Chapter 2 Overview of the Health System in Kenya

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This chapter provides an overview of the health system in Kenya as a context in which to view the findings of the 2004 Kenya Service Provision Assessment (KSPA 2004) survey. It presents information on the background of the Kenya Health Policy Framework and the general organisation of the healthcare system.

Health is defined here in its broad sense, being not only the absence of disease but also general mental, physical, and social well-being. In this definition, the environment in which people live—including access to nutritious food, safe water, sanitation, education and social cohesion—also determines health.

2.1 Historical Background of Kenya Health Framework

In 1994, the Government of Kenya (GOK) approved the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. It spells out the long-term strategic imperatives and the agenda for Kenya's health sector. To operationalise the document, the Ministry of Health (MOH) developed the Kenya Health Policy Framework Implementation Action Plan and established the Health Sector Reform Secretariat (HSRS) in 1996 under a Ministerial Reform Committee (MRC) in 1997 to spearhead and oversee the implementation process. A rationalisation programme within the MOH was also initiated. The above policy initiatives aimed at responding to the following constraints: decline in health sector expenditure, inefficient utilisation of resources, centralized decisionmaking, inequitable management information systems, outdated health laws, inadequate management skills at the district level, worsening poverty levels, increasing burden of disease, and rapid population growth.

The 1999 National Census estimated Kenya's population to be 28.7 million, of whom 56 percent was less than 20 years of age. In 2004, the population was estimated at 32.8 million. Life expectancy is on the decline, at 48 years for women and 47 for men, and expected to fall further due to the rising incidence and prevalence of HIV/AIDS. There is also a steady decline in the fertility rate, from 8.1 in 1978 to 5.4 in 1992, and to 4.9 in 2003 (but up from 4.7 in 1998). According to the 2003 Kenya Demographic and Health Survey (KDHS 2003), more married women are using modern contraceptive methods. The prevalence rate has risen from 18 percent in 1989 to 27 percent in 1993, 32 percent in 1998, and 33 percent in 2003.

Overall morbidity and mortality remain high, particularly among women and children. An infant mortality rate (IMR) of 62 in 1993 increased by 12 percentage points to 74 in 1998 and was not significantly different (at 77) in 2003. The under-five mortality rate also rose from 110 deaths per 1,000 live births in the period 1993-1998 to 115 in the 1998-2003 period. Maternal mortality in 2003 was estimated to be 414 maternal deaths per 100,000 live births, which is a decline from the 590 deaths estimated for 1998, but also with large sampling errors, which makes comparing the rates over time uncertain.

Malaria is the leading cause of outpatient morbidity in Kenya, accounting for one-third of all new cases reported. After malaria, the most common illnesses seen in outpatient clinics are diseases of the respiratory system, skin diseases, diarrhoea, and intestinal parasites. Other frequent health problems include accidental injuries, urinary tract infections, eye infections, rheumatism, and other infections. Combined, these ten leading conditions account for nearly four-fifths of the total outpatient cases reported. This pattern has persisted for the past decade. Recurrent outbreaks of highland malaria and widespread emergence of drug resistance strains have aggravated the problem of malaria.

In 2003, full immunisation coverage declined to under 60 percent (from 65 percent in 1998 and 78 percent in 1993), with the percentage of children receiving no vaccinations at all increasing from 3 percent in 1998 to 6 percent in 2003. The major causes of this decrease in coverage are the declining availability, access to, and quality of public health services; the increasing level of poverty is a main underlying factor. In addition, because fewer people are dying from immunisable diseases, the focus on immunisation services has reduced, and funding has decreased.

The challenge facing the government is to reverse this decline. The National Development Plan of 2002-2008 states that the health care system in its current form (at the time of the National Plan's preparation) does not operate efficiently. Some of the areas targeted in the plan include drugs, personnel, and facility utilisation. Drugs, which account for 14 percent of the health budget, were deemed to be the most promising area for improvement, particularly in drugs' selection and quantification. Staffing norms for key cadres would be developed for deployment purposes. The plan also calls for formulating a health manpower policy, to develop and retain human resources in the sector.

