Health Financing in Kenya

THE CASE OF RH/FP
Acknowledgements

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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ARV(s)</td>
<td>Antiretroviral(s)</td>
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<tr>
<td>CBOs</td>
<td>Community Based Organizations</td>
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<tr>
<td>CDF</td>
<td>Constituency Development Fund</td>
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<tr>
<td>CMR</td>
<td>Child Mortality Rate</td>
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<td>CPP</td>
<td>Core Poverty Programme</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Care</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSOs</td>
<td>Civil Society Organizations</td>
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<td>DHMT</td>
<td>District Health Management Teams</td>
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<td>EPI</td>
<td>Expanded Immunization Programme</td>
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<td>ERS</td>
<td>Economic Recovery Strategy</td>
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<td>FPE</td>
<td>Free Primary Education</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GoK</td>
<td>Government of Kenya</td>
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<td>GoT</td>
<td>Government of Tanzania</td>
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<td>GoU</td>
<td>Government of Uganda</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSSF</td>
<td>Health Sector Service Fund</td>
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<td>HSSP</td>
<td>Health Sector Strategy Plan</td>
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<td>ICPD</td>
<td>International Conference on Population &amp; Development</td>
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<tr>
<td>ICT</td>
<td>Information and Communication Technology</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>ITNs</td>
<td>Insecticide treated (bed) nets</td>
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<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<tr>
<td>KIPPPRA</td>
<td>Kenya Institute for Public Policy Research and Analysis</td>
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<td>LATF</td>
<td>Local Authority Transfer funds</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<tr>
<td>NACC</td>
<td>National Aids Control Council</td>
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<td>NASCOP</td>
<td>National Aid and STI Control Programme</td>
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<td>NCAPD</td>
<td>National Coordinating Agency for Population Development</td>
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<td>NHSSP II</td>
<td>Second National Health Sector Strategic Plan (2005 – 2010)</td>
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<td>NSHIS</td>
<td>National Social Health Insurance Scheme</td>
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<tr>
<td>ODA</td>
<td>Overseas Development Assistance</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<tr>
<td>PEM</td>
<td>Public Expenditure Management</td>
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<tr>
<td>PETS</td>
<td>Public Expenditure Tracking Systems</td>
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<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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Foreword

The health sector in Kenya relies on several sources of funding: public (government), private firms, households and donors (including faith based organizations and NGOs) as well as health insurance schemes. Unfortunately, limitations in implementing an overall healthcare financing strategy has hindered effective planning, budgeting and provision of health services. The health system has also struggled with stagnant or declining budgets for health, system inefficiencies, persistently poor service quality and lack of equity.

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 should be intensified. The goal should be a functioning health system that relies upon collaboration and partnership among all stakeholders, and whose policies and services have an impact on health outcomes. The system should encompass a sector-wide approach and emphasise flexibility for rapid disbursement and constant monitoring of budgetary resources.

‘Health Financing: The Case of RH/FP in Kenya’ recognises that the State budget is the most concrete declaration of a government’s national priorities. Budgets express government commitment to a policy and indicate the level of priority assigned to it. It is hoped that improved budget transparency will increase public engagement in the budget process. This will in turn enhance pro-poor budget policies, allocations and outcomes.
Reviewer’s Comments

Using budget analysis as an advocacy tool for Reproductive Health and Family Planning, and the approach of combining a national level analysis with district or county-level case studies is excellent. Documented evidence by one estimate, indicates that Kenya is spending 60.7% of its health spending on HIV/AIDS. This raises major issues of distorted priorities and very serious issues of sustainability in health service delivery.

To look at overall health spending really requires a comprehensive study of all health spending. But for donor support and for NGOs this can be very difficult, as it is often difficult to collect the data, and some organizations do not have their own budgets disaggregated by sector. Future studies should aim at undertaking comprehensive district or county analysis of budget commitments and health financing resources that includes available donor and NGO resources. District Health Stakeholders Forum would be excellent venues for sharing information on resources and allocations. In general the paper has made the point: health services need to be improved, and analysis of the budgeting of health resources can be a very useful point for advocacy. It would be useful to discuss some of the formats or trend analyses that could be used to do the advocacy. There are some good examples in the recent focus on gender-based budgeting that could be adapted to health-based budgeting analysis.

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Executive Summary

Over the past decade, RH/FP has experienced limited financing in Kenya. Several studies attribute this to the apparent deliberate shift toward HIV/AIDS program at all levels (i.e., politically, officially and programmatically) at the expense of RH/FP programs. Limited integration of HIV/AIDS and RH/FP programs, and changes in the aid architecture have also affected RH/FP financing; this has disproportionately hurt the poor, who bear the brunt of inequity in access to services, poor service delivery and high maternal and child mortality rates.

Knowledge of budget analysis techniques therefore is key, as it enables Non State Actors to make more inclusive decisions and thereby paves the way for greater accountability and transparency in governance. Regular access to budget information, sound analytical and advocacy skills, alliance-building with other oversight government institutions as well as mutual trust are all key to ensure that Non State Actors substantiate policy arguments and strengthen public advocacy initiatives. Budget analysis creates public arguments for policy change, increases the bargaining power of Non State Actors and ensures a more equitable distribution of resources by creating opportunities for pre-budget lobbying.

Challenges facing the health sector require comprehensive and multi-dimensional policy responses informed by fiscal facts. This publication seeks to stir intensified advocacy for RH/FP at local, national, regional and international levels. It intends to reposition RH/FP policies and programmes and place them prominently on the funding agenda at all levels. The publication encourages Reproductive Health stakeholders to increasingly utilise several windows of opportunity to ensure Kenyans reap the benefits of enhanced Health and RH/FP financing.

Key findings

Trends in Budget Allocations to Health
The budget allocation to the health sector—Ministry of Medical Services (MoMS) and Ministry of Public Health and Sanitation (MoPHS)—for 2009/2010 was 47 billion KShs. This represents approximately 5.3% of the total estimated government budget and 1% of the Gross Domestic Product (GDP). That amounts to USD15 per capita. Total Government budget increased by 14% from 2008/2009 to 2009/2010.

Limited Allocations for Primary Health Care
The health budget allocation has continued to skew in favour of tertiary and secondary care facilities, which absorb 70% of health expenditures. Yet primary care units—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. 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% 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.

3 In pursuit of the recently signed National Accord and Reconciliation Act and as part of Government’s reorganisation process, the Government of Kenya split the Ministry of Health into two: Ministry of Public Health and Sanitation and Ministry of Medical Services.
4 GoK estimates of recurrent and development expenditures, Gross estimates.
5 Net expenditures, excluding AIA.
6 GDP estimates from IMF (retrieved 2009-04-22); exchange rate 77.02 KShs/$.
Limited Access to Health Care by the Very Poor
Under Kenya’s current health care financing system, 53% of health care costs are paid by clients when accessing services. This severely limits access to care by the very poor—who may not be able to afford service fees and who are least likely to have access to alternative financing options. With almost half of Kenya’s population living below the poverty line, this represents a significant restriction on access to health care. The cost-sharing system does include a set of fee exemptions and waivers designed to enhance access to services for the poor. Unfortunately, the system’s effectiveness has been hampered by an inability to accurately identify poor clients and by little incentive for facility managers to offer exemptions and waivers. Offering these options to poor clients may also result in a revenue loss that is rarely compensated for through other resource allocation.

Top Down Budgeting
District health budgets are prepared under NHSSP II (2005-2012) and run through district Annual Operations Plans (AOP) that are sent to the central government for financing. This means that district health facilities do not get sufficient funds to respond to their particular needs as they lack control of the budget allocations for the AOPs.

Breakdown of the Budget
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% of the budget, leaving 30% for drugs and medical supplies, 11% for operations and maintenance (O&M) at the facility level and 10% for other recurrent expenses. Expenditures for curative care constitute more than 48% of the total MOH budget.

Separation of MoMS and MoPHS
Prior to 2008, Kenya had one Ministry of Health; but in 2008, the political situation in the country led to new governance structures. The Ministry of Health and Sanitation was split into two entities: The Ministry of Medical Services and the Ministry of Public Health and Sanitation. A Health Sector Coordinating Committee is alternately chaired by the permanent secretaries of the MoMS and MoPHS.

