoted under the implementation of the common cadre expansion exercise. In addition, the programme absorbs all the doctor interns into regular establishment upon completion of their internship, as has been the practice.

There was recruitment of over 700 doctors in the last year to ease the work load in health facilities as well recruitment of other cadres of staff. There was an increase of middle level trainees at Kenya Medical Training College from 4,957 in 2009 to 7,000 in 2012.

2.1.1.4 Service Delivery

A number of measures were undertaken to strengthen health service delivery system which included:

1) Strengthening the referral system and communication across all levels of the healthcare delivery system from dispensaries to the national referral hospitals in order to increase access to appropriate quality hospital referral services and provide for continuity of care;
2) Provincial General Hospitals and high workload district hospitals given more powers to manage their affairs as referral facilities.
3) Other reform efforts aimed at strengthening the referral systems were:
    i) Updated the National Referral Strategy
    ii) Reviewed norms and standards for service delivery at public hospitals;
    iii) Revised and distributed Referral guidelines and feedback tools to public hospitals;
4) Enhanced periodic supportive supervision to hospitals improved the environment and quality of services offered within the available financial resources;
5) Key human resources for health were provided to faith based hospitals to complement government efforts in the provision of health care service.
6) Health managers trained on health systems management and leadership.

7) Rural Health Facilities (RHFS) that were upgraded to hospitals during the period were prepared and placed on the pull system of Essential Medicines and Medical Supplies (EMMS).
8) Training in Health Systems strengthening has led to improved leadership and management of hospitals.

2.1.2 Preventive Programme

The mandate of the Preventive Programmes is to support the achievement of the highest attainable Public Health and Sanitation goals of the people of Kenya, with special focus on community (Level I); dispensary (level II), and Health Centers (Level III) structures.
In the period 2010/11 to 2012/13, preventive health programme approved budget increased form Kshs. 26 Billion to Kshs. 42.5 Billion. On the other hand, actual expenditures more than doubled from Kshs. 17 Billion in 2010/11 to Kshs. 34.3 Billion in 2012/13 financial year.
Over this period, most health indicators showed improvement, for instance child mortalities reduced, ARV uptake increased e.t.c. Though this, there were some indicators that did not improve. In-depth analyses of the indicators are shown below;

2.1.2.1 Reduction of Malaria prevalence

About 25 million Kenyans live in Malaria endemic regions of Western, Nyanza and Coast, with majority of them being under the age of 15. These regions have received increased malaria treatment and prevention intervention programmes over the period. Some of the interventions include; health education long lasting insecticide treated nets, use of Artemisinin Based Combination Therapies (ACTs) and use of indoor residual spraying. These interventions have resulted in reduction of prevalence from 38% in 2010 (KMIS) to 21% in 2012 in the Country (DHIS). However, regions of Western and Nyanza still have contributed to little or no changes in the period under review (between 37% and 47% (DHIS).

2.1.2.2 Construction of health Facilities and Recruitment of HRH

The period under review has seen major changes in the number of health facilities operationalized and new HRH employments. This has been accelerated through efficient use of the Economic Stimulus Programme (ESP) funds and the Constituency Development Funds (CDF). The number of health centers increased from 633 in 2010 to the current figure of 718. The number of Dispensaries has also increased from 2,858 to 3,100. In these facilities, a total of 43 ambulances were procured and delivered to cater for referral services.
During the period, a total of 5,998 HRH were recruited. This included 3,087 Nurses and 2,093 Community Health Extension Workers, 776 Public Health Officers (PHOs). It is noted that the increase in the number of health facilities and health workers will greatly boost the health sector in delivery of services.

2.1.2.3 Health Care Financing

Under the period, three projects were implemented with the intent of reducing burden of disease to the population. The projects were; Health Sector Service Fund (HSSF), Output Based Approach (OBA) and the Elimination of User Fees (including Free Maternity Services in levels 2 and 3 implemented in the last quarter of the FY 2012/13).

In total, the HSSF Project disbursed payments to public health facilities and district management teams in levels 2 and 3 amounting to KES 1.9 Billion from November 2010 to present, with a total of 718 health Centers and 2,291 dispensaries and 214 DHMTs.

The Output Based Approach (OBA), issued subsidized vouchers to 200,000 identified poor Expectant women in five Counties of Kiambu, Kisumu and Nairobi (Korogocho and Viwandani slums).Currently a total of 224,966 women have benefitted from safe motherhood services while 36,216 have benefitted from family planning services. During the period, the number of accredited facilities also increased from 58 to 154 in all levels (from level 2 to level 5). Total reimbursements to the facilities during the period amounted to KES 1.6 Billion. It has also been observed that facility-based deliveries amongst the beneficiary population (both basic and comprehensive), has increased from the national average of 43% to 78% during the review period.

After the March 2013 Presidential elections, user fees were abolished in all public health centers and dispensaries. In this regard, the Ministry disbursed a total of KES 100 Million to cushion the health centers and dispensaries after the exemption in the last Quarter of FY 2012/13.

2.1.2.4 Improved efficiency in procurement of goods and service

During the review period, the Ministry of Public Health introduced a demand driven 'PULL' system of distributing Essential Medicines and Medical Supplies (EMMS) to the Primary Health Facilities.

The distribution system allocates virtual 'Drawing Rights' dependent of a Resource Allocation Criteria (RAC) to the facilities, which relies on the facility workloads, catchment population and regional poverty indicators to allocate resources. This system allows the facilities to quantify and place orders for EMMS as per their need and dependent on the available 'drawing rights'. This is a major shift from the traditional 'PUSH' system of allocating EMMS, where the facilities were given standard 'KITS' independent of their needs. The PULL system is expected to reduce wastage and delays in procurement.

This system of distribution was introduced on a pilot basis in 2006 and from 2007 a gradual scale-up has been going on. Currently, all health centers and dispensaries are on the 'PULL' system.

2.1.2.5 Health Information Systems (HIS)

Collection and collation of Health information had been a major weakness in the health sector. Timely and accurate information is paramount for effective planning and decision making.

With this context, the Ministry commenced upgrading of the Health Information System to ensure accurate and consistent health information database.

The Ministry developed an online inventory of all health facilities in Kenya during the review period, detailing the type and ownership of the facility, services available in the facility and the Geo-code location of each facility. The inventory has been dubbed as the 'Master Facility List' and is envisaged to form the foundation of all health care services offered in the country.

The Ministry has also developed a modular web-based software package for reporting and analysis of health related indicators by the Districts. The system, known as the District Health

Information System (DHIS), was rolled out in the review period. Reporting by Districts through the system has improved to 251 Districts across the country. A national help desk team has also been established to provide emerging day-to-day requirements.

2.1.2.6 Governance and Leadership

The sector developed the following policy documents during the period under review to support the process:

Position Paper on Devolution
The Ministries of Health developed a Position Paper which addressed the issues raised in the constitution in health sector context.

Health Policy Framework (2012 - 2030);
Subsequently Kenya Health Policy 2012-2030 was developed; which outlines the country's long term aspirations in attaining the overall health goals. The Policy paper received Cabinet approved and subsequently translated into Draft Sessional Paper No. 6 of 2012 on the Kenya Health Policy, 2013-2030

Health Sector Strategic Plan;
The sector has also collaborated with relevant stakeholders to speed up the development of the National Health Strategic Plan III 2013 - 2017 in order to facilitate improved service delivery.

Developed Health Bill which was submitted to parliament, CIC and the AG. Regarding delinking, the ministry has completed and submitted to Transition Authority the Health Sector Function Assignment and Transfer Policy Paper.

2.1.2.7 Medium Term Plan 2013 – 2017

During the period under review, the Sector produced its second Medium Term Plan to cover the period 2013-2017. The MTP was based on the six policy objectives; eliminate communicable diseases, halt and reverse burden of Non communicable diseases, reduce the burden of violence and injuries, provide essential health care, minimize the exposure to health risk factors and strengthen collaboration with sector providers.

2.1.2.8 Health Sector Strategic Plan

Based on the National Health Sector policy and the Medium Term Plan (2013-2017), the sector has also collaborated with various stakeholders to produce the third National Health Sector Strategic Plan (NHSSP) 2012/13- 2016/17 in order to facilitate improved service delivery.

2.1.2.9 HIV and AIDS Prevention

National HIV prevalence declined from 7.2% to 5.6% of adults aged 15-64 years; age group 15-24 years prevalence has dropped from 3.8% to 2.1% and age 25-34 prevalence has dropped from 10.5% to 6.4% over the same period.[6]

[6] Republic of Kenya, KAIS Report

Awareness of HIV status among HIV infected persons aged between 15-64 years increased from 16% to 47 % in the period under review.

2.1.3 Research & Development

Research & Development has continued to contribute immensely to the overall achievement of National and international health goals. Key achievements within the period include tremendous increase in development partner grants. Donor funding for KEMRI has increased from Kshs. 6,657 Millions to Kshs. 7,982 Millions; a 19% increase over the last 3 financial years.

There are notable achievements in HIV prevention through multi-centre collaborative research that demonstrated use of ARVs as a method of prevention. The KEMRI scientists are also part of International group working on a promising malaria vaccine that has shown interim efficacy of over 50 percent in preventing malaria. The in-depth analyses of the achievements are presented below;

Programme Name	Planned Output	Achieved Output	Reason for variance
Research and Development Sub-Programmes: 1. Sexual, Reproductive and Child health 2. Infectious & Parasitic Diseases 3. Non-communicable Diseases 4. Public Health & Health Systems 5. Traditional Medicines & Drugs Development 6. Biotechnology 7. Grants Administration 8. REACH-PI-Knowledge Translation Platform 9. KASH 10. Planning, Monitoring &	Reduction in disease burden due to parasitic infections, particularly due to malaria, schistosomiasis, leishmaniasis, filariasis and intestinal parasites Reduction in disease burden due to infectious agents, in particular, due to HIV/AIDS and related infections, opportunistic infections, tuberculosis, sexually transmitted infections, viral hepatitis, acute respiratory infections. Define incidences and prevalence of diseases and health issues of major public health importance and develop strategies for promotion of better health. Health systems research, public health education, applied human nutrition, maternal and child health, reproductive health and population studies, behavioural studies, environmental, and occupational health fall under this programme. Strengthened research in modern biotechnology and innovations for application in the promotion of human health; and to promote research in non-communicable diseases including oncology, cardiovascular and renal diseases- To conduct basic,	1. Advising the Ministry of Health on rational use of drugs. Through the Institute's advice the malaria drug Daraprim was withdrawn from the market. Chloroquine was withdrawn as a first line drug in the treatment of malaria 2. Development of treatment regimens that have reduced the treatment period of leishmaniasis (Kalazar) from 30 days to 10 days. 3. Demonstrated the benefits of Insecticide Treated Bed nets (ITNs) for use in the control of malaria 4. Development of a strong network for health research collaboration, which has contributed immeasurably to health research capacity building in Kenya and the region. 5. International recognition in the promotion of global health research initiatives. KEMRI is a World Health Organisation (WHO) collaborating centre for HIV/AIDS, polio immunization viral haemorrhagic fevers, leishmaniasis, leprosy and antimicrobial resistance. It hosts several regional and global health research initiatives. 6. Development of treatment regimens that have reduced the treatment period for leprosy from 18 months to 1 month (which has almost eliminated leprosy in Kenya); tuberculosis (TB) from 18 months to 3 months 7. Development of various formulations for treatment of HIV/AIDS and opportunistic infections. 8. Establishment of P3 laboratory 9. Establishment of state-of-the –art laboratory for paediatric HIV diagnosis to support National HIV/AIDS prevention, treatment and Care Program 10. Development of capacity for HIV-Drug resistance testing 11. The development of national disease surveillance and rapid response capacity for major disease outbreaks. It is this capacity that has enabled the nation to	1. Inadequate funding 2. Lack of harmonized updated list of priority research areas 3. Weak partnerships, Collaboration and Coordination among stakeholders- Donors, Scientists, Policymakers and Decision makers 4. Individual competition Vs Institutional cooperation - `Conflict of interests 5. Weak Institutional, Policy and legal research framework 6. Outdated Legal framework- (for example, Research Act- CAP 250, State- corporations ACT) 7. Poorly-informed decision making, coupled with a lack of trust in research, 8. Weak knowledge translation mechanisms 9. Lack of research priority setting mechanisms

