REPUBLICOF KENYA

HEALTH SECTOR WORKING GROUP REPORT

MEDIUM TERM EXPENDITURE FRAMEWORK (MTEF) FOR THE PERIOD 2012/13-2014/15

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LIST OF ABBREVIATIONS

ACUs	AIDS Control Units
ADB	Africa Development Bank
ADF	African Development Fund
AIA	Appropriations in Aid
AIDS	Acquired Immune Deficiency Syndrome
AIE	Authority to Incur Expenditure
AKF	Aga Khan Foundation
ART	Anti Retro Viral Therapy
ARVs	Anti Retro Virals
BOPA	Budget Outlook Paper
CBOs	Community Based Organizations
KNBS	Central Bureau of Statistics
CDF	Constituency Development Fund
CIDA	Canadian International Development Agency
DANIDA	Danish International Development Agency
DFID	Department for International Development
EMMS	Essential Medicines and Medical Supplies
FBOs	Faith Based Organizations
GAVI	Global Alliance Vaccination Initiative
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund Aids TB and Malaria
GoK	Government of Kenya
HIV	Human Immuno – Deficiency Virus
HSSF	Health Sector Services Fund
ICT	Information and Communication Technology
IFMIS	Integrated Financial Management Information System
IRS	Indoor Residual Spraying
ITNS	Insecticide Treated Nets
JICA	Japanese International Corporation Agency
KDHS	Kenya Demographical Health Survey
KMTC	Kenya Medical Training College
Kshs	Kenya Shillings
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MOF	Ministry of Finance
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MPER	Ministerial Public Expenditure Review
MTEF	Medium Term Expenditure Frame Work
NGO	Non-Governmental Organizations
NHSSP	National Health Sector Strategic Plan
O&M	Operation and Maintenance
OBA	Output Based Approach
OVC	Orphans of the Vulnerable Children
PC	Performance Contract
PE	Personal Emoluments
PEPFAR	Presidential Emergency Plan for Aids Relief
PMTCT	Prevention of Mother to Child Transmission

SAGA	Semi-Autonomous Government Agency
STD	Sexual Transmitted Disease
SWAP	Sector Wide Approach
TFR	Total Fertility Rates
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USAMRU	US Army Medical Research Unit
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

These Health Sector Group Working (SGW) paper for **MTEF** period **2012/13-2014/15** presents an analysis of the Sector performance, achievements and the resource requirements for the period **2012/13-2014/15**. The Health Sector comprises of Ministries of Medical Services, Public Health and Sanitation, Research and Development sub-Sectors. The R&D is a sub Sector is borne out of the realization that Kenya must harness in a coordinated manner, the best possible human capital and research technology. This will position the country in modern world economy that is increasingly globalized and knowledge based

In the recent past, Government's efforts and support of Development Partners have resulted in reversing the downward trend in health status indicators of the population observed in the 1990s. Remarkable achievements have been made in the reduction of Under Five Mortality from 115 per 1,000 live births in 2003 to 74 per 1,000 live births in 2008/9 and Infant Mortality from 77 per 1000 live births to 52 per 1000 live births in the same period. The proportion of children fully immunized against communicable diseases increased from 64percent in 2005/06 to 77percent in 2009.However, the declining maternal health indicators are worrying. Maternal Mortality Ratio has deteriorated from 414 in 2003 to 488 deaths per 100,000 live births in 2008-09; only 43percent of children are delivered in a health facility (KDHS 2008-2009). Births attended by skilled health personnel declined from 51 percent in 2007 to 43 percent in 2010/11.

Currently, Public financing for the Sector (recurrent and development) as a percentage of total Government expenditure estimated at about 2percent of GDP and the public per capita health spending was $12.6 in 2010/11. However, this amount remains inadequate when compared to the WHO recommendation of an average of $44 per capita on health care. The overall allocations have remained at 6percent of the overall Government budget for the last three years.

Expenditure analysis

Actual Recurrent expenditures for the Health Sector has increased over the period. In 2010/11 Financial Year, the actual expenditures was at Kshs. 35 billion up from Kshs. 26.9 billion in 2008/09. Although in overall, there is an increase in actual expenditures, recurrent actual expenditures as a percent of the overall expenditure for the health Sector has been declining; from 85 percent in 2008/09 FY down to 79 percent in 2010/11 FY.

The Health Sector has seen an increase in the funds dedicated to the Development. This can be attributed to the Government implementing the facility reforms agenda. Over the period 2008/09 FY to 2010/11 FY; the actual expenditures increase from Kshs. 4.8 Billion to 9 billion. This is 87 percent increase over a period of 3 years. Overall, unlike the Recurrent vote, the Development vote has been increasing from a 15 percent share in 2008/09 to 22 percent in 2010/11 FY.

Analysis of expenditure for the Kenya Medical Research Institute (KEMRI) shows that total receipts increased by 6.5 percent of total revenues from Kshs 7,456.5 in 2009/10 to Kshs 7,939.2 million in 2010/2011. Donor funding accounted for 63 percent of total revenues while the GOK contributed 17 percent of the total funding. Other funds were generated through the institute's research activities and development projects which contributed only 3 percent of the total revenue.

Expenditure review by programmes

Allocations to the Medical Services sub-sector increased during the period under review from actual expenditures of **20.7** billion in 2007/08 to **25.1** billion in 2010/11.Recurrent actual expenditures rose from **19.3** billion in 2007/08 to **23** billion in 2010/11. Further Development expenditures increased from **1.4** billion in 2007/08 to **2.1** billion in 2010/11. Recurrent allocations and expenditures generally dominate overall Medical Services sub-sectorallocations and expenditures. However, it is apparent there has been gradual decrease of recurrent allocations from 87 percent of total ministry's allocation in 2007/08 to 76 percent in 2010/11, indicating the Government's commitment to spending on investments (development).

In the Public Health and Sanitation sub-sector, actual recurrent expenditures totalled Kshs **10.05** billion in 2010/11, up from Kshs **6.9** billion in 2009/10. This represents an increase of **52percent**. In the same year, the share of recurrent allocation to total Public Health sub-sector allocation accounted for 50.3percent while development allocation accounted for 49.7percent.

In the Research and Development sub-sector, recurrent expenditure has increased at an average rate of 6.25percent for the last 4 years (4percent, 3percent, 17percent, and 1percent). However, this is a very small percentage considering the inflation rate of about 17percent per annum and the expected economic growth over the years. The absorption of the recurrent and development budget was 100 percent. However the expenditure in donor funds is much more than budgeted due to the uncertainty of the expected project funding.

Overall, during the period under review, the **Health Sector** had a total of Kshs 4,775.22 Million in pending bills for both recurrent and development. Half of the Pending bills were due to lack of liquidity and lack of provision. There was a slight decrease in overall pending bills in 2010/11 compared to 2009/10 from Kshs 1,494 Million to Kshs 1,271 Million respectively. Medical Services sub-sector had the most (Kshs 636 Million), followed by R&D (KEMRI) (Kshs 628 Million) while Ministry of Public Health and Sanitation had the least pending bills at only Kshs 6.29 Million in 2010/11.

Medium term priorities and financial plan for the MTEF period 2012/13 – 2014/15

To respond to constitutional requirement in priority setting during the budgeting process, the Government undertook a comprehensive consultative process with counties in November 2011 in order to get their views on the actual needs. Some of the key issues that were raised as priority include:

1. Inadequate and poor state of infrastructure.
2. Inadequate human resources
3. Frequent shortages of medicines and medical supplies

The budget for the Heath Sector is based 3 single programmes on account of the split of MOH to the two independent Ministries. The programmes which are being presented for the resource bidding process are preventive, curative 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 Sectorresource requirement is Kshs 143,428Billion,159,693 Billion and 189,849 Billion for the 2012/13,2013/14 and 2014/15 respectively.The resource allocation for 2012/13 is Kshs. 68,149Billion.

Emerging issues and challenges

Health spending has remained low as a share of overall Government budget, and as a proportion of the GDP, and in per capita terms. At the same time, available funding has been used largely to finance recurrent costs, less amounts allocated to the development budget. Development expenditures have therefore continued to be substantially funded through donor support. Unpredictability of donor assistance both in terms of amounts and disbursement patterns has meant that planned projects/Programmes are affected. There is limited control of some of the Development Partners (DPs) funds by the sub Sector, as DPs choose to finance most of the activities directly or channelling funds through non-governmental organisations.

Despite the relatively good performance in health indicators, there are still gaps in health outcomes. Kenya is not likely to achieve some Millennium Development Goals. At 488 per 100,000 live births, its maternal mortality ratio is high, mainly due to a number of factors including low level of health institutional deliveries (43 percent). And despite increasing use of contraceptives, the total fertility rate has been stagnating at around five births per woman for the last ten years. Efforts to improve theseindicators should be supported through cross-sectoral interventions that include improvements in access to clean water.

Kenya is confronted with several emerging health related issues. These include prevalence of non-communicable diseases (NCDs), whose socio-economic consequences would have both short-term and long-term implications on the Government and households. Further the inadequate health personnel, infrastructure, financial resources are important issues of concern. While some diseases, in particular infectious diseases, could disrupt the day-to-day activities and livelihood of affected people in the short-run, diseases such as malaria, tuberculosis and HIV/AIDS could have long-term implications for education and labor markets, with adverse effects on the economy.

The main challenges that the health sector faces includes; high poverty incidence, inadequate funding, shortage and mal-distribution of health personnel, low literacy levels, lack of safe drinking water, sanitation and infrastructure.

Conclusion

With Kenya’s population growing at a rate of 3 percent annually, the population will continue to place a huge demand for health services. Kenya must continue expanding maternal and child health services while developing the capacity of the health systems to cater for communicable and non-communicable diseases which are on the rise. The Government has committed itself to improving the health Sector infrastructure. Attaining acceptable standards and norms has implications for staffing, equipment, infrastructure, and operating costs.

The prospects for additional funds in the health Sector in the medium term are scarce, as available public sources are limited. The medium term challenge for the health Sector is to use available health resources more efficiently to deliver quality services and improve health outcomes. The Sector continues to put emphasis on a departure from the input-based approach to focus on improved outputs and outcomes. Health spending will continue to aim

at meeting the population's health needs. This implies rationalizing existing physical and human resources and use of new budget principles based on outputs.

Analysis has shown the trends in expenditure estimates and actual expenditure for the Sector has significantly increased compared to the previous years. The increase in GoK allocation to the Sector shows the Government’s commitment towards preventive and promotive health. This trend should be maintained so as to reduce outbreak of preventable diseases.

The review has also shown that Government initiatives have started to yield positive results. For instance, the implementation of IFMIS has significantly improved the absorption capacity of the Sector. This implies that there is a potential to improve efficiency in the utilization of budget allocations by exploring other innovative strategies. In particular there is need for the Sector to explore mechanisms for improving efficiency of M & E.

CHAPTER ONE

1 INTRODUCTION

1.1 BACKGROUND

The goal of **Kenya's Vision 2030** for the Health Sector is to ***"provide equitable and affordable health care at the highest affordable standards to her citizens"***. Good health is a prerequisite for enhanced economic growth and poverty reduction and a precursor to realization of the Vision's Social Goals. Further, the **Constitution** under the Bill of Rights, access to equitable healthcare is a right to every Kenyan. Against this background, the Health Sector is re-positioning itself to fulfil the expectations of Kenyans through improved health infrastructure and service delivery systems.

SITUATION ANALYSIS

The Disease Profile

The Kenyan epidemiological profile indicates that disease burden is still high. Top five causes of outpatient morbidity namely Malaria, Diseases of the Respiratory System, Diseases of the Skin, diarrhoea, and accidents account for about 70percent of total causes of morbidity. Malaria contribute about a third of total morbidity. The leading causes of mortality are: Infectious and parasitic diseases (42 percent of total mortality in 2008) followed by Diseases of Respiratory System (11 percent), and Diseases of Circulatory System (7 percent).

HIV prevalence estimates vary widely, but the latest estimates from the 2008/09 Kenya Demographic and Health Survey (KDHS) place the prevalence rate at 6.3 percent, slightly lower than the previous estimate of 6.7 percent (KDHS 2003). Although this reduction is small in terms of number of cases as compared to the total population, effective prevention programmes are considered for keeping infection rates low in the future.

In the recent past, Government's efforts and support of Development Partners have resulted in reversing the downward trend in health status indicators of the population observed in the 1990s. Remarkable achievements have been made in the reduction of Under Five Mortality from 115 per 1,000 live births in 2003 to 74 per 1,000 live births in 2008/9 and Infant Mortality from 77 per 1000 live births to 52 per 1000 live births in the same period. The proportion of children fully immunized against communicable diseases increased from 64percent in 2005/06 to 77percent in 2009.

The declining maternal health indicators are worrying. Maternal Mortality Ratio (MMR) has deteriorated from 414 in 2003 to 488 deaths per 100,000 live births in 2008-09; only 43percent of children are delivered in a health facility (KDHS 2008-2009). Births attended by skilled health personnel declined from 51 percent in 2007 to 43 percent in 2010/11.

Nutritional status of children has also not shown significant improvement over the years. An estimated 16 percent of children under-five years are underweight, 7 percent are wasted, and 35 percent are stunted.

Regional level health indicators show that North Eastern, Coast, Nyanza and Western Provinces have the worst infant and child mortality indicators. High poverty levels and inadequate environmental sanitation among other factors may be contributing to these differentials. .

Human Resources

Kenya has an average of 16 doctors and 153 nurses per 100,000 populations, compared to WHO recommended minimum staffing levels of 36 and 356 doctors and nurses respectively per 100,000 populations Regarding the optimal staff establishment, the two ministries have staff establishment of 72,234 but only 47,247 have so far been approved. However, of the approved establishment, only about 38,000 positions are filled, leaving almost 9,000 positions vacant. The annual recruitment has not drastically altered the numbers because of the high level of attrition.

The Research and Development (R&D) sub-sector has developed the critical mass of human resource to conduct human health research. Currently the number of research personnel (in post) stands at 204. Poor working condition and remains a major challenge which, have resulted in brain drain which is adversely affecting research and development capacity in the sector.

