The
Kenya Health Sector
Integrity Study Report

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Abbreviations

AIDS	-	Acquired Immune Deficiency Syndrome
AIE	-	Authority to Incur Expenditure
ART	-	Anti-Retroviral Treatment
ARV	-	Anti-Retrovirals
APHIA II	-	AIDS, Population and Health Integrated Assistance Programme II
AMPATH	-	Academic Model Providing Access to Healthcare
CCM	-	Country Coordinating Mechanism
CD4	-	Class Differentiation 4 type
CEO	-	Chief Executive Officer
CHE	-	Commission of Higher Education
CRC	-	Citizen Report Card
CSOs	-	Civil Society Organisations
CDC	-	Centre for Disease Control
CDF	-	Community Development Fund
DANIDA	-	Danish International Development Agency
DFID	-	Department for International Development
DRC	-	Democratic Republic of Congo
EMCA	-	Environmental Management and Coordination Act
FBOs	-	Faith Based Organisations
FLI	-	Family Linkages International
FMA	-	Financial Management Agency
GAVI	-	Global Vaccine Initiative
GDP	-	Gross Domestic Product
GIZ (GTZ)	-	German Technical Cooperation
GF	-	Global Fund
GoK	-	Government of Kenya
HIV	-	Human Immunodeficiency Virus
HR	-	Human Resource
HRM	-	Human Resources Management
HP	-	Health Provider
HW	-	Health Worker
IFAD	-	International Fund for Agricultural Development
IMT	-	Integrity Monitoring Tool
KEBS	-	Kenya Bureau of Standards
KEMSA	-	Kenya Medical Supplies Agency
KHS	-	Kenya Health Sector
KHPF	-	Kenya Health Policy Framework
Kshs	-	Kenya Shillings
MDGs	-	Millennium Development Goals
MEDS	-	Mission for Essential Drug Supplies
MoH	-	Ministry of Health
MoF	-	Ministry of Finance
MTEF	-	Medium Term Expenditure Framework
NACC	-	National AIDS Control Council

NEMA	-	National Environmental Management Authority
NGO	-	Non- Governmental Organisation
NHSSP II	-	National Health Sector Strategic Plan II
NSA	-	National Strategic Approach
PAC	-	Public Accounts Committee
PEPFAR	-	Presidential Emergency Programme For AIDS Response
PHC	-	Parliamentary Health Committee
PPOA	-	Public Procurement Oversight Authority
PR	-	Principal Recipient
PRSP	-	Poverty Reduction Strategy Programme
PSC	-	Public Service Commission
SRs	-	Sub-Recipients
STDs	-	Sexually Transmitted Diseases
TB	-	Tuberculosis
UN	-	United Nations
USAID	-	United States Agency for International Development
UNICEF	-	United Nations Children's Fund
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation

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Samuel Mbithi Kimeu
Executive Director
Transparency International-Kenya

Section I : Introduction

1.1 Background Information

1.1.1 Background

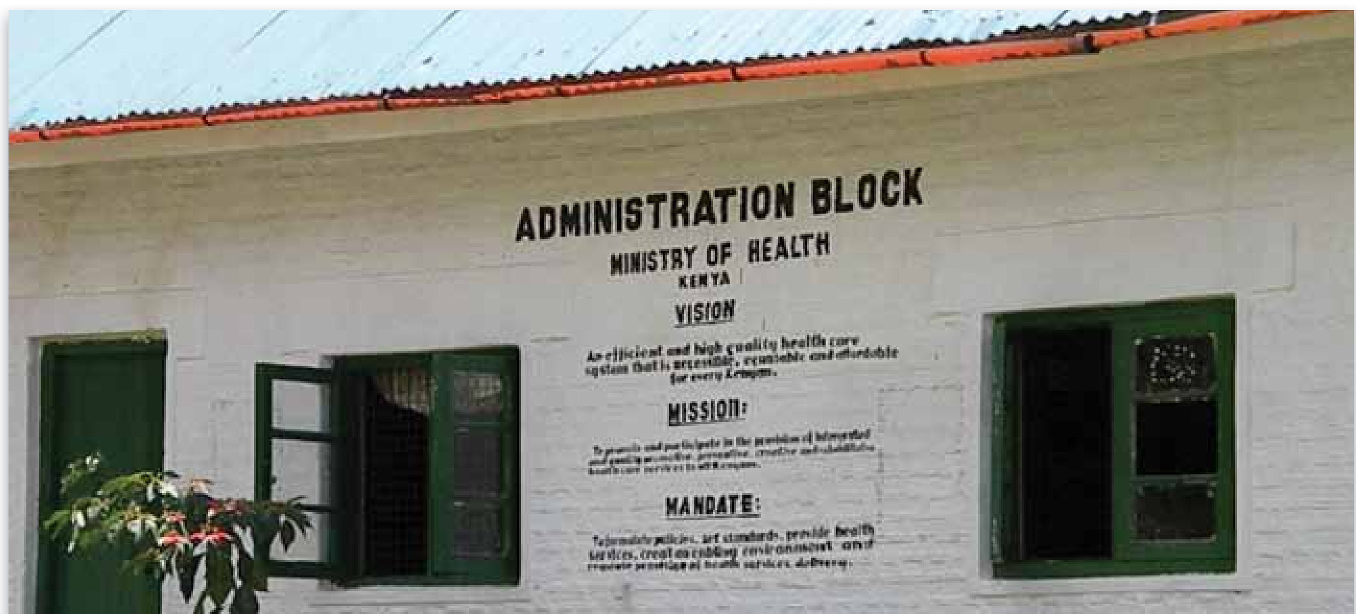
Transparency International-Kenya is a non-governmental organisation founded in 1999. The vision of TI-Kenya is “A transparent, just and accountable Kenyan society”. TI-Kenya’s mission is “To support citizens and governance institutions to effect transparency and accountability in public and business affairs through policy and legal frameworks, skills, knowledge and information.

This is in line with TI-Kenya’s third strategic priority which identifies inefficiency in public service delivery as well as lack of transparency and accountability as a critical issue. This strategic priority forms the basis of the Citizen Demand Programme that seeks to attain a demonstrable optimum level of civic empowerment amongst a critical cadre of Kenyan citizens and empower them to actively engage with public institutions and the private sector by demanding and monitoring integrity in service delivery.

There is therefore need to promote active engagement between the citizenry and the public service institutions. A key outcome of this programmatic intervention is increased responsiveness of public service delivery institutions to citizens’ demands for integrity in the social sectors of water and sanitation, health and education.

The importance of the health sector in economic growth and reduction of poverty is reflected in the Millennium Development Goals (MDGs). Three out of the eight goals refer directly to health. One additional goal refers to access to affordable drugs in developing countries. To ensure universal and equitable access to quality health services, governments must earmark a sufficient share of the public revenues for healthcare. As per the Abuja Declaration of 2001, countries were to earmark 15% of the national budget for the health sector but Kenya is yet to meet this target.

While high income countries spend an average of 7% of GDP on health, low income countries spend an average of only 4.2% on the sector. Insufficient health budgets due to deteriorating economic conditions, combined with burgeoning health problems such as the global HIV/AIDS pandemic, have led to an acute shortage of health



The vision, mission and mandate of the Ministry of Health as displayed on the wall of an administration block of a rural health facility in Kenya.
Courtesy of Paul Davis - Health Gap.

Corruption limits and denies access to quality and affordable healthcare.

workers *(WHO; 2006)*, shortage of drug and medical supplies, unaffordable out-of-pocket costs for health services' consumers, poorly remunerated health personnel or non-payment of health workers, poor quality of care, and inequitable healthcare services in many low income and transition countries. With corruption as both a cause and effect, the result has been the deterioration of general health among individuals and degradation of the health system in developing countries *(World Bank, 2004).*

Corruption drastically reduces the resources available for health, and lowers the quality, equity and effectiveness of healthcare services. It also decreases the volume and increases the cost of provision of health services. It further discourages people from the use and payment for health services and ultimately has a corrosive impact on the population's level of health. A study carried out by the International Monetary Fund (IMF) using data from 71 countries, shows that countries with a high incidence of corruption systematically have higher rates of infant mortality which is an indication of the health status of a country *(IMF, 2000).*

Overall, corruption in the health sector also has a direct negative effect on the access to and quality of healthcare. As resources are drained from health budgets through embezzlement and procurement fraud, less funding is available to pay salaries and fund operations and maintenance, leading to de-motivated staff and low morale among health workers, lower quality of care, poor supplies and working environment, and reduced service availability and utilisation.

To support efforts to improve good governance in Kenya's health sector, TI-Kenya conducted a Health Integrity Study aimed at mapping institutional and political risks, using governance indicators including the necessary desegregation to capture the impact, experiences and perceptions of marginalised groups in society, especially the poor and women; as well as best practices for promoting transparency, accountability and integrity in the sector.

The findings of this baseline study will serve as a basis for an action plan to improve governance in the Kenyan health sector and provide a foundation for empowering the citizens to increasingly and persistently demand for better service delivery in the health sector. It is envisaged that the action plan will include capacity building, learning, media programming, technical assistance and initiation of local projects in relation to the needs identified. TI-Kenya hopes that the plan will contribute towards improved access to and quality of healthcare as well as inform policy recommendations and advocacy campaigns towards the promotion of better health services. It is further expected that the study will be replicated after a number of years to measure the effectiveness of the action plan in promoting good governance and accountability, and policy formulation and implementation in Kenya's health sector.

1.1.2 Methodology

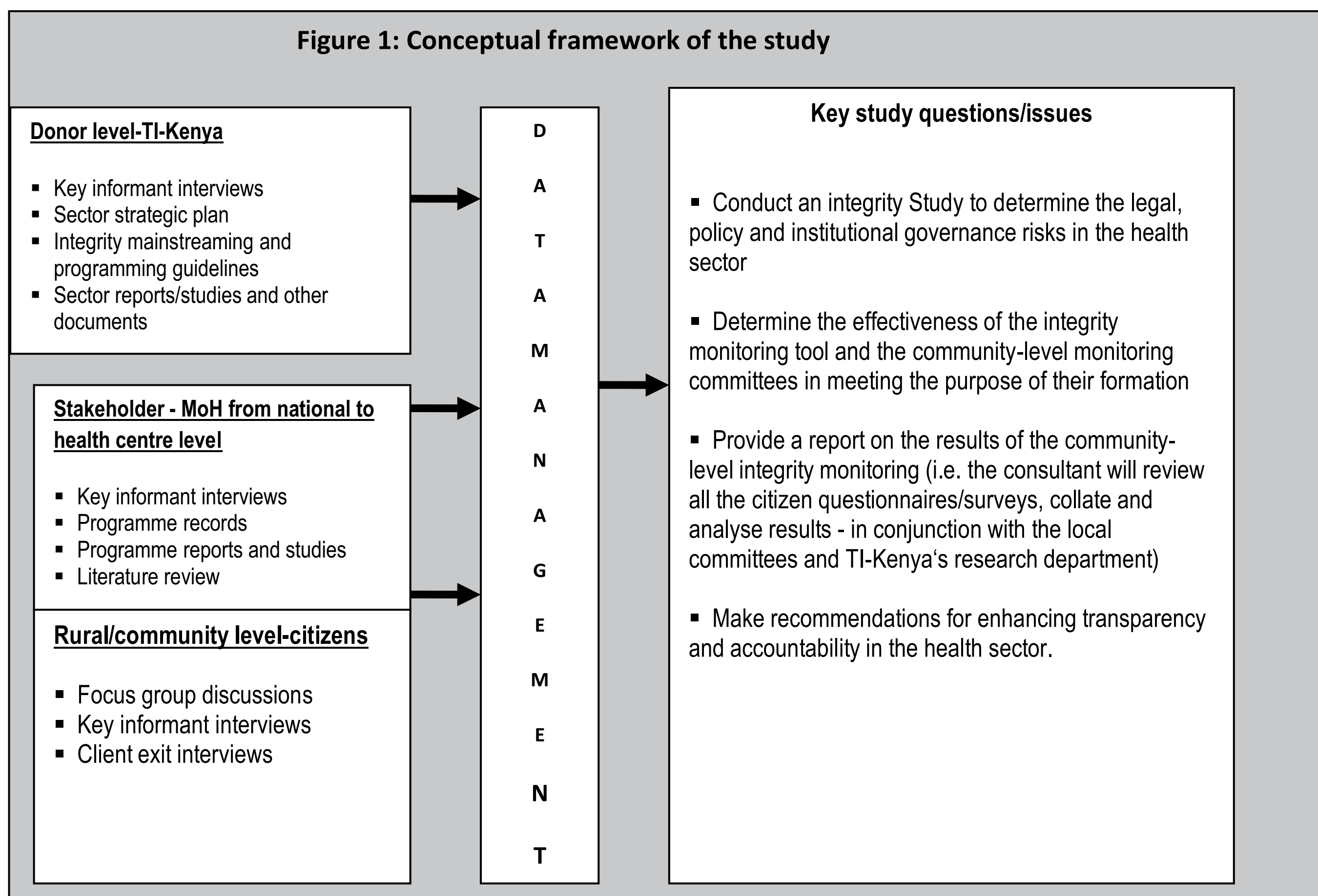
An integrity study is a cross-section survey to obtain primary and secondary data from a selected representative sample of respondents. For an analysis and assessment of governance issues and risks in the health sector in Kenya, the study used both quantitative and qualitative data collection techniques including stakeholders' key informant interviews, focus group discussions, review of integrity monitoring tools and assessment reports, and other existing literature/reports/studies. The assessment was conducted across the country in five selected provinces which are TI-Kenya's operational sites covering three levels of institutional organisations: 1) Donor level –TI Kenya; 2) Key stakeholder in the study – MoH at the district, provincial and national levels, members of civil society organisations and the community. The study covered cities and, large and small towns including Nairobi, Eldoret, Kisumu, Kakamega, and Mombasa. Others areas were:Nyamira, Bokoli, Kabuchai, Kilifi, Ganze, Kabarnet, Marigat, Nyamusi, Mbagathi and Kayole.

Before being interviewed, the purpose of the study was explained and it was made clear that participation in the study was optional and the identity of the respondents would remain confidential. The respondents were also assured of protection against any form of victimisation. Upon consenting to participate in the study, the researcher ticked against the relevant responses (agreed).

At each level, sampling was done systematically to ensure that the geographical coverage, gender and age distributions were addressed. At each of these levels, appropriate data collection tools were administered to gather

data that would inform the four (4) key study questions/issues. Figure one provides a conceptual framework of the study.

Figure 1: Conceptual framework of the study



Summary characteristics of the respondents

1.2.1 Characteristics of health providers

Table one represents a distribution of respondents by age and cadre. A total of 82 healthcare workers whose ages ranged from 21 to 56 years were sampled. The median age was 50 years. 60% and 41.3% were aged below 40 and 30 years respectively, an indication that those interviewed were relatively young in the health sector workforce. The majority of these (62.2%) were female and 41.5% were in the nursing cadre.

Table 1: Distribution of health providers interviewed by age group and cadre

Age category	% (n=82)
Under 30	41.3
30 to 39	18.8
40 to 49	30.0
50 to 59	10.0
Cadre	**% (n=82)**
KECN/EN	12.2
KRCHN/KRN (diploma)	15.9
KRCHN (Bsc/BN)	7.3
KRM	3.7

KEM	2.4
Clinical officer	11.0
Medical officer II (intern)	1.2
Medical officer	2.4
Medical lab technologist/technician	9.8
Pharmaceutical technologist/technician	2.4
Pharmacist	3.7
Other	28.0

Figure 2: Period worked as a healthcare provider, in the current designation and health facility

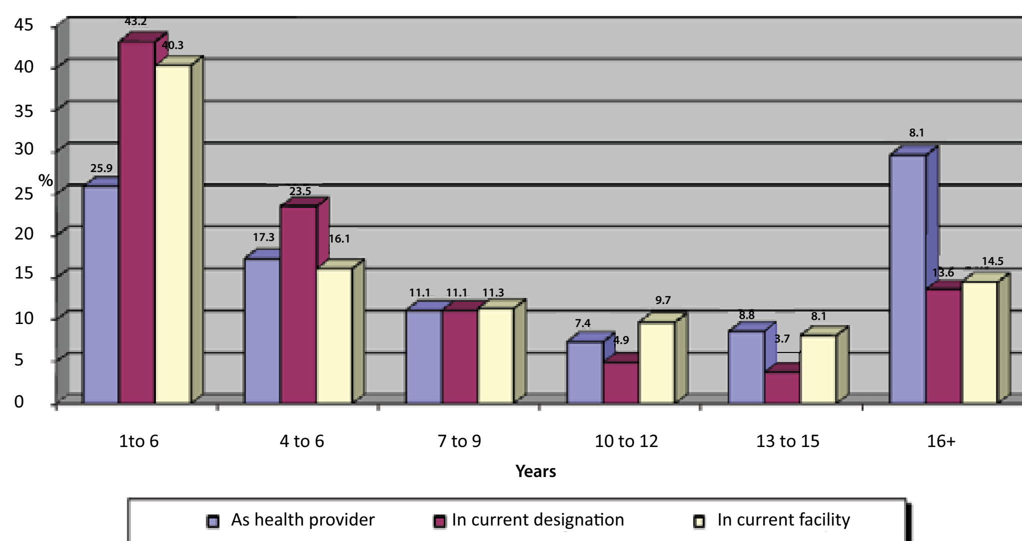


Figure two represents an illustration and distribution of respondents by duration of service as healthcare workers, in the current designation and facility. Most of the respondents had been in the present designation at the current health facility for a period of between one to five years.