Programme Name	Planned Output	Achieved Output	Reason for variance
Evaluation	clinical, operational, implementation and applied research in all matters related to non communicable diseases Strengthened research with identified safe and effective traditional/alternative medicines and drugs for use against human diseases	respond quickly and effectively to yellow fever, rift valley fever and viral haemorrhagic fever outbreaks in Kenya. It is also this capacity that keeps outbreaks, including those for catastrophic diseases such as the Ebola, Marburg, SARS and others away from Kenya 12. Developed a comprehensive training module for HIV/AIDS education awareness at the workplace towards strengthening of HIV/AIDS information, education and communication control initiatives 13. Advice towards the rationalization and regulation of traditional medical practice in the modern health care delivery system in Kenya. This has also led to the identification of useful traditional medicines for asthma, epilepsy, diabetes, hypertension and malaria 14. Development of the KEMRI Hepcell kit for diagnosis of infectious hepatitis, the Particle Agglutination (PA) kit for the diagnosis of HIV and the HLA tissue typing techniques for kidney transplants 15. Establishment of the Nairobi Cancer Registry 16. Established effective Results-based M&E Framework 17. Timely feedback and use of information for planning	
Capacity building and Training	1. Adequate number of graduates with a high degree of professionalism, innovativeness and motivation. 2. Collaboration with local universities, to develop postgraduate training in all aspects of tropical medicine	1. Establishment in liaison with the Jomo Kenyatta University of Agriculture and Technology (JKUAT), of a Graduate School (the Institute of Tropical Medicine and Infectious Diseases – ITROMID) for Masters and Ph.D training in health sciences. 2. Establishment of two global centres for training in the control of parasitic and infectious diseases respectively, under the Government of Japan Hashimoto and Okinawa initiatives.	1. Lack of effective interpretation and implementation of the various MOUs and Partnership agreements 2. Lack of transparency in the operations of the Graduate School 3.

Programme Name	Planned Output	Achieved Output	Reason for variance
	and infectious diseases 3. Coordination of parasite control activities in the region. 4. Number of capacity building (training), operational research and networking sessions 5. Sufficient capacity build for control of parasitic diseases		
Products and services Sub-Programmes 1. Production Unit 2. Specialized Laboratories 3. Office of Health Safety & Environment	4. Production of diagnostic kits for enhancing blood safety 5. Production of disinfectants for enhancing Infection Prevention	1. Establishment of the Production Unit for diagnostic kits and Disinfectant 2. Production and supply of HIV1/2 Rapid testing kit KEMCOM, currently used in National Program for Blood Safety 3. Production and supply of the HEPCELL Kit for Hepatitis B & C testing, being used in National Blood Safety program 4. Production and supply TBCide a broad spectrum disinfectant currently used in National Institutions for cleaning contaminated surfaces	1. Lack of clear business plan for product development & management 2. Lack of clear policy on operations within the specialized laboratories 3. Lack of clear framework on the operations of the OHS&E 4. Poor marketing
Management and Administration Sub-Programmes 1. General Administration 2. ICT 3. Planning,	10. Strengthened framework for monitoring and evaluation on a continuous basis 11. Full exploitation of the potential of Information Communication Technology (ICT) in the development and management of health	1. Established effective Results-based M&E Framework 2. Timely feedback and use of information for planning 3. Established LAN within Nairobi Centres 4. Internet connectivity and email for all staff members 5. Set up a dedicated ICT Research support programme	1. Weak leadership & Governance from the Board of Management (BOM) and the Executive 2. Undue interference and micro-management of operations by the BOM 3. Lack of transparency and accountability

Programme Name	Planned Output	Achieved Output	Reason for variance
Monitoring & Evaluation 4. Human Resource Management 5. Maintenance & Engineering Department 6. Accounts & Finance 7. Corporate Affairs 8. Security & Integrity Affairs 9. Committees (Gender-Mainstreaming, Disability Mainstreaming, Corruption Eradication; Drugs & Substance abuse, HIV & AIDS Mainstreaming, Budget, Tender, Production, Rewards & Recognition)	research 12. Improvement and modernization of the Information Communication Technology (ICT) Infrastructure and services. 13. Strengthened systems for disseminating, translating and transmitting research findings for evidence-based policy formulation and implementation. 14. Number of synthesized and , packaged and communicated Research evidence required for policy and practice and for influencing policy relevant research agendas for improved population health and health equity 15. Improved people's health and health equity in East Africa through more effective use and application of knowledge to strengthen health policy and practice 16. Strengthened human resource capacity	6. Established Websites for all the major KEMRI centres 7. Promotion of dissemination and exchange of health research information through the establishment and support of the African Health Sciences Congress (AHSC) and the African Journal of Health Sciences (AJHS) 8. Successfully conducted National Study to Review existing Policy Documents and Identification of upcoming Priority National Health Policy issues in East African Community Partner States: Kenya country report: April to August 2008 9. Developed a critical mass of health research scientists, with 80 scientists with Ph.D degrees, 140 scientists with master's and bachelor's degrees and 250 highly trained and skilled technical staff 10. Development of a modern infrastructure, with highly sophisticated laboratories, for a wide range of health research investigations. These facilities have been developed by the Government of Kenya and also through bilateral assistance mainly by the Government of Japan, USA, UK and other governments and organizations. The total assets outlays were valued at over KES. 3 billion during the FY 2004 / 2005. 11. The distribution of KEMRI's research stations in different parts of the country has made it easy to achieve wide population coverage, and better understanding of geographic variations in disease conditions and health problems.	4. Lack of incentives for Scientists 5. Lack of clear policy on Human resource management- inconsistent recruitment, retention, reward and appraisal 6.

Programme Name	Planned Output	Achieved Output	Reason for variance
	17. Strengthened research infrastructure 18. Maintained Infrastructure 19. Co-operation with other organizations and institutions of higher learning in training programmes and on matters of relevant research. 20. Liaison with other relevant bodies within and outside Kenya carrying out research and related activities.		

2.2 Review of key indicators of sector performance

2.2.1 Curative Programme

Health Indicators:
During the review period health sector witnessed a glimpse of reversal of some the indicators especially the child health and communicable diseases. Sustained and concerted efforts could speed up efforts towards attainment of some of the Millennium Development Goals (MDGs). However, maternal and neonatal health indicators have remained poor as summarized here below:

1. During the MTEF review period, the sector has recorded success in scaling up access to anti-retroviral treatment where over 540,000 HIV positive patients enrolled for ARV treatment in 2012/13, up from 250,000 in 2008[7]. This was attributed to policy direction on free Antiretroviral treatment (ART) in public health facilities
2. In addition the sector reduced HIV prevalence among adults aged 15 to 64 years nationally from 7.2%, to 5.6% between 2007 and 2012[8].
3. To prevention of HIV transmission the sector undertook major campaigns on Voluntary Counseling and Testing (VCT). During the period under review the sector attained 72% of adults aged 15 to 64 years in 2012 reporting ever having been tested for HIV, up from 34% in 2007.
4. Tuberculosis case detection rate and treatment success rate are high at 80% and 85% respectively compared to the international targets of 70% (detection rate) and 85% (cure rate).
5. In an effort to increase skilled deliveries in the health facilities the Ministry of Health implemented several administrative interventions in major hospitals including reorganization of in-ward services and review of maternal deaths. These interventional are envisaged to indirectly contribute to reduction of maternal mortality ratios. Preliminary results indicate that the there is an increased proportion of mothers attending ANC translating into facility delivery (from 60% in 2009 to 90 in 212).

[7] Ministry of Health, NASCOP
[8] Republic of Kenya, KAIS report

The table below highlight some of the curative indicators reviewed during the period under review. From the table it is critical that hospital define more indicators especially focus in on quality and efficiency of services.

Sub Programme (SP)	Outputs	Performance Indicators	Progress and remarks
General Administration and Planning	**Output 1:** *Kenya Health policy 2012 – 2030 developed.*	Kenya Health Policy 2012 - 2030	Draft policy subjected to review by stakeholders including county governments.
	Output 2: *National Health Sector strategic plan 2012-2017 developed.*	*National Health Sector Strategic plan 2012-2017*	*Draft KHSSP 2012-2017 subjected to stakeholders including county governments*
Technical Support Services	**Output 1:**health facilities with adequate EMMS	Increased facility EMMS fill rates	Increased fill rates of EMMS from less than 50% to 75%
Hospital (Curative Health Services- As Above	**Output 1:***No of women delivered by skilled health personnel*	*deliveries by skilled health personnel increased to 47%*	*The Free Maternity healthcare Services rolled out countrywide*
	Output 3:*115 level 5 and 4 Hospitals rehabilitated.*	*Proportion of Hospitals rehabilitated*	*A total of 115 level 5 and 4 hospitals rehabilitated.*

2.2.2 Preventive programme

2.2.2.1 Status of key health indicators

1. Maternal mortality remained high at 488 per 100,000 live births in 2009 (KDHS), compared to 414 per 100,000 live births in 2003
2. Infant mortality levels improved from 77 deaths per 1,000 live births recorded in 2003 to 52 deaths per 1,000 live births in 2009 (KDHS)
3. Under five mortality rate declined by 36 percent from 115 deaths per 1,000 live births in 2003 to 74 deaths per 1,000 live births in 2009 (KDHS)
4. HIV prevalence in persons aged 15-49 years decreased from 7.4% in 2007 to 5.6% in 2012 (KAIS).

5. TB treatment success rates stands at 85% for new smear-positive pulmonary TB cases. While case detection rates (TB all forms) stands at 80%
6. Between 2003 and 2008/09, Insecticide Treated Nets use among pregnant women and children under 5 years increased tremendously from 5% to 49% and from 5% to 47% respectively

Under the preventative and promotive programme the following table highlights the sub-programmes, outputs indicators and progress.