Against the above background, it is apparent that the Sector is not able to adequately provide services to the citizens. These shortages of Human Resource have negative impact on the Sectors capacity to deliver services.

Physical Infrastructure

Out of 7,395 health facilities in the Sector, the Government owns and operates 48percent (273 hospitals, 579 Health centres and 2,716 dispensaries) of the facilities in the sector. The Private and FBO health facilities complement the provision of health care through the remaining 46 percent (1,044 FBOs and 2,352 private) of health facilities. **(Appendix 1)**

In view of the low investment in infrastructure, most of the public health facilities are old and dilapidated. Given the increases in population and the increase in demand for services, these facilities do not conform to current infrastructure norms and standards.

Accessibility to the health facilities is estimated at 52 percent[1] based on the 5km radius norm. However, there are variations in access in different parts of the country, with the worst areas being in the Northern part of the country.On average, 50percent of the equipment in our public medical facilities and research laboratories are obsolete /unserviceable.

Strengthening research infrastructure (internationally accredited Laboratories, clinics, well equipped field stations, modern Information and Communication Technology infrastructure and Library resource centres) is a priority area for the Research and Development sub-sector. To this end the sector has undertaken a comprehensive review of its resources and facilities around the country in view of addressing the emerging needs in the following areas:

i) Development and maintenance of modern laboratories to cater for a wide range of health research investigations,
ii) Information communication infrastructure and services

iii) Production, marketing and Intellectual property.
iv) Operations and maintenance (Stalled housing projects, GOK/JICA Cooperative Agreement and maintenance of P3 laboratories)

Commodity Supplies and Management

Kenya Medical Supplies Agency (KEMSA) is responsible for the procurement, distribution and proper use of medicines and medical supplies in public health facilities. However, the greatest challenge relates to the shortage of essential medicine and non-pharmaceuticals due to supply chain management. As a result patients are forced to purchase over the counter drugs, leading to risk of drug resistance due to under/over-dosage.

The Sector currently receives just about 50 per cent of the required funds for drugs and non-pharmaceutical. Funding for ARVs, which are funded at 90 per cent by the Development Partners is largely affected. This situation is not sustainable in the long run and poses a major risk to the lives of HIV/AIDS patients in the event that development partners withhold their support.

Health Financing

Currently, Public financing for the Sector (recurrent and development) as a percentage of total Government expenditure estimated at about 2 percent of GDP and the public per capita health spending was $12.6 in 2010/11. However, this amount remains inadequate when compared to the WHO recommendation of an average of $44 per capita on health care. The overall allocations have remained at 6percent of the overall Government budget for the last three years.

With respect to R&D, the significance of increasing investment in research for health has been emphasised globally. The Global Ministerial Forum on Research for Health hosted by the Government of Mali from 17 -19 November 2008, resolved to launch “a Call to Action”, setting out targets for increasing investments in research for health. The “Call to Action” urges national governments to allocate at least 2percent of budgets of ministries of health to research and development agencies, and to earmark at least 5percent of funding for research, including support to knowledge translation and evaluation as part of the research process. Governments are also urged to pursue innovative financing mechanisms for research for health.

KEMRI is the arm which is mandated to conduct, disseminate and translate research findings for evidence based policy formulation and implementation. So far allocation of funding to R&D sub- sector has been negligible compared to the resource requirements of the sub-sector. Over 99percent of research in KEMRI is funded by the donor partners. These funds are expended as per the individual donor budget mainly supporting research activities which often may not be priority issues for Kenya. These funds are not sustainable in the long run affecting the policy formulation in the Sector.

This Health Sector Group Working (SGW) paper for **MTEF** period **2012/13-2014/15** presents an analysis of the Sector performance, achievements and the resource requirements for the period **2012/13-2014/15**. The Health Sector comprises of Ministries of Medical Services, Public Health and Sanitation, Research and Development sub-Sectors. The latter is a new sub Sector, borne out of the realization that Kenya must harness in a coordinated manner, the best possible human capital and research technology. This will position the country in modern world economy that is increasingly globalized and knowledge based.

1.2 SECTOR VISION AND MISSION

The Second National Health Sector Strategic Plan (2005-2010) sets out the Vision and Mission of the Health Sector as:

Vision

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

Mission

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

To fulfil the vision and mission, the Health Sector provides leadership through formulation of health policies and strategic direction, set standards, provide health services through public facilities and regulate all actors/services.

1.3 STRATEGIC GOALS AND OBJECTIVES OF THE SECTOR

The following strategic objectives aim towards the realization of the Health Sector:

- Increase equitable access to health services;
- Improve the financing of the Health Sector.
- Improve the quality and responsiveness of services in the Sector;
- Improve the efficiency and effectiveness of service delivery;
- Conduct research aimed at providing solutions for the reduction of disease burden in Kenya.
- Enhance the regulatory capacity of the Sector;
- Foster partnerships in improving health and delivering services.

1.4 SUB SECTOR AND THEIR MANDATES

1.4.1 MEDICAL SERVICES SUB-SECTOR

The Sub Sector vision is *"To be an efficient and high quality medical services that are accessible equitable and affordable for every Kenyan.*

In line with the Vision, the **Mission** of theMedical Services sub-sector is *"to promote and participate in provision of integrated quality curative and rehabilitative services for all Kenyans".*

The mandate of the Medical Services Sub Sector is to ensure availability of medical care and improve lives through responding to health care needs of the population in Kenya.

1.4.2 PUBLIC HEALTH AND SANITATION SUB-SECTOR

The Sub Sector vision is "to have a nation free from preventable diseases and ill health".

In line with the Vision, the Mission of the Public Health and Sanitation Sub-Sector is "To provide effective and leadership and participate in the provision of quality public health and sanitation services that are equitable, responsive, accessible and accountable to all Kenyans".

The mandate of the Sub Sector is to support the attainment 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.

1.4.3 HEALTH RESEARCH AND DEVELOPMENT SUB-SECTOR

The development of the necessary scientific infrastructure, technical and entrepreneurial skills, is essential ingredients for the transformation of Kenya into a middle income country. The Kenya Medical Research Institute (KEMRI) is the body mandated by the Science and Technology Act of 1979 to conduct research in human health and disseminate and translate research findings in health for evidence based policy formulation and implementation.

The Vision for KEMRI is "To be the leading global centre of excellence in human health research," and the Mission is; "To improve human health and quality of life of in Kenya through biomedical research, innovations and capacity building."

The R&D Sub-Sector has been borne out of the realization that Kenya must harness in a coordinated manner, the best possible human capital and research technology which will position the country in modern world economy that is increasingly globalized and knowledge based. R&D will therefore lay the foundation for attainment of scientifically and technologically advanced society by supporting the national development strategy based on the Kenya Vision 2030.

1.5 AUTONOMOUS AND SEMI AUTONOMOUS GOVERNMENTS AND AGENCIES

The Health Sector has autonomous and semi-autonomous organizations that perform specialized functions. The organizations include:

- Kenyatta National Hospital;
- Moi Teaching and Referral Hospital;
- Kenya Medical Supplies Agency;
- Kenya Medical Research Institute;
- National Health Insurance Fund;
- Kenya Medical Training College.

1.5.1 KENYATTA NATIONAL HOSPITAL (KNH)

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.

1.5.2 MOI TEACHING AND REFERRAL HOSPITAL (MT&RH)

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)

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)

KEMSA is mandated to procure, offer for sale and supply drugs and medical supplies; establish warehouse facilities for storage, packaging and sale of drugs and medical supplies to health institutions; conduct analysis of drugs and medical supplies to determine their suitability; advice consumers and health providerson the national and cost effective use of drugs.

1.5.5 NATIONAL HOSPITAL INSURANCE FUND (NHIF)

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 declared health providersand contracting health care providers as agents to facilitate the Health Insurance Scheme.

1.5.6 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 Ministry of Finance plays a major role as a stakeholder by providing the budgetary support for the operations and maintenance of the Sector's ministries besides the remuneration of all employees within the Sector;

(ii) The Ministry of State for Planning, National Development & Vision 2030 plays a crucial role in policy planning , development and coordination in the Sector;

(iii) The Ministry of State for Public Service provides the relevant schemes of service for career development;

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

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

(vi) The Ministry of Local Government, Parliament, Universities, NGO, FBOs in the Health Sector and the private sector also play crucial roles in augmenting sector funding ;

(vii) Kenya National Bureau of Statistics (KNBS) and Kenya Institute of Public Policy Research and Analysis (KIPPRA);

(viii) Others are the Ministry of water and Irrigation, Ministry of Agriculture, Ministry of Environment, Ministry of Roads and Public Works and Ministry of Education.

(ix) 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.

CHAPTER TWO

2 PERFORMANCE AND ACHIEVEMENTS OF THE SECTOR DURING THE PERIOD 2008/09 -2010/11

2.1 PERFORMANCE OF PROGRAMMES

The Health Sector, with its partners, embarked on a process to actualise a reform process to improve the delivery and management of services. These are outlined in the NHSSP II, the Sector's 5-year Strategic Plan document. In the firstyear of the NHSSP II (2005/06 financial year), the Sector's focus was on defining mechanisms and ways to actualize the respective processes needed to guide the Sector to efficiently, effectively and equitably achieve its service delivery objectives.

2.1.1 MEDICAL SERVICES SUB-SECTOR

Rehabilitation of health facilities

In the last three years, the Sector has been implementing a health facility infrastructure improvement programme that is supported by both the Government and Development Partners. As a result, close to 80 capital projects are at various stages of completion, with 39 of these being large/medium scale projects with partner support. However, the level of investment in many of the facilities has not been adequate to transform the respective facilities to required standards.

Government continued construction and rehabilitation of hospitals. During the period under review a total of 48 hospitalswere constructed and 92 hospitals rehabilitated

Health financing

HMSF was established vide Legal Notice No. 155 of 2009 and operationized in FY 2010/11. During the 2010/11 financial year, a total of Kshs 879 million was disbursed to over 270 hospitals. In the same year, 3.2 billion was collected through user fees in these facilities.

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 have tripled from Kshs 1.03 billion in 2002/03 to Kshs 3.2 billion in 2010/11. However, cost sharing also continuesto be hindrance to accessing healthcare especially for the lower end of the population. If these resources were to be pooled, they will provide a more effective way of addressing healthcare needs than is currently happening.

The development of the draft Health financing strategy,since 2009 is aimed at strengthening the pooling of resources under social health insurance and ensuring their efficient use.

Access to Antiretroviral

There is an estimated 1.5 million people living with HIV/AIDS of which 500,000 people are on ARV treatment leaving nearly 220,000 eligible people without access to the treatmentduring 2012/13.

2.1.2 PUBLIC HEALTH AND SANITATION SUB-SECTOR

Preventive and promotive health

Malaria

With an increasing coverage of effective malaria tools such as long lasting insecticide treated nets, use of Artemisinin Based Combination Therapies (ACTs) and use of indoor residual spraying,there has been a documented 44percent reduction of childhood deaths in malaria evidence districts and a 13percent reduction in outpatient attendances. The malaria indicator survey 2010 showed a marked reduction of malaria prevalence in Coast province from a high of 30percent to 8percent. The prevalence however remains more than 30percent in parts of Nyanza and Western provinces.

Direct Disbursement of funds to Health Centres through HSSF

Health Sector Services Fund (HSSF) is one of the Ministry of Public Health and Sanitation sub sector Flagship project. The Fund was established through Legal Notice No. 401, Kenya Gazette Supplement No.123 of Dec 21st 2007 and amended through Legal Notice No. 79 of June 2009 both under the Government Financial Management Act (No.5 of 2004). The HSSF was set up as a mechanism for pooling resources from the Government and Development Partners through a Sector-Wide Approach (SWAp) and availing the resources directly to Health Facilities for implementing health care interventions. This policy aims at increasing access to health services, addressing equity in health service delivery and improving quality and responsiveness of the health systems and services to the needs of the population. It also aims to increase efficiency and effectiveness in the management of financial resources by empowering the Facility Management Committees, reducing bureaucracies in the disbursement of financial resources to the levels 1-3 facilities that predominantly faced delays in receiving funds from the MOH.

Between November 2010 and 30th June 2011, a total of Kshs 353,352,000 has been disbursed to 653 health Centres in Kenya [how much to dispensaries??]. In addition, District Health Management Teams in 265 districts have received Kshs 130,051,000 to support supervision activities. The HSSF is therefore one of the innovate mechanisms of disbursing funds to the primary health facilities. Given the potential of this mechanism, the Ministry has developed HSSF guidelines on management of finances and subsequently gazette of HSSF management at national and sub national levels is complete.

Increasing Access to Reproductive Health Services Using Rh-OBA Vouchers

OBA is intended to contribute to reduction in both maternal and infant mortality rates by improving access to and utilization of reproductive health services by the economically disadvantaged populations. The program was piloted in three rural districts (Kisumu, Kiambu, and Kitui) and in two urban sites in Nairobi (Viwandani and Korogocho). Plans are

under way to scale-up the initiative to new districts. Since its inception, the program has managed to reach 51 percent of poor pregnant women in the pilot sites, an indication that the program has registered success in increasing the proportion of institutional deliveries with a skilled birth attendant. Although the initiative has the potential of significantly reducing maternal mortality in the poor rural areas, heavy reliance on external funding raises question of long-term sustainability. Out of the total project funding, KfW contribute over 90 percent of the funds. To reduce the reliance on external funding, the Government needs to explore innovative financing mechanisms of sustaining the initiative.

Primary Health

Construction of Model Health Centres

The Ministry of Public Health and Sanitation sub sector has been implementing construction of model health centres as part of Economic Stimulus Programme by the Government of Kenya whose objective was to spur development in the rural areas and more importantly enable the facilities to provide comprehensive health care. The model health centres were identified as part of meeting the Millennium Development Goal 4 and 5 as a high impact intervention. The Government allocated Kshs 16 million for the construction of a maternity, children's ward and the accompanying utilities (Kitchen, laundry, septic tank and placenta pit) in the 210 constituencies' country wide. 108 of the 210 facilities are in operation while the remaining 102 are at different stages of completion.