MoMS and MoPHS have independent operational units at the district level with each ministry having distinct funding structures. While district health funding from MoMS is disbursed to the office of the district medical superintendent, MoPHS pays the office of the District Medical Officer of Health. This separation of the ministry of health into two independent ministries has implications on harmonisation of service delivery at the district level—with patients being the biggest losers. While promotion of safe motherhood, antenatal and family planning pillars fall under the MoPHS, safe and skilled delivery and post-partum pillars fall under the mandate of the MoMS.

The Role of Donors
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 11% of the health budget in 2005/06 to 15% in 2009/10. In some years, donor contributions accounted for over 90% of the development budget of the MoH.

Working around health budgets requires joint participation; therefore, in setting health targets and priorities, participation in planning and costing, monitoring the budget process and utilisation of services are key to suc-
cess. While the ultimate goal of budget advocacy in this case is saving lives, this study implies that advocacy requires comprehensive facts, resilience, regular dialogue and commitment.

**Recommendations**

The overall thrust for future planning in the health sector in Kenya should be to firmly address the downward spiral of deteriorating health status. Indeed, this publication recognises that critical obstacles to change lie in the realm of political economy and governance. The recommendations below target Drivers of Change’ who can affect pro-poor policies and health budgets. These include:

1. **The State realm.** Reformist elements among the political elite, civil servants, parliamentarians, political parties, and local government officials can be important advocates of change.

2. **The Civil Society realm.** Kenyan civil society is vibrant. However the most influential civil society organizations are predominantly Nairobi-based with middle-class leadership, and limited outreach to the poor and rural areas. There is a need to support grassroots-based Non-State Actors with increased resources and capacity building so they can work to achieve the recommendations below.

3. **The Academic realm.** Universities and other tertiary institutions have a crucial role to play in creating a well-educated and enlightened elite who espouse universal and democratic values. This paper hopes to encourage research and teaching on health financing that can have an impact on the quality of the policy process.

4. **The Religious realm.** Religious organizations have been heavily engaged in the provision of health and education services. In many cases they acted as a substitute for services that were not provided by the state. The main potential of faith groups as agents of change is that they have enormous outreach in areas where other civil society organizations are not present; it is therefore key that they increasingly speak out on health financing issues.

5. **The Media.** Some sections of the Kenyan media have acted as agents of change because of their role in disseminating information that is vital to ensuring public accountability. The relative freedom of the press is a positive factor that should help Kenya’s long-term prospects for increasing health finances.

6. **The Private sector.** Kenya has a dynamic private sector. Even though its lobbying efforts have mainly been directed at securing sectoral interests, such as trade protection for final products, tariff reductions on raw materials, and specific infrastructure investments, the private sector—with the right encouragement—can make a difference in pro-poor policies and especially health budgets.

This paper calls upon all the above drivers of change to:

**Address Rural and Urban Disparities**

Health inequalities exist between urban and rural populations and between districts and provinces. They are related to gender, education and disability. Reducing health inequalities can only be achieved effectively by involving both the rural and urban populations in decisions on priority-setting and in the allocation of both centralized and decentralized resources.

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7 Njuguna Ng’ethe et al (May 2004)
Monitor Off-Budget Support
The government should institute mechanisms of monitoring off-budget support both at national and regional levels to ensure contributions to specific service provision sub-sectors are documented and supplemented appropriately. This will enhance accountability and aid effectiveness.

Allow Community Ownership
Communities should be increasingly involved in the drafting, review, and implementation of policies within the general health sector framework, thus promoting community ownership. This will enable better and more responsive monitoring, evaluation and reporting in the lower health facilities for effective primary health care.

Enhance and Increase Advocacy
The government and its stakeholders need to enhance grassroots advocacy activities to empower communities in their role in implementing HSSF and to sensitize communities and healthcare providers to the importance of prioritising reproductive health in allocating these funds.

Internal Financing Targets
The two ministries of health should provide internal financing targets for supporting RH/FP. This will ensure RH/FP receives the attention it deserves within both ministries. It will be useful to follow the lead of those working in HIV/AIDS; for example, the Ministry of Special Programmes aims to spend 10% of the ministry’s budget on HIV/AIDS programmes.

Commodity Security
Additional resources should be dedicated to commodity security—especially for vaccines, reproductive health commodities, and essential drugs.

National Social Health Insurance Fund (NSHIF)
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. National Social Health Insurance Fund (NSHIF) is a social health insurance scheme to which everyone would contribute without exemption8.

Role of the Private Sector
The voice of the private sector—particularly the for-profit sector—has long been absent from the health and population policymaking process in Kenya. It will be useful to bring providers together and enable them to speak with a unified voice on health financing issues.

8 Ministry of Health (2004)
Chapter One  Introduction

1.1  Background

In Kenya rapid population growth is a major contributing factor to poor RH/FP indicators, which both cause, and are caused by, poverty. As the number of people in need of health, education, economic, and other services increases, so do the amount of resources, personnel and infrastructure required to meet the RH/FP needs. Fertility remains high in Kenya at 4.6 births per woman. One of the disturbing reasons for this is that one out of very four married women (25%) has an unmet need for family planning.

Kenya also continues to bear the burden of a high maternal mortality ratio that is not decreasing rapidly enough to reach the Millennium Development Goal 5 (MDG 5). Kenya’s maternal mortality has risen from 414 per 100,000 live births in 2003 (KDHS 2003) to more than 500 and up to 1,200 in some regions. KDHS findings for 2008-09 indicate that maternal mortality stands at 488 per 100,000 live births. This translates to about 21 mothers daily. Recent reports published in local newspapers rate unsafe abortions as a major contributing factor that leads to high maternal mortality rates in Kenya (Daily Nation, Oct. 26, 2009).

In the developing world, Kenya included, a woman’s lifetime risk of dying in pregnancy and childbirth is 1 in 76—as compared to 1 in 8,000 in industrialized countries. High burden of disease among the poor, inequity in access to health resources, ineffective health financing systems, high levels of poverty, weak governance and corrupt systems are all blamed for the slow progress towards meeting RH/FP needs in these countries.

This publication uses Budget advocacy, an approach to ensuring effective participation of citizens in government financing and thereby increasing effectiveness of development interventions. Budget advocacy improves transparency and the poverty focus of government expenditure priorities. Tracking of budgetary expenditures and impacts has also been found to be effective in ensuring effective utilization of health expenditures. Increased budget allocations and improved use of public funds that benefit poor and disadvantaged groups can ensure greater equity in budget priorities and further social justice objectives.

This publication supports activities of advocacy groups to strengthen democracy by fostering accountability, enhancing transparency, and deepening participation and voice on Reproductive Health and Family Planning issues in Kenya.

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10 Kenya National Bureau of Statistics and ICF Macro (2003),
11 UNICEF (2009)
1.2 Research Method and Scope of Study

‘Health Financing: The Case of RH/FP in Kenya’ recognises that poverty and health are intertwined. Low-income countries tend to have worse health outcomes than their better-off counterparts. Within countries, poor people have worse health outcomes than better-off people. The causal relationship is in both directions: poverty breeds ill-health, and ill-health keeps people poor. This study sought to interrogate Kenya’s health budget by asking the questions described in box 1.

This study sought to understand budget formulation and budget execution. The Analysis considered various levels or potential entry points for work. The First level of work was to analyse the design and policy structures, and look at where money is allocated and by whom. At this level, a desk review was undertaken to see whether the existing health, reproductive health and population policies were backed by budget commitments. A Second entry point was to assess whether issues of equity and effectiveness were being taken into account in the allocation of funds across departments, levels of government, regions and programs. The Third level of analysis focused on the facility level programs that provided primary health care. The budget analysis at this level sought to confirm whether reproductive health financing was getting to those who needed it most, and whether those programs or services were making a difference. The research results were derived from semi-structured interviews with respondents in different departments of government, organs of state, and community members. The qualitative data derived from these interviews were supplemented by a survey of budget documentation, audit reports, policy papers, and legislation.