Preventive Promotive Health Care Services: Reduced incidents of preventable diseases and ill-health			
Budgetary Provision 2010/11: Kshs 1,627,719,686	**Budgetary Provision 2011/12:** Kshs 1,609,046,931		**Budgetary Provision 2012/13:** Kshs 1,597,860,195 (million)
Managerial staff:	**Technical staff:**		**Support staff:** No
Sub Programme (SP)	**Outputs**	**Performance Indicators**	**Progress and remarks**
SP 1.1 General Administration and Planning	1. New Health Law	1. New Health Law 2.	1. The Health Law was submitted to the Attorney General's office but was returned for further consultations with stakeholders.
SP Preventive medicine and promotive health	1. Children Under 1 year fully Immunized 2. Mothers attending four (4) ANC visits 3. Pregnant women receiving LLITN's in endemic districts 4. TB cases treated 5. New TB cases detected Promotive health	1. % of children under 1 year fully immunized 2. % of mothers attending four (4) ANC visits 3. % of pregnant women receiving LLITN's in endemic districts 4. TB treatment completion rate 5. TB detection rate	1. The percentage of children under 1 year fully immunized stood at 85% 2. The percentage of mothers attending four (4) ANC visits stood at 32% 3. The percentage of pregnant women receiving LLITN's in endemic districts stood at 94.5% 4. TB Curative rate stood at 55.3% 5. Include

Budgetary Provision 2011/12: Kshs 3,355,332,229	**Budgetary Provision 2012/13:** Kshs 3,757,099,117	**Budgetary Provision 2012/13:** Kshs 642,803,945 (million)
Managerial staff:	**Technical staff:**	**Support staff:**
SP 1.3 Disease Control Services	1. Eligible pregnant women receiving preventive ARVs increased by 65%	1. % of eligible pregnant women receiving preventive ARVs	1. Percentage of mothers who were diagnosed with HIV at ANC and received either maternal or infant Anti-Retroviral Prophylaxis to prevent mother to child transmission stood at 90% (KAIS 2012)
SP 1.4 Primary Health Care Services	1. Eligible Public Health facilities receiving HSSF maintained at 100% 2. Commodities available at the health facility	1. Proportion of Public Health facilities receiving HSSF allocations 2. Drugs fill rates at primary health facilities.	1. The proportion of public health facilities receiving HSSF allocations was maintained at 100%. 2. The sector is yet carry out an analysis of stock out rates in public health centers and dispensaries
SP 1.5 Technical Support Services	1. National radioactive waste management facility	1. Radioactive waste management facility in place	1. The Ololua Radioactive Waste Management Facility is yet to be completed. Completion rate is at 80%

2.2.3 Research and Development Programme

Research and development is an essential ingredient of health service delivery. The table below summarizes the sub-programmes, outputs performance indicators and the progress made.

Sub Programme (SP)	Outputs	Performance Indicators	Progress and remarks
SP 1.1 *Research & development*	New research protocols Scientific Publications Reduction of disease burden	# of New proposals # of Publications # of innovations	Over 600 Publications in peer-reviewed journals Key highlights with strong collaboration led to key discoveries in HIV and Malaria prevention
SP 1.2 *Training & capacity building*	Improved skills and competence Provision of industrial attachment	# of Staff trained # of Students trained # of students on industrial attachment	Over 2000 students including staff and other persons received training. Provided industrial training for over 800 students
SP 1.3 *Products and Services*	Quality products & services	# Products # of clients served	Increased production of rapid test kits for HIV, Hepatitis and production of Kemrub®. Secured a Ksh 35 million tender to supply KEMSA. Continued offering early infant diagnosis of HIV
SP 1.4 *General Administration & Planning*	Ensure compliance with relevant legislation Service charter Performance contracting Ethical relevant research conducted	#Strategic plan #Performance Contracts signed #Annual operation plans # of proposals reviewed and approved by IRB	Increased donor support and improved direct foreign investment Stable governance and leadership has enabled improved outcomes Performance contracting & performance appraisal ensured equitable participation, reward and sanction Improved adherence to research ethics
SP 1.5 Capital *Project Implementation*	Completed relevant projects Completed repairs & maintenance	Timeliness, relevance, Completion rate	Completed the housing project. Completed the renovation of Kwale guest house. Commenced major automation works, such as ERP and VOIP

2.3 Expenditure Analysis

This Section analyses and reports the recent trends of budgeted funds and the actual expenditures over the past three years and the extent to which they are consistent with the health priorities. Specifically, it provides a detailed assessment of the budgetary allocations and actual expenditure of the sector during the FY 2010/2011 to 2012/13. In addition, the chapter analyses the ministry's budgetary absorptive capacity by comparing the budgeted expenditure (approved estimates) with the actual expenditure.

Expenditure can be broadly categorized into recurrent and development expenditure. Recurrent expenditure mostly comprises of expenditures on personnel emoluments, supply of Medical drugs and non-pharmaceuticals, goods and services (O&M). Development expenditure involves non-recurrent expenditure on physical assets and infrastructure.

The Ministry's has remained well below the 15% Abuja declaration. This to an extent is a pointer to the constrained budget status of the Ministry in the light of its mandate.

The dominant component of the Ministry's expenditure is Use of Goods and Services, where the core items Medical Commodities (Drugs, Non-pharmaceuticals, specialized medical equipment), and expansion of facilities. The increase in recurrent expenditure is attributed to government policy addressing harmonization of salaries to state parastatals, award of allowances (extraneous, risk, non-practising) to all medical personnel under the sector. Unforeseen emergencies (emergency relief operations as a result of terrorism, fire and accidents) adversely affect our operations hence increasing the number of person in need for relief assistant.

The high expenditure on Compensation of Employees confirms the high demand of staffing level in the Ministry. In addition the suppressed capital formation levels are attributed to the reactionary nature of the Ministry's operations leaving very little resources, if any, for development and capacity building to tackle disasters in the country. The Ministry expenditures have been rising significantly. In the financial year 2012/13 additional funds were allocated to mitigate against the poor state of our health facilities in terms of our infrastructure and equipment.

There is need therefore to rethink on the need to fund the health sector in order to come up with programmes aimed at increasing sustainable health care in the short-term and long - term to reduce the out-of-pocket expenditure on health.

Analysis of Expenditure: CURATIVE PROGRAMME (Gross in Millions)

The actual expenditures for the curative increased from 25 Billion in 2010/11 to 43 Billion in 2012/13 FY. This is against the Approved budget of Kshs 31.5 Billion to 45.3 Billion in the respective period. The recurrent budget provides for 91.5% of the overall budget whereas an 8.5% on development for the financial year 2012/13. This allocation is utilized towards payment of salaries, procurement of medical commodities, specialized procurements for diagnostic services, construction and rehabilitation of hospitals across the country amongst others.

CURATIVE HEALTH	Approved Estimates			Actual expenditure		
	2010/11	2011/12	2012/13	2010/11	2011/12	2012/13
Recurrent Budget	27,090	31,510	39,556	23,061	27,581	39,426
Development Budget	4,474	3,915	5,768	2,048	1,734	3,642
Total Expenditure	**31,564**	**35,425**	**45,324**	**25,109**	**29,315**	**43,068**

Analysis of Expenditure: PREVENTIVE PROGRAMME (Gross in Millions)

Preventive programme has improved its actual expenditures from 17 Billion to 34 billion in the Financial Years 2010/11 to 2012/13. The recurrent budget constitutes 48.2% of the overall budget whereas 51.8% on development expenditure for the financial year 2012/13. The increase is as a result of the government intervention to prevent communicable and non-communicable diseases. The increased allocation under development vote is as a result of development partners' involvement in the fight against HIV/AIDS through the global fund initiative and immunization programme through the Global Vaccine Alliance (GAVI).

	Approved Estimates			*Actual Expenditures*		
	2010/11	**2011/12**	**2012/13**	**2010/11**	**2011/12**	**2012/13**
1. Recurrent Budget	10,119	12,306	16,474	10,050	12,434	16,554
2.Development Budget	15,694	25,007	26,022	7,041	17,155	17,719
Total Expenditures	**25,813**	**37,313**	**42,496**	**17,090**	**29,589**	**34,274**

Analysis of Expenditure: RESEARCH & DEVELOPMENT PROGRAMME (Gross in Kshs. Millions)

Donor funding for KEMRI has increased from 6,657 Million to Kshs. 7,982 Million a 19% increase over the last 3 financial years. The proportion of donor funds as part of the overall KEMRI funds increased from 77% to 82% within the same period. The donor funds are expended as per the individual donor budget of our collaborators and partners. Thus the government need to allocate some funding for research.

Analysis of Expenditure: RESEARCH & DEVELOPMENT PROGRAMME (Gross in Millions)

	Revised Estimates			Actual Expenditure		
	2010/11	**2011/12**	**2012/13**	**2010/11**	**2011/12**	**2012/13**
Recurrent	1,200	1,213	1,213	1,136	1,175	1,283
Development	149	143	262	131	71	158
Donor Funding				5,158	6,645	6,506
Total	**1,349**	**1,356**	**1,475**	**6,294**	**7,820**	**7,789**

2.4 Analysis of programme expenditure by economic classification

Curative programme

Compensation to employees (personnel emoluments) accounted for 58% of the total expenditure during 2012/13 FY which is an increase from 50% in 2011/12 FY. However, in absolute terms, the Ministry's health spending on personnel emoluments has increased, but there is still a shortage of health workers. Despite the shortage, the other main challenge facing the Ministry is that staff distribution is not aligned to workloads. Majority of the health workers continue to be heavily concentrated in hospitals while health centers and dispensaries continue to be staffed well below the norms. This implies that the Ministry will continue to experience shortage of human resources which is still hampering service delivery.

Expenditure on goods and services (O&M), grants, transfers and subsidies and acquisition of non-financial assets accounted for 42 percent, 12 percent and 0.17 percent respectively in 2011/12 financial year. The table shows the breakdown of approved and actual expenditure on services by economic categories.

Analysis of Expenditure: CURATIVE PROGRAMME (Gross in Kshs. Millions)

VOTE	Approved Estimates			Actual expenditure		
	2010/11	2011/12	2012/13	2010/11	2011/12	2012/13
Recurrent Budget						
Compensation to employees	12,523	15,604	23,136	12,318	15,568	23,133
Use of Goods and Services	3,369	3,367	4,833	3,358	2,994	4,692
Grants , Transfers and Subsidies	11,152	12,494	11,539	7,350	8,997	11,554
Acquisition of Non-financial Assets	45	46	49	35	23	47
Total Recurrent Budget	**27,090**	**31,510**	**39,556**	**23,061**	**27,581**	**39,426**
Development Budget						
Compensation to employees	-		-	-	-	-
Use of Goods and Services	722	465	463	97	73	378
Grants , Transfers and Subsidies	340	390	1,545	328	290	733
Acquisition of Non-financial Assets	3,413	3,060	3,760	1,624	1,371	2,531
Total DEVT	**4,474**	**3,915**	**5,768**	**2,048**	**1,734**	**3,642**
Recurrent and Development						
Compensation to employees	12,523	15,604	23,136	12,318	15,567	23,133
Use of Goods and Services	4,091	3,831	5,296	3,454	3,067	5,069
Grants , Transfers and Subsidies	11,492	12,884	13,084	7,678	9,287	12,287
Acquisition of Non-financial Assets	3,458	3,107	3,808	1,658	1,394	2,578
Total Expenditure	**31,564**	**35,425**	**45,324**	**25,109**	**29,315**	**43,068**

PREVENTIVE PROGRAMME

The table below gives shows the preventive programme as per the economic classification. Personnel Emoluments accounted for 78% of the total expenditure during 2012/13 FY which is an increase from 66% in 2011/12 FY. The Ministry's health spending on personnel emoluments has increased despite the main challenge being staff distribution, harmonization of allowances among others.