A total of 3,866 nurses have also been recruited under the Economic Stimulus Package (ESP) and posted to health centres and dispensaries within the constituencies countrywide (phase 1). This is in comparison with the flagship project of recruiting 20 nurses per constituency starting September 2009.

The Government has scaled-up recruitment of additional health workers including absorption of contract health workers previously recruited by development partners and The Global Fund to Fight AIDS, TB and Malaria (GFATM) programs. In 2010, the Government undertook the single largest ever recruitment of health workers as part of the Economic Stimulus Package (ESP). This was a Government program funded under the ESP initiative that set out to employ 4200 nurses (20 for each of the 210 constituencies) under contract terms. In 2011 there was ESP Phase II in which 6300 health workers were earmarked for recruitment out of which 3,150 were KRCHN and KECN while the other 3,150 were CHEWs of which 1050 comprised PHOs/PHTs and 2100 were KECNs.

Improved Efficiency in Procurement of Goods & Services

As part of the Health Sector Strategic Plan II (2005 -2010) the Ministries of Health introduced the demand driven 'PULL' system of distributing Essential Medicines and Medical Supplies (EMMS) to the Public Health Facilities. In this system unlike the 'PUSH' system where facilities were given standard 'KITS' of EMMS, the facilities are allocated a virtual 'Drawing Rights' dependent on a Resource Allocation Criteria (RAC) that allows them to quantify and place orders for EMMS as per their needs. This system of distribution was introduced on a pilot basis in 2006 and from 2007 a gradual scale-up has been going on. The scaling-up has been finalised in the Dispensaries and Health Centres in North Eastern, Coast and Nairobi Provinces. The scale-up is currently going on in Central and Eastern Provinces with planned roll out in Western and Nyanza provinces later this year. It is hoped that roll out to Rift Valley province will be done early next year ensuring that all facilities in

the republic are in the 'PULL' system of distribution of EMMS by the start of the 2012/2013 financial year. The PULL system is expected to reduce wastage, reduce delays in distributing drugs to facilities and ultimately enhance and address the issue of drug stock-outs.

Health Information System

Policy and operational decision requires robust information guided by accurate data interpreted under the prevailing context. The current health information system is weak and cannot respond adequately to the immediate needs of policy makers and operational managers especially with regards to infrastructure, location, and services offered. The development of Health Information System (HIS) therefore has been driven by the need for Health data and Information by the HealthSector for purposes of policy development, program management, prioritizing public health interventions for policy and management. To achieve these objectives, varied databases have been developed across the Sector by different partners. This has led to multiplicity of databases by various users within the Sector leading to challenges of inter/interoperability and maintenance.

An assessment done by the Ministry of Health in 2007 showed that there were over 70 different stand- alone databases in the Health Sector for health facilities. This has resulted in duplication of data and errors in the data sets.

To address this challenge, HIS developed a master inventory of health facilities and the services (Master Facility List, MFL). However, the accuracy of the data in terms of completeness, location and services is far from satisfactory.

Information, Communication Technology

The information communication technology sector is a fast-changing field. Effective health services also rely on accurate and relevant information that is appropriately managed for decision making. The HealthSector has in past invested heavily on Health Management Information Systems, whose use need to be enhanced in management of patients. In this regard, automation of hospital services will promote efficiency and timely service delivery through the use of e-health and related services.

2.1.3 RESEARCH AND DEVELOPMENT SUB-SECTOR

Research and Development is a sub- sector borne out of the realization that Kenya must harness in a coordinated manner, the best possible human capital and research technology which will position the country in modern world economy that is increasingly globalized and knowledge based. R&D will therefore lay the foundation for attainment of scientifically and technologically advanced society by supporting the national development strategy based on the Kenya Vision 2030. The development of the necessary scientific infrastructure, technical and entrepreneurial skills, is essential ingredients for the transformation of Kenya into a middle income country.

The vision for KEMRI is "To be the leading global centre of excellence in human health research," and the Mission is; "To improve human health and quality of life of in Kenya

through biomedical research, innovations and capacity building." The mandate of KEMRI is to;

(i) To conduct research aimed at providing solutions for the reduction of the infectious, parasitic and non-infectious diseases and other causes of ill-health in Kenya

(ii) To disseminate and translate research findings for evidence-based policy formulation and implementation.

(iii) To strengthen research partnerships and relationships with other stakeholders.

2.2 REVIEW OF KEY INDICATORS OF SECTOR PERFORMANCE

The key Health Sector monitoring indicators are shown in Table 2-1 and Table 2-2. The performance indicators in the Medical Services Sub-Sector include inpatient malaria mortality, births attended by skilled medical personnel and access to ARVs. In the Public Health Sub-Sector, the key indicators are child and maternal mortality, immunization coverage and prevalence of HIV and AIDS. The performance of these indicators during the period under review is highlighted below:

Table 2-1: Performance of Health status indicators in the Medical Services Sub-Sector 2008/09 – 2010/11

INDICATORS	Base Year (2007)	ACTUAL 2008/09	ACTUAL 2009/10	ACTUAL 2010/11	TARGET 2010/2011
Reduce the burden of disease: Inpatient malaria mortality as percent of total inpatient morbidity	19	17	16	16	13
Increase proportion of births attended by skilled health personnel (percent).	51	67	44	43	66
Increase coverage of eligible patients on ARVs (percent)	58	55	55	56.2	70

Source: Kenya Demographic and Health Survey 2008/09; Handbook of National Reporting Indicators, Health Management Information System

Malaria

80percent of the population in Kenya is at risk of malaria infections. Malaria continues to afflict the population and accounts for 30percent of total outpatient attendances. The inpatient malaria is currently estimated at 16percent. Under the MTP, the Sectortargeted to reduce inpatient malaria to 13percent in 2010/11 while the achieved value was 16percent in 2010/11. The malaria target (Inpatient malaria mortality as percentage of total inpatient morbidity) was, however, not met. Nevertheless, the contribution of malaria mortality to total inpatient morbidity is on the decline, declining from 17percent in 2008/09 to 16percent in 2010/11. This is to some extent due to the effort by the Ministriesof Health'sintroduction of a new treatment policy on malaria using Artemisinin Combination Therapy (ACT).

Skilled Birth Attendant

The MTP target for skilled birth attendance for 2010/11 was 66percent. According to the most recent data, only 43percent of deliveries were performed by a health profession during the 2010/11 period, indicating that the target was not met. Factors associated with the low proportions of birth at health facilities include poverty, limited physical access to health facilities; limited skills at delivery and poor client management. During the period under review, the Sectorcontinued to upscale interventions namely: improving access to skilled delivery through construction and equipping of model health centres, employment of health workers per constituency and rolling out of the OBA to cater for the poor.

Access to Anti-Retroviral (ARVs)

The sector targeted to increase the proportion of ARV from 58 percent in 2007 to 70 percent in 2010/11. This target was however not met since only half (56 percent) of those eligible were on the treatment. Although the number of AIDS related deaths has declined from 120,000 annually in 2003 to the current 85,000 because of the availability of the ARVs, this situation may not be sustained because the financing of the ARVs is largely dependent on donor support.

Public Health and Sanitation

Table 2-2 gives a summary of the HealthSector outcomes for the Public Health and Sanitation sub-sector.

Table 2-2: Performance of Health status indicators in the Public Health and Sanitationsub-sector 2008/09 – 2010/11

INDICATORS	Base Year (2007)	ACTUAL 2008/09	ACTUAL 2009/10	ACTUAL 2010/11	TARGET 2010/11
Reduce under 5 mortality (ratio per 1000)	92	74	74	74	45
Reduce maternal mortality (ratio per 100,000)	414	488	488	488	200
Immunization coverage (percent)	71	77	77	77	90
Reduced HIV prevalence (percent)	7.4	6.4	6.4	6.4	6.4

Sources: Kenya Demographic and Health Survey 2008/09; Handbook of National Reporting Indicators, Health Management Information System

Infant and Under 5 mortality

The trend of national Under-five mortality rate has shown a decline over the years. The under-five mortality declined to 74 deaths per every 1,000 live births in 2008/09 down from 115 deaths per every 1,000 live births in 2003. There are no recent data for the period under review. The target set by the sector for the 2010/11 period was 45 deaths per every 1,000 live births. This target was not achieved however; a number of interventions including, full immunization, children sleeping under a treated mosquito net, etc. were put in place to sustain the declining trend.

Maternal Mortality

Maternal Mortality remains a major challenge for the HealthSector. Maternal Mortality Ratio (MMR) is estimated at 488 deaths per every 100,000 live births according to the estimates in 2008/09. There are no recent data for MMR. The Medium Term Plan (MTP) target was to reduce MMR to 200 deaths per every 100,000 live births by 2010/11. The target was therefore not met therefore there is need to upscale interventions in the future to reverse this trend.

Immunization Coverage

One of the effective primary health interventions in reducing child mortality is child immunization. The sector has continued to strengthen immunization activities throughout the country under the Kenya Expanded Programme on Immunization (KEPI). The immunization coverage has significantly increased over the years from 71percent in 2007/08 to 77percent in 20010/11. The target of 90percent in 2010/11 was however not met.

KEPI stepped up surveillance on AFP and B (Hip). The Government and Global Alliance for Vaccine Initiative (GAVI) have introduced B (Hip) vaccination and a site at KNH to vaccinate children aged between one month and five years.

Pneumonia vaccine for children

The pneumococcal vaccine was introduced globally in a bid to reduce child mortality taking into account that Pneumonia is the most common form of serious pneumococcal disease and accounts for 18percent of child deaths in developing countries, making it one of the two leading causes of death among young children.

Kenya is the first African country to roll-out this pneumococcal conjugate vaccine which has been specially-tailored to meet the needs of children in developing countries. It was launched on 14th Feb 2011, presided by the Minister for Public Health and Sanitation and officiated by the president.

Measles threat has declined with active case-based and laboratory surveillance systems. However, during the period under review, sporadic outbreaks of measles were reported and the sub-sectors responded effectively by conducting mass immunization campaigns. Kenya has been able to be polio free except the recent case emanating from one of the neighbouring countries. As a result, several rounds of vaccination campaigns were conducted to contain the disease.

Malaria prevention and control

Under the Public Health sub-Sector which implements the diseases prevention strategies, malaria campaigns were undertaken with a focus to reduce prevalence of the disease. More than 11million long life treated nets targeting children and pregnant women have been distributed. Through this campaign, nearly all children aged below 5 years received nets and it is estimated that 50percent of children aged below 5 years sleep under a net. In addition, over 3 Million households have been sprayed in 33malaria epidemic prone districts. The Government stepped up advocacy and public awareness campaigns at community level on prevention and control of malaria. Due to these interventions, no malaria outbreaks have been reported over the years. Currently, ArtemesininCombination Therapy (ACT) is being availed free of charge in public and Faith Based health facilities and at subsidized price over the counter in private chemists.

HIV Prevalence

The HIV/AIDS pandemic continues to pose tremendous challenges to the health system in Kenya. To contain the HIV and AIDS disaster, the sub-Sectors have continued with prevention,treatmentand care activities, which have contributed to the decline in overall

prevalence to 6.4percent in 2010/11 down from 7.4percent in 2007. The target for 2010/11 according to the MTP was 6.3percent which the sector has nearly met.

On prevention, Voluntary Counselling and Testing (VCT) and Prevention of Mother to Child Transmission (PMCT) services have been scaled up. To date, there are about 1,000VCT sites, compared to 3 sites in 1998. Currently there are 3,000 PMCT sites caring for pregnant women. The public health sub-sector continues to avail condoms whose uptake is estimated at 24million monthly.

Research and Development sub sector

The sub- sector has three main programmes mainly Research and development, Production and services and capacity building.

Research and development

During the period under review, a total of over 315 publications in peer- reviewed journals were published. Key highlights include:

1. Malaria Vaccine trials RTSS
2. Oral Rehydration regimen
3. HIV- prevention trials
4. Contraceptives and HIV

Production and services

1) The development and commercialization of diagnostic kits for HIV 1 and 2 and viral hepatitis
2) 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
3) Production of Panel sera for QA in public labs
4) Production of TCB-cide (general disinfectant micro bacteria) and KEM-rub hand sanitizer antiseptic hands rub.
5) Production of KEMTAQ (Taq Polymerase)

Capacity Building

1. 156 students registered for various postgraduate courses while sixteen (16) students defended their theses in various disciplines
2. 3 International courses on school-based parasite control (targeting National level managers) were conducted where 52 trained.
3. 3 Third Country Training Programmes on school- based parasite control (targeting District level managers/implementers) were conducted where 55 trained.
4. ESACIPAC-PCD joint training courses on Strengthening Contemporary School Health, Nutrition &HIV Prevention Programmes (targeting Educationalists, Public Health Professionals & Community Development Workers): (70 trained)
5. ESACIPAC runs a school-based parasite control project in 92 primary schools in Mwea division, central Kenya.

2.3 EXPENDITURE ANALYSIS

This section provides an assessment of budget and spending of Medical Services sub-sector; and Public Health and Sanitation sub-sector during the period 2008/09 to 2010/11, followed by a discussion on trends by classification of expenditures. The budget and the expenditures are presented into two components: the **Recurrent**and the **Development**votes. The recurrent vote include funds for on-going provision of existing services (recurrent), while the development vote contains funds for capital expenditure (development) - financing expenditure activities like construction work and purchase of equipment.

2.3.1 ANALYSIS OF RECURRENT EXPENDITURE

Actual Recurrent expenditures for the Health Sectorhas increased over the period under review. In 2010/11 FY, the actual expenditures was at Kshs. 35 billion up from Kshs. 26.9 billion in 2008/09. Although overall, there is an increase in actual expenditures, recurrent actual expenditures as a percent of the overall expenditure for the HealthSector has been declining; from 85 percent in 2008/09 FY down to 79 percent in 2010/11 FY.