The study framework examined several issues. The first dimension examined the four stages of the budget process—the drafting, legislative, implementation and auditing stages. The second dimension examined each of these stages by looking at the availability of information, the clarity of roles and responsibilities between institutions in the budget process, and the systems and capacity to generate budget information. The third dimension focussed on the legal framework supporting transparency and participation in the budget process. All these were aimed to increase Non-State Actors’ understanding of how they can participate in, influence and increase health finances and especially budgets for RH/FP.

The budget study interviews in Dagoretti district were conducted with health officials and community members. The interviewees were derived from the health centres (Mbagathi and Mutuini) and the district hospital (Mbagathi). Among those interviewed included the district medical officer of health (DMOH), the district medical superintendent (MedSup), the district public health nurse (DPHN), the district AIDS Control Coordinator (DASCO), the district clinical officer, the health centre in charge and senior nurse. These interviews with health decision makers sought to gain insight on their perception of the health-financing structures available to the facilities in which they work. To complement this data, exit interviews were conducted with community members—particularly women and youth—to better understand their judgment of the quality of services they receive.

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12 WHO Western Pacific Region (2006)
Box 1: Questions guiding this analysis

1.2.1 Budget formulation process

Is the budget process inclusive?
Is there evidence that hierarchical government agencies consult would-be beneficiaries?
Who are the stakeholders in budget formulation?
What are the opportunities for advocacy during budget formulation?
Whom do we need to involve in advocacy and whom do we target to demystify formulation?

1.2.2 Budget allocations

What does RH/FP constitute?
How much have the government and donors allocated to identified RH/FP areas?
How much are citizens spending/cost-sharing on identified RH/FP areas?
Where would we like to see increased funding allocations?
Whom do we need to target to increase allocations?
What are sources of Funding?

1.2.3 Tracking Expenditure and Auditing of resources

How does budgetary allocation move to the implementing agencies?
Is there evidence that there was timely and efficient use of the budget allocation?
How much money remained unused or returned to the exchequer?
Whom do we need to target to address expenditure issues?

1.2.4 Reality Check

Who are the stakeholders in RH/FP?
Who are the Providers? Governors? Auditors? Watchdogs? Recipients?
What do all stakeholders consider the reality/gaps in RH/FP service delivery?
What do all stakeholders consider barriers to RH/FP health service delivery?
What opportunities can we use to sensitize all stakeholders on each others’ plight?
Whom do we need to target to ensure gaps in service delivery are addressed?

1.2.5 Timelines

Can we collect data from 2005/2006 to 2009/2010 to build a case for RH/FP?
Chapter Two  Kenya’s Health and Reproductive Health Needs

Kenya’s population has increased rapidly during the past half-century, from 8 million in 1960 to 40 million in 2010. With a current rate of 2.8% per year, Kenya’s growth is equivalent to about 1,000,000 new births annually. The country’s population is projected to reach 71 million by 2030. Declining trends have been seen in health care financing, high disease burden, inadequate response to manage the disease burden, inefficient use of resources and inadequate management systems in the face of a rapidly growing population13.

2.1 Poverty and Health in Kenya

There are wide disparities in health across the country, closely linked to underlying socio-economic, gender, and geographical disparities14. Some 49% of the urban population and 53% of the rural population in Kenya live below the poverty line. The health care cost-sharing policy shows best the impact of poverty on people’s health. In 2007, 38% of sick Kenyans did not seek health care because they lacked money while another third resorted to self-medication15; 15.3% of those lacking money run into debts or sell personal assets to offset health care expenses. Hence, the poorest Kenyans face the greatest challenges in financing their health care needs—a situation consistent with the national poverty indices for all provinces. The wide gap between the rich and the poor is also evident in that the richest quintile of the population spends seven times as much out of pocket as the poorest quintile to finance their health services. With this they access better services in better-equipped facilities, while the poor get low-quality services from cheap health care providers with poorly equipped facilities16.

2.2 Kenya’s Key Health Impact Indicators

Kenya has seen a mix of positive and negative trends in its health sector. While access to safe water and sanitation is improving (62% and 48% of the rural population had access to an improved water source and improved sanitation, respectively, in 2002)17, selected health indicators suggest stagnation or decline in Kenya’s health status18. Maternal death is the leading cause of death in women of child-bearing age (15%). Only 44% of births in Kenya are delivered under the supervision of a skilled health provider (nurse, midwife, or doctor) and this proportion has been noted to be worse in rural areas and among women of lower socio-economic status. Kenyan women continue to experience a high unmet need for family planning, with roughly one-quarter of currently married women in the three consecutive KDHS surveys since 1998 indicating that they have unmet need for family planning. HIV prevalence is 7.4%, the rate being higher in women (8.5%) than in men (5.6%). The large majority (83%) of those infected do not know their HIV status, and only 35% of those in need of ART are accessing treatment.

14 WHO (2009)  
15 Ministry of Public Health and Sanitation & Ministry of Medical Services (2009b)  
16 Ministry of Medical Services & Ministry of Public Health and Sanitation, (2009c)  
17 World Bank (2006)  
18 WHO (2009)
Table 1: Selected Demographic and Health Indicators for Kenya

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<tr>
<th>Indicator</th>
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<tr>
<td>Total Fertility Rate</td>
<td>4.6</td>
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<tr>
<td>Unmet need for Family Planning among married women</td>
<td>25%</td>
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<tr>
<td>Contraceptive Prevalence rate</td>
<td>46%</td>
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<tr>
<td>Antenatal care attended by trained medical professional</td>
<td>92%</td>
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<tr>
<td>Deliveries at health facility</td>
<td>43%</td>
</tr>
<tr>
<td>Deliveries supervised by trained professionals</td>
<td>44%</td>
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<tr>
<td>Maternal mortality rate (per 100,000 live births)</td>
<td>488</td>
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<tr>
<td>Under 5 Mortality (per 1,000 births)</td>
<td>74</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1,000 births)</td>
<td>52</td>
</tr>
<tr>
<td>Childhood immunization coverage</td>
<td>77%</td>
</tr>
<tr>
<td>HIV/AIDS prevalence among adults 15-49 years</td>
<td>6%</td>
</tr>
</tbody>
</table>


2.3 Kenya’s Status of MDG 5

Maternal health in Nairobi, Coast and Nyanza: According to the KDHS 2008/09, rural Coast has the highest percentage of home deliveries of 83.9% followed by Nyanza at 59%. In the urban areas Kisumu has the worst indicators with 91% of children born at home. Nairobi home deliveries stand at 40.5%.

In Kenya the poor have a higher probability of going through deliveries without the assistance of a trained medical practitioner (72%) as compared to the non-poor at 52%. Traditional birth attendants (TBAs) and self-deliveries are cited as the alternatives to skilled medical assistance at delivery. Kilifi district has one of the highest prevalences of pregnancy-related complications and over 80% of the residents of the district, like Kisii and Rongo districts, have illnesses diagnosed out of hospitals.

While unsafe abortions remain a major concern in Kenya, the situation in Nairobi was most serious in 2003, when 23,063 cases of abortion were reported compared to 6,345 cases in Rift Valley, 4,148 in Nyanza and 686 in Coast. This scenario has since been managed in Nairobi to less than 1,000 while the statistics in Nyanza and Coast get worse each year. The prevalence of malaria in these two provinces is also evident in the number of women affected by the disease during pregnancy, while country statistics for STIs are highest for Coast and Nyanza at over 32,000 cases over five years to 2008. Within the same period Nyanza had the highest number of sexual assault cases (3,438), followed by Coast (946).

Recommendations

The majority of Kenyans fail to seek health care for three main reasons: availability of medicines, cost of treatment and lack of facility staff. The government needs to ensure the three factors preventing Kenyans to seek health care (availability of medicines, cost of treatment and facility staff) should be maintained at high standards.

The number of women between 15-49 years of age has been estimated at 21.6% of the total population. This segment is considered the reproductive age in Kenya and requires reproductive health interventions from the government.

There is a need for enhanced budgetary reforms that will improve efficiency and effectiveness in delivery of services to Kenyans. The poverty index for Healthy action districts calls for the government to change its user-fee policy that is likely to exclude most district inhabitants from accessing quality health care.