Analysis of Expenditure: PREVENTIVE PROGRAMME (Gross in Kshs. Millions						
	Approved Estimates			***Actual Expenditures***		
	2010/11	**2011/12**	**2012/13**	**2010/11**	**2011/12**	**2012/13**
1. Recurrent Budget						
Compensation to Employees	6,724	8,229	12,083	4,824	8,243	12,084
Use of Goods and Services	1,958	2,642	2,946	3,799	2,714	2,899
Grants, Transfers and Subsidies	1,430	1,404	1,412	1,415	1,428	1,542
Acquisition of Non-Financial Assets	7	30	33	12	49	29
Total Recurrent	**10,119**	**12,306**	**16,474**	**10,050**	**12,434**	**16,554**
2.Development Budget						
Compensation to Employees	2,184	3,199	3,851	1,281	2,499	2,875
Use of Goods and Services	6,576	16,267	17,363	1,568	11,514	11,671
Grants, Transfers and Subsidies	1,357	2,577	2,470	677	1,717	1,691
Acquisition of Non-Financial Assets	5,577	2,964	2,338	3,515	1,424	1,482
Total Development	**15,694**	**25,007**	**26,022**	**7,041**	**17,155**	**17,719**
Total Expenditures	**25,813**	**37,313**	**42,496**	**17,090**	**29,589**	**34,274**

RESEARCH AND DEVELOPMENT

The institutes' actual expenditure include amount received from A-in A which is off the budget. Personnel emolument takes an average of 80% of the total recurrent budget. It is important to note that there is no funds allocated for health research which is the core mandated of the institute. This therefore, forces the institution to seek financial assistance from Development Partners.

Expenditure by economic classification

R & D	**Approved Estimates**			**Actual expenditure**		
Recurrent Budget	**2010/11**	**2011/12**	**2012/13**	**2010/11**	**2011/12**	**2012/13**
Compensation to employees	1200	1,213	1,213	1,104	1,000	931
Use of Goods and Services				309	313	321
Grants , Transfers and Subsidies				-	-	-
Acquisition of Non-financial Assets				4		
Social Security				95	74	97
Total				**1,512**	**1,387**	**1,349**

2.5 Analysis of capital projects by programme

The Ministry had various capital projects at various rates of completion, some of the projects have had lack of or insufficient funding hence leading to delays in their completion. Procurement bureaucracy coupled with legal issues has lead to project commencement being challenge.

2.5.1.1 Curative Programme

The table below shows projects being implemented by the curative programme with both GoK and donors revenues clearly showing contract costs and budget provisions for the financial years 2011/12 to 2012/13. Delays as mentioned above have made the projects move to the next financial year.

CAPITAL PROJECTS IN THE MINISTRY/DEPARTMENT/AGENCY		
PROJECT 1: Construction of Centre of Excellence at New Nyanza P.G.H		**Location: Kisumu**
Contract date:	**Contract Completion date:**	**Expected completion date:**
contract cost: **Kshs 200,000,000**	Expected final cost: **Kshs 126,069,459**	
Completion Stage 2011/12: (10%)	Completion Stage 2012/13 :(**50**%)	Completion Stage 2012/13
Budget Provision 2011/12: **Kshs 126,000,000**	Budget Provision 2012/13:Kshs **51,000,000**	Budget Provision 2012/2013: Kshs **51,000,000**
The project is in the Mid way but was scaled downwards after the Donor Baylor college of Medicine scaled down on its counterpart funding**.** This project is aimed at providing comprehensive paediatric care to children with HIV/AIDs		

PROJECT 2: Construction of Maternity ward at Tharaka District Hospital (KIDDP)		**Location: Miramanti, Tharaka Nithi**
Contract date: 26/07/2010	**Contract Completion date: 10/06/2013**	**Expected completion date:**
contract cost: **Kshs 20,202,331**	Expected final cost:	
Completion Stage 2011/12: (15%)	Completion Stage 2011/13 :(**85**%)	Completion Stage 2012/12 (**85**%)
Budget Provision 2011/12: Kshs. **15,700,000**	Budget Provision 2011/13:Kshs **4,502,331**	Budget Provision 2012/13: Kshs **4,502,331**
The project is complete pending handing over to the M.O.H and County Health officials. Land scapping and other allied civil works are complete		

PROJECT 3: Orthopaedic Technology Workshop at Moi Voi Hospital		**Location: Voi**
Contract date:	**Contract Completion date:**	**Expected completion date:**
contract cost**: Kshs 3,616,000**	Expected final cost: **Kshs 3,616,000**	
Completion Stage 2011/12: 100 %	Completion Stage 2012/13 :(**90**%)	Completion Stage 2012/13

Budget Provision 2011/12: **Kshs 3,616,000**	Budget Provision 2012/13:Ksh 1,600,000	Budget Provision 2012/13: Kshs 1,600,000
The project is complete, equipping and training/posting of staff in place. This project was co – funded by the Hilfe Kenea foundation from Spain		

PROJECT 4: Construction of an Operation Theatre at Nyamache District Hospital		**Location: Nyamache,Kisii**
Contract date:	**Contract Completion date:**	**Expected completion date:**
contract cost**: Kshs 20,200,000**	Expected final cost: **Kshs 20,200,000**	
Completion Stage 2011/12: 100%	Completion Stage 2012/13 :(**100**%)	Completion Stage 2012/13:(**100**%)
Budget Provision 2011/12: **Kshs 20,200,000**	Budget Provision 2012/13:Kshs 10,000,000	Budget Provision 2012/13: Kshs 10,000,000
The project is nearing completion and the Hospital is Expected to commence Medical/Specialised operations for its Catchment area.		

PROJECT 5: Improvement of Facilities at Othaya District Hospital		**Location: Othaya,Nyeri**
Contract date: 16/6/2010	**Contract Completion date: 5/04/2012**	**Expected completion date: 5/04/2012**
contract cost**: Kshs 501,745,917**	Expected final cost: **Kshs 501,745,917**	
Completion Stage 2011/12: (20%)	Completion Stage 2012/13 :(**90**%)	Completion Stage 2012/13 (**90**%)
Budget Provision 2011/12: Kshs 310,988,204	Budget Provision 2012/13:Kshs 177,000,000	Budget Provision 2012/13 Kshs 177,000,000
This project which consists of Two main blocks and Service Core areas is complete with additional Auxiliary works e g Public Parking, Ambulance parking and external drainage works being finalised.		

PROJECT 6: Construction of a Maternity ward and Erection of a Perimeter wall at Ahero Sub District Hospital (KIDDP)		**Location: Ahero, Kisumu County**
Contract date:26/06/2010	**Contract Completion date: 10/06/2013**	**Expected completion date:**
contract cost**: Kshs 36,000,000**	Expected final cost: **Kshs 36,000,000**	
Completion Stage 2011/12: (40%)	Completion Stage 2012/13 :(**100**%)	Completion Stage 2012/13 : **100**%
Budget Provision 2011/12:Kshs.18,500,000	Budget Provision 2012/13:Kshs 17,500,00	Budget Provision 2012/13: Kshs 17,500,00
The project is complete with an additional Drainage trench in view of Ahero being in a flood prone area.		

PROJECT 7: Strengthening & Equipping of 23 Hopitals across the country (Dutch Government.)		**Location: 17 counties**
Contract date:30/06/2009	**Contract Completion date: 30/03/2013**	**Expected completion date:**

contract cost**: Kshs 2,000,000,000**	Expected final cost: **Kshs 2,000,000,000**	
Completion Stage 2011/12: (40%)	Completion Stage 2012/13 :(**95**%)	Completion Stage 2012/13 (**95**%)
Budget Provision 2011/12: Ksh.700,000,000	Budget Provision 2012/13:Kshs 700,000,000	Budget Provision 2012/13: Kshs 700,000,000
The project was in Batches 1, 2, 3, and 4.The project is in its last batch 4 involves installation and equipping of the mentioned 23 hospitals. The aim of this project is to improve the provision of Health services in this Hospitals by Rehabilitating ,Expanding and Equipping them		

PROJECT 8: Improvement of Facilities at Wajir District Hospital		**Location: Wajir**
Contract date: 01/05/08	**Contract Completion date: 30/06/13**	**Expected completion date:**
contract cost**: Kshs 450,000,000**	Expected final cost: **Kshs 450,000,000**	
Completion Stage 2011/12: (5%)	Completion Stage 2012/13 :(**12**%)	Completion Stage 2012/13: (**12**%)
Budget Provision 2011/12:Kshs 200,000,000	Budget Provision 2012/13:Kshs 20,000,000	Budget Provision 2012/13 Kshs 20,000,000
The project which is aimed at making Wajir District Hospital into a referral facility for the region has been granted an extension of 3 year i.e. up to June 2017.The project is at Documentation/Consultancy stage e.g. Environmental impact assessment has been done.		

2.5.1.2 Preventive programme

The table below shows the 3 capital projects implemented by the programme in various locations. Project 1 shows the details of Kisumu lab block with an expected completion rate of 74% and the budgetary provisions till 2012/13. The 26% to completion has to be done in the subsequent financial years. The same case applies to the Oloolua project which is supposed to be implemented in 3 phases. The first phase is shown below.

Project 1; Construction of modern lab block

Contract Date	**Project Amount**	**Contract completion date**	30th June 2012	**Location**	Kisumu
Contract Cost	Kshs 56.3 million	**Expected final cost**	Kshs 133.7 million	**Expected completion date**	2014
Completion Stage 2010/11 (%)	_	**Completion stage 2011/12 (%)**	41%	**Completion stage 2012/13 (%)**	74%
Budget Provision 2010/11	Kshs 15 Million	**Budget provision 2011/12**	Kshs 20 million	**Budget provision 2012/13**	Kshs 20 million
Project justification. This project is aimed at testing DNA samples from Kisumu for the prevention and control of crime and other social factors					

Project 2; Construction of 201 model health centres

Contract Date	**Project Amount**	**Contract completion date**	Dec 2010	**Location**	Each constituency
Contract Cost	Kshs 3,240 million	**Expected final cost**	Kshs 6,215 million	**Expected completion date**	Dec 2012
Completion Stage 2010/11 (%)	50%	**Completion stage 2010/11 (%)**	91%	**Completion stage 2012/13 (%)**	99%
Budget Provision 2009/10	Kshs 208 Million	**Budget provision 2010/11**	Kshs 645 million	**Budget provision 2012/13**	Kshs 50 million
Project justification: The project is aimed accessing health care closer to the population					

Project 3; Ololua radioactive waste management complex

Contract Date	**Project Amount**	**completion date**	August 2013	**Location**	Nairobi
Contract Cost	Kshs. 518.5 million	**Expected final cost**	Kshs 518.5 million	**Expected completion date**	August 2013
Completion Stage 2010/11 (%)	50%	**Completion stage 2011/12 (%)**	70%	**Completion stage 2012/13 (%)**	83%
Budget Provision 2010/11	Kshs 100 Million	**Budget provision 2011/12**	Kshs 115 Million	**Budget provision 2012/13**	Kshs 115 Million
Project justification: This is a waste management facility that is aimed at reducing radioactive substances away from the environment and the people.					