2.1.1 The First Health Sector Strategic Plan (1999-2004)

The development of the first National Health Sector Strategic Plan (NHSSP-I) for the period 1999-2004 was a follow-up to the Ministry of Health's efforts to translate the policy objectives into an implementable programme (MOH, 1999a). In addition to taking into account past constraints, the document involved key stakeholders in the planning process from the start through consultative workshops within the Ministry itself and with other stakeholders, such as development partners, public sector, districts, and provinces, the private sectors, NGOs, religious groups, professional organisations, communities, and users of health services, as well as teaching and research institutions. The end product thus incorporated the views and priorities of all these groups.

2.1.2 Findings of the External Evaluation of NHSSP-I

The NHSSP-I was evaluated in September 2004 by an external team of independent consultants. The evaluation found that

> *"...despite having well focused national health policies and reform agenda whose overriding strategies were focused on improving health care delivery services and systems through efficient and effective health management systems and reform, the overall implementation of NHSSP-I (1999-2004) did not manage to make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators of health and socio economic development as expected by the plan". This may be attributed to a set of factors, most of which are inter-related, such as*
>
> - *Absence of a legislative framework to support decentralisation;*
> - *Lack of well articulated, prioritized and costed strategic plan;*
> - *Inadequate consultations amongst MOH staff themselves and other key stakeholders involved in the provision of health care services;*
> - *Lack of institutional coordination and ownership of the strategic plan leading to inadequate monitoring of activities;*
> - *Weak management systems;*
> - *Low personnel morale at all levels; and*
> - *Inadequate funding and low level of resource accountability.*

As a result, the efforts made under NHSSP-I did not contribute toward improving Kenyans' health status. Rather, health indicators showed a downward trend. Infant and child mortality rates increased. The use of

health services in public facilities declined; in 1990 there were 0.6 new consultations per person, while in 1996, there were only 0.4 new consultations per person. The doctor-to-population ratio declined from the 1980s to the 1990s. The public sector's contributions to healthcare stagnated, going from US$12 per person in 1990 to US$6 per person in 2002. In more general development terms, poverty levels also increased, going from 47 percent in 1999 to 56 percent in 2002.

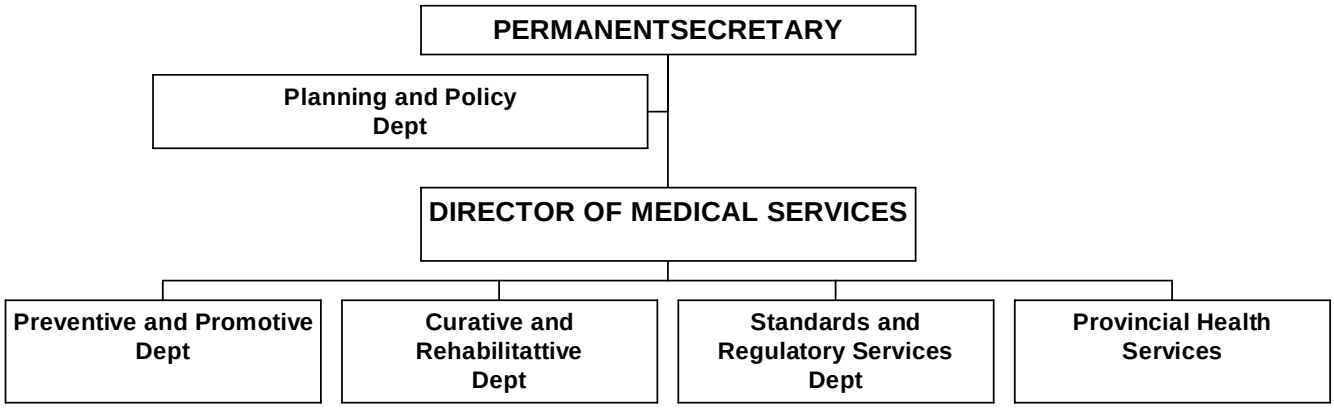
2.2 Organisation of the Health Care System

This section presents a brief overview of the organisation of the health care system in Kenya.

2.2.1 Organisation of the Ministry of Health

The Department of Preventive and Promotive Services (Figure 2.1) is responsible for the Reproductive and Child Health Programme, the Malaria Control Programme, the National AIDS/STI Control Programme, the Occupational Health Programme, the Parasite Diseases Control Programme, and others, with Maternal, Child Health, and Family Planning services included under the Reproductive and Child Health Unit.