Table 2-3: Recurrent Expenditure (Gross in Million Kshs) 2008/09-2010/11

Vote	Printed Estimates			Revised Estimates			Actual expenditure		
	2008/09	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**
Recurrent	25,531.80	28,126.60	35,165.00	27,631.60	30,442.50	37,208.50	26,926.50	30,001.00	35,011.75
Recurrent as % of Total	76	64	70	84	70	65	85	79	79

Source: Budget Estimates Books, Appropriation Accounts

2.3.2 ANALYSIS OF DEVELOPMENT EXPENDITURE

The HealthSector has seen an increase in the funds dedicated to the Development. This can be attributed to the Government implementing the facility reforms agenda. Over the period 2008/09 FY to 2010/11 FY; the actual expenditures increase from Kshs. 4.8 Billion to 9 billion. This is 87 percent increase over a period of 3 years. Overall, unlike the Recurrent vote, the Development vote has been increasing from a 15 percent share in 2008/09 to 22 percent in 2010/11 FY.

Table 2-4: Development Expenditure (Gross in Million) 2008/09-2010/11

Vote	Printed Estimates			Revised Estimates			Actual expenditure		
	2008/09	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**
Development	7,939.10	15,592.80	14,802.79	5,312.90	12,897.10	20,168.53	4,869.80	7,835.70	9,088.80
Development as % of Total	24	36	30	16	30	35	15	21	21

Source: Budget Estimates Books, Appropriation Accounts

2.3.3 ANALYSIS OF EXTERNALLY FUNDS PROGRAMMES-MOMS

A number of donors have continued to support the Sector. There is existence of a fairly active mechanism for donor coordination in the form of the Health Sector Coordinating Committee, and the Development Partners on Health Group.

Donor activities are coordinated by the External Resources Department (ERD) of the Ministry of Finance, while the line ministries generally keep ERD informed about the implementation of donor projects.

The expenditure for the period 2008/09 to 2010/11 is as shown in Table 2-5 below.

Table 2-5: Analysis of externally funded programs 2008/09 to 2010/11

	Sub-Sector	FY 2008/09	2009/10	2010/11
1	Public Health and Sanitation	1,279.9	3,217.5	6,290
2	Medical Services	2,336	2,440	2,098
3	Research and Development	3,452	6,155	5,027

The details of the donor funds expended in the period under review are in **Appendix 2**
On average more than 50percent of the donor funding is used on payment of personnel emoluments. In view of the above and in order to realize the Kenya Vision 2030 goals, the Kenya Government is requested to increase funding for research that will specifically address the critical health needs for the country, while the role of donor funding is coordinated and structured to support such identified National priorities and critical health needs.

KEMRI

KEMRI receives its donor funding from collaborators and partners and individual scientists through proposals.

Donor funding for KEMRI has increased from Kshs. 3,452 Million to Kshs. 5,027 Billion, a 46percent increase over 2008/09 to 2010/11 Financial Years. The proportion donor funds as part of the overall KEMRI funds increased from 73.3percent to 77.9percent within the same period. It is important to note that this are off budgets which are expended as per the individual donor budget mainly supporting research activities which often may not be priority issues for Kenya.

2.3.4 EXPENDITURE REVIEW BY PROGRAMMES

This section presents an analysis of Sectorexpenditure by programme and sub-programmes.In line with the increase in Governmentrevenues, actual expenditures in the Medical services have increased during the period under review from **20.7** billion in 2007/08 to **25.1** billion in 2010/11.

Recurrent actual expenditures rose from **19.3** billion in 2007/08 to **23** billion in 2010/11. Further, Development expenditures increased from **1.4** billion in 2007/08 to **2.1** billion in 2010/11.

The trend analysis revealed that:

a) The recurrent allocations and expenditures generally dominate overall ministry allocations and expenditures. However, it is apparent there has been gradual decrease of recurrent allocations from 87 percent of total ministry's allocation in 2007/08 to 76 percent in 2010/11, indicating the Government's commitment to spending on investments (development).

b) The gross original and revised budgets for the Ministry of Medical Services (MOMS) in 2010/11 financial year were Kshs **28,815.19** million and Kshs**31,564.2 million** respectively. The actual gross expenditure in 2010/11 FY stood at Kshs**25,109.2 million;**

c) Actual development expenditure declined by 45 percent in 2010/11 financial year compared to 2009/10 financial year. Overall expenditure to Development Vote accounted for 13.9 percent of total Ministry's expenditure in 2009/10 compared to 8.16 percent in 2010/11.

Much of the Ministry's expenditure is recurrent expenditure, with only 8.2 percent of total expenditure dedicated to development in 2010/11.

Recurrent expenditure remained high i.e.Kshs**22.8** billion in 2008/09 and to Kshs**23.1** billion in 2010/11 financial year and development as at 2010/11 is **2.05** Billion.
While reliance on donor funding for development spending is not a sustainable solution in the long-term, there is need for increase in government development spending in order to realise the flagship projects as outlines in the Vision 2030.

Table 2-6: Analysis of Expenditure by Programme – Medical Services sub-sector

CURATIVE HEALTH	Approved Estimates				Actual expenditure			
	2007/08	2008/09	2009/10	2010/11	2007/08	2008/09	2009/10	2010/11
Recurrent Budget								
Compensation to employees	11,287.0	12,199.0	12,375.0	12,523.0	11,395.0	11,849.0	12,370.8	12,318.1
as % Total Recurrent	57.8	52.7	53.5	46.2	58.9	51.8	53.6	53.4
Use of Goods and Services	3,112.0	4,941.1	4,424.2	3,369.4	2,558.0	4,955.8	4,384.4	3,357.7
as % Total Recurrent	15.9	21.4	19.1	12.4	13.2	21.7	19	14.6
Grants , Transfers and Subsidies	5,101.0	5,907.0	6,270.5	11,152.1	5,361.0	5,976.9	6,267.4	7,350.2

as % Total Recurrent	26.1	25.5	27.1	41.2	27.7	26.2	27.1	31.9
Acquisition of Non-financial Assets	28	79	75.7	45.3	24	72	73.9	34.9
as % Total Recurrent	0.1	0.3	0.3	0.2	0.1	0.3	0.3	0.2
Total Recurrent (Gross)	**19,528.0**	**23,126.1**	**23,145.5**	**27,089.9**	**19,338.0**	**22,853.7**	**23,096.5**	**23,060.9**
Development Budget								
Compensation to employees	302.0	280.0	0	0	550.0	254.0	0	0
as % Total Development	10.6	10.1	0	0	39	12.9	0	0
Use of Goods and Services	291.0	1,607.6	1,250.9	721.8	88.0	1,054.0	907.4	96.7
as % Total Development	10.2	58.2	28	16.1	6.2	53.4	24.4	4.7
Grants , Transfers and Subsidies	806.0	316.0	262.0	340.0	170.0	204.1	241.0	328.1
as % Total Development	28.3	11.4	5.9	7.6	12.1	10.3	6.5	16
Acquisition of Non-financial Assets	1,453.0	559.0	2,947.1	3,412.6	601.0	463.1	2,573.8	1,623.5
as %Total Development	50.9	20.2	66.1	76.3	42.7	23.4	69.1	79.3
Total Development (Gross)	**2,852.0**	**2,762.6**	**4,460.0**	**4,474.3**	**1,409.0**	**1,975.2**	**3,722.2**	**2,048.3**
Recurrent and Development								
Compensation to employees	11,589.0	12,479.0	12,375.1	12,523.0	11,945.0	12,103.0	12,370.8	12,318.1
as % Total	51.8	48.2	44.8	39.7	57.6	48.7	46.1	49.1
Use of Goods and Services	3,403.0	6,548.7	5,675.1	4,091.2	2,646.0	6,009.8	5,291.8	3,454.4
as % Total	15.2	25.3	20.6	13	12.8	24.2	19.7	13.8
Grants , Transfers and Subsidies	5,907.0	6,223.0	6,532.5	11,492.1	5,531.0	6,181.0	6,508.4	7,678.3
as % Total	26.4	24.0	23.7	36.4	26.7	24.9	24.3	30.6
Acquisition of Non-financial Assets	1,481.0	638	3,022.8	3,457.9	625	535.1	2,647.7	1,658.3
as % Total	6.6	2.5	10.9	11	3.0	2.2	9.9	6.6
Total Expenditure (Gross)	**22,380.0**	**25,889.0**	**27,606.0**	**31,564.2**	**20,747.0**	**24,828.9**	**26,818.7**	**25,109.2**

Table 2.7 shows the breakdown of approved and actual expenditure of public health sub-sector by economic categories. Compensation to employees (personnel emoluments) accounted for 56 percent of the total recurrent expenditure during 2010/11 FY which was a significant decline from 65percent in 2009/10 FY. Although expenditure on employee compensation has significantly improved in absolute terms from Kshs. 2.5 billion in 2008/09 to Kshs. 6.7 billion in 2010/11, in terms of percentage of total recurrent expenditure it represents a decline of almost 17 percent. However, while the ministry's spending on personnel emoluments has increased, 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 centres 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 likely to hamper service delivery.

Expenditure on goods and services (O&M), grants, transfers and subsidies and acquisition of non-financial assets accounted for 32 percent, 12 percent and 0.1 percent respectively in 2010/11 financial year. The analysis further shows that funds allocated to use of goods and services (O&M) in actual terms decreased from 33percent in 2009/10 to 32percent in 2010/11. However there is a significant increase from previous years (2008/09) and these shows the ministry's efforts to improve service delivery and to maintain existing facilities especially the rural health facilities. This trend implies that the ministry should be able to achieve the intended outputs.

Table 2-7: Analysis of Expenditure by Programme- MOPHS

PREVENTIVE AND PROMOTIVE HEALTH	***Approved Estimates***			***Actual Expenditures***		
	2008/09	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**
Recurrent Budget						
Compensation to Employees	1,670.8	3,661.8	6,723.8	2,511.0	3,924.0	6,725.0
as a % of total MOPHS Recurrent	*45*	*61*	*66*	*60*	*65*	*56*
Use of Goods and Services	957.5	2,256.6	1,957.5	607.9	2,006.8	3,799.2
as a % of total MOPHS Recurrent	26	37	19	15	33	32
Grants, Transfers and Subsidies	1,021.9	91.2	1,430.4	1,021.4	83.5	1,414.6
as a % of total MOPHS Recurrent	28	2	14	25	1	12
Acquisition of Non-Financial Assets	31.7	33.3	6.8	25.2	30.2	12.1
as a % of total MOPHS Recurrent	0.9	0.6	0.1	0.6	0.5t	0.1
Total Recurrent	***3,681.9***	***6,042.9***	***10,118.6***	***4,165.5***	***6,044.5***	***11,950.9***
Total Recurrent percent of Total	***59***	***56***	***39***	***59***	***63***	***63***
Development Budget						
Compensation to Employees	475.4	1076.8	2,184.1	154.2	0	1,281.3
as a % of total MOPHS Development	19	22	14	5	0	18
Use of Goods and Services	1,218.6	2,858.2	6,576.2	2,141.7	2,288.1	1,567.5
as a % of total MOPHS Development	48	59	42	74	63	22
Grants, Transfers and Subsidies	320	367.8	1,356.80	312.8	177.5	676.93
as a % of total MOPHS Development	13	8	9	11	5	10
Acquisition of Non-Financial	539.1	502.6	5,577.1	285.7	1,160.5	3,514.9
as a % of total MOPHS Development	21	10	36	10	32	50
Total Development	***2,553.1***	***4,805.4***	***15,694.2***	***2,894.4***	***3,626.1***	***7,040.5***
Total Development as percent of total	***41***	***44***	***61***	***41***	***37***	***41***
Recurrent and Development						
Compensation to Employees	2,146.2	4,738.6	8,907.9	2,665.2	3,924.0	8,006.3
as a % of Total MOPHS	34.4	43.7	34.5	37.8	40.6	42.2
Use of Goods and Services	2,176.1	5,114.8	8,533.7	2,749.6	4,294.9	5,366.7

as a % of Total MOPHS	34.9	47.1	33.1	38.9	44.4	28.3
Grants, Transfers and Subsidies	1,341.9	459.0	2,787.2	1,334.2	261.0	2,091.5
as a % of Total MOPHS	21.5	7.4	44.7	21.4	4.2	33.5percent
Acquisition of Non-Financial	570.9	535.9	5583.9	310.9	1190.7	3526.95
as a % of Total MOPHS	9.2	8.6	89.6	5.0	19.1	56.6
Total Expenditures	**6,235.0**	**10,848.3**	**25,812.8**	**7,059.9**	**9,670.6**	**18,991.4**

Research and Development

The recurrent expenditure has increased at an average rate of 6.25 percent for the last 4 years (4percent, 3percent, 17percent, and 1percent). This is a very small percentage considering the inflation rate of about 17percent per annum and the expected economic growth over the years. The absorption of the recurrent and development budget was 100 percent. However, the expenditure in donor funds is much more than budgeted due to the uncertainty of the expected project funding.

Table 2-8: Analysis of Expenditure by Programme- Research and Development

RESEARCH AND DEVELOPMENT	Approved Estimates			Actual Expenditures		
	2008/09	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**
Recurrent Budget						
Compensation to Employees	993	1,025	1,200	890	899	1,000
Use of Goods and Services	-	-	-	243	269	278
Acquisition of Non-Financial Assets	-	-	-	3	8	4
Total Recurrent Budget	993	1,025	1,200	1,136	1,175	1,283
Development Budget	-	-	-	-	-	-
Construction of staff houses	150	75	149	116	27	128
Total Development Budget	150	75	149	116	27	139
Total Expenditures	**1,143.0**	**1,100.0**	**1,349.0**	**1,253.0**	**1,202.0**	**1,422.0**

2.4 REVIEW OF PENDING BILLS

Table 2.9 presents a summary of pending bills by nature and type during the period under review. The main reasons for the pending bills are due to lack of provision and lack of liquidity (especially drugs).