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**Table 2: Progress towards MDG 5 (Improve maternal mortality)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Target 5A: Reduce by three quarters between 1990 and 2015, the maternal mortality rate</td>
<td>Maternal Mortality Ratio</td>
<td>590</td>
<td>414</td>
<td>488</td>
<td>147</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of births attended by skilled health personnel</td>
<td>44</td>
<td>40</td>
<td>44</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contraceptive prevalence rate</td>
<td>33</td>
<td>39</td>
<td>39</td>
<td>46</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Adolescent birth rate</td>
<td>21</td>
<td>23</td>
<td>18</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Antenatal care coverage</td>
<td>60</td>
<td>52</td>
<td>47</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unmet need for family planning</td>
<td>25</td>
<td>25</td>
<td>26</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Sources: a Baseline MDG NHSSP-II (2005-2010); b Baseline NHSSP-I (2000-2005); c KDHS 2003; d KDHS 2008/9; e MDG 2015

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21 Ministry of Health (2007b)
Chapter Three  
**International and Local Instruments Linked to Health Financing in Kenya**

Efforts to improve health have for decades been a focal point of international and local instruments.

### 3.1 International Instruments: Global

#### 3.1.1 The Millennium Development Goals (MDGs)

Kenya’s health sector is judged against ambitious targets known as Millennium Development Goals (MDGs), which are sets of quantified and time-bound achievable targets for improving human conditions by 2015. MDGs place health at the heart of development. While three of the eight MDGs relate directly to health, all others have important direct effects on health. Out of the 48 MDG indicators of progress, 18 measure health-related progress. Progress towards Kenya’s attainment of the MDGs has been slow and uncertain. Increases in budget allocations for health related MDGs and innovative programmes aimed at overall development and economic and social transformation are key to ensuring MDG progress gets back on track.

#### 3.1.2 International Conference on Population and Development (ICPD)

In 1994, the ICPD called for the improvement of reproductive health as a global priority that all countries should place at the centre of their development efforts. This was echoed the following year by the United Nations Fourth World Conference on Women. Participants at both conferences challenged countries and organisations to redress gender imbalances and to respect the reproductive rights of women and men as necessary conditions for improving reproductive health.

### 3.2 International Instruments: African

#### 3.2.1 Abuja Declaration

In 2001, African governments signed the Abuja declaration, agreeing to devote 15% of their domestic budget to the health sector as a move towards universal health care. This commitment is restricted to domestic public sources of funding and excludes external funding.

#### 3.2.2 Maputo Protocol

On 8 October 2010, Kenya ratified the Protocol to the African Charter on Human Rights on the Rights of Women in Africa. The treaty is popularly known as the Maputo Protocol. This agreement calls for the elimination of discrimination against women and declares each woman’s right to respect for her dignity. It requires member states to pass effective laws criminalising violence against women (including sexual violence) and take steps to end cultural practices that encourage such violence; it also includes prohibiting practices like Female Genital Mutilation (FGM) that negatively affect women. The protocol also requires the state to provide support and rehabilitation to those who have undergone such practices or forms of violence.
Box 2: International and Regional Health/RH-Related Legislative and Policy Instruments

International and Regional Legal Instruments which have been ratified by Kenya:

1. Abuja Declaration
2. African (Banjul) Charter on Human and Peoples’ Rights
4. Alma Ata Declaration (1978)
6. Convention on Discrimination Against Women (CEDAW)
7. Convention on Elimination of All Forms of Discrimination Against Women
10. Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
11. Immediate Action for the Elimination of the Worst Forms of Child Labour
13. International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
15. International Covenant on Civil and Political Rights
17. International Health Regulations
18. Maputo Protocol
20. Optional Protocol on the Involvement of Children in Armed Conflict
21. WHO Framework Convention on Tobacco Control


3.3 Local Instruments: Linked to Health and Reproductive Health

The health sector operates in the context of a number of policy frameworks and within a policy environment that is subject to both internal and external influences.

Fig 1: Policy Framework within which Health and RH/FP Operates
In the current legal framework, there are more than 20 statutes dealing with the health sector and touching on Reproductive Health issues in the country. The legal framework of the health sector is not under a single institution but spread within a number of ministries and departments of the government.

### Table 3: List of Local Health/RH Related Legislative and Policy Instruments

| Ministry of Health | National Health Sector Strategic Plan (NHSSP II)  
|                   | Kenya Health Sector Policy Framework  
|                   | Kenya Essential Package for Health  
|                   | Public Health Act Cap 242  
|                   | Malaria Prevention Act Cap 248  
|                   | National Hospital Insurance Fund Act Cap 254  
| Ministry of Medical Services | Ministry of Medical Services strategic Plan 2008  
| Ministry of Public Health & Sanitation | Reproductive Health Policy  
|                   | Guidelines on the Management of Sexual Violence  
|                   | National Road map for Accelerating the attainment of the MDGs related to maternal and Newborn Health in Kenya  
|                   | Ministry of Public Health and Sanitation Strategic Plan 2008  
|                   | Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level one services  
|                   | National Family Planning Guidelines for Service Providers: Updated to reflect the 2009 Medical Eligibility Criteria of World Health Organization  
| Ministry of Planning, National Development & Vision 2030 | Vision 2030  
|                   | Population and Development Policy 2011-2020  
|                   | Adolescent Reproductive Health and Development Policy  
|                   | First Medium Term Plan (2008-2012) Kenya Vision 2030  
|                   | First Annual Progress Report of the first Medium Term plan 2008-2012  
|                   | Kenya Demographic and Health Survey 2008-2009  
| Ministry of Gender Affairs and Children | National Gender Policy  
|                   | Sexual Offences Act  
|                   | Children’s Act Cap 586  
| Ministry of Youth Affairs and Sports | National Youth Policy  
| Office of the President | Kenya National AIDS Strategic Plan 2009/10 – 2012/13  

3.3.1 Vision 2030

Kenya Vision 2030 is the development blueprint by which the country aims to transform into a middle-income nation, through maintaining a stable macroeconomic environment supported by real-time structural reforms. The vision of Kenya for health is to provide equitable and affordable health care at the highest possible standards for all citizens. This will be achieved through enhanced focus on preventive and promotive health and investment in health infrastructure in rural and severely deprived communities. Achieving this will depend on strong participation by target communities in service management and Public-Private Partnerships (PPP) supported by an increased level of health financing and efficient use of the same resources. Vision 2030 recognises the role of maternal and child health in achieving the MDGs and propelling Kenya to a middle-income, rapidly industrialising state. It sets clear targets. Responding to Kenya’s health care needs will require close attention to geographical and gender disparities, financing, health care policy, efficiency and PPP.

3.3.2 National Health Sector Strategic Plan (NHSSP II)

The first National Health Sector Strategic Plan (NHSSP-I) covered the period 1999-2004. Overall implementation of NHSSP-I did not make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators. This may be attributed to inadequate funding and low resource accountability over a set of factors. The National Health Strategic Plan II (2005-2012) was approved for implementation in 2005. The Plan outlines five major strategic policy objectives: (i) increase equitable access; (ii) improve service quality and responsiveness; (iii) improve efficiency and effectiveness; (iv) foster partnership; and (v) improve health financing.

Recommendations

There is need for constant tracking of government spending on health to step up advocacy for meeting Abuja targets. This should include monitoring levels of health spending as a percentage of government expenditure and GDP and external funding to health. In addition there should be a deliberate effort to segregate and increase reproductive health funding within the health budgets.

In addressing RH/FP, there is need to increase coherence of policies that extend beyond the traditional health sector mandate. This will improve coordination and limit duplication, thus leveraging resources for replication and scale-up.

Governments need to honour the ‘Accra’ commitments and thus take action to accelerate progress on aid effectiveness. Governments must increase country ownership and take stronger leadership of their own policies, and should engage with their parliaments and citizens in shaping those policies.

Governments must achieve development results—and openly account for them. Citizens and taxpayers of all countries expect to see the tangible results of development efforts. Countries are committed to demonstrating that actions translate into positive impacts on peoples’ lives. Governments must continue efforts in monitoring and evaluation that would assess whether countries have achieved the commitments agreed in the Paris Declaration and the Accra Agenda for Action and to what extent aid effectiveness is improving and generating greater development impact.