Figure 2.1 Ministry of Health organisational diagram



2.2.2 The Health Care System

The health sector comprises the public system, with major players including the MOH and parastatal organisations, and the private sector, which includes private for-profit, NGO, and FBO facilities. Health services are provided through a network of over 4,700 health facilities countrywide, with the public sector system accounting for about 51 percent of these facilities.

The public health system consists of the following levels of health facilities: national referral hospitals, provincial general hospitals, district hospitals, health centres, and dispensaries.

National referral hospitals are at the apex of the health care system, providing sophisticated diagnostic, therapeutic, and rehabilitative services. The two national referral hospitals are Kenyatta National Hospital in Nairobi and Moi Referral and Teaching Hospital in Eldoret. The equivalent private referral hospitals are Nairobi Hospital and Aga Khan Hospital in Nairobi.

Provincial hospitals act as referral hospitals to their district hospitals. They also provide very specialized care. The provincial level acts as an intermediary between the national central level and the districts. They

oversee the implementation of health policy at the district level, maintain quality standards, and coordinate and control all district health activities. Similar private hospitals at the provincial level include Aga Khan Hospitals in Kisumu and Mombasa.

District hospitals concentrate on the delivery of health care services and generate their own expenditure plans and budget requirements based on guidelines from headquarters through the provinces.

The network of *health centres* provides many of the ambulatory health services. Health centres generally offer preventive and curative services, mostly adapted to local needs.

Dispensaries are meant to be the system's first line of contact with patients, but in some areas, health centres or even hospitals are effectively the first points of contact. Dispensaries provide wider coverage for preventive health measures, which is a primary goal of the health policy.

The government health service is supplemented by privately owned and operated hospitals and clinics and faith-based organisations' hospitals and clinics, which together provide between 30 and 40 percent of the hospital beds in Kenya.

2.2.3 Kenya Health Service

Services at the provincial and district level. As a result of health sector reforms that have decentralized health services, services are integrated as one goes down the hierarchy of health structure from the national level to the provincial and district levels. Under decentralisation, the district handles supervisory responsibilities. Unfortunately, supervision has not been very effective, as one technical person may supervise several technical areas of service delivery at lower levels.

Structure of service delivery. The Provincial Health Management Team (PHMT) provides supervision and management support to the districts and sub-districts within the province.

At the district level, curative services are provided by district hospitals and mission hospitals. Public health services are managed by the District Health Management Team (DHMT) and Public Health Unit of the district hospitals. The DHMT and District Health Management Board (DHMB) provide management and supervision support to rural health facilities (sub-district hospitals, health centres, and dispensaries).

At the sub-district level, both preventive and curative services are provided by the health centres as well as dispensaries and outreach services to the communities within the catchment areas. Basic preventive and curative services for minor ailments are being addressed at the community and household level with the introduction of the community package.

Non-governmental organisations, faith-based organisations and the private sector. Although several health-oriented NGOs operate throughout the country, the population covered by these NGO health services cannot be easily determined. The MOH and external donors support the health services offered by NGOs and the private sector in several ways. Depending on their comparative advantage, NGOs, FBOs, and community-based organisations (CBOs) undertake specific health services. The MOH provides support to mission health facilities by training their staff as well as seconding staff to these facilities and offering drugs and vaccines.

Currently, the private sector (both for-profit and not-for-profit) contributes over 40 percent of health services in the country, providing mainly curative health services and very few preventive services.

Modalities exist for MOH supervision and monitoring of NGO, FBO and other private-sector facilities. The NGOs and private facilities work with communities in collaboration with the DHMT. The commu-

nity programmes report to the DHMBs, which reports to the headquarters through the Provincial Health Management Boards. Their activities are guided by MOH standards and protocols.

2.3 Health Facilities

Tables 2.1 and 2.2 show the distribution of health facilities and hospital beds and cots by province. As seen in Table 2.1, the overall number of health facilities increased between 2001 and 2002. Although there was a decline in the number of hospital beds/cots per 100,000 population between 2003 and 2004, there has been a drastic increase from the numbers for 2001 and 2002.