The **Health Sector** had a total of Kshs 1,269.6 Million in pending bills for both recurrent and development for the period under review. Pending bills due to lack of liquidity were at 50 percent, while those due to lack of provision were also 50 percent. There was a slight decrease

in overall pending bills in 2010/11 compared to 2009/10 from Kshs 1,494 Million to Kshs 1,271 Million respectively.

Analysing the pending bills by sub Sectors, Ministry of Medical Services had the most (Kshs 636 Million), followed by KEMRI (Kshs 628 Million). Ministry of Public Health had the least pending bills at only Kshs 6.29 Million in 2010/11.

Unpredictability of the budget leading to, in particular, variations between the budget, and budget out-turns leaves the wide gap between estimates and actual expenditures. Together with delays caused by the existing capital project procurement policy, the accumulation of pending bills has become a problem, and to non-completion and stalling of development projects.**(Appendix 3)**

2.4.1 RECURRENT PENDING BILLS

Table 2-9: Summary of Recurrent Pending Bills by nature and type (Kshs Million)

Sub-Sector	Due to lack of liquidity			Due to lack of provision		
	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
Public Health and Sanitation	105.53	4.51	0.52	23.00	11.39	5.13
Medical Services	24	0	0	340	1,000	636
Research and Development	628	628	628	0	0	0
SUB TOTALS	757.5	632.5	628.5	363.0	1,011.4	641.1

Source: Various pending bill returns

The KEMRI owes the staff pension scheme a total of Kshs 597 Million exclusive of interests. The personal claim of Kshs 31 Million has since been written off the books.

2.4.2 DEVELOPMENT PENDING BILLS

Development	Due to lack of liquidity			Due to lack of provision		
	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
Public Health and Sanitation	0	0	1.15	0	0	0
Medical Services	740	0	0	0	0	0
Research and Development	0	0	0	0	0	0
SUB TOTALS	740.00	0.00	1.15	0.00	0.00	0.00

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

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

RECOMMENDATIONS TO REDUCE PENDING BILLS

a) Further disbursements should be accompanied by implementation guidelines especially for RHFs
b) The DHMB'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 AIE's and subsequent of funds should be done within the 1st quarter of the Financial year as this allows for proper planning/adequate consultation with Management Committees
d) Improving budget predictability.
e) 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.
f) A review of current procedures governing the release of certified and voted funds is needed in order to avoid delays, and to facilitate overall improvement in the implementation of the budget.
g) As revenues and resources for health improve, the MOH needs to add medical supplies, maintenance and repairs especially at the rural health facilities to its list of protected budget items as is the case for selected expenditures for core poverty programs

CHAPER THREE

3 MEDIUM TERM PRIORITIES AND FINANCIAL PLAN FOR THE MTEF PERIOD 2012/13 – 2014/15

INTRODUCTION

The Government through Vision 2030 has deliberately committed to undertake development processes aimed at making Kenya a globally competitive middle income country by 2030. Health is one of the key sectors in the social pillar social in the vision. In order to effectively address the challenges, the HealthSector prioritized key flagship projects that need to be implemented to support realization of the goal of the vision. The priority flagship projects are:

1. The develop and maintain human resource capacity to appropriately respond to the needs of the HealthSector;
2. To revamp, build and maintain the HealthSector infrastructure equitably across the country;
3. To strengthen procurement, warehousing, distribution and enhance availability of medicines and medical supplies across the sector through identification and implementation of priority reform agenda;
4. To develop innovative financing mechanisms within the sector to facilitate access to basic health care across the country;
5. To reorganize and modernize health information system to support decision making processes across all levels of the sector;
6. To reform and strengthen the governance and management structures within the HealthSector by delinking the roles of service delivery from policy, regulation and quality assurance from central Government;
7. Strengthen the management of health information for planning and decision making.
8. Health Research

To respond to constitutional requirement in priority setting during the budgeting process, the Government undertook a comprehensive consultative process with counties in order to get their views on the actual needs. Some of the key issues that were raised as priority include:

1) Inadequacy and poor state of infrastructure.
2) Inadequate human resources – in terms of numbers and skills mix
3) Frequent shortages of medicines and medical supplies
4) High level of disease burden

This chapter therefore outlines the sector's priority programmes and sub-programmes that need to be implemented to address the needs of vision 2030 and the concerns of the Counties as elaborated through the consultative forums. It further provides a detailed analysis of resource requirements for sector, sub-Sector, programmes, sub-programmes, Semi-Autonomous Agencies and the economic classification. Similarly, the criteria for resource allocation against the programmes and sub-programmes have been elaborated. The section below gives a detailed account of these priorities as well as their respective financial implications.

3.1.PRIORITIZATION OF PROGRAMMES AND SUB-PROGRAMMES

In order to efficiently utilize the limited resources within the HealthSector and gain maximum benefit, the HealthSector has defined the following programmes and sub-programmes in order of their priority

This chapter covers the Sector resource requirements and allocation in the medium term. These requirements are broken down into three (3) major programmes in the 3 sub-sectors.

3.1.1 PROGRAMMES AND THEIR OBJECTIVES

The Health Sector plans to implement three (3) programmes and fourteen (14) sub programmes during the 2012/13-2014/15 MTEF period. The programmes and sub programmes have been prioritized using the following criteria:

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,

The three (3) programmes in and their objectives are highlighted below**(Appendix4):**

Programme 1: Preventive and Promotive Health Services
Objective: To increase access to quality and effective Promotive and Preventive health care services in the country

Programme 2: Curative Health
Objective: Improve the health status of the individual, family and community by ensuring affordable health care services

Programme 3: Research and Development
Objective: To conduct and disseminate health research findings for reduction of infectious and non-infectious diseases and other causes of ill health.

3.1.2 PROGRAMMES, SUB- PROGRAMMES, EXPECTED OUTCOMES, OUTPUTS, AND KEY PERFOMANCE INIDCATORS FOR THE SECTOR

This section highlights the programmes and sub programmes that will be implemented by the sector in the 2012/13 Financial Year. It also presents the key outputs and key performance indicators for the programmes/sub-programmes.

Table 3-1: Programmes, sub-programmes and their outputs and outcomes

Sub Programme (SP)	Key Outputs	Key Performance Indicators
Programme 1: **Preventive and Promotive health care services** **Outcome:*Improved health through preventive and promotive care***		
SP 1.1 *General Administration and Planning*	1. *New Health Policy in place and implemented* 2. *National Health Sector Strategic Plan 2012-2017*	1. *Health Policy developed and finalized* 2. *National Health Sector Strategic Plan 2012-2017 developed and implemented*
SP 1.2 *Preventive medicine and promotive health*	1. *Immunization coverage for 1 year olds increased to 80%* 2. *ANC coverage (4 Visits) increased to 50%* 3. *Awareness on preventable diseases increased by 20%* 4. *Pregnant women receiving LLITN's increased* 5. *TB cases reduced by 20%*	1. *% of children under 1 year fully immunized* 2. *% of mothers attending ANC (4Visits)* 3. *No. of awareness campaigns held on preventable diseases* 4. *No of pregnant women receiving LLITN's* 5. *No of TB cases treated*
SP 1.3 *Disease Control Services*	1. *Eligible HIV clients on ARV's increased by 20%*	1. *% of eligible patients receiving ARVs*
SP 1.4 *Primary Health Care Services*	1. *Health facilities receiving HSSF increased to 90%* 2. *Supply of Essential Medicines and Medical Supplies increased*	1. *No. of Health facilities receiving HSSF allocations* 2. *No. health facilities with/without Essential Medicines/Supplies*
Programme 2: Curative Health **Outcome: *Improved health status of the individual, families and communities through acceptable and affordable curative health***		
SP 2.*1 General Administration and Planning*	1. *Development Kenya national Health policy framework* 2. *National Health Sector Strategic Plan 2012-2017*	1. *Health Policy developed and finalized* 2. *National Health Sector Strategic Plan 2012-2017 developed and implemented*
SP 2.2 *Technical Support Services*	1. *Sector annual operation planning process strengthened*	1. *Sector planning reports (AOP) produced*
SP 2.*3 Hospital (Curative) Health Services*	1. *Deliveries by skilled health personnel increased to 47%* 2. *Increase no. of Hospitals rehabilitated* 3. *Eligible patients on ARVs*	1. *No. of women delivered by skilled health personnel* 2. *No. of hospitals rehabilitated* 3. *No. of eligible patients on ARVs*

Sub Programme (SP)	Key Outputs	Key Performance Indicators
	increased to 20% 4. *Inpatient malaria morbidity reduced* 5. *Supply of Essential Medicines and Medical Supplies increased*	4. *No. of inpatients with malaria* 5. *No. health facilities with/without Essential Medicines/Supplies*
SP 2.4 *Standards, Research and Training*	1. *Hospitals accredited increased* 2. *Health facilities inspected increased*	1. *No. of hospitals accredited* 2. *No. of health facilities inspected*
SP 2.5 *Referral Health Services*	1. *Nurse to patient ratio improved* 2. *% of morbiditydue to Malaria reduced to 13%*	1. *Nurse to patient ratio* 2. *% of morbiditydue to Malaria*
Programme 3: Research and Development **Outcome:** ***Reduced infectious and non-infectious diseases though research findings***		
SP 3.1 *Sexual, Reproductive & Child Health*	*Scientific Publications*	1. *No. of products patented/commercialized* 2. *No. of innovations* 3. *No. of publications* 4. *No. of partnerships*
SP 3.2*Non-communicable Diseases*	*Scientific Publications*	1. *No. of products patented/commercialized* 2. *No. of innovations* 3. *No. of publications* 4. *No. of partnerships*
SP 3.2*Infectious Diseases & Parasitic Diseases*	*Scientific Publications*	1. *No. of products patented/commercialized* 2. *No. of innovations* 3. *No. of publications* 4. *No. of partnerships*
SP 3.3*Traditional Medicines & Drugs Research*	*Scientific Publications*	1. *No. of products patented/commercialized* 2. *No. of innovations* 3. *No. of publications* 4. *No. of partnerships*
SP 3.4*Biotechnology*	*Scientific Publications*	1. *No. of innovations* 2. *No. of vaccines, drugs, diagnostic tools developed* 3. *No. of publications* 4. *No. of partnerships*
SP 3.5*Public Health & Health Systems*	*Scientific Publications*	1. *No. of disease prevention models* 2. *No. of publications* 3. *No. of partnerships*

Sub Programme (SP)	Key Outputs	Key Performance Indicators
Programme 4: Capacity Building & Training		
SP 4.1 *ITROMID ESACIPAC Internships*	*Courses offered*	*1. No. of persons trained* *2. No. of courses developed*
Programme 5: Products & Services		
SP 5.1 *Services*	*Partnerships/networks established*	*1. No. of persons trained* *2. No. of courses developed* *3. No. of institutions* *4. No. of participating countries*
SP 5.2*Specialized diagnostics*	*Range of diagnostics*	*1. No. of diagnostics test*
SP 5.3*Prevention, Treatment & care*	*Scope of conditions covered*	*1. No. of patients covered;* *2. No. of institutions* *3. No. of targeted populations*
SP 5.4*Hazardous waste management*	*Safe disposal of hazardous waste*	*1. No. of institution served/tonnage of waste handled*
SP 5.5*HIV work place*	*Prevention programmes established*	*1. No. of Institutions served* *2. No. of policy documents developed*
SP 5.6*Food handlers*	*Improved hygiene*	*1. No. of institutions/individuals served*
SP 5.7*Outbreak investigation*	*Control of disease outbreak*	*2. No. of outbreaks investigated*
SP 5.8*Community outreach*	*Communities served*	*1. No. of outreaches conducted*
SP 5.9*Diagnostic kits*	*Licensed kits*	*1. No. of diagnostic kits produced*
SP 5.10*Diagnostic reagents*	*Approved reagents*	*1. No. of packs/sets produced*
SP 5.11*Disinfectants*	*Approved disinfectants*	*1. Volume produced*
Programme 6: Project Development		
SP 6.1 *Construction of laboratories*	*New equipped laboratories*	*1. No. of laboratories constructed and equipped*
SP 6.2*Completion of staff houses*	*Completion of staff housing units*	*1. No. of units completed*
SP 6.3*ICT Infrastructure and services*	*Improved ICT infrastructure across all the centers*	*1. Structured cabling of all the centers* *2. Installed the required hardware and software* *3. Internet and email services*

3.1.3 PROGRAMMES BY ORDER OF RANKING

Vision 2030 objectives and National Health Sector Strategic Plan II prioritizes the HealthSector programmes as follows;

1. Preventive and promotive Health Services
2. Curative health
3. Research and development

3.1.4 KEY STRATEGIC INTERVENTIONS IN COUNTIES

County consultations forums were conducted in October –November 2011in compliance with the constitution which recognises participation of the peoples good governance, integrity and accountability (Article 10) and public participation in financial matters (Article 201 (a)). The Consultative forum covered all the 47 counties and involved all the MTEF sectors.

In the health sector the Key areas of concern were:

- Human Resources In Health
- Health Infrastructure Development
- Supply Of Essential Medicines And Medical Supplies
- Disease Burden
- Service Delivery

The table below shows county interventions by order of ranking

Area of Intervention	**STRATEGIC INTERVENTIONS**	
	CURATIVE	**PREVENTIVE**
Human Resources In Health	Recruit more health workers and specialist.re-distribute and re-deploy the existing staff according to needs	Recruit more health workers e.g. Nurses, anaesthesist , clinicians., CHWs, Public Health Workers
	Avail more funding for Health workers training(capacity building on specialized skills)	
Health Infrastructure Development	Construct and equip hospitals country wide with amenity wards and equipment e.g. MRI Machines, CT Scans etc and other diagnostic equipment.	Construct and equip health centres and hospitals, Level 1,2,3 Health facilities
Supply Of Essential Medicines And Medical Supplies	Strengthening the procurement	Strengthening procurement and supply of essential medicines and medical supplies, establishment of regional depots
	Distribution and supply of commodities by implementing the pull strategy in hospitals	
Disease Burden	Health education and promotion	Research and prevention of communicable and non-communicable diseases
	Disease screening and control with regular check ups	
	Management and research on non-communicable and communicable diseases.	