22 Kenya Institute for Public Research and Analysis (2009)
Chapter Four  Health Financing in Kenya: Fiscal Facts

4.1 Health Budget Trends

Estimates of Ministry of Health expenditures between 2005/06 and 2009/10 grew from Ksh 30 billion to Ksh 47 billion, as shown in Table 4 below. This represents an overall growth of 56%. As a percentage of the Government of Kenya’s (GOK) total budget, the expenditures remain low at 5.3% in 2009/10—almost eight years after the government committed itself to increasing this ratio to 15% by signing the Abuja Declaration. Yet, there are signs of improvement, as the Mid-term Expenditure framework for 2009-2010 indicates that the government intends to increase allocation to the health sector consistently in the two upcoming financial years.

The picture looks worse when analyzing actual expenditures. In 2005/06 the sector spent only 77% of its budget, i.e. Kshs 23 million. The absorption of funds increased to 85% by 2007/08 when Kshs 29 million was spent.

<table>
<thead>
<tr>
<th>Description</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent — gross</td>
<td>20,210</td>
<td>21,611</td>
<td>22,745</td>
<td>25,552</td>
<td>28,184</td>
</tr>
<tr>
<td>Development — gross</td>
<td>9,943</td>
<td>11,716</td>
<td>11,609</td>
<td>9,293</td>
<td>18,827</td>
</tr>
<tr>
<td>Total</td>
<td>30,153</td>
<td>33,327</td>
<td>34,354</td>
<td>34,845</td>
<td>47,011</td>
</tr>
<tr>
<td>Annual growth of MoH expenditures</td>
<td>10.5%</td>
<td>3.1%</td>
<td>1.4%</td>
<td>34.9%</td>
<td></td>
</tr>
<tr>
<td>Total health expenditures (net) as a percent of GoK expenditures (net)</td>
<td>6.0%</td>
<td>6.0%</td>
<td>5.3%</td>
<td>4.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Total health ministries expenditures as a percent of GDP</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: Data are extracted from Estimates of recurrent expenditure and estimates of development expenditure for the fiscal years 2005/06 to 2009/10.

4.2 Who Funds the Health Sector in Kenya?

The health sector in Kenya obtains varying levels of funding from the traditional sources: public (government), private firms, households and donors. According to the 2005/06 National Health Accounts (NHA), households remain the largest contributors of health funds, at 35.9%, followed by the government, and then donors, who contribute approximately 30%.

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23 Cieza, Holm (2010)
24 Ministry of Planning, National Development and Vision 2030 (2010b)
4.3 Health Financing: How much is available?

The GOK funds the health sector through budgetary allocations to the MoH and the MoPHS and related government departments. As far as government spending is concerned, the Ministry of Finance sets three-year budget ceilings for each sector in Kenya. In practical terms this means that the Ministry of Health creates a budget based on what the Ministry of Finance has said it will allocate for health expenditures rather than submitting a budget request based on actual needs. The Ministry of Health then disburses the funds it receives through its District Health Management Boards. The health budget shortfalls are manifest in the widespread lack of adequate drugs and pharmaceuticals, staff shortages and poor maintenance of equipment, transport, and facilities.

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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.
The Budget Outlook Paper (BOPA) and Budget Strategy Paper (BSP) 2003-2007/08 indicate that the government was committed to gradually increasing health spending to facilitate greater access to better quality health care. The sector ceiling for health as a percentage of total GOK was to grow from 9.90% in 2005/06 to 10.30% in 2006/07, and reach 10.67% in 2007/08. The ministerial ceiling, on the other hand, was to grow as a ratio of government expenditures: 9.09% in 2005/06 and 9.32% in 2006/07.

These projections meant that public expenditure on health would grow in absolute terms, as well as in proportion to GDP, overall government expenditures, and in per capita terms. However, because of macroeconomic factors, and due to the government’s intention to limit its expenditures to a managed level of GDP, subsequent substantial increases in budgetary resource allocations to health have not been experienced. Instead, low spending has characterised the health sector and little progress has been made toward meeting the government’s own expenditure targets, let alone the 15% commitment reached at Abuja, as well as other international spending benchmarks—US$35 (recommended by WHO).

In fact, the gap between budget expenditure estimates and the Abuja target has constantly widened. In 2005/06, the health budget represented 6% of the total government budget and in 2009/10 this has shrunk to only 5.3%.

4.3.2 From the Kenyan People (Cost Sharing)

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% of the recurrent expenditure and about 21% 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 Ksh 10 or 20 for client cards.

Studies conducted in developing countries have demonstrated that high out-of-pocket medical spending can plunge the sick, their families and even their extended clan into poverty.

4.3.3 From the Donors

Kenya depends significantly on donor funds, many of which supplement the development component of the national health budget. In 2009/10, on-budget external resources accounted for 15.1% of all health spending in Kenya, or Kshs 7.1 million. In 2005/06, Kenya’s health budget was made up to 11.3% by donor contributions. Over the years, Kenya’s health sector has increased its dependency on external sources.

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26 Which were set to increase from 7.66% in 2004/05 to 9.32% of total government expenditures in 2006/7: Source GoK.
27 Health gross estimates as a percentage of GoK (net excluding Aid), Source: Estimates of recurrent expenditure and estimates of development expenditure for the fiscal years 2005/06 to 2009/10.
28 Ministry of Public Health and Sanitation & Ministry of Medical Services (2009a)
29 Ministry of Public Health and Sanitation & Ministry of Medical Services (2009b) and WHO Regional Office for the Western Pacific (2006).
30 Health gross estimates – Appropriation in Aid. Source: Estimates of recurrent expenditure and estimates of development expenditure for the fiscal years 2005/06 to 2009/10.
All donor commitments for Kenya’s health sector—on and off budget—represent USD 99 million in 2008, down from USD 147 million in 2005. The United States is the largest bilateral donor, channelling funds through PEPFAR, the President’s Malaria Initiative and USAID with USD 32.4 million in 2008. The United Kingdom also commits significant bilateral funds to the health sector (USD 30 million).

When analyzing donors’ actual health disbursements to Kenya, the picture looks different. In 2008, donors provided USD 116 million up from USD 102 million in the previous year. The biggest donors were GAVI, Global Fund to Fight Aids, Tuberculosis and Malaria and the United Kingdom. This graph shows that the US ranks only fifth.

### 4.4 Kenya National Budget Process

In Kenya the budgetary process comprises three main stages: drafting, legislation, and implementation and audit. Reforms aimed at improving the budgetary process have sought to impose greater fiscal discipline on the government among other objectives such as attaining allocative and operational/technical efficiency. The constitution requires the executive to raise and allocate resources for government projects within this rigorous budget process.

The Budget cycle is based on the Medium Term Expenditure Framework (MTEF) cycle. The MTEF process prioritizes definition of a global resource envelope, determination of inter-sectoral allocations based on core functions and proposals of inter-sectoral allocations based on outcomes, activities and outputs. Public hearings and involvement of private and civil society in the budget preparation enhances transparency. The MTEF process revolves around the activities of ten MTEF sectors, including the human resource development sector.

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31 OECD DAC CRS. Sept 2010.
32 This chapter is based on Institute for Economic Affairs’ training curriculum.
To guide the preparation of MTEF, the Ministry of Finance issues to all ministries, departments and government agencies in August a circular detailing the guidelines with objectives for the financial year. The Circular—Budget preparation guidelines for budget 2010-11 for example directed that the preparation of the budget for the next MTEF period should be within the context of stimulating growth and creating jobs, reducing poverty and enhancing food security, and protecting the poor and most vulnerable of the society while improving government efficiency in delivering services.

The budget is prepared through Sector Working Groups (SWGs) comprising different ministries, departments, and agencies. The overall fiscal and macroeconomic framework—including strategies, outlook and forecast—determines the role of ministerial working groups (MWGs). The Ministry of Public Health and Sanitation (MoPHS) and the Ministry of Medical Services (MoMS) both appoint representatives to the ministerial working group who then work within the SWG. The two ministries fall under the human resource development sector.