Table 2.1 Health facilities and hospital beds and cots, 2001-2002

Number of health facilities in Kenya, and number of hospital beds and cots available, Kenya SPA 2004

Facility type	2001	2002
Hospitals/maternities	500	514
Health centres	611	634
Dispensaries	3,310	3,351
Total	4,421	4,499
Number of beds and cots	58,080	60,657
Number of beds and cots per 100,000 population	18.9	19.2

Source: Health Management Information System, Ministry of Health, 2005

Table 2.2 Health facilities and hospital beds and cots by province, 2003-2004

Number of health facilities in Kenya, and number of hospital beds and cots available, by province, Kenya SPA 2004

	Number of institutions								Hospital beds & cots			
	2003				2004				2003		2004	
Province	Hospitals	Health centres	Dispen-saries	Total	Hospitals	Health centres	Dispen-saries	Total	Number of beds/cots	Number per 100,000 population	Number of beds/cots	Number per 100,000 population
Nairobi	58	54	381	493	71	61	395	527	5,528	21.6	5,528	20.1
Central	65	89	372	526	69	95	392	556	8,542	22.9	8,543	21.2
Nyanza	64	42	334	440	72	37	344	453	8,871	31.4	8,871	30.3
N/Eastern	65	80	692	837	64	79	695	838	8,261	15.4	8,261	16.1
R/Valley	8	12	68	88	13	14	74	101	1.954	14.2	1,954	13.6
Eastern	98	117	333	548	102	118	336	556	12,871	23.2	12,871	26.3
Western	100	161	1006	1267	98	196	1080	1,374	12,832	16.5	12,951	15.4
Coast	68	94	196	358	73	91	198	362	6,992	19.4	6,992	18.0
Total	526	649	3,382	4,557	562	691	3,514	4,767	65,851	19.5	65,971	18.1

Source: Health Management Information System, Ministry of Health, 2005

2.3.1 Dispensaries

The dispensaries are at the lowest level of the public health system and are the first point of contact with patients. They are staffed by enrolled nurses, public health technicians, and dressers (medical assistants). The enrolled nurses provide antenatal care and treatment for simple medical problems during pregnancy such as anaemia, and occasionally conduct normal deliveries. Enrolled nurses also provide basic outpatient curative care.

2.3.2 Health Centres

Health centres are staffed by midwives or nurses, clinical officers, and occasionally by doctors. They provide a wider range of services, such as basic curative and preventive services for adults and children, as well as reproductive health services. They also provide minor surgical services such as incision and drainage. They augment their service coverage with outreach services, and refer severe and complicated conditions to the appropriate level, such as the district hospital.

2.3.3 District Hospitals

District hospitals are the facilities for clinical care at the district level. They are the first referral hospital and form an integral part of the district health system.

A district hospital should provide the following:

- Curative and preventive care and promotion of health of the people in the district;
- Quality clinical care by a more skilled and competent staff than those of the health centres and dispensaries;
- Treatment techniques such as surgery not available at health centres;
- Laboratory and other diagnostic techniques appropriate to the medical, surgical, and outpatient activities of the district hospital;
- Inpatient care until the patient can go home or back to the health centre;
- Training and technical supervision to health centres, as well as resource centre for health centres at each district hospital;
- Twenty-four hour services;
- The following clinical services:
  - Obstetrics and gynaecology;
  - Child health;
  - Medicine;
  - Surgery, including anaesthesia;
- Accident and emergency services;
- Non-clinical support services;
- Referral services;
- Contribution to the district-wide information generation, collection planning, implementation and evaluation of health service programmes.

2.3.4 Provincial Hospitals

Provincial hospitals form a secondary level of health care for their location. They provide services to a geographically well-defined area. Provincial hospitals are an integral part of the provincial health system. They provide specialized care, involving skills and competence not available at district hospitals, which makes them the next level of referral after district hospitals. Their personnel include medical professionals, such as general surgeons, general medical physicians, paediatricians, general and specialized nurses, midwives, and public health staff.

Provincial hospitals should provide clinical services in the following disciplines:

- Medicine;
- General surgery and anaesthesia;
- Paediatrics;
- Obstetrics and gynaecology;

- Dental services;
- Psychiatry;
- Accident and emergency services;
- Ear, nose and throat;
- Ophthalmology;
- Dermatology;
- ICU (intensive care unit) and HDU (high dependency unit) services.

They should also provide the following services:

- Laboratory and diagnostic techniques for referrals from the lower levels of the health care system;
- Teaching and training for health care personnel such as nurses and medical officer interns;
- Supervision and monitoring of district hospital activities;
- Technical support to district hospitals such as specific outreach services.