Service Delivery	Enhance access and reach of health services at all levels and provide requisite equipment e.g. scanning equipment, ambulances.	Procure support services in hospitals e.g. ambulances, cold storages, flu vaccines
	Equip and operationalize facilities under C.D.F	

3.2 ANALYSIS OF RESOURCE REQUIREMENT VERSUS ALLOCATION

Table 3.3 below illustrates the sector resource requirements for 2012/13 and current allocation. The change in allocations for health sector between the period 2011/12 and 2012/13 was Kshs. 4.2 billion.

3.2.1 SECTOR (RECURRENT AND DEVELOPMENT)

The budget for the Heath Sector is based on three programmes on account of the split of MOH to the two independent Ministries. The programmes presented for the resource bidding process are preventive, curative 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 2012/2013 is 143,428million and their justifications are as provided below:-

Table 3-2: Total HealthSector requirement for FY 2011/12 – 2014/15

Sub-Sector	**Estimates**	**Allocations**	**Projected**		
	2011/12	**2012/13**	**2012/13**	**2013/14**	**2014/15**
Preventive	27,549	29,378	70,939	75,916	93,816
Curative	33,479	37,415	67,744	77,895	89,568
R&D	1,589	1,356	4,745	5,882	6,465
Total Sector Budget	**62,987**	**68,149**	**143,428**	**159,693**	**189,849**

3.2.2 SUB-SECTOR (RECURRENT AND DEVELOPMENT)

The Sub-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 First Medium Term Plan (2008 – 2012) while ensuring alignment of the HealthSector policies. The following table shows sub-sector resource requirements for both recurrent and development for the FY 2012/2013 as 143,428 Billion comprising of preventive, curative and research & development.

Table 3-3:Sector requirement for both Recurrent and Development FY 2011/12 – 2014/15

	Estimates	Allocations	Projected		
	2011/12	**2012/13**	**2012/13**	**2013/14**	**2014/15**
Recurrent					
Preventive	11,591	12,190	26,209	29,181	34,691
Curative	29,866	33,281	70,866	74,543	89,136
R&D	1,446	1,231	1,231	5,729	6,295
Sub-total	**42,903**	**46,702**	**98,305**	**109,453**	**130,122**
Development					
Preventive	15,958	17,188	36,290	40,882	49,394
Curative	3,613	4,134	8,690	9,204	10,163
R&D	143	143	143	154	170
Sub-total	**19,714**	**21,465**	**45,123**	**50,240**	**59,727**
TOTAL	**62,987**	**68,167**	**143,428**	**159,693**	**189,849**

3.2.3 PROGRAMMES AND SUB-PROGRAMMES

The programme and sub-programme requirement for the health Sector is Kshs **143,428**billion,**159,693**Billion and **189,849**Billion for the 2012/13,2013/14 and 2014/15 respectively.

Table 3-4 Programme and Sub- programme requirementfor FY 2012/13– 2014/15

Programme		**Estimates**		**Projected**	
	Sub-Programme	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Preventive and Promotive Health	General Administration and Planning	10,712	16,791	19,310	22,206
	Preventive medicine and Promotive health	13,216	29,941	34,432	39597
	Disease prevention and control	243	4,925	,5,664	6,513
	Primary Health Services	8,650	18,856	21,684	24,937
	Technical Services	144	426	490	563
Sub-Total		**32,965**	**70,939**	**75,916**	**93,816**
Curative Health	General Admin. and Planning	2,591	3,463	3,982	4,580
	Curative Health	14,744	43,138	49,609	57,050
	Health Training and Research	2,006	2,682	3,084	3,547
	Medical Supplies Coordinating Unit	467	6,281	7,223	8,305
	SAGAs	8,883	12,180	13,997	16,086
Sub-Total		**28,690**	**67,744**	**77,895**	**89,568**
Research and Development	Research and Development	45	2,237	2,684	2,953
	Capacity building and training	23	140	168	185
	Products and services	33	89	106	117

	Management and Administration	1,231	2,279	2,924	3,210
Sub-Total		**1,332**	**4,745**	**5,882**	**6,465**
Total Sector Requirements		**62,987**	**143,428**	**159,693**	**189,849**

On research and development, the sub-sector has been relying on donor funding for its research which is based on the donor budget and priorities. It is therefore imperative that the Government allocates more funds to the Institute in order to fulfil its research mandates in line with the Vision 2030.

3.2.4 ALLOCATION TO STRATEGIC INTERVENTIONS IN COUNTIES

The table below shows the costing allocation for both the National and County functions for the health sector.**(Appendix 5)**

SECTOR COSTING	**MEDICAL SERVICES**	**PUBLIC HEALTH**
Recurrent National expenditures (Various Heads)	12,633,494,342	9,309,787,983
Development National expenditures(Various Heads)	885,460,000	1,081,605,232
GROSS NATIONAL TOTAL	**13,518,954,342**	**10,391,393,215**
County Recurrent expenditures (Various Heads)	13,157,662,825	9,774,134,768
County Development expenditures (Various Heads)	3,588,875,730	3,229,212,017
GROSS COUNTY TOTAL	**16,746,538,555**	**13,003,346,785**

3.2.5 SEMI-AUTONOMOUS GOVERNMENT AGENCIES

The following table shows resource requirements of the HealthSector both recurrent and development for SAGAs namely Kenya Medical Training College,Kenya Medical Supplies Agency,Kenyatta National Hospital and Moi Teaching and Referral Hospital for the FY 2012/13,2013/14 and 2014/15 respectively.

Table 3-5 Semi-autonomous Government Agencies FY 2011/12 – 2014/15

Sub-Vote		**Budget Estimates**		
	2011/12	**2012/13**	**2013/14**	**2014/15**
RECURRENT vote				
KMTC	2,294	2,569	2,878	3,223
KEMSA	344	385	432	483
KNH	5,483	6,141	6,878	7,703
MTRH	2,107	2,360	2,643	2,960
Total	**10,309**	**11,855**	**13,634**	**15,679**
DEVELOPMENT vote				

Sub-Vote		Budget Estimates		
	2011/12	**2012/13**	**2013/14**	**2014/15**
KMTC	100	112	125	140
KEMSA	20	22	25	28
KNH	100	112	125	140
MTRH	70	78	88	98
Total	**290**	**325**	**364**	**407**

3.2.6 ECONOMIC CLASSIFICATION

The following table shows the Health Sector resource requirements by economic classification for the FY 2012/13,2013/14 and 2014/15 respectively..

Table 3-6 Health Sector requirement by economic classification for FY 2011/12 – 2014/15

	Estimates	Projections		
	2011/12	**2012/13**	**2013/14**	**2014/15**
Recurrent Expenditure				
Compensation to Employees	19,824	37,527	41,783	49,673
Use of Goods and Services	5,908	53,899	60,012	71,344
Current transfers Government Agencies	4,661	5,899	6,568	7,808
Other Recurrent Expenditure	517	980	1,091	1,297
Total Recurrent (Gross)	**30,910**	**98,305**	**109,453**	**130,122**
Development Expenditure				
Acquisition of Non-Financial Assets	11,579	14,863	16,548	19,673
Capital transfers to Government Agencies	3,094	3,915	4,359	5,183
Other Development	17,405	26,345	29,332	34,871
Total Development (Gross)	**32,077**	**45,123**	**50,240**	**59,727**
Total Expenditure	**62,987**	**143,428**	**159,693**	**189,849**

3.2.7 RESOURCE ALLOCATION CRITERIA

The following are the Resource Allocation Criteria used by sectors/Ministries

- Priority on Non-discretionary expenditures e.g. Personnel costs, Grants to Parastatals and transfers.
- Priority for on-going development projects
- Focus on the amounts of G.O.K counterpart funding to Development projects
- Ministerial budget committees agreements and consensus

CHAPTER FOUR

4 CROSS-SECTOR LINKAGES, EMERGING ISSUES AND CHALLENGES

4.1 INTRODUCTION

In executing its mandate, the Health Sector interacts within its sub-sector as well as with other sectors whose services contribute to its outcomes. These sectors include: Environmental protection, Water and Housing; Public Administration and International Relations; Agriculture and Rural Development; Energy Infrastructure and ICT; Education and General Economic, Commercial and Labour Affairs among others. In striving to achieve its goals and objectives, the linkages within the sub sectors and with other sectors need to be harmonized and strengthened. These will ensure optimal resource utilization and avoid wasteful overlaps and duplications.

4.2 INTRA LINKAGES WITHIN SUB SECTORS IN THE HEALTH SECTOR

4.2.1 Medical Services

The linkages with other Sub-Sectors could be viewed on the need to have a healthy nation. Every individual has a duty to lead good health promoting lifestyles. The Government is duty bound to provide health care services as it seeks to promote her socio-economic agenda.

A healthy nation will lead to less expenditure on curative services and the resultant impact will be a more productive population leading to higher economic development. This will propel the population to a higher standard of living.

Important linkages are basically related to the social determinants, which contribute to improved health status. The social determinants include literacy levels, employment and poverty levels, globalization, urbanization and housing conditions, occupational hazards.

4.2.2 Public Health and Sanitation

The Public Health and Sanitation sub-sector works closely with KEMRI and Medical Services sub-sectors to provide stewardship to the health sector development and implementing partners. For instance, the sub-sector collaborates with these two sub-sectors in policy development, strategic planning, resource management and monitoring and evaluation.

Where disease intervention measures are informed by research and innovation, then a healthy nation will also lead to less expenditure on preventive and promotive health services. The resultant impact would be a productive population leading to less referral cases. These linkages in the sub-sector are related to the social determinants such as literacy levels, unemployment, and occupational hazards etc which contribute to improved lifestyle.

4.2.3 Research and Development

The activities of KEMRI will contribute significantly to the scientific evidence base necessary for policy formulation and enhance evidence-based practices in service delivery in Kenyan Hospitals to achieve overall goals in the National Health Sector Strategic Plan II (NHSSPII). Other Objectives elaborated in the Kenya National AIDS Strategic Plan (KNASP) will also be accomplished using research evidence from KEMRI and other Institutions. Increased interactions and exchange of technical information with Ministry of Medical services and Ministry of Public Health and Sanitation will contribute to the improvement in quality of health services.

KEMRI will support and facilitate the translation and dissemination of research findings into policy and practice guidelines, through its Knowledge management and Knowledge

translation platform being set-up through the Regional East African Community Health-Policy Initiative (REACH-PI) currently based at KEMRI.

4.3. LINKS TO OTHER SECTORS

4.3.1 Energy, Infrastructure and ICT Sector

Infrastructural development and maintenance is a core responsibility of the Ministries of Roads, Transport, Energy, Information and Communications and Public Works (MRPW). The Health Sector will undertake various investments in infrastructure development at all levels including construction, rehabilitation and expansion of health facilities, research institutions infrastructure and thus will heavily rely on the Energy, Infrastructure and ICT Sector for technical support. Efforts will continue being pursued to ensure that the institutions under this Sector are connected to electric supply. The success of this programme can only be realized when all institutions are able to access reliable source of energy. The Ministry of Energy which falls under the infrastructure Sector through its rural electrification programme will continue fast tracking electricity connection to health facilities (dispensaries, Health Centres, Hospitals and medical training institutions infrastructure). The two sectors therefore, will work closely to ensure a well co-ordinated and speedy process of energy supply. The sector is in the process of providing ICT infrastructure to health institutions most of which are not connected to the main national grid. The success of this programme can only be realized when all institutions are able to access reliable source of energy. The Ministry of Energy through its rural electrification programme can fast track connection to HealthSector facilities. The two sectors therefore, will work closely to ensure a well co-ordinated process of energy supply. One of the key issues in the access to healthcare is lack of good roads especially in the rural areas. The distance to the nearest facility can be reduced if there is a proper road network. This will boost the referral system and allow pregnant women have access to health care facilities.

As the Health Sector continues to embrace ICT as medium for e-health delivery, internet connectivity will be a key resource for implementing e-health and Tele-medicine. The delivery of medical training programs and retrieval of research material from research and development sub-sector (KEMRI) is also depended upon the same. It will therefore be necessary to forge closer linkages with the Information and Communication Technology ministry to ensure these institutions benefit from the increasing investments in rural based e-services and the in-land/terrestrial connectivity programmes. At the same time, the sector will continue its linkages with the e-Government.

Local authorities have a duty to improve the standards of its health facilities. Currently the Ministry of Medical Services is providing staff Health Facilities under the City Council of Nairobi. The gesture was extended in order to have a proper referral system within the city and expected to decongest the Kenyatta National Hospital to allow it to concentrate on its core mandate of dealing in specialized health services.

4.3.2 Environmental Protection, Water and Housing Sector

The Ministry of Housing is charged with improving housing conditions in the country especially the slum dwellers. Provision of proper housing, water, environmental protection and sanitary conditions will lead to better the living conditions and hence reduce the incidence of vector-borne and other communicable diseases resulting in better health for all.

Provision of a clean living environment is crucial in delivering health services as it ensures a healthy population. The target for MDG goal No. 7 was to halve the proportion of people

without sustainable access to safe drinking water and basic sanitation by 2015. In line with this goal, the sector has been providing sanitation facilities in health facilities. The Health Sector will continue to work closely with the relevant ministries within the housing and amenities sector to ensure that water and sanitation facilities provided meet the set standards and the regulatory requirements.

4.3.3 Social Protection, Culture and Recreation Sector

One of the challenges facing the HealthSector is how to achieve gender equity in the provision of health training in line with MDG goal Number 3 and the national Gender Policy. In order to ensure that medical training programmes developed by the education sub sector are gender responsive, the sector will work closely with the Ministry of Gender, Sports, Culture and Social Services.