The Sector Working Groups are urged to ensure that they only consider proposals for funding that support the achievement of the objectives and priorities outlined in the Medium Term Strategy of Vision 2030. The Circular from the Ministry of Finance encourages the involvement of districts and other stakeholders in the MTEF budget process through the sector hearings. The purpose of the Sector Hearings is to ensure transparent discussions of priorities of government for the next financial year with key stakeholders including development partners, civil society, private sector and research institutions.

Fig 5: The MTEF Cycle

1. Drafting/Design: Normally driven by the executive, in particular the Budget Supplies & Economic Affairs Department

2. Legislation/Approval: Parliament considers, debates, possibly amends and approves the budget

3. Execution/Implementation: Revenues are raised and apportioned to spending units

4. Audit/Evaluation: The KENAO and parliament consider whether actual spending was in line with the approved budget
The two ministries in the health sector receive funds from the Ministry of Finance, where the national treasury is situated. Funding for health is derived from the government’s resources drawn from local sources and on-budget support from donors. An allocation to the ministries’ budget items follows the generic MTEF process before it is collated at the ministry for disbursement to lower level institutions. The ministries operate within institutions that include a six-level healthcare facility structure, parastatals and Semi-autonomous Government Agencies (SAGAs). Figure 7 is a presentation of the facility structures financed by the ministry. Level-six facilities receive the highest allocations while level one has serious challenges of resource allocation for their activities. This funding mechanism is informed by over-emphasis on preventive rather than promotive health that implies high expenditures on curative rather than preventive health. The increasingly poor health indicators imply that poor citizens cannot access higher level and more expensive healthcare.

**Fig 6: Health facility governance structure in Kenya**

**Fig 7: Kenya’s Health Care System**

Source: Ministry of Public Health and Sanitation & Ministry of Medical Services (2009c), Ministry of Health (2006a)

Source: NCAPD (2005)
Three ratios are used to analyse governments’ efforts in health funding. The first expresses the level of health commitments as a percentage of the gross national product. This shows how much of a country’s economic strength is used to improve the health of its people. In other words, how does the health sector benefit from economic growth?

The second ratio shows what portion of the government budget is committed to health. This helps understand whether health is a priority for government and can be compared to other sectors such as education or defence.

The third ratio looks at per capita health commitments—how much money on average is committed per citizen. This also helps explain whether public budget commitments keep pace with population growth.

5.1 Comparing total health commitments as a percentage of GDP

In relation to Kenya’s dramatic economic growth, the government’s health budget has steadily declined from 1.9% of GDP in 2005 to 1.4% of GDP in 2008. Regionally, Kenya ranked second in 2008 behind Uganda (1.5%) and ahead of Tanzania (0.94%).

Fig 8: Total health budget as % of GDP

5.2 Total Health as % of total government spending (Commitments)

Kenya, Uganda and Tanzania have subscribed to the Abuja target of 15%. Of all those, in 2009 Uganda fares best with health having a share of 9% in the government budget (net estimates). Kenya is second with 5% and Tanzania is last with 4%.

**Fig 9: Health as % of government budget**

Approved budget, govt only

Source: GoK “annual budget estimates 2005/06 to 2008/09”, GoT “comprehensive health plans 2005/06 to 2008/09”, GoU, “approved estimates of revenue and expenditure 2005/06 to 2008/09”

5.3 Total Health Commitments per capita in USD

Analyses of governments’ health efforts per citizen show that over the past five years, Kenya has been most advanced with USD 15 per capita in 2009. The neighbouring Republics of Uganda and Tanzania spend USD 11 and USD 8 per capita respectively. However, all three countries have a long way to go before reaching the WHO minimum recommendation of USD 34 per capita.

**Fig 10: Total annual health budget per capita**

(in USD)

Source: GoK “annual budget estimates 2005/06 to 2008/09”, GoT “comprehensive health plans 2005/06 to 2008/09”, GoU, “approved estimates of revenue and expenditure 2005/06 to 2008/09”
Chapter Six  Reproductive Health Financing in Kenya: Fiscal Facts

6.1 Government health and reproductive health commitments

Reproductive health receives little attention within government budgets. In 2005, only KShs 51.6 million was dedicated to reproductive health out of a total health budget of KShs 30 billion. In other words, the total health expenditures were 581 times bigger than reproductive health expenditures. Five years later, figures showed some improvement. KShs 1.2 billion was committed to reproductive health out of a health budget of KShs 47 billion. This came after an all-time peak in 2008.

![Health and Reproductive health budgets](image)

Fig 11: Health and Reproductive health budgets
In million Kshs, gross estimates

Source: Data are extracted from Estimates of recurrent expenditure and estimates of development expenditure for the fiscal years 2005/06 to 2009/10. Health budget includes vote 11 and 49. RH budget is summarized under vote 328.

6.2 Government of Kenya Reproductive Health Efforts

The low priority given to reproductive health is also reflected in two key ratios. Per citizen, the government of Kenya committed KShs 30.5 in 2009, compared to KShs 1.5 in 2005. The reproductive health portion of the state health budget was 2.58% in 2009.

<table>
<thead>
<tr>
<th>Table 5: Reproductive Health Commitments per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total RH Commitments per capita in KShs</td>
</tr>
<tr>
<td>2005/06</td>
</tr>
<tr>
<td>Total RH Commitments per capita in KShs</td>
</tr>
<tr>
<td>Total RH as % of Total Health (Commitments)</td>
</tr>
</tbody>
</table>


6.3 Breakdown of Reproductive Health Budgets (Government of Kenya)

In Kenya, funds are committed to the treasury based on approved ministry budgets through the Mid Term Expenditure Framework process. The commitments are then allocated to the respective vote heads. In Kenya, the ministry in charge for reproductive health has changed since the financial year of 2006/07. This shift has led to an increased focus on reproductive health concerns. Indeed, the new vote head (328) of the Ministry of Public Health and Sanitation Budget refers to family planning and maternal and child health. Allocations to this vote head are divided into three focus areas—with each area divided into sub-activities with special allocations. But the line items of materials and special supplies and special machinery and equipment are the only activities that can be directed to commodity security and service provision. The other activities go to reimbursements, meetings, trainings and other such expenditures. In 2009/010 there was no allocation to maternal health and just Ksh 200,000 was allocated for special materials and supplies for child health. Most of the budget allocation is earmarked for family planning.

6.4 Breakdown of Reproductive Health Budgets (Development Partners)

From 2005 to 2008, overall funding for reproductive health increased from USD 108.6 million in 2005 to USD 335 million in 2008. The scene is dominated by the United States, which provided 80% of all development assistance in this sector. Its contribution rose from USD 64 million in 2005 to USD 269 million in 2008. Traditionally, US aid focuses on project support. This partly explains why government programmes by donors are less well-funded. The Global fund was the second largest donor with USD 19 million in 2008. Then came the United Kingdom with USD 12 million in 2008.

Fig 12 and 13: RH/Population Assistance to Kenya by development partners

Disbursements, in million USD

Source: OECD DAC CRS, Sept 2010
Chapter Seven  

Case Studies

7.1  Overview

Case studies were conducted in four separate districts in three regions in Kenya. They included Gucha and Rongo in Nyanza region, Dagoretti in Nairobi and Kilifi in Coast region. The narrative presentation of the case studies presents evidence gathered in these districts. Kilifi and Rongo have a mix of urban and rural populations while Dagoretti is purely urban. The choice of these two rural districts is based on poverty index analysis over time that continues to present them among the poorest in the country. Dagoretti district provided an opportunity to analyse access to health care services by the urban poor. The case studies below present information received from district opinion leaders, health workers and community members and portray their perception of sufficiency of services to the communities around specific district health facilities.
All districts in Kenya are expected to develop Annual Operations Plans (AOP) that are sent to the Ministry for funds allocation. According to the officers interviewed, the process involves departments coming together and developing activities that are presented to the District Health Management Team (DHMT), which costs the activities before submitting the full document to the Ministry. Drugs and staff salaries are not included in the AOP; KEMSA is mandated to supply drugs while the Ministry pays health care providers directly. In carrying out our research in the districts, it was apparent that the participation of lower level officers in the AOP process is not guaranteed, with some reporting having participated in only one 2010/11 process while others reported having participated in up to AOP 5.