Regarding the level of education, most (40.5%) of the respondents (healthcare workers) had attained a diploma level of education, while the rest were certificate level (27.8%), advanced diploma level (13.9%), degree holders (13.9%) and masters degree (3.9%) holders.

1.2.2 Characteristics of clients

Information was collected from a random sample of clients, who had received care in the facilities. They were asked questions on personal characteristics such as age, care-seeking behaviour, service delivery and quality of care/satisfaction. This was done through exit interviews where 258 clients were interviewed. The majority (80%) of the clients interviewed were drawn from hospitals and the rest from health centres (16.8%) and dispensaries (3.2%). The distribution by sector was as follows: public/GoK – 94.7%, mission/faith based organisations (4.4%) and private/NGOs (0.9%).

Table two provides a summary of respondents by gender, age category, marital status and level of education. Two thirds (65.1%) of the clients were female, and 70.5% were aged 35 and below, and the majority were married. About 49.6% had attained secondary level of education and above.

Table 2: Distribution of clients by selected characteristics

Characteristic	% (n=258)
Gender	
Male	34.9
Female	65.1
Age category	
1 under 25 years	31.6
26 – 35 years	38.9
36 – 45 years	15.8
46 – 55 years	8.4
56 and over	5.3
Marital status	
Single	23.8
Married/cohabiting	69.8
Widowed	3.2
Unspecified	3.2
Education	
None	2.5
Primary (incomplete)	15.1
Primary (complete)	32.8
Secondary +	49.6

Section 2: The Policy Framework of the Health Sector in Kenya

2.1 The Policy Context of the Health Sector

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. Kenya's Poverty Reduction Strategy Paper (PRSP), the public reform programme under the office of the President, the Economic Recovery Strategy (ERS), the Public Expenditure Review (PER), the Global Fund, the Millennium Development Goals (MDGs), Kenya Vision 2030 Sector Plan For Health and other global initiatives comprise the major external influences on the Kenyan health sector system.

The Kenya Health Policy Framework of 1994, the NHSSP II 2005-2010 and the Community Health Strategy and factors within the institutional and organisational context shape the internal environment. In addition, the demand for a skilled healthcare workforce is influenced by service needs, service utilisation and new technologies, while the supply of qualified health personnel is influenced by factors such as the availability of institutions for education and training, labour participation, efficiency and migration of human resources for health (HRH).

The strategies and interventions envisaged in this integrity study have been designed to cover the national and health policy framework programme and plans. Most prominent among these are the PRSP, MTEF, the Health Sector Reform Programme, the Sector Wide Approach (SWAp), the National Health Sector Strategic Plan II, the Legal Framework for Health particularly KHSPF of 1994 and other macro-economic and fiscal reforms. Other recent documents that inform the planning for the delivery of the healthcare system include the strategic plans for the ministries of health (Medical Services and Public Health) and the National Human Resources for Health Strategic Plan as well as the strategic plans for specific programmes such as the Kenya National HIV and AIDS Strategic Plan III (KNASP III) 2009/ 2010- 2012/2013.

The goals formulated in the Kenya Health Policy Framework of 1994 identified 15 areas for reform measures. Key among these was the strengthening of the public health policy with a periodic review and revision of a comprehensive health sector policy. In that framework, MoH was to spearhead efforts aimed at ensuring that health sector policies are elaborated and implemented, and where necessary suitable legislation is either enacted or amended appropriately.

The Accident and Emergency Department of the Kenyatta National Hospital in Nairobi. *Source: Daily Nation.*

The strategies and interventions proposed by this integrity study have been designed to cover the national health policy framework programme and plans.

Similarly, meeting the objectives of Kenya's Second National Health Sector Strategic Plan II (NHSSP II 2005-2010) of "reversing the trends" in declining health indicators requires action on several fronts. Key among these involve the development and strengthening of the health workforce, to ensure that they are equipped with skills, competencies and professional attitudes necessary to offer quality health services and able to respond to the current and emerging priorities prompting the development of the National Human Resource for Health (HRH) Strategic Plan 2009-2010. Unfortunately these ambitious yet noble ideas remain unachieved because of too many policy frameworks that operate at cross purpose rather than complementarily. For instance to address health workers' migration to other countries, there is need to develop coherent policies that extend even beyond the traditional health sector mandate- the improvement of security and infrastructure is well beyond the scope of two ministries of health yet it impacts on health workers' migration. The classification of health workers together with other civil servants who are hired and fired by the Public Service Commission requires consideration. The Ministry of Health should play a key role in the determination of the staff levels, deployment, discipline and training.

Another example of policy working in a discordant manner is partnership with international development partners especially in the area of HIV and AIDS. Key informant interviews revealed that the Ministry of Health has very little or no input in the policies of these partners. For instance in one site where there is a "joint programme" on the roll out of ARVs by the Government and the development partners, the medical officer in charge of that institution could not give the figures on the number of patients on ARVs both by the Government and the development partner. The Ministry of Health had to get permission from the partners in order to access this mundane information from the development partner's database. The conclusion is that where there is an alleged partnership of that nature, development partners call the shots and they advance their policy agenda at the expense of the Government's. In fact in such an arrangement, the only commonality between them is that they operate under one roof.

This confusion is also seen in the management of HIV/AIDS programmes which are currently under three different ministries namely the Ministry of Medical Services, Ministry of Public Health and Sanitation and Ministry of Special Programmes.

2.2 Findings from Key Informant Interviews

During interviews with key stakeholders, the following were the key findings/issues that require attention of the relevant parties:

1) Health facilities are constructed in a very haphazard manner without clearly defined policies to govern the establishment of new health facilities and plans for their subsequent management. For example, in a number of the areas visited, there were many CDF constructed health facilities that did not have sufficient staff, drugs and medical supplies. The construction of the facilities was influenced by politicians following the misconception that access to health facilities signifies good health for the community without necessary consideration of any substantial health indicators.

2) The Ministry of Health's strategic development plan is formulated to attract donor funding and not tailored to meet the needs of the community and further address capacity gaps in the sector. The country should borrow from the approach adopted in formulating the Kenya National AIDS Strategic Plan III. The Ministry of Health and donors do not participate in the development of annual action plans of civil society organisations (CSO) to guide the harmonisation of CSO interventions to the Health Sector Strategic Plans leading to poorly coordinated and duplicated interventions.

3) Kenya has excellent health policies in the region but the greatest challenge is their implementation. The Ministry of Public Health and the Ministry of Medical Services pose the greatest challenge in implementation as they are evidently pulling in different directions, especially in the implementation of the HIV Treatment, Care and Support policy.

4) The HIV Prevention and Control Act (2006) is facing major challenges in its implementation as the tribunal created to oversee its execution was only appointed and gazetted in December 2009. The Ministry of Health is not able to fund the dissemination of existing policies to the districts, provinces and communities. Majority

of the healthcare providers and community members are therefore not aware of the existing policies and strategies that have been developed to govern the healthcare delivery system, for example the reproductive health and the HIV/AIDS policies among others.

5) Overall, there is poor management of the awarded grants and resources in the sector due to the limited capacity of MoH and implementing partners coupled with limited or no documentation, reporting and communication among the government departments and implementing partners. There are areas of duplication for example the construction of health facilities through CDF where some clans have put up their own health facilities. There is need to review existing partnerships and policies that govern healthcare delivery systems.

2.3 Policy Framework Recommendations

1) Strengthen MoH's planning capacity by improving the Health Management Information Systems which will help generate timely and accurate data to inform planning and resource allocation, staff training and deployment, and performance contracting among other functions.

2) Empower MoH planners with health economics skills, knowledge and competencies for efficiency and effectiveness in planning for Human Resources for Health. There is need to establish a human resource information system to inform planning, recruitment and human resource deployment in the country to bridge the existing gaps in distribution of staff between rural and urban set-ups and regional variations.

3) Donor coordination and reporting on governance issues is weak. The establishment or strengthening of sector donor coordination committees should be considered. Mechanisms to establish a more harmonised system of channeling funds towards strengthening healthcare delivery should also be developed. For example support for human resources through Global Health Initiatives such as PEPFAR sponsored staff and MoH staff. Support for setting up the committee for operationalisation should be provided together with plans for sustainability.

4) The Ministry of Health should review the existing referral system to ensure that level five and six facilities (provincial and tertiary/referral hospitals) are used for specialised treatment only and adequate medical personnel are provided to level one to four facilities for efficient and effective healthcare delivery. The MoH should provide a favourable working environment for staff in these levels as well as incentives and development of appropriate policies to inform governance and leadership. The National HRH Strategic Plan should be widely disseminated and operationalised since it will greatly contribute towards better management of the workforce in the health sector in Kenya.

Section 3: Legal Regime of Kenya's Health Sector

3.1 The Legal Framework of the Health Sector

The legal framework of the health sector in Kenya is governed primarily by Kenya's Health Policy Framework (KHPF) of 1994. The document in its agenda for reform, identified the strengthening of the central public policy role of the Ministry of Health in all matters pertaining to health as a key priority. In terms of regulation and enforcement, the government asserted its commitment to continue regulating the health sector by enforcing the following Acts of Parliament which it identified as pertaining to the health sector:

1) Public Health Act cap 242
2) Radiation Protection Act cap 243
3) Pharmacy and Poisons Act cap 244
4) Dangerous Drugs Act cap 245
5) Malaria Prevention Act cap 246
6) Mental Health Act cap 248
7) Medical Practitioners and Dentist Act cap 253
8) Nurses Act cap 257
9) Clinical Officers (Training, Registration and Licensing) Act cap 260
10) National Hospital Insurance Fund Act cap 255
11) Food, Drugs and Chemical Substances Act cap 254
12) Animal Diseases Act cap 364.

A health worker attends to a patient. *Source: Daily Nation.*

The Ministry of Health should de-link healthcare workers from the mainstream civil service.

Unfortunately, the drafters of this policy framework did not look beyond the health sector for other legislation that have an impact on the health sector. The following are some of the other statutes that impact on the health sector:

1) The Medical Laboratory Technicians and Technologist Act (1999) *(This was enacted after the KHPF of 1994)*
2) The Science and Technology Act cap 250
3) The Local Government Act cap 265
4) HIV and AIDS Prevention and Control Act, Act no 14 of 2006
5) The Anatomy Act cap 249
6) The Public Procurement and Disposal Act 2005 Act no 3 of 2005 and the Regulations made thereunder
7) The Finance Act (enacted every financial year)
8) Education Act cap 211
9) Kenya Medical Training College Act cap 261
10) The various public universities' acts
11) The Constitution of Kenya Chapter 15, Article 248(2) creates the Public Service Commission
12) The Penal Code(1960)
13) The Sexual Offences Act(2006)

All these statutes have an impact on the health sector, for instance the Finance Act directly affects the budgetary allocation to the Ministry of Health. The Public Procurement and Disposal Act affects the manner in which the Ministry of Health acquires its supplies. The Education Act and various legislation governing public universities affect the quality of training given to health workers in those institutions. The Public Service Commission Act affects the Ministry of Health's organisational structure, appointments, promotions and staff discipline. The Penal Code provides for criminal liability for health workers who facilitate abortions. The National Commission on Gender and Development is mandated to promote gender equity in health. There exist discriminatory practices especially on reproductive health. The Public Health Act, section 3(1) establishes a Central Board of Health whose function is to advise the minister on all matters affecting public health. This study established that this board has not been in existence for a long period yet it is one of the most crucial governance institutions in the health sector. It also established that Kenya does not have a National Health Training Policy (it was in the draft stage at the time this report was published). This affects the regulatory bodies within the health sector in ensuring the quality and standards in the training of the health workers. The new Constitution provides for equality and freedom from discrimination (Art 27) and the right to health and reproductive health (Art 43).

The mandate of Kenya's health sector laws is in a state of confusion. In the current legal framework, there are over twenty statutes dealing with the health sector in the country. As rightfully pointed out in the 1994 Kenya Health Policy Framework, most of these legislation are due for reforms. 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. Even within the Ministry of Health itself, there are divisions, departments and specialised agencies responsible for different aspects of health regulations. These agencies have not been well coordinated in the past, often resulting into inefficiencies, duplicity of efforts and wastage of resources. It is important to note that the coordination of the key functions of health institutions is paramount in ensuring the effective implementation of policies and programmes in the sector.

For instance health education and training is regulated by the provisions of the Education Act Cap 211 (which is limited in terms of dealing with health education and training) and the various statutes setting up health professional bodies such as the Nursing Council (Cap 257), Kenya Medical and Dentist Practitioners Board (Cap 253), Pharmacy and Poisons Board (Cap 244), The Clinical Officers Council Cap 260, Medical Laboratory Technicians and Technologist Act no 10 of 1999, the various universities' acts and private universities' charters. It should be noted however, that only about four acts deal directly or indirectly with health education and training in addition to other statutes which are not directly related to the health sector but are found in the entire educational sector. Even the principal act in the health sector, the Public Health Act Cap 242 has no provisions for health education and training. It is noteworthy that there is no coordinated and structured legal and institutional framework for the management of health training institutions in Kenya. The responsibilities for policy and strategic planning as well as the performance of the necessary functions are assigned to various institutions which leads to complicated and often ineffective coordination.

The current health services' system is fragmented and sometimes inconsistent. This is exacerbated by the existing legal framework which has created a lot of conflict and overlaps in the management of education and training in the health sector. This does not allow standardised guidelines for health education and training, and quality assurance at all levels. For instance the Commission for Higher Education (CHE) deals with accreditation of universities but has no capacity in terms of manpower and the legal framework to enforce its post-accreditation guidelines. Public universities operating under their own statutes have resorted to frenzied expansion under the module two (parallel) programmes for privately sponsored students, way beyond their institutional capacities thereby compromising the standards of training, yet CHE cannot legally reign in such offending institutions. There are very many mushrooming middle level health education and training institutions which are currently unregulated. There is no system of accreditation or certification. This is currently being conducted by the respective professional regulatory bodies such as the Kenya Medical and Dentists Board and the Nursing Council among others. The draft National Health Training Policy seeks to remedy this by creating a central Commission for Health Education and Training with the mandate inter alia: to standardise health training curricula and regulate the certification and accreditation of all health training institutions and workers in the country.

The governance system with regard to the licensing of health professionals is inadequate. Just as with regard to their training, the responsibility of licensing health professionals lay with their own professional bodies. There are also incidents pertaining to conflict of interest evident in cases of medical malpractices. There are widespread views that sporadic raids on unlicenced clinics are aimed at playing to the public gallery rather than enforcing regulations and standards.

In terms of resource allocation, the government regulatory agencies are not well resourced to enforce the existing regulations. The government has in several instances undertaken to review and evaluate health sector laws and regulations but there has been no tangible progress on this. The most urgent is the harmonisation of the various laws dealing with the health sector.

The Central Health Board and the Medical Department which are mandated under the Public Health Act to inter alia protect drinking water and its sources are ineffective. Key informant interviews conducted during this study revealed that the Central Health Board is moribund since the Minister of Public Health has not appointed the members as required by the law. There is also an overlap and duplicity of this function by the National Environmental Management Authority (NEMA) under the Environmental Management and Coordination (EMC) Act.