The HealthSector together with National AIDS Control Council (NACC) collaborates in implementing the HIV and AIDS programmes as well as with the responsibility of co-ordination, advocacy and mobilization of resources towards the scourge of HIV&AIDS. The HealthSector takes cognizance of the fact that every disaster becomes a health issue. The Disaster Preparedness Unit at Office of President is responsible for co-ordination of disaster efforts and mobilization of resources. Notable occurrences include the current drought, the frequent highway accidents, and the floods. The concern of the sector is the high attendant costs associated with such disasters. These costs are normally borne by the hospitals especially KNH (currently the waivers and exemptions at KNH total 771 million). The above is compounded by the high poverty levels in the country leading to low ability to pay for healthcare services. The sector proposes the creation of a revolving fund to cater for hospital costs.

4.3.4 Public Administration and International relations

The success of any programme in any sector is dependent on the funding levels and the timely disbursement of the same. In order for the sector to achieve its goals it will provide the necessary data and information to enable the Ministry of Finance provide the necessary funding in time.

The HealthSector will continue to play its role in the context of the policy environment. The ERS, the Public Service Reform under the Office of the President, the Public Fund (for HIV&AIDS, STD and Malaria), and the MDG's and other global initiatives will influence the mandate health of sector. One of the pillars of 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 by directing resources in promotive and preventive aspects of healthcare.

4.3.5 Education Sector

Education sector play a key in role providing the required knowledge, skills and attitude necessary for growth and global competitiveness. The education sector programmes such as free primary education and activities have geared at improving efficiency in core service delivery of providing accessible, equitable and quality education and training. The sector by ensuring the provision of an all inclusive quality education that is accessible and relevant to all Kenyans will contribute substantially to economic growth, expansion of employment opportunities and overall healthy population.

4.3.6 Governance, Justice, Law and Order Sector

The success of HealthSector services delivery is depended upon implementation of fundamental human basic rights in which health services provision to the citizenry is one of them. Therefore the HealthSector will work closely with relevant departments and agencies under this sector to develop HealthSector legal and policy framework including review of health related Acts and professional regulatory bodies. For instance, KEMRI embraces the core values which include: Sanctity of life; Equity; integrity; Quality; Creativity and innovation; Professionalism; Good corporate governance which guides its legislative endeavours while dealing with key integrity issues such as eradication of Corruption, and increased efficiency for cost reduction. The enforcement of HealthSector related legislation will require close cooperation between the national police service, state law among law enforcement entities.

4.4. EMERGING ISSUES

4.4.1. Financial Issues

Health spending has remained low as a share of overall Government budget, and as a proportion of the GDP, and in per capita terms. At the same time, available funding has been used largely to finance recurrent costs, less amounts allocated to the development budget.

Development expenditures have therefore continued to be substantially funded through donor support. However, the unpredictability of donor assistance both in terms of amounts and disbursement patterns has meant that planned projects/Programmes are affected. There is limited control of some of the Development Partners (DPs) funds by the sub sector, as DPs choose to finance most of the activities directly or channelling funds through non-governmental organisations.

4.4.2 Key Health Sector Issues

Despite the relatively good performance in health indicators, there are still numerous gaps in health outcomes. Kenya is not likely to achieve some Millennium Development Goals. At 488 per 100,000 live births, its maternal mortality ratio is high, mainly due to a number of factors including low level of health institutional deliveries (43 percent). And despite increasing use of contraceptives, the total fertility rate has been stagnating at around five births per woman for the last ten years.

Thus efforts to improve child health outcomes should be supported through cross-sectoral interventions that include improvements in access to clean water. Future interventions should also build on the success so far achieved.

Currently, infectious and communicable diseases as well as non-communicable diseases are prominent causes of mortality. Injuries (road traffic accidents) are also a significant cause of death. The contribution of injuries and non-communicable diseases to total morbidity and mortality is projected to increase, placing new challenges on the health system.

Besides the shortfalls in health outcomes, substantial inequalities persist in many health indicators, especially those relating to child health.

4.4.3. Access and Equity

Despite the expansion of health facilities, provision of health services remains uneven and the sub sectors continue to face a challenge in geographical distribution of its health workforce. Many health facilities are not adequately equipped according to norms and standards. Furthermore, ensuring sufficient supplies and equipment remains problematic, due to

inadequate funds. Although the Government continues to invest in the rehabilitation of health infrastructure, a lot still needs to be done.

4.4.4. Human Resources

The medical services sub sector has inadequate crucial health staff like doctors and nurses. Overall, Kenya has only 17 doctors per 100,000 people. There are regional disparities in the distribution of the existing health workers, where the hard- to-reach areas get disadvantaged with less staff.

To address this imbalance in the distribution of health personnel, standard and norms will be enforced. In the meantime the staffing norms will be revised to reflect the real demand for staff. Human Resources for Health Strategic Plan has been developed and addresses issues of the supply and demand for human resources in the entire public HealthSector in the country.

4.4.5. Emerging issues in the Health Sub - Sector

Kenya is confronted with several emerging health related issues. These include prevalence of non-communicable diseases (NCDs), whose socio-economic consequences would have both short-term and long-term implications on the Government and households. Further the inadequate health personnel, infrastructure, financial resources are important issues of concern.

While some diseases, in particular infectious diseases, could disrupt the day-to-day activities and livelihood of affected people in the short-run, diseases such as malaria, tuberculosis and HIV/AIDS could have long-term implications for education and labour markets, with adverse effects on the economy.

A pragmatic approach with a focus on issues of major health and socio-economic concern is vital for the improvement in health services. Striking a balance between different service providers taking into account overall resource constraints, efficacy of service delivery and gains is a key challenge. There is need to continue prioritization of interventions and targeting.

Policy reforms that encourage private sector participation in health service delivery and health insurance, and a regulatory framework to protect the environment could be important elements of a re-oriented health policy agenda.

4.4.6. Emerging priorities from the new constitution

The new constitution has brought issues that need to be addressed and include:

- Define legal, policy and operational imperatives of the constitutional “right to health”.
- Define new roles and responsibilities for Ministries of Health and County Health Management Teams.
- Plan for institutional restructuring of central MOH;
- Plan for and begin building capacity of County Health Management Teams.

4.4.7. OTHER EMERGING ISSUES

a) **Child Health, maternal and reproductive health**: While the 2008/09 KDHS indicates gains in child health outcomes since 2003, attention still needs to be paid to increasing and sustaining coverage of key high-impact interventions including immunization, LLITNs and nutrition. Maternal and reproductive health and family planning outcomes are still poor and need urgent attention by increasing access to emergency obstetric care (EOC), and stepping up high impact interventions.

b) **Nutrition:** poor maternal and child nutrition contributes directly to 30-50percent of maternal and child deaths, and can compromise achievement of higher-level national development objectives. While high impact interventions can be prioritized by the HealthSector, effectively addressing chronic and acute under-nutrition requires well-planned and coordinated multi-sectoral actions.

c) **Improving access for the poor:** Physical access to services is a challenge particularly in poorer districts and urban poor areas; user fees continue to be an obstacle to poor populations.

d) **Health systems strengthening to improve service delivery:** Many health facilities still lack adequate health personnel and stock-outs of essential medicines and medical supplies (EMMS) are common.

e) **Reporting:** Improving reliability of HMIS data for monitoring and evaluation remains a priority, and some progress has been made in improving reporting rates.

f) **GOK public funding for the health sector** continues to be inadequate. The GOK budget for health is about 7percent of the total Government budget, well below the Abuja target of 15percent.

4.5. RESEARCH AND DEVELOPMENT

KEMRI through its Graduate School for Health Sciences and extensive state-of-the art laboratories studentship attachments will link and integrate Research, Training and Specialized services to support National Health Sector Priorities as identified in the Vision 2030. KEMRI laboratories offer specialized diagnostic services such as Paediatric HIV diagnosis using PCR. This service is linked to National HIV/AIDS prevention, treatment, care and support programme.

4.5.1. POPULATIONS BEING TARGETED

KEMRI research is driven by the priority National Health issues. Special emphasis is placed on vulnerable groups such as women, children under five, youth and adolescents, as well as extremes of age. All Research and Technical staff of KEMRI as well as other stakeholders in the Health, STI and ICT sectors in Kenya will continue to give priority to critical health issues in Kenya affecting the target populations.

4.5.2. KEY LEGISLATIVE ISSUES

This activity will embrace the core values of KEMRI which include: Sanctity of life,Equity,integrity,Quality,Creativity and innovation; Professionalism andGood corporate

governance. Specific key focus will be Eradication of Corruption, and increased efficiency for cost reduction.

4.5.3. MONITORING AND EVALUATION

The KEMRI M&E Department and the Quality Management Systems department have developed robust indicators for quantitative and qualitative measures. The key concept throughout this section is that Functional Units can only assess the impact of an activity if they have previously defined what the activity is intended to accomplish, how the various inputs should work together to achieve the desired results, and how these results will be measured.

In order to successfully implement performance management and learn from experience, functional/operating Units will establish ways to collect performance information, analyze it for trends, and review it for meaning. Appropriate tools for each section and centre will be used to collect data and generate quarterly reports. Scheduled centre and departmental meetings for feedback will be used to discuss the progress and make necessary adjustments to achieve the desired goals. Internal audit and quality assurance and control will be carried out in accordance to the set operational guidelines and standard operating procedures. Centre Directors and heads of Units/sections or departments will take direct responsibility for ensuring achievement of the objectives set out in the annual operational plans.

4.5.4. EMPHASIS AREAS

This activity includes major emphasis on development of Network/Linkages/ research collaborations as well as Quality Assurance and integrated research, policy planning and enhancement of evidence-based medicine and public health practice. Community Mobilization/Participation and feedback of research results as well as application of research evidence to reduce disease burden.

4.6. CHALLENGES AND CONSTRAINTS

4.6.1 Medical Services

The Ministry of Medical Services faces several constraints including inadequate funding which result in gross inadequacy in:

i) infrastructure,
ii) Human resources and service delivery.
iii) Short of essential drugs and supplies.

Other challenges and constraints facing the Ministry include the following:

a) The shortage of health personnel is further compounded by mal-distribution, with a predominant urban bias;
b) High prevalence of preventable communicable diseases and rising incidence of non-communicable diseases;
c) The HIV/AIDS pandemic complicates the situation as substantial additional resources are required;
d) Few people have easy access to a health care Facility (only 52 percent of the population live within 5 kilometres of a health facility);
e) High poverty levels constrain demand for health services;

4.6.2. Public Health and Sanitation

Though commendable efforts towards addressing the inter-sect oral challenges affecting preventive and promotive health and particularly partnerships for development may have been initiated, nonetheless, shortfalls in agriculture, low literacy levels and lack of safe water,

sanitation, electrification and infrastructure, and frequent ethnic conflicts all drive up preventable disease burden. A vicious cycle remains in which poverty and its determinants drive up the burden of preventable diseases. While ill-health contributes to poverty, investment in promotive and preventive health could therefore contribute to economic development.

Preventive and promotive health system factors that will undermine the efforts to reduce the disease burden that are inter sector related as captured in county budget consultative fora have been:

- In sufficient sustainable financial resources and the efficient allocation thereof;
- Lack of social protection to the vulnerable groups especially those in catastrophic situations;
- A shortage of appropriately trained and motivated health worker;
- Poor commodity and supply system and unfair trade practices favouring the rich regions;
- Weak health systems operations;
- Marginalization of African Traditional medicine in national health systems;
- In adequate communities involvement and empowerment;
- Capacity of the private sector, including NGOs not full mobilized;
- Effective coordination with other sectors and harmony with partners not yet attained; and
- Lack of optimal inter-sectoral action and coordination.

4.6.3. Research and Development

KEMRI has foreseeable challenges which have existed and will continue to pose a threat to realizing the objectives set out above.

The first major challenge is sustained funding for basic science, continued innovation and Private Public Partnership (PPP), product development. Other aspects include: better balance for more neglected diseases; better management of translation research; enhanced Evaluation and Implementation Research for all diseases; enhanced coordination and interaction between initiatives, funding agencies, governments and regional bodies and the role for international agencies.

Secondly there is need for capacity building coupled to capacity utilisation; need to enhance community participation, 'stakeholdership' and ownership of research; need to 'embed' the output of research activities within the institutions ;need to enhance capabilities of Research Institutions to engage in 'innovation' as well as implementation

The following are specific issues which require urgent attention as well:

- Infrastructure - Health systems and research Infrastructure
- Funding – research funds not sustainable
- Dependence on donors
- Funding priorities for Vision 2030 First Medium Term Plan 2008 – 2012 (FMTP)
- Non-competitive terms of service for research scientists
- Translation of research findings into policy (push –pull mechanisms not enough)
- Human Research legal and regulatory frame work
- Institutional frame work
- Management and leadership

Final challenge is the need to address the non-competitive terms of service for research scientists in order to stem the “brain drain”.

CHAPTER FIVE

5 HEALTH SECTOR CONCLUSIONS

With Kenya's population growing at a rate of 3 percent annually, the population will continue to place a huge demand for health services. Kenya must continue expanding maternal and child health services while developing the capacity of the health systems to cater for communicable and non-communicable diseases which are on the rise.

The Government has committed itself to improving the HealthSector infrastructure. Attaining acceptable standards and norms has implications for staffing, equipment, infrastructure, and operating costs.

Kenya's Health Sector continues to put effort to deliver quality health services to the population with limited funds. Kenya enjoys the existence of a well-developed human resource base. The health care delivery system provides reasonable service in terms of both the amount of services produced and their appropriateness and quality.

The prospects for additional funds in the HealthSector in the medium term are scarce, as available public sources are limited. The medium term challenge for the HealthSector is to use available health resources more efficiently to deliver quality services and improve health outcomes. The Sector continues to put emphasis on a departure from the input-based approach to focus on improved outputs and outcomes. Health spending will continue to aim at meeting the population's health needs. This implies rationalizing existing physical and human resources and use of new budget principles based on outputs.
National Human Resources for Health Strategic Plan 2009 – 2012 which identifies the required distribution pattern and skill mix, has been developed. The plan helps the HealthSector to set realistic targets in the training and recruitment of health professionals. A considerable portion of the budget remains devoted to personnel. Health personnel deployment traditionally has not been based on existing needs. Health personnel, remain inequitably distributed across regions. Incentives should be provided to deploy health professionals to work in remote rural areas with a shortage of health care personnel.