For all the districts covered in the survey, the Government gives specific allocations in any given financial year with the shortfall being met through cost-sharing funds and other sources such as CDF and LATF, as well as private donors. Funds allocated by the central Government are expended through AIEs (Authority to Incur Expenditure). But these AIEs are usually subject to bureaucratic delays and are thus not reliable. According to some of the interviewees, funding has not been available since April 2010; most activities have been supported by other partners. Through the District Health Stakeholders Forum, requests are often made to partners for support on issues such as equipment purchase, financing meetings and paying allowances. This study discovered that a large chunk of funds was paid directly to such ventures and therefore could not be accurately quantified nor adequately captured.

7.2 Family planning commodities do not meet Gucha South demands

Millennium development goals 4 & 5 (which seek to address child mortality and maternal mortality, respectively) lag in Gucha district where deliveries under skilled attendants stands at 53%—an indicator worse than the national average. Internationally and nationally it has been proven that providing women with family planning options reduces the number of unplanned births by ensuring that children are appropriately spaced, that women get the right number of children they require and that they deliver at the right age. Unmet need for family planning remains a major reproductive health challenge in Gucha South, yet traditional birth attendants who are most popular with mothers in this community have little reproductive health knowledge.

At Gucha district hospital, the provision of maternal health care and family planning services is marred by challenges at national, facility and community levels. The 2010 case study of Gucha South district hospital revealed that family planning commodities that were demanded most by the clients were out of stock while those they did not need lay unused, risking expiry at the facility stores. The district budget can only cater for the needs of about 50% of the population and community health centres have no allocation from the government. This problem is compounded by the poverty levels in the districts that have rendered community members unable to fully pay the requisite user fees.
The central government has failed this community by disbursing funds that cannot meet their family planning demands and the Kenya Medical Supplies Agency (KEMSA) is no better at delivering the medical supplies to the district as is its mandate. By quarter four of 2009/2010 financial year KEMSA had delivered drug supplies to the district facility twice instead of the expected five times. The community and the facility managers were hopeful that supplies, though late, would be soon forthcoming—more condoms, pills and injectable depo provera (the community’s preference).

Long term methods of family planning, such as implants and IUCDs, remained in hospital stores for lack of demand from the community and incompetency of the staff in inserting such family planning devices. This by extension means that while the government delayed in supplying the next stock of the most relevant contraceptives, women in Gucha continued conceiving unplanned babies, delivering them under risky conditions, paying more for family health care and contributing to the already worrying levels of poverty in the district.

If the Kenyan government still believes in the economic benefits of family planning and pays close attention to the population explosion projected for the year 2030, then it needs to strengthen the management efficiency at KEMSA; invest in staff capacity building at facility level; re-examine budget allocation to lower level health facilities; revamp community distribution of family planning commodities; and institute measures to respond to community concerns about access to quality health care—including family planning and reproductive health. The Gucha South story would be even better if there were measures to include local government and constituency funding structures in preventive and promotive health care provision and community members participated more actively in budget formulation for the district health care.

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**Fig 14: Percentage contribution to health financing 2009/2010 in Gucha South and Kilifi District hospitals**

Source: District Medical Officer of Health Gucha; Kilifi District Medical Superintendent
Rongo community members interviewed in 2010 longed for nothing more than a mortuary to preserve the bodies of their loved ones. This may imply hopelessness among a poor population convinced they cannot have access to better health care; they resign themselves to death and seek a decent send-off for their loved ones. In their opinion healthcare is not affordable, not easily accessible, not friendly and sometimes not available. This is supported by claims that health care providers at the facility have little knowledge about skilled deliveries, leading to unprecedented numbers of delivery-related complications and death among mothers seeking services at the hospital and in surrounding health centres. Other challenges to health care in this district include widespread TBAs-assisted deliveries; lack of commodity stock; drug insufficiency; lack of transport for referrals and capacity building opportunities for staff.

Financing the health sector is a way of providing hope to citizens. In receiving quality health care communities are free to focus on other productive activities while in good health. Rongo, like other surrounding districts, decries the limited resources allocated to its health sector from the central government. Reproductive health, for example, was reported to have no allocation from the central government and activities related to it are limited to commodity distribution and stipends for communication for the district public health nurse. Facility managers report that apart from receiving insufficient funds from the government, many times money is returned to the ministry when it is not spent because of late disbursement.

While other ministries have little contribution to the district’s budget, the local authority and constituency structures have added value to the infrastructure in this district. A total of 19 structures have been created within the health facilities by the constituency development fund. But these funds focus only on infrastructural development and cannot provide software health care services. The question that begs an answer is what level of participation can the community expect in deciding how the devolved funds are used. These funds might have gone toward constructing a mortuary for Rongo Residents. But do we want to propagate the demand for mortuaries as the only futuristic vision we can bequeath to this community?

Health care providers in Rongo district are convinced that community sensitisation on immunization, family planning, voluntary counselling and testing is a sure way of responding to the needs of the community. In their opinion the government should allocate resources to primary health care facilities so that grassroots communities are reached with services. The Health Sector Service Fund should be used to mitigate the apathy within this district and devolved fund managers should work closely with providers in giving outs information on citizen participation in health care decisions. In this way development efforts will not be directed to a population that is convinced they are dying rather than contributing to their prosperity.
7.4 The Nightmare of Teenage Pregnancies in Dagoretti District

Reproductive health challenges facing young people are not limited to rural areas and slums. In Dagoretti District of Nairobi County, community members are privileged to have some of the best indicators of development in the country. The district’s literacy stands at above 90%; it is home to two referral health facilities in addition to five above-average health centres in the midst of the country’s capital city. All these factors notwithstanding, Dagoretti experiences some of the most difficult challenges related to teenage pregnancies and other RH-related complications.

The district public health nurse, the clinical officer, health centre in-charge and senior nurse interviewed noted a high number of women of reproductive age—91,530 in the year 2010—using the health centres in the District. Most of the women were teenage mothers between the ages of 15-22 seeking antenatal and postnatal care as well as family planning services. These young girls comprise 30% of the total population of women in their reproductive age. It was also noted in one of the health centres that intervening for safe motherhood needs of school girls and street mothers in their teens is a big challenge for the facility. The age of sexual debut is young, resulting in young mothers from poor backgrounds. In some of the most horrendous cases girls come in school uniform or from the streets direct to the health facility to deliver with no money, no delivery kit, no clothes for the baby nor other related needs. The implication is that the facility, with no allocation for these services from the government, has to innovatively respond to the needs of the pregnant mother and her newborn baby.

This high number of teenage pregnancies can be attributed to lack of youth friendly services within the health centres in the district that are to inform, educate and empower the youths on sexual and reproductive health issues. Such youth targeted programmes and services would contribute to delayed sexual debut, safer sexual activities, contraceptive uptake, safe motherhood awareness, delayed marriages and better health seeking behaviour.

At another health facility, Mutuini health centre, most women had no reliable sources of income to even afford the cost of RH services which at Kshs 50 they consider unaffordable. The centre further reported two bizarre cases in which a young mother lost her child while awaiting first contact with the health care providers. She was later forced to abandon the body of the baby at the reception area of the facility to search for an ambulance to transport the body to the mortuary at the district hospital. In another instance at the same facility an expectant mother lost her life for lack of any means of transport to the district hospital for

<table>
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<tr>
<th>Kshs. 30M District AOP Budget</th>
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<tr>
<td>2009/2010</td>
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<tr>
<td>Kshs. 200,000 Amount allocated to the DMOH in the same year</td>
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<tr>
<td>Kshs. 50,000 Money needed to train one healthcare provider in FP for 5 months</td>
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specialized care. Meanwhile an ambulance contributed to the facility by a well-wisher remained at a nearby health centre (Waithaka) with neither fuel nor a driver.