These are some of the International and Regional Legal Instruments which have been ratified by Kenya:

- Maputo Protocol
- Abuja Declaration
- WHO Framework Convention on Tobacco Control
- The International Health Regulations
- International Covenant on Economics, Social and Cultural Rights
- International Covenant on Civil and Political Rights
- Convention on Elimination of All Forms of Discrimination against Women
- Convention on the Rights of the Child
- Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
- African (Banjul) Charter on Human and Peoples' Rights
- International Convention on the Rights of Persons with Disabilities
- Convention on Discrimination Against women (CEDAW)
- International Convention on the Elimination of All Forms of Racial Discrimination
- Convention of the Rights of the Child (CRC)
- Optional Protocol on the Involvement of Children in Armed Conflict
- African Charter on the Rights and Welfare of the Child
- Immediate Action for the Elimination of the Worst Forms of Child Labour
- Convention on the Elimination of Racial discrimination (ICERD)
- The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families

It should be noted that these are mainly dealing with human rights and are fairly well covered in the new Constitution. For instance, the principle of non discrimination is the cornerstone of human rights' laws and it is embedded in all human rights treaties. This is also embodied in the new Constitution in Art 27. Others like the Convention on the Rights of the Child have been domesticated through the Children's Act 2003.

As it has been rightly pointed out, Art 2 (5) & (6) makes international treaties, customary laws and rules part of Kenya's laws. However it will take some time before they are all implemented.

3.2 Legal Framework Findings

1) Healthcare regulatory systems are uncoordinated, very fragmented, and are spread under different health legislation thus lacking harmony and are difficult to coordinate.

2) Regulatory bodies/councils have become lax in enforcing laws, guidelines and standards that govern the quality of healthcare services in this country for various disciplines. The bodies/councils play a minimal role in regulating the quality of healthcare services and facilities in the country. On several occasions, Kenyans learn through the media and other sources of many reported complaints which have attracted little or no action. The bodies have a tendency to protect and defend medical practitioners instead of addressing issues to streamline the quality of healthcare services. This is one of the shortcomings of self-regulation and peer trials as a mechanism of quality assurance control. The recent standoff between the Nursing Council and the medical training centres, regarding the setting of professional examinations amongst other issues is a case in point.

3) Laxity among the regulatory boards has largely encouraged unscrupulous individuals to utilise existing loopholes without fear of victimisation and penal consequences. Many mushrooming clinics, chemists and laboratories among others, are now being operated by people who are not medical professionals. In some countries, for example South Africa, an uncertified/unregistered individual cannot operate a medical laboratory without being a pathologist or a chemist without being a pharmacist or a clinic without being a doctor/clinician. However Kenya faces major challenges in enforcing the existing laws and regulations as several individuals receive licences to practice without technical expertise, an area that requires redress. Concerns have also been raised over the Kenya Bureau of Standards' (KEBS) and the Kenya Pharmacy and Poisons Board's inability to curb the sale of imported sub-standard medicines; a key concern mentioned by several respondents in this study.

4) Many laboratories, chemists and clinics operating in Kenya do not meet the required legal standards and regulatory requirements. They are not certified to practice thus endangering the lives of many Kenyans who are presumed to be their clients. Already many people have lost their lives in unclear and suspicious circumstances as a result of poor quality medical services.

5) The sanctions for noncompliance to the existing laws, standards and regulations are inadequate and not sufficiently deterrent to potential offenders. This encourages contravention of the laws since the penal consequences are not stiff and there is a high probability of evading punishment due to corruption within the enforcement machinery. Key informant interviews revealed very disturbing trends where nearly expired drugs are re-packaged and/or donated free of charge to the community.

6) The Country Coordinating Mechanism (CCM) for the Global Fund (GF) is not a legal entity that is recognised within the Kenya Government system. This makes it difficult for the CCM to enforce policies and principles especially when working with the Principal Recipient (PR) who is the Ministry of Finance (MoF) and Sub Recipients (SRs), Ministry of Health (MoH), National AIDS Control Council (NACC) and CARE-Kenya (for CSOs) who are CCM members. Because of this weakness in the Global Fund structure, accountability for GF resources even by MoH accounting officers is questionable since there are no clear mechanisms of monitoring expenditure and linking the outflows to programming. It is not one of their expected performance results leading to the many accountability challenges stalking the fund in Kenya.

7) There is generally lack of information and/or knowledge about existing policies and legislation which the communities can take advantage of in enhancing their health. For example, in nearly all of the communities living around the health institutions sampled, majority of the respondents were unaware that the treatment of children below the age of five and adults over sixty years is free. Other healthcare services which are free in government facilities include the provision of ARVs. However, there is need for community education to create awareness.

3.3 Legal Regime Recommendations

1) In line with the country's new constitutional dispensation, the government should ensure that the country meets its international obligations in the health sector by effectively implementing international treaties and conventions such as the Abuja Declaration, WHO Framework Convention on Tobacco Control and the International Health Regulations (2005).

2) Due to capacity and resource constraints to enforce the existing legislation or regulations, the regulatory bodies require support to identify funding sources and ensure proper enforcement of safety and quality standards as an integral aspect of promoting quality healthcare.

3) Reform and harmonise all laws and policies that affect the health sector into one regulatory regime that clearly spells out the duties, functions and roles of each body/department to avoid overlapping and duplication of functions for efficiency and harmonisation in the sector. Where conflicting legislation exists, technical assistance may be useful in pinpointing inconsistencies and formulating clarification.

4) De-link healthcare workers from the mainstream civil service and manage them under a 'Health Service Commission'. This can be proposed to the cabinet for approval as part of the amendments to be done in the new Constitution.

5) Work towards legislation of the Global Fund Country Coordinating Mechanism (CCM) or another structure that will perform oversight functions with powers to enforce policies and principles in the management of the Global Fund in Kenya.

6) Ensure proper implementation of laws and policies related to the health sector through awareness creation and capacity development of all the stakeholders, including the citizenry, on the provisions of these frameworks.

Section 4: Institutional Governance of the Health Sector

4.1 Introduction

The study was conducted in selected areas and health facilities shown in the table below. In all the regions visited, interviews were conducted with health workers, key informants (National MoH staff, programme heads, medical superintendents, hospital administrators and hospital board members among others), exiting clients, other stakeholders (excluding the MoH) and community members.

Table 3: Sampled areas and health facilities

Province	Provincial Facility	District Facility	Rural Facility/ Community	National Level
1. Coast	Coast General Hospital	Kilifi	Ganze	Key stakeholders: MoH departments (CEO, policy, planning, HIMS, Malaria control, NASCOP, TB and Leprosy, finance, HR), medical suppliers, private sector actors (health institutions, pharmaceutical firms, KMA), civil society organisations (CBOs, FBOs, NGOs), and the health sector donor community (DFID, Global Fund)
2. Nairobi	Mbagathi Hospital	Kayole	Dandora	
3. North Rift	Moi Teaching and Referral Hospital	Kabarnet	Malgat	
4. Nyanza	New Nyanza General Hospital	Nyamira	Nyamusi	
5. Western	Kakamega Provincial General Hospital	Bungoma- Kabuchai	Bokoli	

4.2. Key Findings on the Institutional Governance of the Health Sector

4.2.1 Management of Health Institutions

The complexity of services that must be delivered through any health system is staggering. A health system must finance and deliver a wide range of public health, prevention and promotion programmes, as well as provide for direct services to individuals that include immunisations, ante-natal, peri-natal and post-natal care, treating injuries, control of infectious diseases, treatment for non-communicable diseases and management of emerging chronic conditions.

These services are delivered by a wide range of players: public providers, FBOs, NGOs, CBOs, private providers and traditional healers in a variety of settings including doctors' offices, clinics, hospitals, homes and communities. Complexity requires good organisation and management. This means applying all the management functions taught in business schools including planning, organising, defining roles, creating processes and incentives, ensuring accountability, and hiring and motivating staff.

Effective management also entails setting sound policies and ensuring their implementation and clearly defined performance management systems. The fragmentation of health services in Kenya and sub-Saharan Africa in general is an indicator that strong management is absolutely essential. Despite this need, research indicates that

An understocked dispensary in a rural town in Kenya. *Courtesy of Paul Davis - Health Gap.*

The complexity of services that must be delivered through any health system is staggering; complexity requires good organisation and management.

the region has the lowest management ratio in the world; only 17% of its total healthcare workers are employed as managers or support workers, compared to 43% in America and 33% globally, *(World Bank, 2008)*. This skill deficit has drastic ramifications on the improvement of health programmes.

According to *The World Health Report 2006* "Health management and support workers provide the invisible backbone for health systems; if they are not present in sufficient numbers and with appropriate skills, the system cannot function . . . ."

The World Health Report names improved management as the highest priority for country leaders if they are to address human resource deficiencies successfully. It suggests that the focus of improved management should be to reduce waste, enhance incentives, and create and sustain a high-performing workforce. During its first meeting in Nairobi, Kenya (Centre for Public-Private Partnership, World Economic Forum 2006), the group visited several sites to get a firsthand experience of the range of healthcare services in the country. The reports from Nazareth Hospital in Kiambu County and another nearby rural facility captured the contrasts highlighted in the text boxes below.

Nazareth Hospital

Nazareth Hospital, in Kiambu County, is a faith-based institution that provides hospital care for US$5 (Kshs 400) per day. It is self-sustaining, covering all its operating costs within that charge, although it relies on private and donor contributions for capital improvements. It serves the neediest communities in its rural location 25 kilometers from Nairobi. By all accounts, it provides quality care to its patients in a clean and hygienic environment. On average, 80% of its 220 beds are occupied at any given time. Its contribution to the provision of quality and affordable healthcare has been recognised by the Global Fund and PEPFAR, which have collectively given it several million dollars in grants to provide ARVs through a community outreach programme.
When asked the reasons for the hospital's success, one of the medical doctors who worked in one of Kenya's public hospitals before moving to Nazareth said: "Management. At government facilities doctors can't do what they are trained to do. Staff don't show up or are de-motivated when they do, operations are delayed because there is no oxygen in the operating theatre; the bureaucracy creates inertia among staff and supervisors. Here staff are motivated; doctors have the supplies and tools to do their job."

Government-run rural facility in Kiambu

Here, it was alleged that the government had not procured enough reagents for CD4 or viral load tests used in HIV/AIDS testing and treatment, and it was impossible for hospitals or clinics to buy supplies directly, even though they had funds in hand from patients' user fees. Pharmaceuticals, they said, were centrally supplied but were often of very poor quality—for instance syrups turning black, tablets crumbling, weak sutures—because contracts were awarded to the lowest generic bidder and their quality was not properly checked.

Although the equipment to perform complex tests was in the laboratory, the hospital did not have sufficient gloves to ensure the safety of the staff. This was not due to lack of money but the bureaucracy involved in ordering for the gloves. On staff motivation, one of the workers interviewed said: *"If someone decides to be a rotten egg, we can make a recommendation [to the ministry] that they be sacked but it takes many years. If the manager here had the power to hire and fire, things would improve."*

"Management makes organisations possible; good management makes them work." Joan Magretta, Author.

In summary, the key challenges experienced in public health facilities sampled in the study pertain to the management of people, funds, drugs and health supplies.

4.2.2 Governance of Health Facilities

The subject of integrity in governance ensures a standard value of accountability and transparency. In each of the health facilities visited, there existed a set of governance structures consisting of various bodies such as the hospital management where the head of the facility is the medical superintendent (Med. Supt), the board and the Hospital Management Team (HMT). There were three key integral compartments of the governance structures noticed in all the health facilities that is the HMT, District Health Management Team (DHMT) and Health Facility Management Board. However some facilities, such as the provincial institutions, had several committee units based at the departmental level and there was a variation in numbers depending on the number of departments functional at the facility level.

The boards were established by an act of Parliament to ensure high performance in service delivery, accountability and transparency in the respective facilities. They are expected to represent the community perspective with the assumption that the community owns the facility. All the facilities surveyed had boards comprising of twelve members where six represented the beneficiary community members, two ex- officio and the rest were members of the facility's management team. The board is expected to perform the following functions:

1) Oversight of accountability and transparency
2) Custodian and responsible for the growth of the facility
3) Communicate to the public on the successes, progress and challenges of the facility
4) Upgrade the health standards in the catchment area
5) Uplift the standards of service delivery
6) Ensure compliance to all statutory requirements, review and approve strategic plans
7) Ensure effective communication with all stakeholders
8) Approve funds and recruit subordinate staff among others.

The findings indicated that the hospital management boards were less effective in the community health facilities. For example in Nyanza and Western provinces, the boards were totally ineffective as the community oversight mechanism. Most of the community members interviewed at a hospital in Nyanza felt that the boards were not effectively representing their issues in the health facility. The community problems were not addressed by the board at the functional facility level. Reasons established for these were:

1) Insufficient academic qualifications and experience
2) Inadequate knowledge and access to information
3) Heavy workload with little motivation or reward
4) Lack of sufficient influential capacity.

To further gain an understanding of governance issues in the sampled health facilities, the study requested the healthcare workers, facility-in-charges and departmental heads to rate: 1) Their level of satisfaction on selected governance issues including transparency, accountability, employment malpractices and political interference among others; and 2) The effectiveness of their facilities in selected areas touching on governance such as structures, the board, procurement systems and control systems among others. Tables four and five below represent findings from the health providers and facility-in-charges or departmental heads respectively.

Table 4: Health providers' level of satisfaction/dissatisfaction on selected governance issues				
	Level of satisfaction/dissatisfaction			
Governance issue	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
Transparency	13.4	61.0	22.0	3.7
Accountability	6.1	67.1	23.2	3.7
Fraud	9.3	61.3	28.0	1.3
Funds misappropriation	8.5	54.9	35.2	1.4
Service fee charges	17.7	55.7	22.8	3.8
Employment malpractices	9.6	49.3	32.9	8.2
Political interference	15.1	45.2	30.1	9.6

Table 5: Facility-in-charges/departmental heads' level of satisfaction/ dissatisfaction on selected governance issues				
	Level of satisfaction/dissatisfaction			
Governance issue	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
Transparency	30.6	61.1	8.3	0.0
Accountability	13.9	77.8	8.3	0.0
Fraud	38.2	47.1	14.7	0.0
Funds misappropriation	28.6	65.7	5.7	0.0
Service fee charges	23.5	61.8	14.7	0.0
Employment malpractices	18.8	65.6	15.6	0.0
Political interference	12.1	51.5	24.2	0.0

As highlighted in table four above, over 70% of the health providers expressed satisfaction with matters of transparency, accountability, fraud and service fee charges. However a significant number, over 36%, expressed dissatisfaction in three areas: funds misappropriation, employment malpractices and political interference.

In table five, over 70% of the facility in-charges or heads of departments expressed satisfaction with the governance issues. However a significant number, 36.3% expressed dissatisfaction due to a high level of political interference in the management of health facility affairs. Political interference was cited by both the healthcare workers and facility in-charges/head of departments as a key governance issue that requires attention in terms of strengthening systems and putting in place effective policies.

Tables six and seven show healthcare workers, facility-in-charges and departmental heads' ratings of effectiveness on selected governance and service provision issues. From the study, it emerged that about a third of the health workers perceived governance structures and facility CEOs (in charge of facilities) to be very effective. On the other hand, in reference to the proportion who rated their level of satisfaction as "somewhat effective" and "neutral", the general implication is that health providers lack complete confidence in the structures and systems as shown in table six while those in-charge of health facilities and departmental heads have confidence in the existing systems and structures as per the proportion who rated the level of effectiveness as "very effective and somewhat effective" as shown in table seven.