The analysis has shown the trends in expenditure estimates and actual expenditure for the sector. The results show that the sector's allocation has significantly increased compared to the previous years. The increase in GoK allocation to the sector shows the Government's commitment towards preventive and promotive health. This trend should be maintained so as to reduce outbreak of preventable diseases.

The review has also shown that Government initiatives have started to yield positive results. For instance, the implementation of IFMIS has significantly improved the absorption capacity of the sector. This implies that there is a potential to improve efficiency in the utilization of budget allocations by exploring other innovative strategies. In particular there is need for the sector to explore mechanisms for improving efficiency of M & E.

Although the AOPs have information on donor commitments that are not reflected in the budget estimates (off-budget), the information does not indicate whether these are actual expenditures. For the information to be useful for planning purposes, it would be imperative for the donors to provide information on actual expenditures and not just their commitments. This will enable the sector to compare the outputs with the inputs.

The analysis shows that budget allocation to personnel emoluments has declined in 2010/11 financial year. Given that the sector continues to experience severe human resource shortage, the cut in budget allocation may impact negatively on the sector's capacity to delivery services.

The sector's intention is to fully implement the planned activities with the allocated funds. Inadequate budget allocation and the deteriorating economic conditions in the country seriously affected implementation of projects and other operations of the sector. Implementation of the income generation policy is expected to stimulate expansion of income generation activities. In addition, delays in disbursement of allocated funds caused delays in the utilization of funds.

CHAPTER SIX

6 KEY RECOMMENDATIONS

Priority setting involves directing resources to areas which benefit the most needy and have the highest payoff in terms of improving health outcomes.

The key Sector recommendations are as follows:

- Policy reforms that will reduce obstacles to efficiency.

- Reviewing existing recruitment procedures/guidelines with an aim of reducing recruitment and deployment bottlenecks in order to improve the capacity.
- implementing staffing norms and developing deployment policy
- Develop a mechanism for deployment of staff to Faith Based health facilities
- Recruitment, training, deploying and retention of Community Health Workers (CHEWS)
- Make Health Sector jobs more attractive in order to reduce turnover by conducting periodic review of compensation packages commensurate with qualification, experience and responsibility, lobbying for improved staff welfare amenities including housing and recreation facilities especially in hard-to –reach areas and regular review of the schemes of service.
- Improved management and Health worker performance by revising and developing leadership and management competencies for key management Posts

- Prompt availability of information on actual donor expenditures for purposes of improving the flows on off-budget financed health expenditures. The sector needs to establish a reporting mechanism that allows regular reporting by semi-autonomous and autonomous institutions and primary health facilities that receive off-budget funds from development partners. The off-budget financed expenditures should be aligned with the budget process. There is also need to have systematic and timely reporting of development partner financed activities that are off-budget, preferably according to a standard classification that is useful for managing for results.

- Treasuryensures that funds are released on time in order to give the Sector adequate time to spend the funds. Address absorption capacities of the sector so as to eliminate observed variances between approved estimates and actual expenditures for development expenditures.

- The Sector to put in place an effective monitoring system that links resources to outputs and strive to improve the efficiency of current spending to make room for investment and operational costs for most of the activities being implemented.

- Linking the preparation of AOP to the calendar budget

- Development of contingency plans to cater for unexpected increase in costs or to accommodate unexpected challenges in the future such as new disease outbreaks.

- Strengthen research infrastructure (internationally accredited Laboratories, equipment

- Improve and modernize the Information and Communication Technology infrastructure, Library resource centres.
- Contingency plans to cater for unexpected increase in costs or to accommodate unexpected challenges such as new disease outbreaks

- In the medium term, the government should consider increasing the allocation to the sector to progressively approach the Abuja target of 15 percent.

- Invest in equipments needed to address the majority of the types of cases handled, which tend to be primarily surgeries of low complexity.

- Improving the referral system to ensure that beneficiaries use hospitals for more complex services instead of bypassing lower level health facilities and that people utilize the level of service appropriate to their needs.

- Ensure that all facilities in the republic are in the 'PULL' system of distribution of EMMS by the start of the 2012/2013 financial year. The PULL system is expected to reduce wastage, reduce delays in distributing drugs to facilities and ultimately enhance and address the issue of drug stock-outs

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8 APPENDICES

Appendix1

Table 8-1: Number of health facilities by type and ownership (2010)

Controlling Agency	Hospitals	Health centres	Dispensaries	Maternity & Nursing Homes	Clinics	TOTAL
Ministries of Health	273	579	2,716	1	1	3,570
Faith Based Organization & Other NGOs	80	174	691	21	78	1,044
Other Public Institutions	11	47	336	-	35	429
Private	108	47	167	160	1870	2,352
TOTAL	472	847	3,910	182	1,984	7,395
Source: Health Management Information Systems (HMIS)						

Appendix2

Details of Research and Development Donor funds

Name of Donor	**2008/09**	**2009/10**	**2010/11**
Academy For Educational Development	2.80	-	3.60
American Embassy	963.36	871.38	874.29
AVAC-USA	-	0.22	2.86
Bill And Belinda Gates Foundation	34.32	14.78	24.56
Boston	-	1.75	0.51
Boston University	-	-	1.97
Case western Reserve University	6.31	3.13	(0.92)
DNDI	10.87	9.34	20.20
EARAS - Global TB Baccine Foundation	-	-	168.11
EDCTP	-	5.89	8.99
Embassy of Japan	-	0.07	-
European Union	-	1.13	2.31
Food Agriculture Org of United Nations	-	-	2.13
Garp – Kenya	-	0.28	1.22
Global Alliance Against TB	6.10	2.77	18.13
Global Fund Malaria	2.75	0.82	0.00
Global Development Network	0.45	0.03	-
Global Forum For Health Research	0.87	-	-
Global Fund Round 5	2.23	-	-

Government Treasury - USA	1,758.25	4,218.01	2,950.29
Hospital & Health admin services	2.07	1.37	1.28
IDRC	16.79	17.94	16.03
IMP	-	20.57	-
Imperial College of Sciences	-	-	3.17
International Parnership For Microbicide (IPM)	22.18	33.75	183.89
Inter-University Council of E.A	-	0.18	0.12
ITM – Belgium	1.15	1.36	13.24
Liverpool School of Tropical Medicine	-	-	3.20
Local Grants	-	14.70	31.44
M.A.C. AIDS Programme	-	1.00	1.00
National Institutes of Health - (NIH)	38.80	50.90	58.94
NCST	-	1.83	2.43
Other Collaborative Agencies	103.05	135.12	75.44
PATH	17.89	185.41	130.13
Pfizer	2.11	0.52	6.30
SUNY	-	-	0.62
UBS Optimus F/D	-	4.24	3.60
ULM University	-	0.59	0.61
UNICEF	-	0.33	0.54
Universal Corporation Ltd	-	-	0.75
USA University	129.81	185.68	6.92
VesterGaardFrandsen(SA)	-	2.84	3.03
Volkswagen Foundation	-	3.72	10.60
Welcome Trust Research Laboratories	311.57	328.75	355.15
World Food Programme	-	1.66	-
World Health Organization	18.60	33.80	40.32
	3,452	**6,156**	**5,027**

Appendix 3:
Summary of Pending Bills by Sub-Sector (Kshs million)

	Due to lack of liquidity			**Due to lack of provision**		
Type/Nature	**2008/09**	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**
MOPHS						
Recurrent	105.53	4.51	0.52	23.00	11.39	5.13
Development	0	0	1.15	0	0	0
SUB TOTALS	**105.53**	**4.51**	**1.67**	**23**	**11.35**	**4.62**
MOMS						
Recurrent	24	0	0	340	1,000	636
Development	740	0	0	-	-	-
SUB TOTALS	**764**	**0**	**0**	**340**	**1,000**	**636**
RESEARCH DEVELOPMENT						

Recurrent	628	628	628	0	0	0
Development	0	0	0	0	0	0
SUB TOTALS	**628**	**628**	**628**	**0**		**0**
TOTAL REC	757.53	632.51	628.52	363.00	1011.39	641.13
TOTAL DEVT	740	0	1.15	0	0	0
GRAND TOTALS	**1497.53**	**632.51**	**629.67**	**363.00**	**1011.39**	**641.13**

Appendix 4:
Programmes and Sub-Programmes

Programme	Sub-Programme	Objective
Preventive Services	General Administration and Planning	▪ To provide support to enable the provision of quality and effective health care.
	Disease prevention and control	▪ To reduce the burden of disease resulting from communicable disease
	Primary health services	▪ To provide essential health care to mothers and children
	Health promotion	▪ To support technical programmes and mechanisms in designing the necessary advocacy and information to the general public on disease and injury prevention and control
	System support	▪ To provide the essential health systems support necessary to execute the various health interventions
Curative health	Administration and Support Services	▪ To provide support to enable the provision of quality and effective health care.
	Curative (hospital) services	▪ To provide integrated and high quality curative and rehabilitative services to all Kenyans.
	Health Training (KMTC), Standards & Research	▪ To develop human resource capacity in health and enforce regulations.
	Technical support services (Medical Supplies Coordinating Unit, Preventive and Promotive Health)	▪ To ensure effective procurement and supply of essential medical supplies.
Research and Development	Sexual, Reproductive & Child Health	▪
	Infectious and Parasitic diseases Research	▪ To reduce 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. ▪ To reduce disease burden due to parasitic infections, particularly due to malaria, schistosomiasis, leishmaniasis, filariasis and intestinal parasites.
	Non-communicable Diseases	▪ To promote 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
	Epidemiology, Public Health & Health Systems Research	▪ To define and investigate the incidences and prevalence of diseases and health issues of major public health importance and develop strategies for promotion of better

Programme	Sub-Programme	Objective
		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.
	Traditional Medicines & Drugs Research	▪ To explores ways of developing therapeutics from herbs or traditional medicines in partnership with traditional healers, and also, exploits ethno-medicinal approaches to discover and develop therapeutic agents for infectious, parasitic or non-communicable diseases. ▪ To ensure toxicology and safety of herbal preparations.
	Biotechnology	▪ To promote 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
Capacity Building & Training	ITROMID	▪ To develop graduates with a high degree of professionalism, innovativeness and motivation. ▪ To collaborate with local universities, to develop postgraduate training in all aspects of tropical medicine and infectious diseases
	ESACIPAC	▪ To coordinate parasite control activities in the region. ▪ To do capacity building (training), operational research and networking. ▪ To build capacity for control of parasitic diseases
Products and Services	Production	▪ To produce diagnostic kits for enhancing blood safety ▪ To Produce disinfectants for enhancing Infection Prevention ▪ To produce pharmaceutical products
Management and Administration	Human Resources	▪ To Strengthen human resource capacity
	Operations & Maintenance (O&M)	▪ Strengthen research infrastructure ▪ Infrastructure establishment ▪ Maintain Infrastructure
	REACH-PI	▪ To strengthen systems for disseminating, translating and transmitting research findings for evidence-based policy formulation and implementation. ▪ To access, synthesise, package and communicate evidence required for policy and practice and for influencing policy relevant research agendas for improved population health and health equity ▪ To improve people's health and health equity in East Africa through more effective use and application of knowledge to strengthen health policy and practice
	ICT Infrastructure and Services	▪ To exploit fully the potential of Information Communication Technology (ICT) in the development and management of health research ▪ To Improve and modernize the Information Communication Technology (ICT) Infrastructure and services.
	Staff housing project	▪
	M&E	To strengthen the framework for monitoring and evaluation on a continuous basis
	Cross – Cutting	▪ To co-operate with other organizations and institutions of

Programme	Sub-Programme	Objective
		higher learning in training programmes and on matters of relevant research. ▪ To liaise with other relevant bodies within and outside Kenya carrying out research and related activities.

Appendix 5

COUNTY STRATEGIC INTERVENTIONS – MEDICAL SERVICES SUB SECTOR			
Programme: Curative health Programme			
Area of Intervention	**Tentative Cost**	**County**	**Remarks(Details of Summary of the intervention)**
Inadequate Human Resources In Health	5 Billion	47	Recruit more health workers and specialist. Re-distribute and re-deploy the existing staff according to needs Avail more funding for Health workers training(capacity building on specialized skills)
Health Infrastructure Development	3 Billion	47	Construct and equip hospitals country wide with amenity wards and equipment e.g. MRI Machines, CT Scans etc and other diagnostic equipment.
Supply Of Essential Medicines And Medical Supplies	4.5 Billion	47	Strengthening the procurement, distribution and supply of commodities by implementing the pull strategy in hospitals
High Disease Burden	1 Billion	47	Health education and promotion Disease screening and control with regular check ups Management and research on non communicable and communicable diseases.
Service Delivery	1 Billion	47	Enhance access and reach of health services at all levels and provide requisite equipment e.g. scanning equipment, ambulances. Equip and operationalise facilities under C.D.F

COUNTY STRATEGIC INTERVENTIONS – PUBLIC HEALTH SUB SECTOR			
Programme: Preventive health Programme			
Area of Intervention	**Tentative Cost**	**County**	**Remarks(Details of Summary of the intervention)**
Inadequate Human Resources In Health	9.8 Billion	47	Recruit more health workers e.g. Nurses, anaesthesist , clinicians., CHWs, Public Health Workers
Health Infrastructure Development	7 Billion	47	Construct and equip health centres and hospitals, Level 1,2,3 Health facilities
Supply Of Essential Medicines And Medical Supplies	9.3 Billion	47	Strengthening procurement and supply of essential medicines and medical supplies, establishment of regional depots
High Disease Burden	2.5 Billion	47	Research and prevention of communicable and non-communicable diseases
Service Delivery	2 Billion	47	Procure support services in hospitals e.g. ambulances, cold storages, flu vaccines

Key outputs, performance Indicators by programme andSub programmes in the health sector