2.3.5 Teaching and Referral Hospitals

Moi Referral and Teaching Hospital and Kenyatta Hospital are the referral and teaching hospitals in Kenya. They are centres of excellence and provide complex health care requiring more complex technology and highly skilled personnel. They have a high concentration of resources and are relatively expensive to run. They also support the training of health workers at both pre-service and in-service levels.

Teaching and referral hospitals have the following functions:

Health care. Referral hospitals provide complex curative tertiary care. They also provide preventive care and participate in public health programmes for the local community and the total primary health care system. Referrals from the districts and provinces are ultimately received and managed at the referral hospitals. The referral hospitals have a specific role in providing information on various health problems and diseases. They provide extra-mural treatment alternatives to hospitalisation, such as day surgery, home care, home hospitalisation and outreach services.

Quality of care. Teaching hospitals should provide leadership in setting high clinical standards and treatment protocols. The best quality of care in the country should be found at teaching and referral hospitals.

Access to care. Patients may only have access to tertiary care through a well-developed referral system.

Research. With their concentration of resources and personnel, teaching and referral hospitals contribute in providing solutions to local and national health problems through research, as well as contributing to policy formulation.

Teaching and training. Teaching is one of the primary functions of these hospitals. They provide both basic and post-graduate training for health professionals.

2.3.6 Private Maternity and Nursing Homes

Private maternity homes fall under the governance of the Kenya Registered Midwives Association (KRMA). Some maternity and nursing homes are run by other health care professionals, such as doctors and clinical officers. Working in close collaboration with the Reproductive Health and Child Health Divisions of the Ministry of Health, they offer reproductive and family planning services. In addition, some child welfare activities are carried out on their premises by health staff of public health facilities.

2.3.7 Private Clinics

These provide mostly curative services and are operated by FBOs, NGOs, nurses/midwives, clinical officers and doctors.

2.3.8 Voluntary Counselling and Testing (VCT) facilities

VCT facilities provide HIV/AIDS counselling and testing services. They may be managed by the government, NGOs, FBOs, or private for-profit enterprises.

2.4 The Second Health Sector Strategic Plan (NHSSP-II): 2005-2010

In a renewed effort to improve health service delivery, the Ministry of Health and stakeholders have reviewed the NHSSP-I service delivery system in order to devise a new strategy for making it more effective and accessible to as many people as possible (MOH, 2004a). The recommended changes are contained in the Second Health Sector Strategic Plan. This plan proposes to improve service delivery by using the following levels of care delivery (see Figure 2.2).

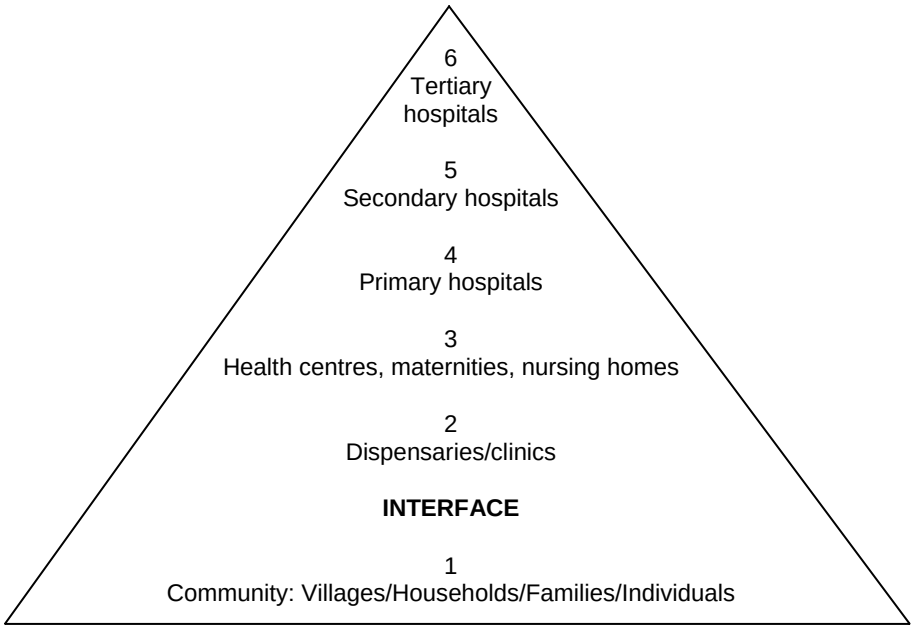
Level 1, the community level, is the foundation of the service delivery priorities. Once the community is allowed to define its own priorities and once services are provided that supports such priorities, real ownership and commitment can be expected. Important gains can be reached to reverse the downward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

Levels 2 and 3 (dispensaries, health centres, and maternity/nursing homes) will handle Kenya Essential Package for Health (KEPH) activities related predominantly to promotive and preventive care, but also various curative services.