Table 6: Health providers' rating of effectiveness on selected governance issues						
Effectiveness of…….	Very effective (%)	Somewhat effective (%)	Neutral (%)	Somewhat ineffective (%)	Very ineffective (%)	Not sure (%)
Governance structure of the health facility	32.1	45.7	16.0	3.7	2.5	0.0
Health facility board in fulfilling its mandate	20.0	41.3	17.5	11.3	3.8	6.3
Health facility CEO in carrying out his/her duties and responsibilities	35.8	43.2	12.3	7.4	0.0	1.2
Procurement system and distribution of supplies	11.3	42.5	12.5	22.5	11.3	0.0
Employment system	10.3	34.6	23.1	17.9	12.8	1.3
Communication and dissemination of information	25.9	39.5	16.0	14.8	2.5	1.2
Strategic plan	12.3	55.6	14.8	9.9	3.7	3.7
Governance control systems	17.5	40.0	26.3	10.0	6.3	0.0
Funds' utilisation	24.5	18.5	30.5	10.7	16.5	0.0

Table 7: Facility-in-charges and departmental heads' rating of effectiveness on selected governance issues						
Effectiveness of…….	Very effective (%)	Somewhat effective (%)	Neutral (%)	Somewhat ineffective (%)	Very ineffective (%)	Not sure (%)
Governance structure of the health facility	52.8	27.8	16.7	0.0	0.0	2.8
Health facility board in fulfilling its mandate	37.5	50.0	6.3	3.1	0.0	3.1
Health facility CEO in carrying out his/her duties and responsibilities	62.9	25.7	5.7	2.9	0.0	2.9
Procurement system and distribution of supplies	36.1	41.7	13.9	8.3	0.0	0.0
Employment system	26.5	38.2	17.6	8.8	0.0	8.8
Communication and dissemination of information	36.1	50.0	8.3	5.6	0.0	0.0
Strategic plan	30.6	55.6	5.6	5.6	0.0	2.8
Governance control systems	33.3	52.8	11.1	2.8	0.0	0.0
Funds' utilisation	52.8	38.9	5.6	2.8	0.0	0.0

4.2.3 Acute drug shortages in public hospitals

During the field assessment it was evident that an acute shortage of medicines and other essential supplies in public hospitals is creating a trail of misery for patients across the country. The drugs missing included: malaria drugs, rehydration salts, ARVs and antibiotics (Amoxicillin and treatments for STDs). From the facilities sampled, the study shows that many patients are unable to afford the extra charges demanded by hospital staff to source for drugs elsewhere. The patients accused nurses and other medical personnel of hoarding the drugs and secretly supplying them to private pharmacies. A practice they cited as a key contributor to the shortage of drugs. The only drugs available were pain killers (aspirin, panadol, brufen) and de-wormers. Clients reported being given the appropriate prescription on consultation but they had to purchase the drugs from chemists dotting the facility at inflated prices. Therefore, it is highly likely that these chemists either work in cahoots with the medical staff or are actually owned by them. Likewise, out-patient record books (common A5 size school exercise books divided into two) are strategically placed and sold at the gate to the patients. In case the doctor recommends an injection, patients are forced to buy needles, syringes and gloves from the private chemists or clinics around the public facility.

During a focus group discussion with groups at one of the facilities visited in western Kenya, respondents consistently mentioned that health providers at the facility deny them some drugs in the facility, but sell the same to other patients from their bags at higher prices or refer them to nearby private facilities. It is not clear how they access the drugs; whether they buy for re-sale or in collaboration with the pharmacist or facility in-charge.
In one of the facilities visited, some clients narrated an incident where a mother took her sick daughter to hospital for treatment at night in January 2010. She arrived at the facility at 11 p.m and after being attended to by the clinician, there were no drugs and all the pharmacies were closed. Upon pleading for assistance for about 30 minutes, the mother was asked by a nurse whether she had Kshs1,500 to purchase the necessary drugs from a friend's pharmacy. The nurse returned a few minutes later with the drugs and asked for more money for needles and syringes for administering the drugs.

In yet another facility in western Kenya, a mother aged 43 years who was diabetic said that she was unable to access drugs for her condition for several days. She feared that her condition could worsen since she could not afford unsubsidised drugs at the private pharmacies. She had been turned away several times at the hospital pharmacy. She said that her only hope lay in herbalists who had set up shops on the streets of Kakamega town and whose supplies were more affordable. From the discussion held with the community members, it was apparent that in western Kenya, a number of sick people consult traditional herbalists. Similar trends were observed at various health facility levels (dispensaries, health centres and sub-district hospitals in the region).

Shortages of supplies in the health facilities were cited across all the regions visited. For example at one facility visited in the coast, some patients had been waiting for supplies to arrive for many months. A female client aged 65 years had been on the waiting list for four months after being referred to the facility following a fracture on her thigh. Her injury could not be treated because the 'metals' and 'cement' required for surgery were not available. At the point of data collection, she had been waiting since September 2009 and was worried that she may not get adequate funds to pay the bill that was increasing by Kshs 400 per day for the hospital bed only.

At the Moi Teaching and Referral Hospital in Eldoret, suppliers had threatened to stop the delivery of drugs and other supplies due to unpaid debts amounting to Kshs 75 million. Funds from treasury are not adequate to meet the needs of the facility. Some suppliers had stopped deliveries due to non-payment, a move that does not augur well for a referral hospital. The hospital's director made a special appeal to the government to salvage the situation; a plea that was echoed in all the sampled institutions. The experience at the Moi Teaching and Referral Hospital was attributed to the lack of alignment between budgetary allocations and service provision. The hospital being a referral unit provides highly technical services which are costly and it serves a large volume of clients. In terms of drugs and medical supplies, the institution was fairly resourced.

4.2.4 Funds' Management

While the challenge of running an effective health system is not limited to resource-poor settings, those with few resources face even greater obstacles. The amount of money in the system and how it is collected, pooled and distributed are critical elements for providing essential services, ensuring financial protection against high medical costs and improving equity and access to care. The manner in which the money flows through the system can also pose a greater constraint to delivery of services than overall financing. Budgeting processes, particularly in public facilities, are often bureaucratic and complex with no incentives to promote cost-effective practices. Profit and loss responsibilities do not clearly rest with districts or health facilities and financial management tools are weak or non-existent. Basic information about costs of care is lacking and financial accountability is often not measured or even expected. While ensuring sufficient resources for health continues to be a challenge in the country and requires sustained external assistance, changing internal incentives for cost-effectiveness and promoting financial discipline are steps that can be taken immediately to achieve greater impact from current funds within the sector.

According to the study findings, 83% of the facility in-charges and heads of departments reported that the ministries of health regularly communicate with their constituencies and partners at all levels (national, provincial, district and local) on priority health needs. The government, through the health ministries, has provided and published guidance for prioritising health expenditure based on available resources and priority needs, according to 91.4% of the respondents.

The government through MoH is the principal financial source for most of the facilities in the study sample. Table eight provides a summary of the financial and in-kind resources for the health facilities and the proportion of in-charges and departmental heads who mentioned the source. According to 69.4% of the respondents, the community is a source of financial and in-kind resources for the facilities – through facility improvement funds (cost sharing).

Table 8: Sources of financial and in-kind resources for health facilities

Source	% (n=36)
Ministries of health	100.0
Local authorities	25.0
Community	69.4
Corporate/Business community	33.3
UN agencies	30.6
Global Fund	44.4
USAID	66.7
DFID	16.7
World Bank	13.9
Bilateral or government agencies	5.6
National NGOs	22.2
International NGOs	50.0

Table 9: Sources of funding and level of contribution

	Level of contribution				
Source	Over Kshs 20 million (%)	Kshs11-20 million (%)	Kshs1-10 million (%)	Less than Kshs1 million (%)	Does not contribute (%)
Ministry of Health	48.0	8.0	24.0	20.0	0.0
Local authorities	0.0	0.0	6.3	31.3	62.5
Community	30.0	10.0	25.0	30.0	5.0
Corporate/Business community	6.7	0.0	20.0	33.3	40.0
USAID	31.6	5.3	21.1	31.6	10.5
DFID	16.7	8.3	25.0	0.0	50.0
Global Fund	25.0	16.7	16.7	0.0	41.7
UN agencies	15.4	23.1	7.7	7.7	46.2
World Bank	0.0	12.5	0.0	37.5	50.0
Other Bilateral or government agencies	0.0	0.0	14.3	28.6	57.1
Nairobi-based embassies	16.7	0.0	0.0	0.0	83.3
National NGOs	14.3	14.3	0.0	28.6	42.9
International NGOs	20.0	10.0	20.0	30.0	20.0
Others	40.0	0.0	20.0	0.0	40.0

4.2.5 Accountability

The study findings reveal the existence of financial accountability mechanisms to the public for government spending on health through regular publication of financial expenditure reports, MoH budget, expenditure documents, periodic newsletters, website reports, national health accounts, health facility budget and the Parliamentary Public Accounts Committee (PAC). However, it is important to note that PAC reports are released two to three years later but are very useful for that financial period. There are concerns whether these reports reach the health facilities therefore influencing and informing accountability.

Interviews with the heads of facilities and departments revealed the inadequacy of reports on government health sector performance and spending. Such reports are not only accountability documents to the public but also serve as a transparency mechanism. On the other hand, there could be a possibility of generated reports reaching intended targets for example the health workers. Table ten below represents the distribution of facility in-charges and heads of departments by reports available to health workers in the past two years.

Table 10: Availability of reports on health sector performance and spending

Type of report	% (n=36)
Regular publication of budgets	30.6
Regular publication of spending rates	27.8
Ministry of health budgets	44.4
Ministry of health expenditure documents	30.6
Ministry of health periodic newsletter	16.7
Ministry of health website reports	13.9
National health accounts	16.7
Health facility budgets	30.6
Health facility expenditure documents	30.6
Parliamentary Public Accounts Committee	11.1

The qualitative information from focus groups and policy makers indicates that there is financial accountability to the public on government spending on health e.g. regular publication of spending reports, MoH budget, expenditure documents, periodic newsletters, website reports, and national health accounts, health facility budget and Parliamentary Public Accounts Committee. There was a sense that the officials at the health facility level have the responsibility of ensuring prudent spending as they are held accountable by the existing management board. This is done through the submission of monthly financial reports, periodic supervision by national authorities and monthly dissemination meetings.

However, it is worth noting that only a third of the facility in-charges and heads of departments had (in the past two years) seen health facility budgets and expenditure documents since the records are not based at the health facilities. In addition, health facility officials particularly heads of facilities and departments are responsible for budgetary expenditure but their lack of awareness regarding health facility budgets raises concern on accountability to their constituents and national health authorities. Asked how they are held accountable for facility level spending, 72% mentioned the production of monthly financial reports, periodic auditing (61%), periodic supervision by national authorities (47%) and monthly dissemination meetings (30.6%). A small proportion (8.3%) did not know.

Bottlenecks and delays in the transfer of funds which ultimately lead to low levels of budget execution seem to be a common feature according to the respondents. Among those interviewed, 64.7% of the heads of facilities and departments, reported having experienced such delays in the past two years. About 65% had experienced less than four similar delays in the past two years and 25%, above four of such setbacks. This is further corroborated with findings from the health providers; 52.6% had experienced budget delays and 72.7% and 16% in less than four and more than four instances in the past two years, respectively.

Table 11 represents the rating of the health facility's budget management by the heads of facilities and departments in selected areas. It emerged that a medium majority of the respondents were satisfied with all the areas. However, a significant number 29.4% had concerns regarding alignment to national budget cycles, promoting and strengthening national public financial management and procurement systems.

Table 11: Rating of budget management in selected areas				
Budget management area	Rating			
	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
Reducing transaction costs/overhead costs	17.6	58.8	23.5	0.0
Aligning to national budget cycles, promoting and strengthening national public financial management and procurement systems	20.6	50.0	29.4	0.0
Promoting common simplified planning and reporting procedures	28.6	62.9	8.6	0.0
Managing for results and improving decision-making	20.6	67.6	8.8	2.9
Building on active policy-dialogue and broad partnership throughout the lifespan of budget support programmes	15.6	59.4	21.9	3.1

During interviews with key stakeholders and policy makers the following accountability concerns were identified:

- ***High levels of corruption at various levels in the sector especially in the procurement of drugs and medical supplies are hindering many donors from working with the government or MoH directly.*** The Kenya Medical Supplies Agency (KEMSA) lacks the institutional capacity, autonomy, financial and human resources capacity to perform this critical function efficiently and effectively since it works under the influence of the MoH ministers, politicians or senior MoH staff. In the 2009 financial year, due to inefficiency and high corruption levels at KEMSA, the MoH decided to procure drugs and medical supplies directly. The donor group (World Bank, USAID, GIZ (previously GTZ) and others) decided to improve governance and efficiency at KEMSA by awarding a two-year contract to the GF Kenya Consortium to strengthen procurement and supply chain management in Kenya funded by the Ministry of Finance (Kenya's Global Fund "Principal Recipient"). The work of the consortium focused on building the capacity of KEMSA staff in both procurement and supply chain management, establishing national procurement strategies for GF–financed commodities, and strengthening Kenya's health logistics systems.

  As part of the strategy, the Consortium attached experts from JSI and Crown Agents to build procurement management and logistics, management capacity, conduct a capacity building training programme, and design and implement a procurement management database for KEMSA ***(Source: John Snow Inc. 2010 Report).*** This culminated into several accusations and conflict among MoH ministers and senior staff that had an interest in KEMSA operations. The team was frustrated and left; as a result the already established systems were run down to create loopholes for corruption. This is one of the reasons why efforts to make KEMSA autonomous have been frustrated by intense vested interests.

- ***Cases of conflict of interest that affect the quality of health services.*** This was evident among MoH doctors or senior staff who are consultants in many health institutions especially those in stationed in Nairobi and other cities and major towns. There are situations where some of the staff are consulting in more than four private health facilities. This means that they are juggling jobs at different health facilities therefore they have inadequate time to rest, relax and concentrate on their primary duties which may compromise the quality of healthcare provided to citizens. From the focus group discussions it was evident that most of the health workers: doctors, clinical officers and nurses tend to concentrate their efforts in major urban centres. Not only for the purpose of seeking opportunities for upward mobility but also in searching for a ready market for their professional services. Doctors spend few hours in public facilities looking after patients but create more time for private professional services and consultancies (at private health facilities, NGOs, UN Agencies, lecturing in universities and colleges) or operating their own businesses (clinics, pharmacies, training institutions etc). The staff are rarely seen at public facilities and when available, they are in a hurry and intimidate their clients, leading to poor service delivery.

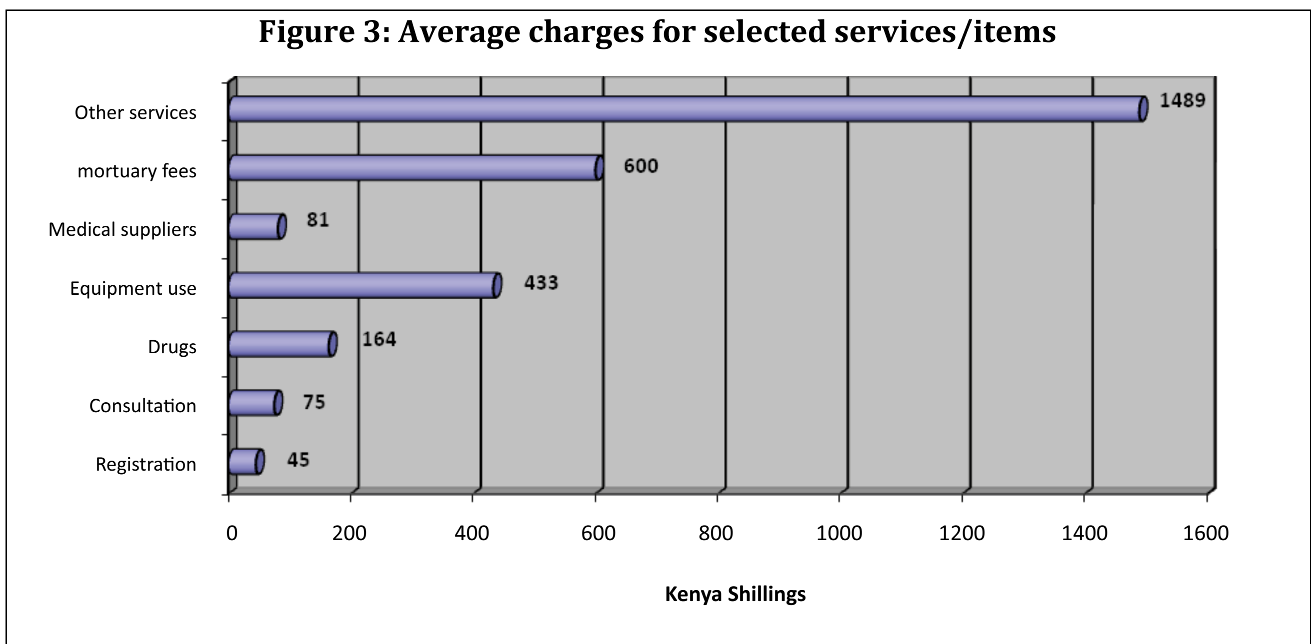
The KEMSA head office in Industrial Area, Nairobi. *Source: Daily Nation.*

Efforts to make KEMSA autonomous have been frustrated by intense vested interests.

- Accountability is a major concern among governmental institutions, implementing partners and members of the various consortiums in the health sector in Kenya. This is an issue at all levels; internally within the organisations, among the partners and externally among members of the public.

4.2.6 Income Generation/ Service Charges/Facility Improvement Funds

About 95% of the facility in-charges and departmental heads, and 90% of the health providers reported their facilities being engaged in generating income (facility improvement funds) through levying charges for various services including consultation, registration, drugs and many other services provided at the facility. Amounts charged vary by type of service provided and health facility. For example, charges for registration ranged from Kshs 10 to 100 with most facilities charging Kshs 20. Consultation fees ranged from Kshs 20 to Kshs 200. Figure three presents the average charges for selected services and items.