2.3.3.2 Research and Development

S/No.	**Project Name**	**Project Details**		**2010/11**	**2011/12**	**2012/13**
1	Staff Housing	Contract Date	Jul-09			
		Contract cost	300 Million			
		Completion Stage %		73%	100%	
		Expected completion Stage				
		Budget Provision		109	83	
2	ICT Infrastructure and automation	Contract Date	Jul-10			
		Contract cost	295M			
		Completion Stage %		30	52	67
		Budget Provision		14	34	41
3	Laboratory Expansion (Busia)	Contract date	July 2012			
		Contract cost	220 M			
		Completion stage%				20%
		Budget provision		0	0	52
4	Foot Bridge	Contract Date	Jul-12			
		Contract cost	27 M			
		Completion Stage %				100
		Budget Provision				

Pending Bills

2.6 Recurrent Pending Bills

The table below shows pending bills for the recurrent vote in 2010/11 to 2012/13, the bills were mainly due to the suppliers, pension deficits and NSSF. Managing the pending bills in the ministry has been a problem in the last two years that is attributed to inadequate provision for resources and the reactionary nature of the ministry's operations in mitigating against disasters. At the end of the financial year 2012/2013, the sector had pending bills amounting to Kshs 6,457 million; a total of Kshs. 3,786 Billion was outstanding towards the end of the last financial year due to lack of liquidity. However, occasional savings within the budget allocations are utilized to pay off the outstanding bills.

The Research and development further owes the pension scheme a total of 567 million. The institute has therefore requested the government to bail it out by injecting a total of Kshs. 597,723,422 to save the staff pension scheme from total collapse.

	Due to lack of liquidity			**Due to lack of provision**		
Programme	**2010/11**	**2011/12**	**2012/13**	**2010/11**	**2011/12**	**2012/13**
Preventive	0.52	0	4.2	0.28	3.4	0
Curative	636	545	485	0	0	0
Research & Development	597	597	597	0	0	0
KNH	0		2,700	0	0	0
MTRH	0	0	0	0	0	0
SUB TOTALS	**1,233.52**	**1,142.00**	**3,786.20**	**0.28**	**3.40**	**-**

2.7 Development Pending Bills

The table below shows pending bills for the Development Vote in 2011/12, only curative programme had a pending bill of Kshs 2.104 Billion towards the end of the last financial year.

Development	**Due to lack of liquidity (Million)**			**Due to lack of provision (Million)**		
	2009/10	**2010/11**	**2012/13**	**2009/10**	**2010/11**	**2012/13**
Preventive Programme	1.150	0	0	0	0	0
Curative Programme	0	0	2.104	0	0	0
KNH	0	0	0	0	0	0
KEMRI	0	0	0	0	0	0
Research and Development	0	0	0	0	0	0
SUB TOTALS	**1.150**	**0**	**2.104**	**0**	**0**	**0**

The Health Sector has taken up various initiatives aimed at addressing the problem of pending bills. These proposed and or taken up initiatives include:

a) Decentralization of the health services to the county governments.
b) Procurement of medical commodities has been transferred to KEMSA;
c) Payment of electricity bills have been decentralised;
d) Introduction of prepaid telephone lines to health facilities
e) Disconnection of illegal water connections e.g. to staff quarters in health facilities; and
f) Treasury to finance 100 percent of the approved budget

RECOMMENDATIONS TO REDUCE PENDING BILLS

a) Further disbursements should be accompanied by implementation guidelines especially for RHFs;
b) The CHMB's should be enabled/empowered to oversee implementation of projects and detect omissions/mistakes early enough i.e. not leaving everything to the ministry of Roads and public works alone;
c) Processing of conditional grants and subsequent funds should be done within the 1st quarter of the financial year as this allows for proper planning/adequate consultation by the county government;
d) Recognizing and increasing the budget for operation and maintenance expenditures such as supplies, utilities, communication, etc. At present, approved budgets are not matched with timely release of exchequer funds by the Government;
e) A review of current procedures governing the release of voted funds is needed in order to avoid delays, and to facilitate overall improvement in the implementation of the budget.

3 CHAPER THREE - MEDIUM TERM PRIORITIES AND FINANCIAL PLAN FOR THE MTEF PERIOD 2014/15 - 2016/17

3.1 Prioritization of programmes and sub- programmes

The Health Sector has prioritized and ranked the programmes in order to efficiently utilize and maximize on benefits from the limited resources available to the sector. The ranking of the programmes is as follows:

5. **Preventive and Promotive Health Care Services;**
6. **Curative Health Care Services**
7. **Research development & Training**
8. **General Administration, Planning & Support Services**

3.1.1 Programmes and their objectives

The resource requirements of the Health Sector as captured under the four(4) programmes are guided by the sector policy commitments and the core mandates of the sub-sectors. These programmes are consistent with the strategic objectives of achieving the Kenya Vision 2030 and the Millennium Development Goals (MDGs).

The Vision 2030 has key flagship projects which the sector will execute. These projects are aimed at achieving accessibility, affordability of health services, and reduction of health inequalities and optimal utilization of health services. These resources will, therefore, target to improve access, quality and equity in the provision of health services,

Programme, sub-programmes and priorities for 2013-17

	Programme	Sub-Programmes	Specific Objective	Priorities 2013/14-16/17
			▪	▪
1.	**Preventive and Promotive Health Care Services**	▪ Communicable disease prevention ▪ Non-communicable disease prevention & control ▪ Family health ▪ National Public health laboratories & Government Chemist ▪ Environmental Health	▪ To increase access to quality and effective Promotive and Preventive health care services in the country ▪ To provide the essential health support systems necessary to execute the various health care interventions ▪ Eliminate Communicable Conditions ▪ Halt, and reverse the rising burden of non-communicable conditions	▪ Country wide Scale up of Community Health High Impact Intervention ▪ Develop and maintain a disease surveillance system and rapid response capacity to outbreaks in collaboration with MoH and other partners in the region.

	Programme	Sub-Programmes	Specific Objective	Priorities 2013/14-16/17
			▪ Reduce the burden of violence and injuries ▪ Minimize exposure to health risk factors	
			▪	▪
2.	**Curative Health Care Services**	▪ Curative & rehabilitative services ▪ Emergency & disaster management ▪ Forensic & medico-legal services ▪ Referral & Specialized services	▪ Improve the health status of the individual, family and community by ensuring affordable health care services ▪ Provide essential healthcare services ▪ To provide integrated and quality curative and rehabilitative services.	▪ Improve access to referral systems ▪ Modernize Kenyatta National Hospital ▪ Modernize Moi Teaching & Referral Hospital ▪ Exploit fully the potential of Information Communication Technology (ICT) in the development and management of healthcare services
				▪
3.	**Research, Development & Training**	• Capacity Building & Training ▪ Research & innovations ▪ Research Ethics, Standards & Regulation ▪ Products, Technologies and services	▪ To develop critical mass of human resource for health in preventive, curative, research and leadership aspects ▪ To provide stewardship and oversight on Research. ▪ To conduct research in human health and disseminate and translate research findings in health for evidence based policy formulation and implementation ▪ To collaborate with local universities to develop postgraduate training curricula in tropical medicine and infectious diseases graduates and produce postgraduates with	▪ Re-engineering human resource for health ▪ Mainstreaming research & development in health (National priority setting and identification of sustainable funding mechanisms; To establish and maintain a policymaker–targeted website architecture) ▪ Develop human resource capacity in health research and appropriate technologies. ▪ To develop human resource capacity in health and enforce standards and regulations ▪ Develop cadre of internationally recognized scientists capable of research leadership & excellence ▪ Health Products and Technologies ▪ Identification, documentation & translation of research findings into products &

	Programme	Sub-Programmes	Specific Objective	Priorities 2013/14-16/17
			high degree of professionalism, innovativeness and motivation. ▪ Promote industrial production of traditional medicines and the practice of traditional medicine. ▪ To produce pharmaceutical products, diagnostic kits for enhancing blood safety and disinfectants for enhancing Infection Prevention	technologies
		•	▪	•
4	**General Administration, Planning & Support Services**	• Health Policy, Planning & Financing • Health Standards, Quality Assurance & Standards • National Quality Control Laboratories • Human Resource Management • General Administration	▪ To strengthen leadership, management and administration in the sector for improved efficiency & effectiveness in programme prioritization, design, implementation, Monitoring & evaluation ▪ Strengthen collaboration with health related sectors ▪ Strengthen the framework for monitoring and evaluation on a continuous basis.	• Health care subsidies for social health protection • Construct Model level 4 Hospitals • Establish e-health hubs in 58 health facilities • Health and Medical tourism • Locally derived natural health products • Establish a designated research & Development liaison office to improve interfacing between KEMRI, MoH, relevant Ministries, Communities, WHO Country Office and other relevant organizations. • Develop an epidemic intelligence system and maintain a comprehensive database on epidemics.

3.1.2 Programmes and sub-programmes, Expected Outcomes, Outputs and Key Performance Indicators for the sector

Programmes, and key performance indicators

	Programme	Sub-Programmes	Specific Objective	Priorities 2013/14-16/17	Outcomes/Outputs	Key Performance Indicators
1.	**Preventive and Promotive Health Care Services**	▪ Communicable disease prevention ▪ Non-communicable disease prevention & control ▪ Family health ▪ National Public health laboratories & Government Chemist ▪ Environmental Health	▪ To increase access to quality and effective Promotive and Preventive health care services in the country ▪ To provide the essential health support systems necessary to execute the various health care interventions ▪ Eliminate Communicable Conditions ▪ Halt, and reverse the rising burden of non communicable conditions ▪ Reduce the burden of violence and injuries ▪ Minimize exposure to health risk factors	▪ Country wide Scale up of Community Health High Impact Intervention ▪ Develop and maintain a disease surveillance system and rapid response capacity to outbreaks in collaboration with MoH and other partners in the region.	▪ Improved access to level 1 services ▪ Improved Health status for expectant women, newborns and children ▪ Improved health status of WRA ▪ Zero HIV transmissions	▪ % of functional community units ▪ % of newborns with low birth weight ▪ % under 5's stunted ▪ % under 5 underweight ▪ % of women of Reproductive age receiving family planning ▪ Number of HIV transmissions ▪ % of LLITNs distributed
2.	**Curative Health Care Services**	▪ Curative & rehabilitative services ▪ Emergency & disaster management ▪ Forensic & medico-legal services ▪ Referral & Specialized services	▪ Improve the health status of the individual, family and community by ensuring affordable health care services ▪ Provide essential healthcare services ▪ To provide integrated and quality curative and rehabilitative services.	▪ Improve access to referral systems ▪ Modernize Kenyatta National Hospital ▪ Modernize Moi Teaching & Referral Hospital ▪ Exploit fully the potential of Information Communication Technology (ICT) in the development and management of healthcare services	▪ Country-wide framework of referral systems ▪ Improved access to emergency services	▪ % deliveries conducted by skilled attendant ▪ % of facility based maternal deaths (per 100,000 live births) ▪ % of facility based under five deaths (per 1,000 under 5 outpatients) ▪ # of institutional framework established.