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

In this way, the existing vertical programmes will come together to provide services to the age groups at these various levels. The plan adopts a broader approach—a move from the emphasis on disease burden to the promotion of individual health based on the various stages of the human cycle: pregnancy and the newborn (up to two weeks of age); early childhood (two weeks to five years); late childhood (6-12 years); youth and adolescence (13-24 years); adulthood (25-59); and the elderly (60+ years).

Figure 2.2 Levels of health care delivery in the Kenya Essential Package for Health (KEPH)



2.5 Health Manpower

Table 2.3 presents the number of health providers, both registered and in training, in comparison to the population.

Table 2.3 Number of medical personnel registered and in training, 2003-2004

Number of registered medical personnel and medical personnel in training, by year and type of personnel, Kenya SPA 2004

	Registered medical personnel				Medical personnel in training	
	2003		2004			
Personnel	Number	Number per 100,000 population	Number	Number per 100,000 population	2003/2004	2004/2005
Doctors	4,813	15	5,016	16	1,818	2,177
Dentists	772	3	841	3	141	147
Pharmacists	1,881	6	2,570	8	295	266
Pharmacists and pharmacy technologists	1,405	4	1,620	5	132	142
Bsc. Nursing	-	-	280	1	302	349
Registered nurses	9,869	33	10,210	32	1,281	1,342
Enrolled nurses	30,212	100	30,562	96	3,940	4,015
Clinical officers	4,804	16	4,953	16	406	425
Public health officers	1,216	4	1,314	4	282	296
Public health technicians	5,627	19	5,861	18	289	307
Total	60,509	192	63,227	198	9,086	9,455

Source: Health Management Information System, Ministry of Health, 2005

The total number of registered medical personnel increased slightly (by 4.3 percent) from 60,599 in 2003 to 63,277 in 2004. The number of medical personnel per 100,000 population improved from 192.1 in

2003 to 197.6 in 2004, and the number of medical personnel undergoing training increased by 4.1 percent, from 9,086 in 2003 to 9,455 in 2004.

2.6 Public Health Programmes

The MOH is focusing on a number of health priorities in Kenya, and specific health programmes have been developed to address these priorities.

2.6.1 Reproductive and Child Health

The Ministry of Health has sanctioned the existence and free unfettered operation of the Reproductive Health and Child Health Divisions. The Divisions have provided an annual report based on data from provincial, district, sub-district and rural health facilities.

The components of the reproductive health programmes are as follows (MOH, 1996):

- Safe motherhood, including antenatal, safe delivery, and postnatal care, especially breastfeeding, infant health and women's health;
- Family planning;
- Prevention and treatment of unsafe abortions and post-abortion care;
- Prevention and treatment of reproductive tract infections, including sexually transmitted diseases and HIV/AIDS;
- Prevention and treatment of infertility;
- Management of cancer, including prevention and management of cervical cancers;
- Discouragement of harmful traditional practices that affect the reproductive health of men and women, such as female genital mutilation;
- Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, preconception care, and sexual health;
- Gender and reproductive rights.

The reproductive health care system, which was designed for adults, is currently being modified to meet the needs of adolescents as well.

The Child Health Division constitutes all child health activities aimed at promoting and maintaining the optimal growth and development of children age 0-18 years. Its specific responsibilities are:

- To ensure survival, growth and development of children age 0-5 years;
- To promote health in all children, pre-school and school-age, including adolescents (up to 18 years), both in and out of school;
- To promote good nutrition to children, expectant and nursing mothers, the sick, and the general population, including elimination of micronutrient deficiencies;
- Promotion of child's rights and child protection.

The following strategies are applied to ensure quality child health:

Early childhood:

- Integrated Management of Childhood Illnesses (IMCI) 0-5 years
- Comprehensive school health programme 6-18 years

Neonatal health care:

- Nutrition programme;
- Promotion of exclusive breastfeeding for six months and timely intervention of complementary feeding;
- Immunisation;
- Growth promotion and nutrition rehabilitation;
- Curative care for minor ailments and injuries;
- Promotion of family/household practices that have greatest impact on child health;
- Child rights promotion.