From the study findings, 89% of the facility in-charges and departmental heads reported the existence of adequate procedures on how money is collected and utilised although a much lower proportion of health workers (60.3%) were of the same view. In most instances (reported by 79.4%), funds collected and expenditure are reported to higher authorities. Again, a slightly lower proportion of health workers (65.2%) cited the reporting of collections and expenditure to higher authorities. This is mainly done on a monthly and quarterly basis by compiling financial reports that are sent to the district, provincial and national level. The report is reviewed by the facility and departmental head before submission to higher levels.

Some of the existing procedures that govern funds generated included:

- Authority to incur expenditure (AIEs)
- Cash registers
- Receipts
- Bank slips and statements
- Proposals
- Government regulations
- Approvals by teams/boards
- Financial reports

The funds are required to enhance various functions in the health facilities including: payment of casual staff, supplement the facility management budget, purchase equipment, increase the facilities' capital base to ensure effective functioning of the health facility. The study indicated that there were several sources of funds, which included: partner support, cost sharing and government support through KEMSA. This support is mainly through cash, equipment, materials, human resource or facilities/supplies/drugs. The following were some of the fund contributions calculated at the overall average levels.

Table 12: Fund contributions

Source	**Level of Contribution**	***Remarks***
Partners	20%	*Facilities and staff*
GOK (KEMSA)	30%	*Medical Supplies only*
Cost sharing	*50%*	*Cash*

The funds are administered by the health facility management, the board and the partners. The facility's chief executive officer (CEO) plays an important role in the management as the accounting officer on the utility of funds within the facility functions. However the main source of liquid cash available to the facility is from cost-sharing/facility improvement funds, which are used to support the health facility. It is evident that the amount of funds collected depends on the size/level of the facility, where the provincial health facilities collect more than the district and the latter more than the rural facility. In some rare cases, the district facility, depending on the economic capacities of the surrounding communities, record less collections than expected because of the waiver system for those who cannot afford to pay for the services as per the laid down criteria. However, the study could not confirm the average cases of waiver per region, but there is a regional variation in terms of numbers.

During the study, it was observed that the sampled facilities at Coast Province: Ganze, Kilifi and Coast General Hospital have improved, institutionalised funds' collection and developed effective accountability systems with the assistance of development partners. All financial transactions have been computerised. Improved systems have had a significant impact on the amount of funds collected for example in one hospital facility visited at the coast, the cost sharing revenue increased from Kshs 500, 000 to seven million shillings per month. The cash collected is banked daily as a strategy to reduce the potential risks of loss. Once the money is banked, health facility officials are not required to withdraw the money. The withdrawals are authorised by provincial health officials who will only authorise by confirming the budget drawn by the health facility to cover the year on a quarterly basis.

The process of drawing the budget is conducted by the health facility boards which are integrated into one comprehensive budget for the facility. The budget is then approved and dispensed in quarters to the medical

facility, and the money that is utilised in a particular quarter is drawn from funds collected from the previous quarter. However, from all these collections and utilities, most health facilities run at a deficit of more than 60%, pushing some of the health facilities into heavy debt. This situation leads to suppliers refusing to provide the health facility with commodities due to fear of delayed payments. Despite the huge collections, facility managers are limited in ploughing back the income to meet the cost of supplies and other items thus compromising the effective functioning of the health facility.

The funds from the government to the facility are mainly in terms of employees' facilitation and medicine/ drugs from KEMSA which are received and recorded by store managers for onward dispatch to the requisite departments. The study also found that the government through the Ministry of Health had a mechanism of ensuring accountability for the funds utilised. In addition, the facility conducts a monthly internal audit exercise through its accounts department to oversee the management of funds. There is also the provision for external auditing which is conducted by auditors sent by the government to the institution to check accountability.

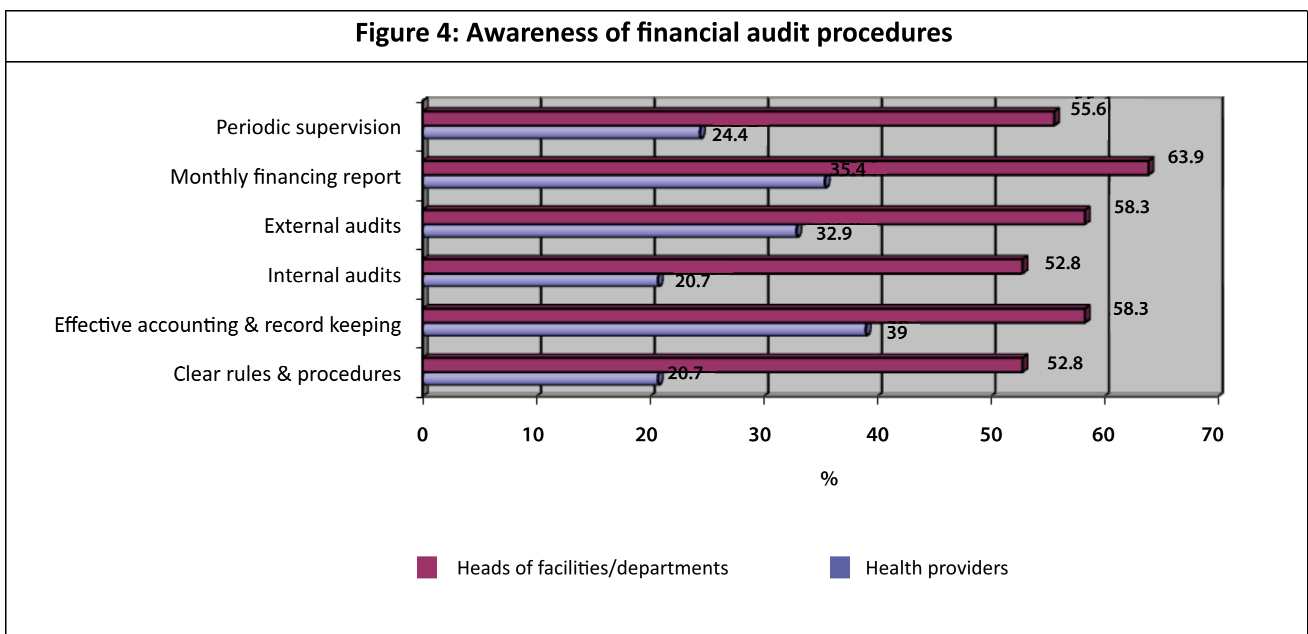
In other facilities visited, poor accountability mechanisms were noted where revenue collected is not receipted as revealed by the community members interviewed. The respondents expressed concern over the additional payments demanded for services which were different from charges posted on the hospital walls.

4.2.7 Auditing procedures

According to the heads of facilities and departments, auditing procedures exist at both the district and facility level. There were variations with 84.8% and 73.5% of the respondents reporting the existence of these procedures at the district and facility level respectively. However, 56% and 53.8% responses from the health providers, reported the existence of audit procedures at the district and facility level, respectively.

There were several financial audit procedures cited by both heads of facilities and departments, and health providers. Figure four below presents the types of procedures that existed in their facilities. There is a significant difference in the proportion of awareness of health workers and the heads of facilities/departments in audit procedures where the latter are more informed. The audit is carried out by government designated internal auditors while the external audit is conducted by the Kenya National Audit Office (KENAO) that is responsible for auditing all government institutions; a system that is likely to increase corruption risks.

Figure 4: Awareness of financial audit procedures



Patients share a bed in a district hospital in Kenya. *Source: Daily Nation.*

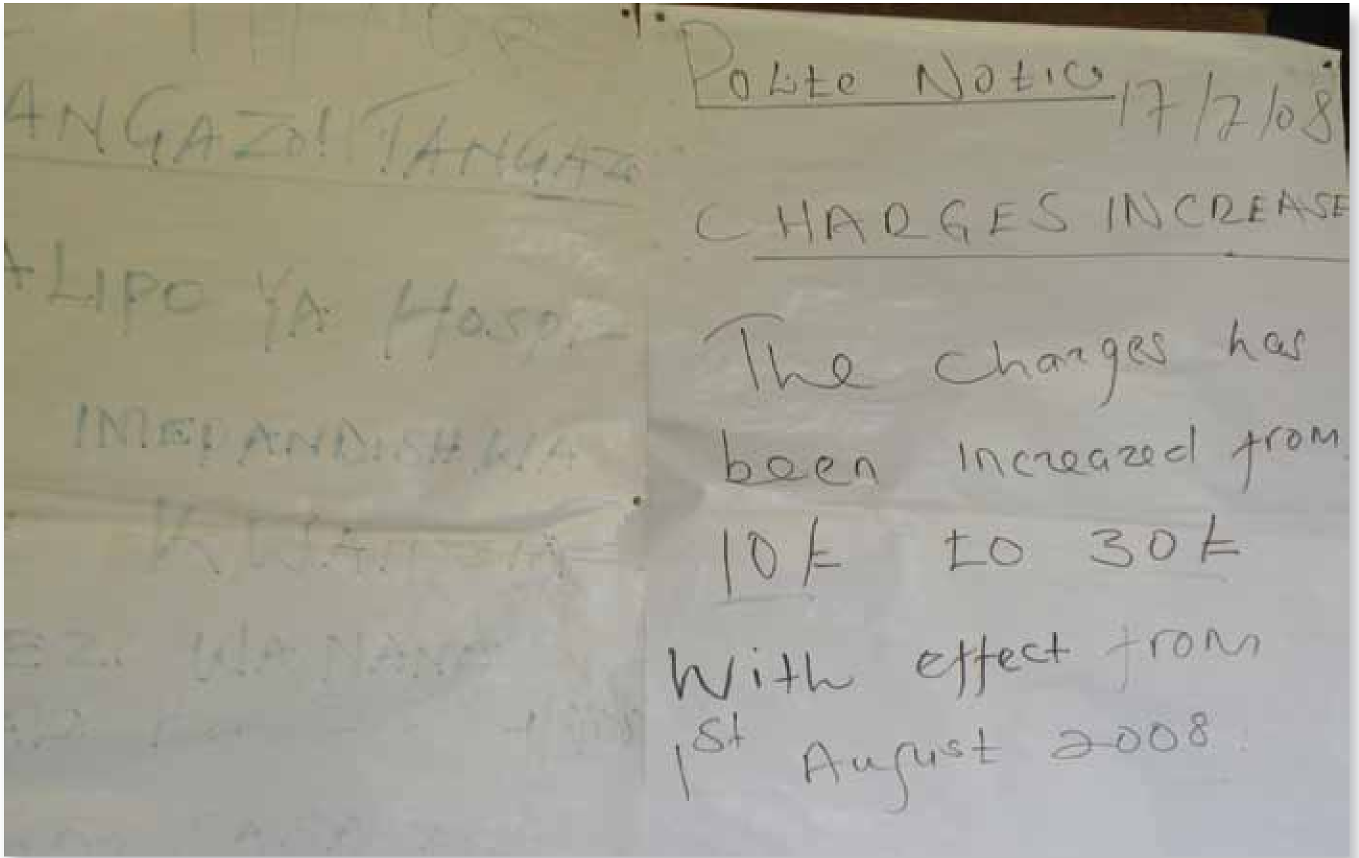
Some of the health facilities at the rural level lack essential facilities despite the high demand for health services by the local communities.

4.2.8. Capital Outlay

The provincial facilities are well placed in terms of capital outlay, while the districts are slightly better. The worst affected are the rural health facilities. Some of the health facilities at the rural level lack essential facilities and the basic assets available are either insufficient or depilated. There is usually a high demand from the community for the facility to offer adequate services. Most rural facilities do not even have wards to admit critically sick patients.

For example, Ganze has a large compound but very few buildings hence there is room for future expansion. Due to poor infrastructure, clients walk for long distances to reach the facility and most of those referred rarely get to the district hospital thus the need to expand and equip the facility for in-patient care. On the other hand, Kabuchai Health Centre had buildings that were not furnished (no beds, equipment and other basic facilities). Nyamusi in Nyanza was recently upgraded to a sub-district hospital but the capital outlay in the form of infrastructure is deficient to house the wards and other facilities for the facility to function as a level four health facility. Support given to Nyamusi has mainly been through coalition efforts to increase the wards from CDF, APHIA II Nyanza and World Vision.

From these findings it is indicative that the rural health facilities, despite the high demand from the community for healthcare services, are still lagging behind in the delivery of services. The lack of equipment and other core supplies impacts negatively on the performance of the health facilities in question. In as much as the rural health facilities are not sufficiently established, the district health facilities also lack essential facilities. For example in Nyamira, staff complained of lack of sufficient office space and furniture. This compromises the workers' ability to perform their duties diligently and thus the capacity of the health facility to deliver the desired level of services efficiently and effectively.



Handwritten charges posted on a hospital wall. *Courtesy of Paul Davis - Health Gap.*

There have been several complaints of inflated medical fees at public health facilities.

Sufficient capital outlay was seriously hampered by the health facility's access to adequate funding from the government and other donors. The minimal charges levied as part of cost sharing are not enough to cover the running costs of the health facility. The provincial health facilities, its status and functions are also limited in their capital outlays. Some of these facilities lack ample equipment and facilities to cater for referrals compelling the patients to seek medical care from the private facilities at a higher cost while the lives of those who are unable to afford private healthcare are left at risk.

4.2.9 Quantity and Procedure of Payment at the Health Facilities

Like other non-health facilities, the fee charged in health facilities is determined by their management. According to the health facilities' boards, the fee charged is comparatively determined by verifying the rates of other facilities in the region that are of similar status to the facility in question. In most health facilities the charges are displayed in the front area of the facility, depending on which department each service is offered. For instance, laboratory charges are clearly displayed outside the laboratory next to the entrance. Comparatively, the rates are quite reasonable although most community members may not afford these rates due to high poverty levels. Some NGO's such as World Vision have supplemented these charges. The boards feel that despite the relatively affordable charges, some community members will always express dissatisfaction.

An individual who cannot afford treatment will be denied medical services. However, the community felt that they are usually over–charged for services. Sometimes, what the patients pay is not what is indicated on the price list posted on the wall, and they dare not complain for fear of victimisation. Most services are paid for after a discussion on how much is to be charged implying that the quality of services depends on the capacity of the patient to pay more.

In addition to the Development Fund receipt of Kshs 20, which is to be paid monthly, other payments made by patients at some health facilities are not accompanied by any receipts. For example at a facility visited in Nyanza, the maternity fee of Kshs 400 posted on the wall was not the fee levied. The community members in the discussion group reported paying a gender variation fee of between Kshs 800 to 1200 for the delivery of a baby boy and between Kshs 600 to 800 for a baby girl. The night consultation fee is Kshs 150 instead of Kshs 50 as stipulated. For ambulance services, the patients are required to pay for fuel which is normally charged at between Kshs 1,000 to 3,000 to transport patients to the nearest district hospital which is 30 kilometres away. The fee depends on the number of patients to be transported to the district hospital at the same time. This happens only when the ambulance is available; otherwise the patients hire private vehicles to carry out emergency evacuation. In this facility the researchers were unable to verify the location of the ambulance.

4.2.10 Communication and Information Dissemination

In most health facilities studied, partners played an important role in providing quality healthcare services with a focus on VCT services, and care and support to People Living With HIV and AIDS (PLWHA). Monthly meetings are held while minutes and recommendations are kept by the head of department. To enhance communication and information dissemination, the health facilities collect data twice a week and keep it in their database.

From the study it appeared that information dissemination is not effective since the facilities, the boards and the communities have limited information on each other. Surprisingly, the facilities' staff and the community members do not know the members of the boards. Some key issues discussed and recommendations given at the board level are not communicated to the staff and community members. Most community members do not know who to channel their greivances because most health facilities do not have a suggestions/complaints box therefore they resort to consulting their friends and family, creating a stereotype and bad attitude about the facility among members of the community. From the key informant interviews it was established that MoH is not able to fund the dissemination of existing information including free medical services and policies to the provinces, districts, and communities. People are not aware of their rights as citizens especially the availability of free health services including malaria treatment for children under five years, tuberculosis and HIV/AIDS. Citizens also lack awareness on the many existing policies for instance those on reproductive health and HIV/AIDS.

In some of the facilities, children aged below five years pay for free treatment. In one of the facilities visited it emerged, through a focus group discussion, that receipts were not issued for payments made.

One hospital in Nyanza has a fee charter posted on the walls as required by the Ministry of Health. However, the community members claimed that they are charged more than what is indicated on the charter and some of the payments are not receipted. Another complaint was that they are sometimes charged close to Kshs 2, 000 for P3 forms above the standard price of Kshs 500.

Some public healthcare workers have seemingly used this weakness in communication and information dissemination to fleece the public by overcharging or demanding payments for medical services that are meant to be free.