Health facility staff in this district, however, appreciated the government’s decision to involve them in drafting the district annual operation plan for 2011/11 financial year. Within this plan they recommended integration of youth-friendly services within their operations. This should incorporate health-awareness campaigns among youth to reduce incidence of pregnancies among young women. For this vision to be realised, the government needs to invest resources in youth-friendly programs and reposition family planning in this district—including creating awareness among youth and youth serving institutions. It could also scale up the output-based approach to safe motherhood and family planning.

Dagoretti district had the most vibrant demonstration of participation of decentralized structure in promotion of health care. The constituency development fund constructed one facility with a maternity wing and paid wages for some health care providers. The Nairobi city council also chipped in to some administrative expenses of the facility based on remittances they get from the health care from user fees. The government needs to revise policies governing decentralized funding structures to include provision of medical services like family planning commodities and other supplies.

7.5  Giving birth isn’t free in Kilifi District, Coastal Region

| Ksh 5.6 million Total district health allocation in 2009/2010 |
| Ksh 31 million Total funds from cost sharing and other sources in 2009/2010 |
| Ksh 40 million Total funds required to deliver RH services in 2009/2010 |

Despite a steady increase in Government allocation for Health in Kilifi district over the last three financial years, the reproductive health needs of the people are still a long way from being met. The total allocation constitutes less than 15% of the reproductive health needs alone, yet has to be shared between maternal & child health; HIV/AIDS & TB; malaria; and recurrent expenditures such as stationery, fuel and communication. During the financial years 2007/2008, 2008/2009 and 2009/2010, the Government allocated Ksh 4 million, 4.8 million and 5.6 million respectively to cater for all health needs within the district.

During interviews carried out with administrators of health facilities as well as end users, this amount was established to be significantly inadequate. At the Kilifi District Hospital for instance, the Medical Superintendent stated that the hospital has a target of attending to 500 young women yet ends up attending to as many as 700 in a typical year. This contrasts sharply with the 3,000 young women eligible for medical services, yet are unable to access them. On its present budget, the hospital therefore only caters for 24% of eligible young women and youth. Based on the number of mothers attended to in 2009, Kilifi District
hospital requires approximately Ksh 40 million per year in order to deliver reproductive health services to
the people. During that year, an average 2,000 normal deliveries at a cost of Ksh 1,000 (total Ksh 2 million)
were handled at the facility. A further 600 Caesarian sections were handled at a cost of Ksh 5,000 (total
Ksh 3 million). Other costs such as human labour, equipment and utilities were also incurred at a cost of
approximately Ksh 11.7 million to cater for about 30% of eligible women. A further Ksh 2 million and 0.5
million would be required to fully cater for young people and health workers per year respectively.

The most prevalent reproductive health needs in the area remain to be unmet family planning needs, pre and
post-natal care, delivery, the pillars of Safe Motherhood, Gender Based Violence and lack of youth friendly
services. According to those in charge of the district hospital, the greatest challenges in meeting these
needs include: Few equipment (some of the present ones are old or in bad disrepair); Inadequate funds (both
budgetary and from cost sharing); Low medical supplies; Low staffing (the Medical superintendent actually
estimates the staffing to be only at 60%) and; High staff turnover due to poor remuneration.

Part of the budgetary shortfall is met through cost-sharing funds. In order to receive medical attention,
patients at the district hospital are required to pay Ksh. 20 per visit, referred to as ‘card’ fee. Other services
such as family planning were initially free but presently cost Ksh. 20. The cost of drugs ranges from Ksh. 50
to Ksh. 500 depending on the particular ailment being treated. Some of the key challenges faced by patients
seeking treatment include: Low economic power to access prescribed medication; Long queues and slow
service; Drug stock outs; Long distances to access health facilities; Lack of an ambulance for referrals and;
Poor culture among locals in ‘jumping’ queues so as to seek attention before the ones who arrived earlier.
According to the interviewees, funds should be allocated so as to alleviate these challenges as well as
increasing medical personnel at the facility, increase bed space and improving the in-patient diet.
Chapter Eight  Key Findings

Centralized system undermines implementation of District AOPs.
The government partially funds district plans, seriously compromising health care at that level and below. This is demonstrated by lack of distinct RH funding from GoK to districts with certain districts reporting intermittent support from donors.

User Fee still a burden to patients utilizing health services at the district.
Patients still pay for services including drugs that should be procured by KEMSA. The burden of user fees is greater on mothers who seek delivery services at the facility. This undermines efforts to seek skilled deliveries. A baseline in Nairobi indicated that mothers pay twice what they spend for home deliveries when they seek hospital deliveries.

Commodities problems persist.
KEMSA has been noted to inconsistently deliver commodities to facilities with some hospitals receiving as little as two deliveries per year instead of five. On the other hand, some facilities were noted to lack health provider-driven demand for RH commodities, leading to lack of or sub-optimal use of some RH commodities such as the long-term methods.

Fragmentation of the Health Ministry creates two centres of power at district health facilities.
Is the separation of the operations of MoMS and MoPHS at the district a blessing or a curse to poor Kenyans?
9.1 Conclusion

- The burden of health financing still rests on the public, who are already highly taxed (thanks to the cost-sharing policy). This is a sure way of denying poor Kenyans quality health care.

- National allocations to the health sector (MoMS & MoPHS) show greater financial investment in MoMS than MoPHS. This can be attributed to high expenditures on curative health, which is handled by MoMS. Moreover, disbursement to health facilities is highest at level 4 to 6 facilities also dominated by the Ministry of Medical Services. The Ministry of Public Health and Sanitation is mandated with preventive health and is more present at level 1 to 3 facilities. Within MoPHS’s budgeting framework, reproductive health falls under family health. The lower national financial allocations to the ministry translate not only into little resources for RH but also negligible disbursements to the districts.

- It is evident that donor support to HIV/AIDS is very high compared to their contribution to reproductive health. While HIV/AIDS receives Ksh 40,288 million (85%) in off-budget support estimations of 2009/10, RH receives a mere 3,395 million (7%) of the same budget.

- Inpatient care for RH-related complications accounts for over 60% of the RH expenditure yet most of these conditions are preventable.

- The introduction of the Constituency Development Fund (CDF) remains a commendable move by the government to empower rural communities.

- Budget allocation and expenditure take very little regard of community level health care needs with some like AOP 5 having absolutely no allocation for level 1 services. It is however commendable that the government has introduced the Health Sector Service fund from 2011 with the aim of empowering rural communities to engage with health facilities in deciding priority health care services to be provided to them.

- The allocation of total government expenditure to health has been below 10% since 2002. Compared to all other seven sectors in the country, this allocation to health was only higher than the general economic sector and the agricultural and rural development sector between 2002 and 2007. If this trend continues and if the population growth maintains the current rate of an additional 1 million people per year, Kenya will not be able to achieve its Millennium Development Goals, Abuja targets for health, or even its own Vision 2030.
9.2 Recommendations

- The government should commit more resources to health and/or revise existing health policies to ensure poor Kenyans access free health care. The targets for MDG 5 could be better achieved if Kenya emulated the policy in Uganda, where deliveries are absolutely free in all public health facilities.

- There is need for a comparative analysis of the real versus perceived risk of both HIV/AIDS and RH-related health complications as a justification for advocacy for increased or even equal funding to RH.

- For RH to get the attention it deserves, the two ministries of health should provide internal financing targets for supporting RH. This is currently evident in the fight against HIV/AIDS where the Ministry of Special Programmes targets 10% of the ministry’s budget on the pandemic.

- The government and its stakeholders need to enhance grassroots advocacy activities to empower communities on their role in the implementation of HSSF and to sensitise communities and health care providers on the importance of prioritising reproductive health when planning to use these funds.

- There is need for increased attention to preventive RH initiatives. This should be demonstrated through strengthened community engagement and education.

- Considering that CDF constructed an additional 1,000 dispensaries in 2008 alone, the government needs to proactively respond to the human resource and supplies demand of these facilities to ensure they benefit the target communities. If possible this should include revision of CDF regulation that restricts the fund to development of infrastructural facilities.

- The government should institute mechanisms of monitoring off-budget support both at national and regional levels to ensure contribution to specific service provision sub-sectors are documented and supplemented appropriately this will enhance accountability and Aid effectiveness at country level.
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