School health services:

- Screening and examination of school children and food vendors;
- Immunisation and micronutrient supplementation;
- Health education on current public health issues;
- Management of minor ailments and injuries;
- Introduction of life skills and moral values including reproductive health;
- Maintenance of a hygienic school environment;
- School deworming;
- Referrals.

Adolescent health:

- Referrals identification and management of common health problems affecting adolescents;
- Provision of services focused on adolescents, including counselling, information, education and communication (IEC), and reproductive health issues in general;
- Referrals.

2.7 Health Insurance

Table 2.4 shows a breakdown of National Hospital Insurance Fund resources by receipts, benefits and contributions net of benefits for the 1999/2000-2003/2004 financial years. Total receipts rose by 4.6 percent (from Ksh. 2,523.9 million in 2002/2003 to Ksh. 2639.5 million in 2003/2004). Benefits accrued to members, however, dropped by 13.3 percent (from Ksh. 822 million in 2002/2003 to Ksh. 713 million in 2003/2004). Contributions net of benefits continued to rise throughout the five-year period (from Ksh. 1,286 million in 1999/2000 to Ksh. 1,926.2 million in 2003/2004).

Table 2.4 National Hospital Insurance Fund resources, 1999/2000-2003/2004

Kenya National Hospital Insurance Fund resources, including receipts, benefits, and contributions net of benefits, Kenya SPA 2004

Financial year	Receipts (millions)	Benefits (millions)	Contributions net of benefits (millions)
1999/2000	1,694.3	497.9	1,196.4
2000/2001	2,147.7	710.0	1,437.7
2001/2002	2,143.9	591.4	1,552.5
2002/2003	2,523.9	822.0	1,701.9
2003/2004	2,639.5	713.3	1,926.2

Source: MOH, National Hospital Insurance Fund, 2005

2.8 Financing the Health Sector

Adequate resources are critical to sustainable provision of health services. The Kenya policy framework of 1994 identified several methods of health services financing, including taxation, user fees, donor funds, and health insurance. These methods have evolved into important mechanisms for funding health services in the country. They should reflect the cost of service provision as well as the ability of the population to pay. In the non-governmental sector, health services are financed primarily through the revenue collected from fees and insurance premiums charged to service users. These are based on costs of service provision and on ability to pay.

2.8.1 Current Financing Trends, Policies, and Expenditures

Over the past decade, real financing allocations to the public sector have declined or remained constant. Reviews of public expenditures and budgets in Kenya show that total health spending constitutes about 8 percent of the total government expenditure and that recurrent expenditures have been consistently higher than the development expenditures, both in absolute terms, and as a percentage of the GDP. Per capita total health spending stands at about Ksh. 500 (US$6.2), far below the WHO's recommended level of US$34 per capita.

The per capita expenditure falls short of the Government of Kenya's commitment to spend 15 percent of its total budget on health, as agreed in the Abuja Declaration. The under-financing of the health sector has thus reduced its ability to ensure an adequate level of service provision to the population.

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

Over the past two decades, the GOK has pursued a policy of cost sharing to bridge the gap between actual budgets and the level of resources needed to fund public health sector activities. The revenue from the cost-sharing programme has continued to grow in absolute terms and as a percentage of the recurrent government budget. In 2002-03, cost sharing contributed over 8 percent of the recurrent expenditure and about 21 percent of the non-wage recurrent budget of the MOH.

However, because of the worsening poverty situation in the country, the MOH has changed its cost sharing policy and replaced it with a "10/20" policy, in which dispensaries and health centres are not to charge user fees for curative care other than 10 or 20 Ksh for client cards.

In addition, the MOH is planning to introduce in the coming years a National Social Health Insurance Fund (NSHIF). This is a social health insurance scheme to which everyone would contribute without exemption. For administrative purposes, contributions should be per head and not per family, although current entitlements in the National Hospital Insurance Fund also include family members of the insured. For those too poor to pay, the government would pay for them. In its tenth year of phased implementation, the scheme would be targeted to give comprehensive health care to 80 percent of the population. The sources of funding would include payroll harmonisation, general taxation, informed sector contributions, donations and grants. The scheme is outlined in Sessional Paper No. 2 of 2004 (Ministry of Health, 2004c).