4.2.11 Procurement

Procurement practices in the health facilities strictly adhere to the guidelines provided by the Public Procurement Oversight Authority (PPOA). They have access to PPOA manuals. They use three systems of procurement: open national tenders: pre-qualified, low value purchases, in case of emergencies; and quotations, for small items. The public health facilities sampled in this study have a tendering committee comprising 12 members who meet after every three months or when need arises. The community is not adequately involved in the procurement processes and cases of malpractices based on available evidence are rare. In an evaluation of facilities of the same class by the Public Procurement Oversight Authority (PPOA), the New Nyanza Provincial General Hospital performed well. However, there were rampant complaints relating to the debts owed to suppliers mainly due to limited funds to the hospital.

Interviews with in-charges of facilities and heads of departments had three quarters (75%) of the respondents reporting the existence of a national procurement policy compared to 46.9% of the healthcare workers. According to 73% of the in-charges of facilities and heads of departments, the policy was used very often compared to only 24% of the healthcare workers. 19% of the facility and department heads said that the procurement policy was applied often against 36% of the providers. However, not many respondents said that their respective facilities were implicated in procurement malpractices in the past two years; only 8.3% of the heads and 14% of the health providers reported in the affirmative. Table 13 provides a distribution of reported malpractices and the proportion of respondents reporting.

Table 13: Reported malpractices in procurement

Type of malpractice	Heads of facilities/ departments	Health providers
Canvassing	5.6	4.9
Favouritism	2.8	2.4
Bribery	0.0	2.4
Ignoring procedures	2.8	3.7
Funds misappropriation	2.8	2.4
Diversion of financial resources	2.8	1.2
Diversion of in-kind resources	0.0	7.3
Acceptance of sub-standard, expired or counterfeit drugs	2.8	1.2
Withholding payments for supplies	2.8	1.2
Chronic underfunding of drugs, medical supplies, equipment etc	0.0	2.3

Over 100,000 Kenyans on ARVs are suffering because of delayed procurement of the drugs. KEMSA's award of a tender for the supply of ARVs in 2010 ended up in court when a supplier raised concerns over the procurement process. The matter was initially ruled in favour of the pharmaceuticals company (Hetero Drugs Limited) but following judicial review, the decision was overturned by the High Court giving KEMSA the go-ahead to procure and distribute medicines but it is still not clear if the procurement has been concluded.

During key stakeholder interviews, the slow procurement process by KEMSA and MoH, lengthy ministerial consultations, inflated tenders, and budget limitations were some of the challenges raised and recommended for reform. According to the information obtained from key informant interviews, funds allocated for procurement are not sufficient to meet the needs of the facilities. There are also cases of inefficiency in the use of resources, for instance a worker using two pairs of gloves for the same task; if there is a telephone call one removes the gloves throws them away and gets another set immediately after the conversation. This is repeatedly done throughout the day.

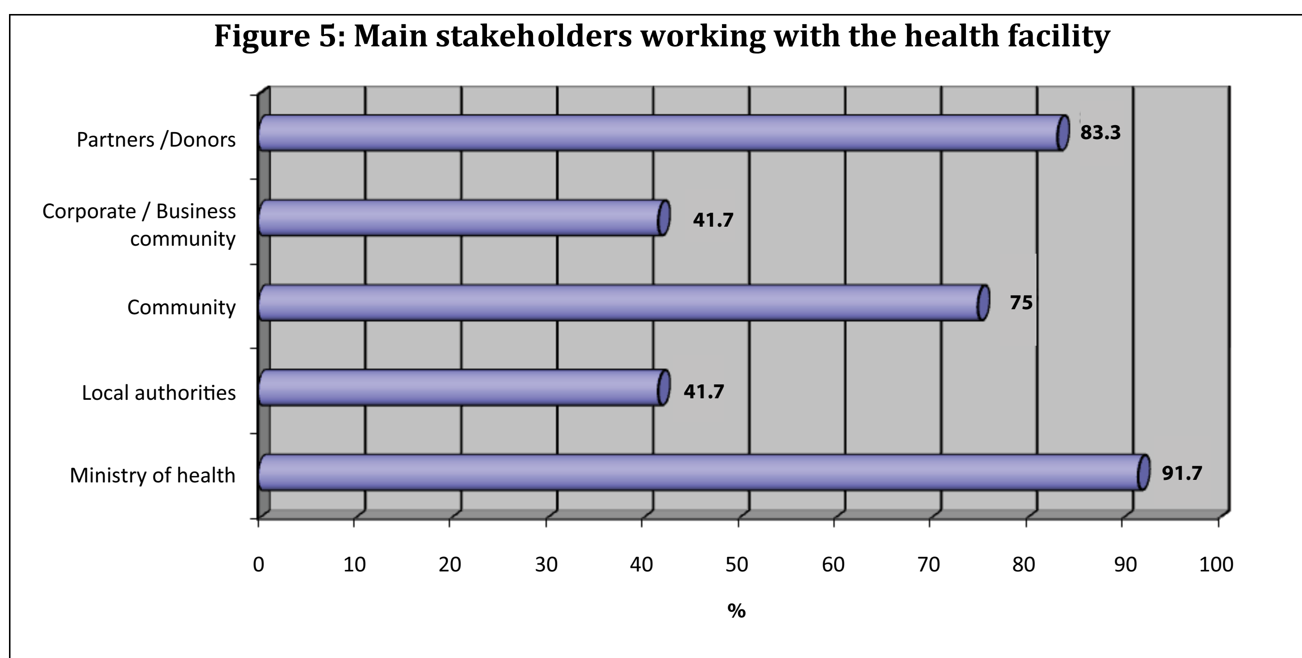
In one of the hospitals sampled, it was found that acquiring items is sometimes problematic since suppliers decline to supply due to poor debt clearance by the hospital. KEMSA stopped supporting the facility in the provision of drugs and medical supplies hence the hospital is supposed to meet the direct cost of purchasing these items. It does not have obsolete stock as it already has a system in place to deflate supplies that are about to expire. This is done upon confirmation that it may not exhaust the stocks before they expire. This system ensures that there are no obsolete stocks, which are donated in advance to other needy health facilities in the region. The stock of deviated facilities and drugs is accounted for by the receiving medical facility. The procurement department has a shortage of staff, heavy debts and untrained staff. Commodity price fluctuations have also been a problem due to limited or insufficient budget provisions.

Improved procurement and health systems should aim at delivering quality services as well as enhance the health

of the people served; respond to people's needs and expectations; and provide financial protection against the costs of illness.

4.2.12 Participation/Partnerships

The study findings demonstrated that collaboration among stakeholders is a common feature particularly at provincial and district health facilities. Besides MoH, other stakeholders include the local community, local authorities, corporate/business community and development partners/donors. The Ministry of Health followed by development partners/donors and the local community were mentioned as key stakeholders by the heads of facilities and departments as shown in figure five below. Some of the notable partners also mentioned included USAID, AMPATH, World Vision, the Catholic Church, Kenya Red Cross, Global Fund, APHIA II, CDF, DANIDA, and CDC.



In terms of contribution/integration to the health facility, MOH is rated by a majority of respondents as "highly important" followed by the development partners/donors and the community. This is an indication that the three will have a greater impact if they have a well coordinated approach to address the health needs of the country. Some of the partners have made an impact through their contributions to the health facilities especially those who assist in the development of capacity assets, such as buildings. This is the most prudent mode of support to the health facilities. Partners have also seconded staff and ensured payment of their salaries.

Table 14: Contribution/integration of main stakeholders

Stakeholder	Level of contribution/integration			
	Highly important	Important	Low importance	Does not contribute
Ministry of Health	85.7	14.3	0.0	0.0
Local authorities	16.7	33.3	10.0	40.0
The community	64.5	32.3	3.2	0.0
Corporate/Business community	31.0	34.5	10.3	24.1
Partners/Donors	63.0	33.3	3.7	0.0

Most development partners monitor the facilities and evaluate the outcome of their contributions. However KEMSA's support and the cost sharing contributions have not been effectively monitored by the MoH, creating opportunities for misappropriation. In addition, the government lacks a mechanism for collecting information on contributions and utilisation of funds by the various stakeholders despite the importance of these contributions in the enhancement of service delivery in the health sector. Information from key stakeholder and policy makers' interviews indicated that grants for the current civil society activities are signed before human resource gaps and implementation strategies are worked out and addressed. The study established that CSOs do not engage MoH and other stakeholders at lower levels (district and regional) in the proposal development process and vice versa.

4.2.13 Health Services and Service Quality

"Health systems have a responsibility not only to improve people's health but to protect them against the financial cost of illness and to treat them with dignity." *(The World Health Report, 2000).*

While there is general agreement that health systems in Sub-Saharan Africa need to be strengthened, not everyone is clear on the implication. Even when health systems are strengthened, systematic measuring of performance of health systems is not easy. Traditionally, indicators of health status such as life expectancy and the infant mortality rate provided information on the health condition of the reference population; however, these measures are now more influenced by factors such as financing and responsiveness which may be external to the health system.

According to the *World Health Report, 2000*, Sub-Saharan Africa where Kenya falls is ranked among the lower 50% in terms of performance health systems where infectious diseases contributed to high mortality. Kenya like most developing countries is experiencing a double pattern of disease: the traditional communicable diseases and the affluent chronic illnesses. These demand well developed performance health systems to efficiently and effectively address this challenge.

The purpose of a health system is to: 1) Improve the health of the people it serves 2) Respond to people's needs and expectations and 3) Provide financial protection against the costs of illness.

To successfully address this, the system must perform four key functions:

1) It must define the policies and regulations under which the healthcare market operates and ensure compliance with these rules through its ***stewardship*** or ***governance*** role
2) It must provide adequate financial and human capacity through its ***creating resources*** role
3) It must ensure financial protection from high medical costs and provide sufficient funds for health through its ***financing*** role
4) It must ensure quality and accessibility of services through its ***delivery*** role.

Findings from focus group discussions and observations indicated a general delay in service delivery to clients/ patients. In some institutions, patients/ clients waited for long hours before receiving attention. In some health facilities it would take almost four hours for a client to conclude medical consultations and other treatment procedures. In others, patients reported spending a whole day at the facilities for them to be attended while others reported that they arrived at the facility at 6 a.m and had to wait up to 4p.m to receive medical attention.

Furthermore, based on interviews and observations, most of the health facility staff were very arrogant and unfriendly leading to the mistreatment and harassment of patients. In the rural community facilities, staff availability was a concern especially in the provision of emergency services during the odd hours, weekends and at night. Nyamusi and Bokoli in Nyanza and Western regions respectively were the most highly affected by the lack of staff to offer services to the public. However, in most rural facilities this was due to lack of sufficient personnel since the few staff in the facility were most likely overwhelmed and fatigued.

Facilities for the provision of emergency services were very poor in the whole range of institutions sampled, from the provincial to the district to rural facilities. However, the worst hit is the rural facility where most did not have ambulance services in place. Interviews with the heads of facilities or departments revealed that a majority of health facilities – based on the feedback from 94% of the respondents - have a service quality track feedback system and tools to capture information on the quality of services where clients are expected to give feedback to the health facility. According to 80.6% of the respondents, some of the tools include conducting client satisfactions surveys (client questionnaires), suggestion boxes, customer care desks and computers for record keeping

Health providers' conduct

In almost all the facilities sampled, there were revelations of some degree of conflict of interest exhibited by the staff. Some personnel were engaged in other businesses/income generation activities. This was evident especially among the doctors who had several clients to attend to outside the hospital.

In some rural facilities staff were engaged in farming within the compound for instance cattle rearing within the hospital premises. Some staff had "pocket" pharmacy and shop pharmaceuticals within the facility to sell to the patients. Normally, patients are directed to where they can purchase these drugs as a shortage of supplies was quite evident in these facilities.

In some health facilities, there were reported cases of favouritism in the delivery of services based on who the patient knew at the facility. Such a patient/client received relatively faster treatment as opposed to those who did not have a relative or know any staff at the facility. In Ganze, the study findings show that patients walked for long distances to the health facility only to discover that drugs were out of stock.

At one of the health facilities in western Kenya, there were a few reported cases of immoral behavior by health providers particularly the male staff who made advances to female clients especially young girls in exchange for better and quality services while the female health providers were accused of being very arrogant. Alcoholism among healthcare providers was cited during the focus group discussions as one of the factors affecting the delivery of health services in some facilities which further compromises the quality of healthcare.

About 86% of the department heads highly prioritise matters touching on client satisfaction compared to only 59% of the health providers.

As shown by table 15, both heads of facilities and departments, and health providers were generally satisfied with services on the basis of a seven-set criteria including quality, accessibility, efficiency, effectiveness, sufficiency, timeliness and sustainability. That 97% and 82.9% of department heads and health providers, respectively, were satisfied with the quality of services is a vote of confidence on their performance. However there are persisting concerns regarding sufficiency, timeliness and sustainability which are core for any health service provision initiative.

Table 15: Satisfaction/dissatisfaction level by selected criteria

Criteria	Level of satisfaction/dissatisfaction							
	Very satisfied		Satisfied		Dissatisfied		Very dissatisfied	
	Heads	HP	Heads	HP	Heads	HP	Heads	HP
Quality	22.9	32.9	74.3	50.0	2.9	15.9	0.0	1.2
Accessibility	38.9	26.8	55.6	64.6	5.6	7.3	0.0	1.2
Efficiency	28.6	17.3	68.6	64.2	2.9	18.5	0.0	0.0
Effectiveness	16.7	23.2	77.8	64.6	5.6	12.2	0.0	0.0
Sufficiency	16.7	8.5	63.9	56.1	19.4	35.4	0.0	0.0
Timeliness	17.6	18.8	64.7	55.0	14.7	22.5	2.9	3.8
Sustainability	25.0	19.5	52.8	53.7	22.2	23.2	0.0	3.7

Key: Heads - heads of facilities or departments, HP - health providers

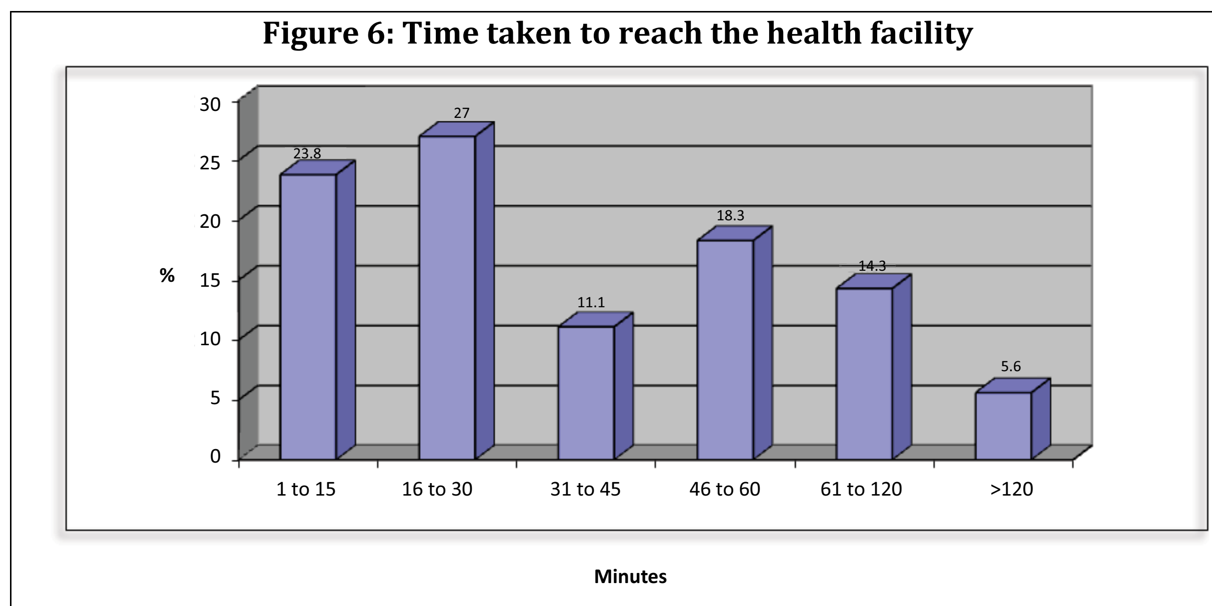
4.2.14 Clients' care-seeking behaviour

Majority (87.1%) of the clients had been to the facility more than once. Asked where they sought care the previous time they were sick, 78.3% went to another facility and 17.4% bought medicine from a shop and the rest went elsewhere. Overall, the health facility is the preferred place to receive treatment as reported by 95.2% of the clients. Other preferred sources were traditional healers (0.8%), buying medicine over the counter (3.2%) and other unspecified sources (0.8%).