						▪ # policies and pieces of legislation adopted. ▪ % of referred clients reaching referral unit ▪ # of ambulances procured. ▪ # of communication devices procured
3.	**Research, Development & Training**	• Capacity Building & Training ▪ Research & innovations ▪ Research Ethics, Standards & Regulation ▪ Products, Technologies and services	▪ To develop critical mass of human resource for health in preventive, curative, research and leadership aspects ▪ To provide stewardship and oversight on Research. ▪ To conduct research in human health and disseminate and translate research findings in health for evidence based policy formulation and implementation ▪ To collaborate with local universities to develop postgraduate training curricula in tropical medicine and infectious diseases graduates and produce postgraduates with high degree of professionalism, innovativeness and motivation.	▪ Promote industrial production of traditional medicines and the practice of traditional medicine. ▪ To produce pharmaceutical products, diagnostic kits for enhancing blood safety and disinfectants for enhancing Infection Prevention ▪ Re-engineering human resource for health ▪ Mainstreaming research & development in health (National priority setting and identification of sustainable funding mechanisms; To establish and maintain a policymaker–targeted website architecture) ▪ Develop human resource capacity in health research and appropriate technologies.	▪ Improved Evidence based policies and decision making ▪ Highly skilled human resource for addressing national health issues ▪ Appropriate technologies, products and utility models for improved service delivery	No. of staff trained in new technologies No. of new technologies introduced Increased use of new technologies # of trainees Type of trainings # of cadres trained No. of scientific publication No. of policies formulated No. of synthesis workshop No. of research findings implemented No. of policy guidelines adopted and launched No. of products and technologies

				▪ To develop human resource capacity in health and enforce standards and regulations ▪ Develop cadre of internationally recognized scientists capable of research leadership & excellence ▪ Health Products and Technologies ▪ Identification, documentation & translation of research findings into products & technologies		
4	**General Administration, Planning & Support Services**	• Health Policy, Planning & Financing • Health Standards, Quality Assurance & Standards • National Quality Control Laboratories • Human Resource Management • General Administration	▪ To strengthen leadership, management and administration in the sector for improved efficiency & effectiveness in programme prioritization, design, implementation, Monitoring & evaluation ▪ Strengthen collaboration with health related sectors ▪ Strengthen the framework for monitoring and evaluation on a continuous basis.	• Health care subsidies for social health protection • Construct Model level 4 Hospitals • Establish e-health hubs in 58 health facilities • Health and Medical tourism • Locally derived natural health products • Establish a designated research & Development liaison office to improve interfacing between KEMRI, MoH, relevant Ministries, Communities,	• Improved access to comprehensive health services • Efficient and effective system for mobilization and dispensation of services • Improved quality services • Reduction of the No. of those seeking treatment outside the country. • Regulatory framework for certification of locally	% of facilities equipped as per norms # of facilities per 10,000 population # of facilities Rehabilitated. Institutional framework established # Functional e-hubs established # of patients seeking specialized treatment local # of facilities fully expanded to provide

				WHO Country Office and other relevant organizations. • Develop regulatory guidelines to allow registration of natural health products of acceptable standards. • Develop an epidemic intelligence system and maintain a comprehensive database on epidemics.	derived value-added natural health products	specialized treatment # of pieces of legislations enacted to support uptake of locally derived products.

3.1.3 Programmes by order of ranking

1. Preventive and Promotive Health Care Services;
2. Curative Health Care Services
3. Research, Development & Training
4. General Administration, Planning & Support Services

3.1.4 Criteria for prioritization

As per treasury guidelines, a prioritization criteria was developed, presented and accepted by the sector before the prioritization process. The process of prioritization further took into consideration the current configuration of the Ministry of Health into 5 directorates namely:-

1. Preventive & Promotive services
2. Clinical services
3. Health Policy, Planning & Financing
4. Health Standards, Quality Assurance & Standards
5. National Quality Control Laboratories

New additional 2013 Criteria

1. Aligned to MTP II of Kenya Vision 2030
2. Constitution of Kenya-applicable legal, institutional and policy framework as well as devolution & other policy statements
3. National Government Policies & Guidelines
4. Aligned to Sector Strategic Plan
5. Strategic plans for SAGAs in the Sector
6. On-going projects & new Government Initiatives
7. Core poverty programmes
8. Leadership, Governance, Stewardship, & Oversight
9. International Goals & Development Agenda
10. Emerging & re-emerging health issues (emergency preparedness, response and mitigation, Disease Surveillance, Outbreak Investigations & response)

Previous 2008 Criteria

(Ref. Treasury Circular 25th November 2008 (**Ref: ES 1/03 TREASURY CIRCULAR NO.)**

1 **Linkage of the programme/sub programme with Vision 2030 Objectives;** the programme is consistent with the strategic objectives for achieving the Vision 2030 and is directly linked to one or more of the Vision 2030 objectives or flagship project.

2 **Degree of addressing Core Poverty; programme/sub programme** is a direct intervention to core poverty reduction as outlined in the criteria for selection of core poverty interventions.

3 **Degree to which the programme/sub programme is addressing the objectives of the Sector/ Core mandate of the Ministry/department;** programme is consistent with the strategic objectives of the Sector or Core mandate of the Ministry/department.

4 **Expected output or results from a programme/sub programme;** the programme demonstrates its ability to achieve the Vision 2030 strategic objectives through the expected output.

5 **Linkage with other Programmes; programme/sub programme** has direct linkages (forward and backward) with other programmes

6 **Sustainability of the programme; programme/sub programme** demonstrates high level of sustainability. Among the factors considered include, human capacity, future costs of implementation and source of funding.

7 **Cost Effectiveness;** The **programme/sub programme** is the most cost effective in comparison with the other competing programmes i.e. the programme is able to achieve *the intended objectives at minimum cost possible*.

Scoring Method

- All the above 7 criteria carry an equal score of 1 mark.
- A programme that meets the above 7 criteria scores 7 marks
- Degree to which the programme meets criteria is awarded 0.25, 0.5, 0.75 or 1 marks

3.1.5 Table showing Programme ranking

Programme	**Criteria as discussed above**							**Score**	**Ranking**
	Linkage of programme to Vision 2030 objectives	Degree of addressing core poverty issues	**Degree to which the programme is addressing the objectives of the Sector/ Core mandate of the Ministry/department**	**Expected output or results from a programme**; The programme should demonstrate its ability to achieve the Vision 2030 strategic objectives	**Linkage with other Programmes**	**Sustainability of the programme**	**Cost Effectiveness**		
1. Preventive & Promotive	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7	High
2. Curative	Yes	Yes	Yes	Yes	Yes	Yes	No	6	High
3. Research & Training	Yes	Yes	Yes	Yes	Yes	No	No	5	Medium
4. Administration & Planning	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7	High

Yes = 1; No = 0

MTP II Health Sector Flagships 2013-17

- Country wide Scale up of Community Health High Impact Interventions
- Improve access to referral systems
- Construct Model level 4 Hospitals
- Health care subsidies for social health protection
- Re-engineering human resource for health
- Health Products and Technologies
- Establish e-health hubs in 58 health facilities
- Mainstreaming research and development in health

Flagships Projects to be implemented through Public Private Partnership (PPP) approach include;

- Health and Medical tourism
- Locally Derived Natural Health Products: This will be achieved through refining existing regulatory guidelines to allow registration of natural health products of acceptable varying standards of processing.
- Modernize Kenyatta National Hospital: This will entail implementation of the ICT master plan, and constructing and equipping a fully-fledged 300 bed private wing, 2,000 accommodation units and conference facilities for health tourism.
- Modernize Moi Teaching and Referral Hospital: This will entail developing Cancer Management Centre, constructing a children hospital and modernization of infrastructure and hospital equipment.

3.1.6 Allocation of Funds

As a consequence of applying the above mentioned principles, the sector will shift resources from low to high priority programmes as guided by the following criteria:

- **Compulsory Expenditures** – These are expenditures that sectors may not have the discretion to trade off. These expenditures form the first charge in a programme and may include salaries and standing commitments such as contributions to international organizations;
- **Existing Commitments and Ongoing Obligations** – These are obligations previously entered into by the implementing agencies and may not therefore be postponed. Examples of such expenditures include payment of rent, commitments for Free maternity services, Free Primary and Secondary Education, commitments for Orphans and Vulnerable Children; purchase of drugs e.t.c. Commitments made on low priority expenditures will need re-evaluation for relevance and cost and should be weeded out of the budget.
- **Operational Expenses** – These are expenditures that enable the delivery of service. On the basis of the classification of programmes, these expenses should be critically evaluated with a view to making savings which can be shifted to new and existing high priority programmes
- **New Expenditures** – These will constitute of any extra funding or efficiency savings realized from the Sector. Such resources should only be considered to fund high priority programmes such as emergency, and disaster preparedness and response. No low priority programmes should be considered for new funding.
- **Reduction in non-priority Expenditures**- On overall all medium, low and very low priority programmes should surrender at least 10%, 20% and 30% respectively of their 202/13 allocation less the one-off expenditures. This surrender should increase progressively over the medium term with a view of weeding out the low and very low priority programmes from the budget.

3.2 Analysis of Resource Requirement versus allocation

Table below illustrates the sector resource requirements for 2014/15 and current allocation in (Kshs. Millions)

PROGRAMME	RESOURCE REQUIREMENTS	RESOURCE ALLOCATION	PROJECTED ESTIMATES	
RECURRENT	**2014/15**	**2014/15**	**2015/16**	**2016/17**
Preventive and Promotive Health	10,822	**624**	13,318	13,935
Curative Health	30,292	**11,075**	28,984	30,267
General Administration and Support Services	2,531	**2,028**	2,629	2,715
Research and Development	9,443	**3,939**	10,175	11,026
Total	**53,088**	**17,666**	**55,106**	**57,943**
DEVELOPMENT	**RESOURCE REQUIREMENTS**	**RESOURCE ALLOCATION**	**PROJECTED ESTIMATES**	
	2014/15	**2014/15**	**2015/16**	**2016/17**
Preventive and Promotive Health	9,507	**349**	9,803	10,100
Curative Health	3,344	**596**	3,448	3,553
General Administration and Support Services	14	**50**	15	15
Research and Development	687	**360**	650	566
Total	**13,552**	**1,355**	**13,916**	**14,234**

Sector (recurrent and Development)

The budget for the Heath Sector is based on the Four programmes. The programmes presented for the resource bidding process are Preventive, Curative, General Administration and Research & Development. This is predicted on the need to control factors that lead to ill health in the country; including the need for accessible, quality, efficient and effective public health care system. The sector requirement for the FY 2014/2015 is Kshs **66,640** million and their justifications are as provided below;

Sector requirement for both recurrent & development FY 2014/15 – 2016/17(Kshs. Millions)

		Estimates		Projected	
No.	**Recurrent**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
1	General Administration and Planning	1,422	2,531	2,629	2,715
2	Preventive	1,970	10,822	13,318	13,935
3	Curative	15,428	30,292	28,984	30,267
4	R&D	4,180	9,443	10,175	11,026
	Total Recurrent	**23,000**	**53,088**	**55,105**	**57,942**
	Development	**2013/14**	**2014/15**	**2015/16**	**2016/17**
1	General Administration and Planning	13	14	15	15
2	Preventive	4,944	9,507	9,803	10,100
3	Curative	1,739	3,344	3,448	3,553
4	R&D	310	687	650	566
Total Development		**7,006**	**13,552**	**13,916**	**14,234**
Grand Total		**30,006**	**66,640**	**69,021**	**72,176**

Sector (recurrent and Development)

The Sector's resource requirements in the medium term are guided by the sector policy commitments as broadly articulated in the Vision 2030 and more specifically in the Second Medium Term Plan (2012 – 2017) while ensuring alignment of the Health Sector policies. The following table shows sub-sector resource requirements for both recurrent and development for the FY 2014/15.