The health budget allocation has continued to be skewed in favour of tertiary and secondary care facilities, which absorb 70 percent of health expenditures. Yet primary care units, being the first line of contact with the population, provide the bulk of health services and are cost effective in dealing with the disease conditions prevalent in communities.

Health personnel expenditures are high, compared to expenditures on drugs, pharmaceuticals, and other medical inputs such as medical equipment and supplies. Personnel spending accounts for about 50 percent of the budget, leaving 30 percent for drugs and medical supplies, 11 percent for operations and maintenance (O&M) at the facility level and 10 percent for other recurrent expenses. Expenditures for curative care constitute more than 48 percent of the total MOH budget.

The GOK works closely with development partners to raise money for the health sector. Donor contributions to the health sector have been on the increase, rising from 8 percent of the health budget in 1994-95 to 16 percent in the fiscal 2001-2002. In some years, donor contributions accounted for over 90 percent of the development budget of the MOH.

In summary, the Ministry of Health Public Expenditure Review (Ministry of Health, 2004b) reported that the flow of funding to health facilities, especially at the primary care level, is poor. Leakages amount to 22 percent of the user fee revenue collected. The review advised allocating more resources to community-based facilities, where health resources have been shown to be most effective in dealing with prevailing disease conditions and in promoting and improving people's health.

2.8.2 Ministry of Health Total Expenditures

Budgetary allocations to the MOH between 2000 and 2005 have increased steadily (Ksh. 12 billion in 2000-01 to Ksh. 23 billion in 2004-05). Table 2.5 shows MOH expenditures for both the Recurrent Account and the Development Account. Recurrent expenditures have increased both in absolute terms and as a proportion of total GOK spending and GDP, while development expenditures are somewhat variable, reflecting fluctuations in donor spending (Ministry of Health, 2005b).

Table 2.5 Ministry of Health expenditures

Kenya Ministry of Health expenditures, for the Recurrent and Development Accounts, in Ksh and US$ (millions), by year, Kenya SPA 2004

	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
Recurrent Account	11,041	12,715	14,405	15,438	15,952
Development Account	1,032	2,519	945	1,003	7,659
Total	12,072	15,234	15,351	16,441	23,611
Per capita Ksh	395.49	488.44	481.97	506.05	712.67
Per capita US$	5.05	6.28	6.29	6.52	9.10
MINISTRY OF HEALTH EXPENDITURES AS PERCENTAGE OF TOTAL GOVERNMENT EXPENDITURES					
Recurrent Account	7.67	8.23	8.69	7.76	7.22
Development Account	4.49	17.18	5.12	2.77	8.83
Total	7.23	9.01	8.33	6.99	7.67
MINISTRY OF HEALTH EXPENDITURES AS PERCENTAGE OF GDP					
Recurrent Account	1.32	1.38	1.40	1.41	1.29
Development Account	0.12	0.27	0.09	0.09	0.62
Total	1.44	1.65	1.49	1.51	1.91

Source: MOH, 2005b

2.9 General Recommendations for Future Health Sector Planning (2005-2010)

The overall thrust for future planning in the health sector should be to firmly address the downward spiral of deteriorating health status. The goal should be to reduce health inequalities and to reverse the downward trend in the impact and outcome indicators. These health inequalities exist between urban and rural

populations and between districts and provinces (66 percent of the population of Western Province is below the poverty line, compared with 46 percent in Central Province). They are related to gender, education and disability. The goal to reduce health inequalities can only be achieved effectively by involving the population itself in decisions on priority setting and consequently in the allocation of the resources. This requires a fundamental change in the existing governance structures in order to allow such a community ownership to take place.

Future planning needs to recognize that "reversing the trends" cannot be achieved by the government health sector alone. Active involvement and partnership with other stakeholders in the provision of care is needed. A functioning health system should be established that relies upon collaboration and partnership with all stakeholders whose policies and services have an impact on health outcomes.

The system should give a frame for sector-wide approach arrangement and bring flexibility for rapid disbursement of budgetary resources. A human resource plan will need to be developed to better staff the lower health facilities for effective primary health care. The new plan should strengthen monitory evaluation and reporting system. Additional resources should be dedicated to commodity security, especially for vaccines, reproductive health commodities, and essential drugs.

Gradually introducing the National Social Health Insurance Fund (NSHIF) to provide universal health care will help to reduce the current inequalities in access to care.