Walking (38.4%) and public transport (38.4%) - buses/matatu (minibus or van used for public transport)were the most common modes of transport (to the health facility) followed by motorcycles (9.6%), automobile/cars (4.8%) and bicycles (8.8%).

Figure six summarises the time taken to reach health facility, in minutes. Thirty minutes was the median time taken to reach the health facility while 80.2% took sixty minutes or less. About two thirds (63.8%) of the clients took 30 or less minutes to get to the facility.

Figure 6: Time taken to reach the health facility



4.2.15 Service delivery and Client Satisfaction

Table 16 shows the services received by clients. As would be expected, most clients sought out-patient services followed by ante-natal care and well-baby visits.

Table 16: Services received	
Type of service	**%**
Ante-natal services	7.9
Well-baby visits	11.9
Family planning/Reproductive health	2.4
Out-patient services	56.3
Post-natal care	5.6
Tuberculosis	2.4
HIV/AIDS and related illnesses	0.0
Don't know	3.2
Refused to respond	1.6

Table 17 shows a summary of interactions between the client and the provider. Some of the interactions are suggestive of the quality of care received; for example if the client was handled in a friendly and cordial manner. Only 52.8% of the clients asked the health provider questions and this is a positive pointer to the level of interaction and confidence-building that took place. This is further supported by 63.6% of the clients who were satisfied with the level of care or services received.

Table 17: Client treatment by staff and providers

Treatment attribute	%
Was talked to in a friendly and cordial manner	74.2
Asked staff questions	52.8
Understood answers to questions	75.9
Asked to come back for another visit	65.3
Satisfied with care/services received today	63.6

Table 18 presents more information on the interactions between the client and provider. These responses rate the type of treatment given like the provision of medicine upon discharge. Overall, 54.7% felt that the facility offered the best services.

Table 18: Clients affirming quality services

Attribute	Strongly Agree (%)	Agree (%)
I was very well attended to	16.1	42.7
I was provided with sufficient hospital materials	11.3	41.9
I was given adequate medicine upon discharge	13.9	40.2
I was advised on how to use the medicine	27.3	47.1
I was provided with what I requested for	10.7	46.7
The hospital staff were kind and caring	16.4	45.9
I was asked to pay for the services received	14.3	37.8
The hospital was clean and conducive	19.7	50.8
Overall: The hospital offered me the best services	13.7	41.0

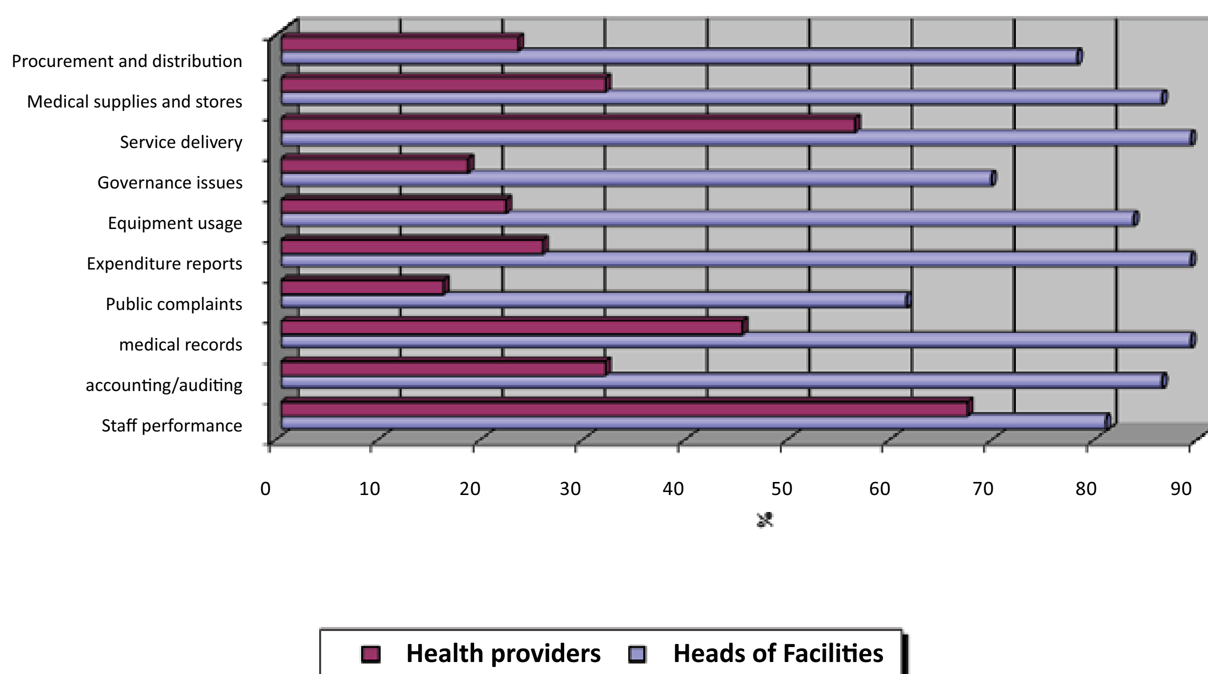
Some of the tools the health facilities use to capture information on the quality of services are offered through customer care service/staff, service charters, questionnaires on customer satisfaction and suggestion boxes. The study established that there is inadequate staffing and most of the equipment is not available thus giving poor quality services. In some health facilities such as Nyamira District Hospital there are efforts to ensure that the provision of quality services to patients is a first priority therefore the institution has put in place a quality feedback system comprising a suggestion box, customer care desk and surveys carried out at the hospital. This enables the patients to express their grievances on the quality of services offered at the hospital. The community is somewhat satisfied with the services rendered at the hospital and they recommend that the cleanliness of the facility should be maintained and the nurses should be friendly to the patients.

4.2.16 Support Supervision

Support supervision from line managers and higher level authorities is necessary to ensure the provision of quality services in a timely, efficient, effective and sustainable manner. Over three quarters (78%) of the health providers reported that they received support supervision in the past one year. In the same period, 97% of the heads of facilities and departments reported receiving support supervision.

Health providers were asked to state areas/aspects that usually form the focus of the supervisory visit as well as the emphasis of the previous visit. As shown in figure seven, the three most common areas of focus for health providers were staff performance, service delivery and medical records, while the focus areas for the heads were cross cutting excluding governance and public complaints.

Figure 7: Areas of focus during supervisory visits



Regarding the handling of complaints, 87% of heads and 72% of the health providers reported the presence of a complaints handling system. And asked to rate how the facility handles complaints, on the basis of getting it right, being customer-focused, being open and accountable among others, as shown in table 19, a significantly higher proportion of the heads of facilities and departments expressed confidence in the outcome of complaints handled by the system compared to health providers. Being customer-focused is an area that most respondents from both heads of facilities and departments were most likely to focus on.

Table 19: Rating of complaints' handling systems by selected focus areas

Area	Rating (%)							
	Most likely		Likely		Least likely		Not applicable	
	Heads	HP	Heads	HP	Heads	HP	Heads	HP
Getting it right	41.9	37.7	54.8	42.6	3.2	16.4	0.0	3.3
Being customer focused	77.4	45.0	16.1	36.7	3.2	15.0	3.2	3.3
Being open and accountable	54.8	36.7	32.3	38.3	9.7	21.7	3.2	3.3
Acting fairly and proportionately	58.1	30.0	32.3	45.0	6.5	18.3	3.2	6.7
Putting things right	58.1	40.0	38.7	40.0	3.2	16.7	0.0	3.3
Seeking continuous improvement	80.6	43.3	12.9	36.7	6.5	16.7	0.0	3.3
Key: *Heads - heads of facilities or departments, HP – health providers*								

4.2.17 Human Resources Management Issues

1) Qualification of staff:
The study revealed a general shortage of healthcare providers in line with the established international (WHO) standards for efficient and equitable delivery of healthcare services aimed at meeting community needs. Some departments in the health facilities had as few as one qualified staff or even none. The situation was even worse for technical staff particularly in provincial hospitals where their services are based on the available technology for referral services. The deficiency was more pronounced in the provincial health facilities which were largely affected by lack of adequate technical staff. The rural health facilities were deficient in almost all the cadres of staff. In some health facilities over 50% of the personnel were employed by the partners.

Recommendation: The government should strategise on the sustainability of these positions once the partners reduce or withdraw their support.

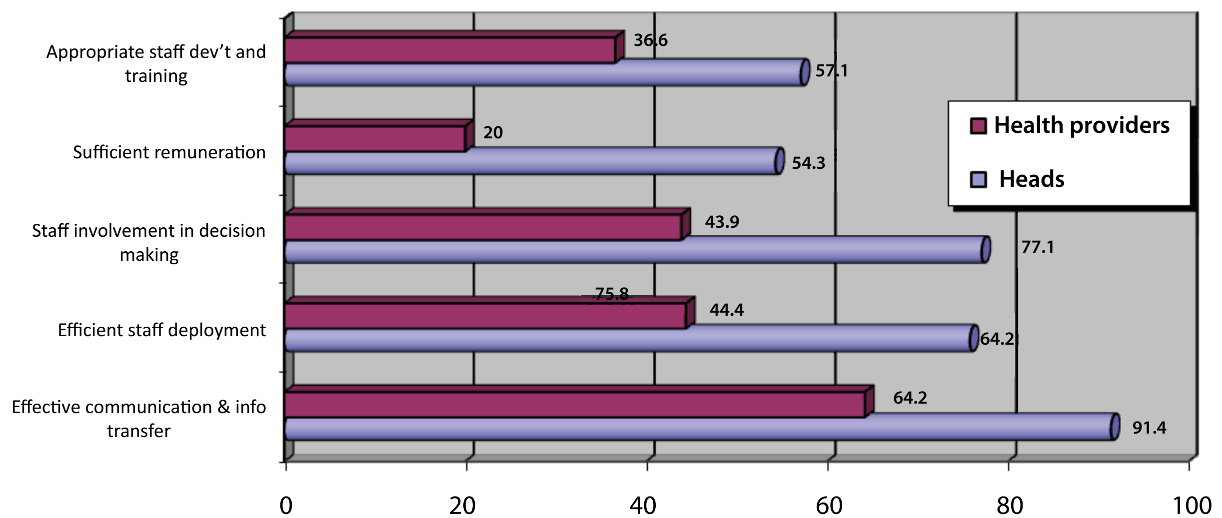
All the health facilities were authorised to employ only subordinate staff through the boards through the support of the facility improvement funds. However, the hiring was not conducted in a fair and transparent manner since there were alleged cases of bribery, nepotism and favouritism. Overall, there was gross understaffing by a range of between 50% and 80% in the provincial and the rural health facilities. All the facilities studied had chronic staff shortages compromising effective management as expected by the communities. Some departments in the health facilities had just one qualified staff or none at all. An example was one health facility which had a pharmacy but no qualified pharmacist; it is instead managed by subordinate staff who received basic on-the-job training. The situation was worse in instances where unqualified technical staff handled new technological equipment. However, it was noted that the provincial health facilities were more affected by a shortage of technical staff while those in the rural areas faced a deficit in almost all the categories of staff.

There are National Standard Staffing Norms that guide the number of health workers for specific cadres that should be deployed at various levels of health facilities (tertiary, provincial, district, health centre and dispensary). However, this information is not available to the community necessitating awareness-creation and empowerment for the public to demand adequate staffing levels.

2) Motivation:
Staff motivation is critical in ensuring the provision of quality health services. The study sought to establish the existence of basic work environment issues such as communication and transfer of information, decision making, staff development and training. As shown in figure eight there are proportionately more (by about 30%) in-charges of facilities and heads of departments, who agreed to the existence of specific work environment concerns than the health providers. Effective communication and information transfer seemed to be the most prevalent issue among the respondents. Staff development and training, and staff remuneration seem to be a problem for in-charges of facilities and heads of departments as well as health providers though with varying proportions. However, some health facilities had some budgetary allocations for staff development and training. For example, the New Nyanza Provincial General Hospital had an allocation of Kshs 100,000 per month for short term staff training.

According to the health workers, withholding of salaries (delayed payment) was not a common problem as only 23.2% experienced it in the previous two years. Equally low were the proportions citing payment of salaries to fictitious (ghost) workers – 8.3%. This is further corroborated by responses from the heads of facilities and departments; 25% reported having experienced the withholding of salary payments in the past two years and a very small proportion (2.8%) was aware of salary payments to ghost workers.

Figure 8: Basic work environment issues



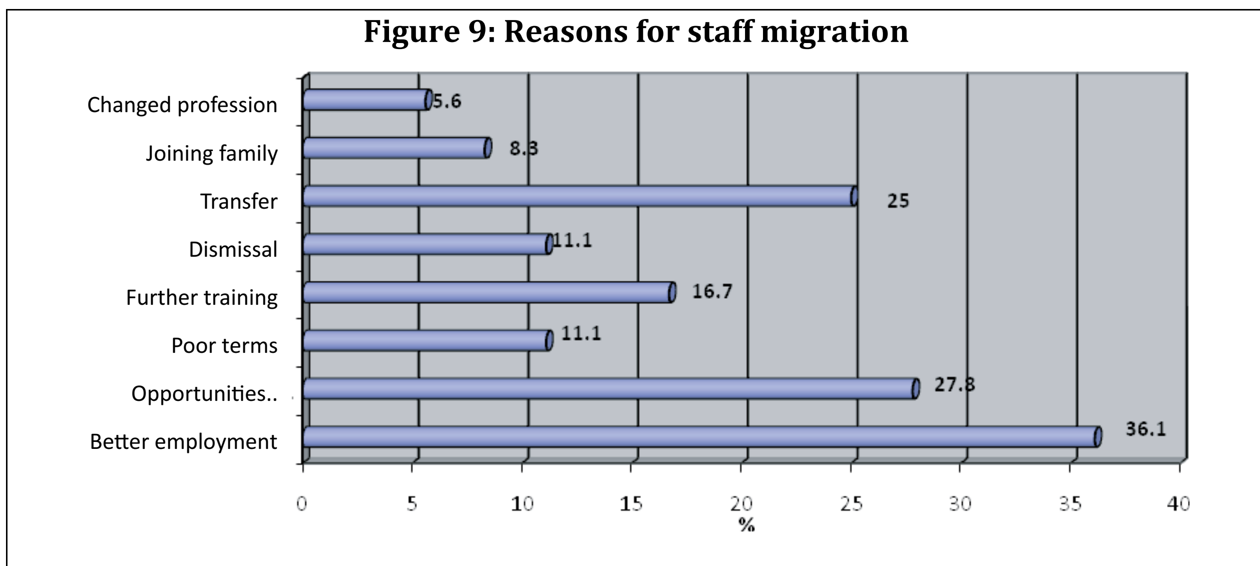
Some attempts have been made at performance contracting but its management and impact on the individual healthcare workers is unknown. For example in the private sector, the system is working very well. Nairobi Hospital has through incentives and its retention strategy offered its healthcare staff car loans and mortgages. This ensures that the worker remains with the hospital during the term of the loan and/or mortgage and their productivity levels are also increased due to an efficient mode of transport and comfortable living conditions.

3) Staff satisfaction

To assess the health providers' level of satisfaction, the respondents were asked to respond to questions focused on selected attributes. Table 20 provides a distribution of respondents who answered the question in the affirmative. The low proportions of health providers agreeing to the questions on salaries and benefits may be an indication that these two attributes may be contributing to dissatisfaction among health providers. Matters of career growth/progression as exemplified by the responses on "whether the ministry provides opportunities for career development" may also be contributing to lack of motivation and even satisfaction among the providers. Health providers from Coast and Western Kenya reported that they had stagnated in one job group for a long time without a promotion due to lack of training. A health provider in Coast had been in one job group for about 25 years until two years ago when he was promoted by one grade. Promotion and selection for training are highly biased implying that those who miss such opportunities stagnate in one job group for a long time. Other than additional training, promotion should be based on merit.

Table 20: Staff satisfaction level	
Question/attribute	**%**
My salary is fair compared to other staff with the same level of responsibility.	16.3
My benefits are fair compared to other staff at my level.	19.0
My job description is accurate and up to date.	41.9
My supervisor and I have agreed on the priorities of my job.	57.0
I get clear feedback from my supervisor about how well I am performing in my job.	51.9
My annual performance appraisal is based on the priorities in my work plan	62.3
My supervisor seeks my input when faced with a challenge or problem.	64.6
The ministry acknowledges and values my work	42.3
The ministry provides me with the essential coaching and training to do my job.	42.9
The ministry works (as much as possible) to provide me with opportunities for career growth.	38.5

4) Staff mobility:
Half (50%) of the heads of facilities and departments had experienced staff resignations in the past two years. Reasons given for departure included seeking better employment, new opportunities (greener pastures), better terms and further training among others. Heads of facilities and departments were further interviewed on the perceived factors contributing to staff resignations. Figure nine shows the proportions of the responses from the respondents. From the reactions, a large proportion of staff resign following transfers, other opportunities and better employment.