Sector requirement for both Recurrent and Development FY 2014/15 – 2015/16 (Kshs. Millions)

		Estimates		Projected	
1	General Administration and Planning	1,435	2,545	2,643	2,730
2	Preventive	6,452	17,479	21,037	22,006
3	Curative	17,167	33,636	32,432	33,819
4	R&D	4,952	12,980	12,909	13,621
	Total Sector Budget	**30,006**	**66,640**	**69,021**	**72,176**

Programmes and sub-programmes

The total health sector requirement for is Kshs 66.6 Billion, Kshs 69 Billion and Kshs 72.1 Billion for the 2014/15, 2015/16 and 2016/17 respectively.

Table: Programme and Sub- programme requirement for FY 2014/15 – 2016/17 (Kshs. Millions)

Programme		Estimates		Projected	
	Sub-Programme	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Preventive and Promotive Health	Communicable Disease	1,478	2,007	2,537	3,160
	Non Communicable Disease	111	245	234	235
	Family Health	4,267	13,376	16,432	16,682
	National Public Health Laboratory & Govt chemist	595	1,599	1,598	1,693
	Environmental Health	-	251	236	235
Curative Health	Curative & rehabilitative	3,733	5,281	5,468	6,102
	Referral & Specialized Services	13,434	28,356	26,964	27,717
Research and Development	Research and Development	1,567	7,205	7,231	7,714
	Capacity building and training	3,386	5,775	5,677	5,907
General Administration & Support services	Health Policy, Planning & Financing	40	55	69	86
	Health Standards & Quality assurance	107	912	866	853
	National Quality Control Laboratories	201	273	345	430
	General Administration	1,087	1,304	1,363	1,361
Total Sector Requirements		**30,006**	**66,640**	**69,021**	**72,176**

3.1.1 Semi-autonomous Government agencies

The following table shows resource requirements of the Health Sector both recurrent and development for SAGAs namely Kenya Medical Training College, Kenya Medical Supplies Agency, Kenyatta National Hospital, National Aids Control Council, HIV & AIDs Tribunal and Moi Teaching and Referral Hospital for the FY 2014/15, 2015/16 and 2016/17 respectively.

Semi-autonomous Government Agencies FY 2014/15 – 2015/16

Sub-Vote		Budget Estimates		
RECURRENT vote	**2013/14**	**2014/15**	**2015/16**	**2016/17**
KEMRI	1329	5263	5744	6329
KMTC	2,851	4,180	4,431	4,697
KEMSA	398	434	437	437
KNH	7,794	13,833	14,044	14,730
MTRH	3,644	4,453	4,720	5,003
NACC	271	586	599	599
HIV/AIDS Tribunal	11	186	203	203
Total	**16,298**	**28,935**	**30,178**	**31,998**

DEVELOPMENT vote	2013/14	2014/15	2015/16	2016/17
KEMRI	146	360	320	236
KMTC	164	327	330	330
KEMSA	19	86	100	100
KNH	393	2440	2443	2450
MTRH	132	1403	1405	1405
NACC	288	2720	2729	2729
HIV/AIDS Tribunal	0	0	0	0
Total	**1,142**	**7,336**	**7,327**	**7,250**

3.1.2 Economic classification

The following table shows the Health Sector resource requirements by economic classification for the FY 2014/15, 2015/16 and 2016/17 respectively.

Health Sector requirement by economic classification for FY 2014/15 – 2016/17 (Millions)

By Economic Classifications	Estimates		Projected Estimates	
Recurrent Budget	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Compensation to Employees	1,755	6,041	6,151	6,274
Use of Goods and Services	927	2,529	3,110	3,692
Current transfers Government Agencies	16,298	28,935	30,178	31,998
Other Recurrent Expenditure	4,020	15,584	15,666	15,978
Total Recurrent (Gross)	**23,000**	**53,088**	**55,105**	**57,942**
Development Budget				
Acquisition of Non-Financial Assets	2,064	2,188	2,319	2,458
Capital transfers to Government Agencies	1,142	7,336	7,327	7,250
Other Development (Free maternity)	3,800	4,028	4,270	4,526
Total Development (Gross)	**7,006**	**13,552**	**13,916**	**14,234**
GRAND TOTAL	**30,006**	**66,640**	**69,021**	**72,176**

3.3 Resource allocation criteria

The following are the Resource Allocation Criteria adopted by the Health sector in allocating Resources

- Priority on Non-discretionary expenditures e.g. Personnel costs, Grants to Parastatals and transfers.
- Priority for on-going development projects including G.O.K counterpart funding to Development projects
- Ministerial Budget Committees agreements and consensus.

4 CHAPTER FOUR: CROSS-SECTOR LINKAGES, EMERGING ISSUES AND CHALLENGES

Introduction

The Constitution established two distinct and interdependent levels of governments consisting of the national and 47 county governments with specific functions. These two levels must conduct their relations through consultation and cooperation[9] in order to effectively deliver their mandates. At the national level, the health sector interacts to various degrees with other sectors of the economy that contribute to its outputs/outcomes. These sectors include: Environmental Protection, Water and Natural Resources; Governance, Justice, Law and Order (GJLO); Public Administration and International Relations; Agriculture, Rural and Urban Development; Energy, Infrastructure and ICT; Education; General Economic and Commercial Affairs; National Security; and Social Protection, Culture and Recreation. Identification and harmonization of intra and inter sectoral linkages will be critical to ensure optimal utilization of limited resources.

Intra Sectoral Linkages within the Health Sector

The national health sector comprises of the Ministry, KEMRI, National Referral Hospitals, NACC, KEMSA, NHIF, HIV and AIDS Tribunal, among others. Intra-sectoral collaborations are mainly in the major programme areas of curative, preventive, promotive health, social protection and research and development. The departments and agencies of the Ministry will collaborate in information sharing, policy and strategy formulation, planning, programme implementation, setting of standards and monitoring and evaluation. With devolved system of government intergovernmental sectoral linkages with structured dialogue processes will be paramount if the two levels of governments have to contribute to accelerated realization of rights to health.

4.1 Links to other SECTORS

The collaboration with other sectors focuses mainly on issues that impact and contributes to improved health care and quality of life. These include literacy, employment, poverty, globalization, urbanization and housing conditions, nutrition, environmental and occupational hazards among others.

4.1.1 Energy, Infrastructure and ICT Sector

Expansion, modernization and operation of the health sector to effectively respond to the changing health service needs is highly dependent on energy, infrastructure and ICT sectors. Structured and deliberate engagement by the health sector with these sectors will be critical to ensure accelerated attainment health sector meet its goal. Reliable infrastructure will facilitate access to health care facilities and emergency services across the country hence improving clinical outcomes.

[9]The Constitution of Kenya, 2010

As the Health Sector continues to embrace ICT as medium for improved health care delivery, internet connectivity will be a key resource for implementing e-health, tele-medicine and training. Strengthening collaboration with the ICT subsector will be prioritized to ensure sectoral standards, cost efficiency and effectiveness, and reliability of data for national planning. Specifically, the two sectors in consultation with the county governments will work together towards establishment of web portal, national e-health hubs and health facility based e-health hubs across the country.

4.1.2 Environmental Protection, Water and NATURAL RESOURCES Sector

Provision of clean water, safe environment, adequate sanitation lead to improved living conditions and reduction in incidence of vector borne and other communicable diseases, hence better health for all.

The target of MDG goal No. 7 is to halve the proportion of people without sustainable access to safe drinking water and basic sanitation by 2015.In line with this goal the health sector will engage with these sectors in policy and regulatory dialogue to ensure safe environment, water, and sanitation facilities meet the set standards and the regulatory requirements.

4.1.3 Social Protection, Culture and Recreation Sector

The Health Sector through the National AIDS Control Council coordinates the national HIV and AIDS programmes, advocacy and mobilisation of resources to deal with the scourge. HIV and AIDS had been recognized as a serious challenge facing human development and identified as a target to be addressed in the national and Millennium Development Goals and Vision 2030. The newly established HIV and AIDS Equity Tribunal shall arbitrate on related human rights issues to ensure non-discrimination of all those infected and affected.

The Health Sector will cooperate with the sub sector of labour, social security and services in the area international recruitment as well as mainstreaming occupational safety and health into management systems across the sector. Further, the sector will contribute towards review of policies and legislation on occupational safety and health.

The Health Sector is committed to promote industrial peace and harmony, and guarantee social economic rights of workers in order to boost the healthcare workers' productivity and performance.

The Health Sector will adhere to ergonomic principles for provision of conducive work environment. The health sector will train key medical staff on sign language and endeavour to print customer information such as service delivery charters in Braille. The sector is committed to ensure accessibility to physical facilities, service points and social amenities by persons with disabilities.

4.1.4 Public Administration and International relations

The success programmes in health sector is dependent on the funding levels and the timely disbursement. In order for the sector to achieve its goals it will provide the necessary data and

information to enable the National Treasury to provide the necessary funding in time. The Health Sector will continue to play its role in line with the national and sectoral policies. One of the objectives of the Vision 2030 is to restructure public expenditure to be more growth and pro-poor oriented and this will benefit the sector significantly. The need to invest in human capital will also be emphasized. Resource allocation will be directed towards promotive and preventive aspects of healthcare, giving adequate attention to curative care.

The Health Sector will make its contribution towards achievement of gender equality in the provision of health training in line with MDG goal Number 3 and the National Gender Policy. The sector will work closely with the National Gender and Equality Commission and will initiate affirmative action in admission of students in various paramedical disciplines, especially in female dominated or male dominated professions. Further, Gender Based Violence Recovery Centres in KNH and MTRH will continue providing psycho-social and medical support to the survivors, as well as cooperate with relevant government sectors in order to bring culprits to justice.

National disasters like droughts and floods, frequent road traffic accidents, fires and acts of terrorism take heavy toll on the performance of the sector especially referral hospitals. The sector will commit funds for disaster preparedness, response and recovery as well as develop guidelines for use by county governments.

The Sector will institutionalize and strengthen public private partnerships as resource mobilisation strategy for the purpose of bridging budgetary deficit in accordance to the Public Private Partnership Act (2013).

4.1.5 Education Sector

The direct link between education and positive economic development including improved health outcomes is indisputable. The education sector programmes are geared towards improving efficiency in core service delivery of accessible, equitable and quality education and training. The sector by ensuring the provision of an all-inclusive high level and quality education can contribute substantially towards health seeking behaviour as it rolls out health education and outreach programmes. The two national teaching and referral hospitals will continue facilitating training of medical and Para-medical students from public and private institutions.

The Health sector will collaborate with Education Sector the provision of high health impact intervention including deworming.

4.1.6 Governance, Justice, Law and Order Sector

The Health Sector is guided by the relevant constitutional provisions on the right to highest quality of health care. *C*ap 4 Article 43 supported by the relevant legislation and statutory regulatory mechanisms such as such *Public Health Act, Research Ethics and Standards, Food and Drug Administration among others.*

The Health Sector will review and finalize the Health Bill 2013 to facilitate its enactment into law. The enforcement of this law and other related legislations will require close cooperation between the National Police Service Commission, Office of the Attorney General and Department of Justice, among others.

4.1.7 General Economic and commercial affairs

The sector is committed to improving its systems specialized health care services thorough benchmarking to effectively compete globally. These services will be modelled and benchmarked around the experiences from middle income countries like India, Thailand and South Africa India in order to will accelerate the development of Kenya as a medical tourism destination hub for specialised health and medical services, attracting local, regional and global clients. This tourisms subsector is anticipated to contribute significantly to economic growth.

The priority areas will include advocacy for developing Kenya as a medical tourism destination hub and defining the roles of each sector of the economy to support this process. In addition technical input like setting quality standards in line with international best practices, and development of human resource capacity, establish the necessary infrastructure, financing mechanisms and marketing strategy through the relevant sectors will be prioritized.

4.1.8 Agriculture, Rural and Urban Development

The Health Sector will ensure strengthening of platforms for policy dialogue on nutrition, housing, water and environment in order to improve these services to Kenyans. Discussion s on nutrition will emphasize on women of reproductive age and children under five (5) years of age including joint implementation of the National Nutrition Action Plan 2012-2017 will be critical.

4.2 Emerging Issues

The health sector is complex, dynamic and is sensitive to both internal and external environmental changes that require swift and appropriate strategic and operational responses. Key among the emerging issues includes;

4.2.1 Devolution

Through the new Constitutional dispensation a two tier health service delivery system has been introduced whereby the national level deals with Health policy, National Referral Hospitals, Capacity Building and Technical Assistance to counties. On the other hand, the County Health Services will focus on County Health Facilities and Pharmacies, Ambulance Services; Promotion of Primary Health Care; licensing and control of selling of food in public places; veterinary services, cemeteries, funeral parlours and crematorium; referral removal; refuse dumps and solid waste. This scenario will need concerted efforts in restructuring human resource management, infrastructure development and maintenance, health financing,

donor funding and partnerships, among others. The Constitution has brought issues that need to be addressed. These include:

- Define legal, policy and operational imperatives of the constitutional "right to health".
- Define new roles and responsibilities for the Ministry of Health and County Health Management Teams.
- Institutional restructuring of MOH.
- Building capacity of County Health Management Teams
- Coordination, monitoring and evaluation.

Consequently relevant health sector laws, legislations, policies and regulation will be formulated to guide the devolution of health services and programme implementation. This is very critical and important precondition if the Health sector is to meet its key performance indicators.

4.2.2 Burden of Communicable and Non- Communicable diseases

Although significant progress towards containing the threat of communicable diseases such as HIV/AIDS, Malaria, Pneumonia, TB and Cholera have been made, the burden to the sector is still significant. This is at the backdrop of rising non-communicable diseases like cancer, hypertension, heart diseases and diabetes due to changes in life styles. Injuries (road traffic accidents) are also significant causes of death and disability. This combined double burden is projected to further increase, posing new challenges and pressure on the already fragile health care delivery system. The situation is further aggravated by the high cost of medical care for such cases and poverty (inability to pay for services rendered).

4.2.3 The Public Health Security and Bioterrorism Preparedness and Response

In the recent threats to disease outbreaks like Ebola and HN1virus and acts of terrorism have the potential of affecting health and loss of lives. These emerging trends call for additional resources allocation in order to contain, prepare and respond to such emergencies. This will entail policy and guidelines formulation, establishment of emergency centres in strategic locations in the country. To this end, Health Sector Disaster Management Policy should be developed, disseminated and implemented across the country by the two levels of governments. In addition strengthening intergovernmental consultative mechanisms to address national security threats will be given priority.

4.2.4 Quality of Health Care, Standards and Accreditation

The Constitution guarantees every Kenyan the highest attainable standards of health and the sectoral policies and guidelines must accordingly align to this requirement. The Ministry of Health has been spear-heading various initiatives to institutionalize quality management including the rolling out of Kenya Quality Model for Health (KQMS/H). These approaches need to be further strengthened in order to gradually elevate the health care systems to international levels.

There is an urgent need to come up with a national accreditation mechanism for health facilities. The process will be deepened through international accreditation such ISO, Joint Commission International (JCI), Planetree Authorisation (for patient-centred hospitals), among others.

5 CHAPTER FIVE: CONCLUSIONS

a. During the MTEF period under review, the performance of the health sector recorded mixed results although a number of systematic investment programmes were undertaken. Regarding health status, life expectancy increased from 55 years in 2009 to 62 years; Infant and Child mortality reduced from 77 per 1000 in 2003 to 56 per 1000 while maternal mortality ratio increased marginally from 414 per 100,000 births in 2003 to 488 per 100,00 births. On the other hand, HIV prevalence reduced from 7.2% in 2007 to 5.6% in 2012 and Malaria prevalence reduced from 38% in 2010 to 21% in 2012 countrywide. The positive gains could be attributed to programme interventions which were implemented.

b. Despite the above gains, resource allocation to the sector stagnated at 4.6% of the National Budget falling far short of the requirements to meet the increasing demand and rising cost of health services. This situation is aggravated by the high population growth rate of 2.7% and fertility rate 4.7%. In addition, allocative inefficiency has been identified as one of the major causes of poor performance. During 2014/15 planning period the sector, plans to further deepen implementations of priority programmes aligned to MTPII. Efforts will be made to ensure progressive realization of rights to health as envisioned in the Constitution.

c. To be able to support implementation of programmes at the county levels, the sector will continue to build capacities of county governments and provide the necessary technical support so that the counties can effectively execute the functions assigned to them under the Fourth Schedule. In addition the national health sector will continue to strengthen the national referral hospital to be able to provide the critical backstopping to the counties with regards to specialized health services. All these national government functions will require significant financial inputs.

d. In implementing the sector priority programmes the sector will be guided by the health policy and the Medium Term Plan II.

e. Although the proportion on budgetary allocation to the sector from the government's total budget has remained relatively constant at 4.5%, far below the Abuja targets of 15%, absolute terms show a steady rise. However, the per capita expenditure on health is currently at US$42 adequate to achieve MDGs. This discrepancy emphasizes the need to strengthen efficiency processes within the sector. Progress towards universal coverage is still far as the current coverage rate by NHIF stands at 5%. This needs to be increased to above 30% in the next MTEF period.

f. Investment in improvement of infrastructure amounted to Kshs 7.4 billion in 2012/2103 including Kshs 5.6 billion from development partners. Priority areas where these were invested included Renal equipment for level 5 Hospitals, Ambulances for health facilities, Cancer Treatment equipment for KNH and rehabilitation of level 5 and 4 Hospitals[10].

g. Adequate, motivated and equitably distributed human resources for health still remain a critical input for effective health care system. During the period under review 700 medical officers were recruited and the number of trainees admitted to KMTC increased 4,957 in 2009 to over 7,000 in 2012

[10]Which are the hospitals

h. Service delivery in the health sector was improved over the period through strengthened referral system and communication across all levels of the healthcare, enhanced periodic supportive supervision to hospitals, and provision of human resources for health to faith based hospitals in order to complement government efforts and strengthened training in Health Systems.

i. At the end of the financial year 2012/2013, the sector had pending bills amounting to Kshs 6,457 million.

j. During the period under review the health sector maintained and strengthened partnerships mechanisms with all the health sector actors, the government, development partners and the implementing partners. The partnership mechanisms like Inter-agency Coordinating Committees (ICC) continue to play important role programme policy formulation and implementation in curative, preventive, promotive health, social protection and research and development areas.

k. Recognizing the significant contribution by other sectors to health, the health sector will continue to strengthen inter sectoral linkages under the umbrella of social determinants to enhance achievement of health goals. The social determinants literacy levels, employment and poverty levels, globalization, urbanization and housing conditions, national security, environmental and occupational hazards, good infrastructure, fundamental human rights, promotion of health tourism among others.

l. In the recent past threats to disease outbreaks like Ebola and HN1virus and acts of terrorism have the potential of disrupting health and more often loss of lives. This calls for additional resource allocation in order to support containment, preparation and response to such emergencies. In addition, new policy and guidelines will need to be formulated as well as establishment of emergency centres in strategic locations in the country. To this end, Health Sector Disaster Management Policy should be developed, disseminated and implemented across the country by the two levels of governments. Further, strengthening the intergovernmental consultative mechanisms to address national security threats will be given priority.

6 CHAPTER SIX: RECOMMENDATIONS

This MTEF review process brings to a close the specific analyses of the sector performance based on the two ministries with their constituent semi-autonomous government authorities. In addition, the creation of the two levels of government with clearly distinct functions as well as the establishment of the devolved governments will therefore greatly informed the recommendations regarding the issues to be addressed during the next planning period. This is due to the fact that health care delivery has substantively been devolved to the county governments.

In order to sustain the gains made and improve on the sector performance under the devolved system of government the following are the recommendations for consideration:

- The national government to support the counties in defining cost effective interventions for implementation at the county levels taking into consideration the national priorities as elaborated through flagship projects contained in the Medium Term Plan II and the Kenya Health Sector Strategic Plan, 2013-2017. This process should not compromise the county priorities outlined in the County Integrated Development Plans.
- The national and county governments to establish and strengthen mechanisms for consultation and collaboration with a view to progressively and effectively address the challenges of healthcare especially financing and human resources as well as *other health care issues* of national and county governments interest in order to accelerate realization of rights to health through universal health coverage. These will include implementation of joint programmes like free maternal services
- Strengthen the *capacity* of the health sector to anticipate, prepare, respond and contain national disasters, calamities and emergencies including bioterrorism by developing clear policies, strategies and enhancing additional funding for response. To this end, Health Sector Disaster Management Policy should be developed, disseminated and implemented.
- Strengthen the capacity of the national to effectively provide leading role in closely monitoring implementation of health programmes in consultation with the county governments with a view to learning lessons to inform development of strategies and guidelines critical for improvement of services. The monitoring framework to reflect not only service delivery outcomes but also budgetary allocation by county governments to the health sector.
- The national and county governments taking cognizance of the inadequate budgetary allocation from both national and county treasuries, the two levels of government must consider other alternatives of mobilizing additional resources including establishing systems and mechanisms for implementing health projects through Public private Partnerships
- At the national level, there is a need for continued effective coordination of health subsectors and the health SAGAs to leverage on their competitive advantage to facilitate rapid realization of the sector objectives during the 2013/14 to 2016/17 MTEF.
- In the financial year 2012/13 the sector reported pending bills amounting to Kshs 5,891 million, made up of Kshs 3,786 million for recurrent and Kshs 2,104million for

development budget. These bills have remained pending primarily due to lack of provision or liquidity at National Treasury and delay in overall implementation of the budget due to stringent procedures on release of funds. It is therefore critical that the national and county governments agree on the modalities of addressing these liabilities during the transition period and putting systems and mechanisms to minimize recurrence.

- In the recent past the country has witnessed the potential disease outbreaks like Ebola and HN1virus and acts of terrorism which lead to loss of lives. These emerging trends call for additional resources allocation in order to contain, prepare and respond to such emergencies. It is also important to formulate policies, and operational guidelines, and establish emergency centres in strategic locations in the country. To this end, Health Sector Disaster Management Policy should be developed, disseminated and implemented.

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