5) Staffing:
Human Resources Management (HRM) systems were weak and fragmented in most of the health facilities sampled. Many of them do not have HR professionals leading to a lag in promotions, poor planning and workload allocations with increased irregularity and low staff morale. The managers of the facilities or head of departments have not been empowered with Human Resource (HR) management skills, which reduce their capacity to effectively and efficiently manage human resources for the health sector. During interviews with key stakeholders the following were the key findings/issues;

i. ***Poor regulation, standardisation and implementation of the policy on the training of health professionals:*** Many mushrooming training institutions are not accredited and large numbers of healthcare workers undergo sub-standard training thus compromising the quality of health services. Many healthcare workers in major cities and rural areas who are in private practice are not qualified and are therefore not registered by regulatory bodies. The regulatory bodies are lax in the implementation and enforcement of the existing rules and regulations.

ii. ***Employment and promotion processes in MoH are plagued by corruption, nepotism and tribalism, influenced by politicians and other interested parties.*** There are many healthcare workers in the country who are not evenly distributed. The staff are more concentrated in high potential areas where there are increased opportunities for personnel while the hardship areas have few or none, and the few who are there are strained.

iii. ***Technical staff in the Malaria Division are not deployed at the district and rural facilities for programme implementation unlike the HIV/AIDS, TB and Leprosy units that have fair representation at the district and rural facilities.*** There has been debate on who between a clinician or public health officer is best suited to handle malaria at the field level (district and rural facilities). Also reproductive health departments, particularly, the family planning department lacks essential staff in most of the facilities sampled. This is further limited by the lack of funding to support these programmes.

iv. ***Most MoH staff deployed in high potential areas or at tertiary, provincial and district hospitals (level four to six health facilities) do not spend quality time working at public facilities. It has been observed that they engage more in private practice (own clinics or private hospitals) where they earn more money.*** The staff have three or more facilities where they consult on an almost daily basis yet they are given non-practising allowances by the government. Some staff work through the night in private facilities and in the public facilities during the day, reducing their efficiency and effectiveness, and this may compromise the quality of services.

v. ***The human resource department does not have proper systems to track staffing needs.*** There are instances where salaries are disbursed to retirees and deceased staff, sometimes for several months or up-to a year before the anomalies are discovered and corrected. During the study, a case was reported at the Coast province where a retired employee was retained on payroll for almost one year. In certain areas, donor funding opportunities are used to recruit staff and when the funds delay or are stopped, services are drastically affected and some of the facilities have to be closed temporarily or are poorly operated.

vi. ***Due to lack of skilled staff with adequate capacity, the MoH resorts to returning unspent funds to treasury*** at the end of financial period or spending a bigger share of the annual budget in the last quarter of the financial year due to poor planning. Key staff are principally political appointees lacking professionalism and experience as such competencies are not a priority in politically influenced appointments. Some of them lack experience, knowledge, skills and commitment to the job and this negatively affects the planning of interventions. Delays in the flow of Sub-AIEs (Authority to Incur Expenditure) and the funds thereof also lead to unutilised funds.

Recommendations

1. Implementation of the recently launched National Human Resource for Health (HRH) Strategic Plan
2. Establishment of a Human Resource Information System that is linked to the current Health Information Management System
3. Development of a National Health Training Policy to regulate overall training for health professionals
4. Develop policies to govern and control professional practices in the country.

4.2.18 Healthcare Financing

For many countries in Africa and especially Sub-Saharan states including Kenya, almost a half of the entire healthcare expenditure is paid out-of-pocket when the client visits the health facility unlike in most European countries. Studies conducted in developing countries have demonstrated that high out-of-pocket medical spending can plunge the sick, their families and sometimes their extended clan into poverty. For example in Guinea, 91% of all health services are financed out-of-pocket at the time of treatment while the proportion of such services in the Democratic Republic of Congo (DRC) is over 80%. For countries in Sub-Saharan Africa, governments meet an average of 33% of the costs through national health insurance scheme(s). However, for the richest countries in the region such as South Africa and Botswana, the proportion is much higher and the client only pays 10% and 12 % respectively through out-of–pocket payment for healthcare services.

In some countries such as Rwanda, more than 50% of the financial expenditure on health is through loans or grants. In addition, there is a shift in donor funding from the traditional programme related funding to health systems' support (human resource, supplies, etc). On the other hand, donors can drive national priorities if the government goals have not been clearly defined with policies governing them. For example, in Kenya for the last five to six years, a significant portion of the money received from donors was for HIV/AIDS programmes despite a comparatively low HIV/AIDS prevalence rate. It can be justifiably argued that investing in HIV/AIDS prevention and treatment can cap the HIV/AIDS epidemic in Kenya. Even with resource availability, it is mandatory for countries to have strong health systems to govern resource allocation and management in an area that has attracted a lot of local and foreign donor funding, and identification of possible areas of integration and synergy for better results.

To bridge the gaps in healthcare financing and enhance the achievements of the MDGs, the German government has pledged to provide technical and financial support to Kenya. The German government has committed €138 million (Kshs 14.9 billion) for bilateral technical and financial cooperation for the period between 2010 and 2013 as per negotiations held in September 2010. This will bring the total volume of support provided by Germany to Kenya to €1.289 billion (137.9 billion shillings) to date.

The funds will be directed towards key high impact interventions targeting the poor and women. The implementation will be carried out through Output Based Approach - OBA (which was launched in Kenya in 2005) and the aim is to achieve MDGs four and five on reducing the child mortality rate and improving maternal health respectively. Currently, there are interventions on a pilot phase in three rural areas (in Kisumu, Kiambu and Kitui) and two urban slums (Korogocho and Viwandani in Nairobi) where the programme is planned to cover a population of three million people. This is an agreement between the Government of Kenya and the Federal Government of Germany (through kfw Banking Group) to fund safe motherhood, family planning and gender violence recovery services by an overall budget of €6.6 million (Kshs 706.2 milliom).

In Output Based Approach, the focus is on financing agreed outputs and linking payment to the volume of services through a voucher system. The vouchers are sold at highly subsidised prices, providing a direct subsidy to the poorest people and allowing them to access safe motherhood, family planning services and gender-based violence (GBV) emergency services, ultimately increasing their uptake (GBV vouchers are free while family planning and safe motherhood vouchers are Kshs 100 and 200 shillings respectively). These services are delivered by qualified and certified service providers. The lessons learnt from the voucher program are expected to contribute in developing a National Social Health Insurance Scheme. The OBA is an integral part to the Sector Wide Approach process (SWAp) in the Kenyan health sector.

In most developing countries there are variations from country to country and in the region, there are similar variations with South Africa spending over seven times (US$258 – Kshs 20,640) than Kenya (US$36 –Kshs 2880) and 86 times more than DRC, one of the poorest countries.

"Publicly subsidised care for all is not an affordable option for African governments. Strategies that require better off households to contribute to the costs of their healthcare can increase the availability of limited public financing to assist the poor. Also when people contribute to their care . . they are more likely to expect the system to be responsive."—Improving Health, Nutrition, and Population Outcomes in Sub-Saharan Africa by the World Bank

Studies have demonstrated that for a country to deliver the essential package on health services (HIV/AIDS; TB; Malaria, IMCI and maternal), it costs US$34 (Kshs 2,720) per person per year. However, for better results to be attained there is need for public–private partnership and strengthening of health systems. The cooperation between development partners and implementing partners from the private sector, both profit and non-profit will continue using the Sector Wide Approach process to enhance the achievements of MDGs four and five by 2015.

Kenya like most developing countries does not meet the required standards as far as the provision of healthcare is concerned. During the study, the following were key findings/issues gathered during interviews with key stakeholders that may require attention and action by decision makers in the sector:

1) **Weak procurement and distribution systems.**
Malaria drugs, dehydration salts, ARVs and antibiotics (amoxicillin and treatments for STDs) were missing in most public health facilities sampled. Some of the reasons mentioned for the problem included: slow procurement procedures by KEMSA and MoH, lengthy ministerial consultations (between MoH and MoF), inflated tenders, and budget limitations. MoH had requested additional funds from MoF but was waiting for the approval of supplementary budgets by Parliament. It was very clear from the study that health providers contribute to drug and medical supplies' shortages by taking out the drugs for their own use or sale to private health facilities and pharmacies near the public health facilities.

2) **Substantial resources that are poorly coordinated and mismanaged.**
Kenya has substantial resources for healthcare but there is a general lack of awareness on what projects are funded and their location. Resources are poorly coordinated and there is a large degree of duplication in some areas while others are under resourced. No mechanisms are in place for coordination, monitoring and reporting. This gives room for some organisations to misappropriate funds. During the study the researchers were told of incidents where one report is written by one CSO which is then used by several groups/organisations to justify expenditure for money received including funds not yet used.

3) **Under funding of MoH at 6% of GDP instead of 15% as agreed in the Abuja Declaration has** constrained healthcare service delivery, focusing on critical areas only. This reduces the capability of MoH in the supervision and follow-up of interventions in the country. Over-dependency on donor funding is also a dangerous trend, for example the ARV treatment programme is supported by donors(Global Fund on AIDS, TB and Malaria and PEPFAR).

4) **HIV/AIDS financial and other resources are not reaching the target groups.** Most of the finances are used in administration and staff capacity building, leaving very little for the beneficiaries. There is very little that is reported on ongoing activities. CBOs have more accountability challenges than the bigger NGOs that are well established.

5) **Kenya is experiencing a lot of conflict and politics with the Global Fund (GF).** MOF the principal recipient of the Government GF portion and CARE-Kenya International the principal recipient for CSOs are facing organisational and governance challenges. High turnover of senior staff and conflict between the two ministries in charge of health were mentioned as some of the key contributing factors. According to AIDSPAN, an independent watchdog of the GF, Kenya is on average almost one year behind schedule in implementing and reporting on GF grants with some activities more than three years behind. Kenya's application for round nine was rejected on technicalities. The Global Fund works on a performance based principle, with clear targets and indicators, and time bound activities.

4.3 Recommendations for the Health Sector's Institutional Governance

1. **Building the Capacity of MoH Management and Professional Staff.** The government/ MoH should aim at developing national or regional centres of excellence to provide training on essential management and professional skills. The goals of this strategy will be: 1) to build a skilled cadre of managers and professionals to support scale-up of programmes and promote efficient management of health systems at all levels; 2) to improve management attitudes, practices and capabilities in all sectors systematically and increase the

performance of health systems through effective management; 3) to instill a culture of continuous quality improvement and make skills' development a permanent function in institutions.

Building the capacity of MoH staff in planning, data analysis, data use and information dissemination at the district, provincial and national levels by improving the information system technology, and providing technical assistance to improve the efficiency and user-friendliness of data reporting formats, according to different audiences is one of the key focus areas. The target population for this capacity building will include individuals and institutions associated with any element of the healthcare supply chain that play a management role and healthcare providers such as doctors, nurses, lab technicians, biomedical engineers, finance and planning analysts, community health workers, home-based workers and shopkeepers among others.

2. **Strengthen the MoH Human Resources Management System** to deal with the development of a national strategy for continuous quality improvement, awareness raising and encouragement of practical education in quality management, a system of quality assurance for pharmaceuticals, quality control of laboratory tests, and the execution and acknowledgement of patient satisfaction survey results, staff hiring, skills' development, promotions, harmonisation of salaries and benefits, staff mentoring and care, performance tracking, and use of human resource information systems.

   Ensure deployment of human resource managers/professionals to district and provincial health facilities and train health facility managers and in-charges on basic HR management skills. The MoH policy makers should ensure fair distribution of medical staff in the country and provide incentives (financial/salary increase, training opportunities after a stipulated period of service, promotion, and improving the working environment) to staff working in hardship areas.

3. **Strengthening participation and partnerships:** Civil society participation in governance issues in the sector is weak or absent in most of the sampled areas therefore assistance is required in the formation or strengthening of existing health sector networks, professional associations/boards/councils, advocacy and "watchdog" groups (including consumer protection bodies) through the establishment of organisational development grant programmes, which may be either donor funded or financed by a combination of donors, the government and civil society. Citizen participation in the definition of health needs and services is encouraged through citizen participation in referendums and regional forums. Such participation will be most productive when MoH officers incorporate community health priorities into their planning and budgetary processes.
   MoH should also promote and strengthen partnerships in healthcare provision. For example Turkana has 103 health facilities, 90% of which are operated by churches and NGOs while 10% are run by MoH/GoK. The government should assess their performance in the provision of healthcare to the citizens. MoH can support these groups through the provision of drugs, equipment and secondment of staff. MoH should work with the CSOs and communities towards empowering them and making them responsible for the development of the health sector.

4. **Healthcare Financing:** GoK should invest more resources in health infrastructure development of community facilities, health centres and dispensaries which serve a majority of needy people. Studies done by DANIDA who have been implementing the Kenya Health Support Programme; indicate that 30% to 40% of the donor funds to GoK/MoH are lost during disbursement from the headquarters to the rural facility (Treasury-to-MoH-to-Province-to-District-to-Rural Facility). The most effective strategy of health financing is direct facility funding. Working through MoH structures has become very expensive in terms of unaccounted money, and time spent in making approvals, bureaucratic procedures slow procurement procedures, lengthy consultations, inflated tenders among other issues. For example, the Health Sector Services Fund (HSSF) can be used as a channel of availing resources for community healthcare services which are currently mainly funded by CSOs. MoH should explore the standardisation of service costs in health facilities at each level to minimise corruption and exploitation of the citizens. GoK should meet its commitment to the Abuja Declaration by contributing 15% of the GDP to the health sector budget and establish a country coordinating mechanism comprising donors, the MoH, private sector and CSOs to manage and monitor healthcare resources in the MoH.

The success of Kilifi District Hospital should be highly publicised within the health sector. The facility through the support of partners/CSOs has put in-place systems to track all payments to the facility by clients and all expenses daily. The system ensures that all payments are receipted and serial numbers, amounts, dates, time and nature of service are recorded and stored in computer. Any time the information is required, it is made available. Through the system, one can enter the receipt number in the computer and track the amount paid, the date and time of payment, and the services rendered. It also shows the total revenue for a specific day. The hospital has a service charge of Kshs 20 per day for outpatient services and Kshs150 per night for in-patients. The collected FIF funds are banked daily and used in the succeeding quarter after the board and district health committee have met and approved the expenditure. In the last three years FIF collection has really improved greatly from Kshs 500,000 per quarter to Kshs 7 million. The funds are used to buy critical drugs and other medical supplies to supplement what is provided by the MoH/KEMSA.

Kilifi Hospital is perhaps able to attract direct donor funding because of its prudent financial management practices and improved healthcare systems. The government is working towards having regional facilities that can serve as models of excellence in service delivery through improved health systems, prudent management of resources and equipping key staff with required skills.

5. **Support the development and operations of mandatory health coverage in areas with high out-of-pocket expenditure.** The goals of this strategy will include to: 1) Reduce the number of people plunged into poverty due to a high health expenditure; 2) Allocate public funds more efficiently and equitably; 3) Lower financial barriers to healthcare access; 4) to increase patient choice by funding the "demand side" and giving

A private health facility in Nyanza. *Courtesy of Paul Davis - Health Gap.*

MoH should promote and strengthen partnerships in healthcare provision.

people purchasing power rather than simply funding the “supply side” by providing services; 5) to provide opportunities for governments to focus on the role of stewardship, policy and financing, rather than service provision.

As experiences in other countries show, developing a viable, sustainable insurance sector can encourage private providers and hospitals to enter the market.

The GoK/MoH should add more resources to free services including mandatory coverage for high-cost interventions such as HIV/AIDS treatment and high-cost malaria drugs and surgeries. Secondly, the government could fund all or a portion of the package and establish graduated payment contributions for employers, employees and communities based on their ability to contribute. The target population will include indigent and vulnerable groups, the formal and informal sector.

6. **Strengthening the capacity of Facility Management Boards/Teams. From the information on the governance of health institutions, it is evident that most of the facility boards are not meeting public expectations**. MoH should work towards strengthening the capacity of the boards with the aim of making them fully responsible for ensuring that the recommended and approved facility actions are implemented efficiently and within the defined principles. The membership of the boards should be reviewed to ensure wide inclusion and participation of all stakeholders taking into account education levels, professionalism, gender balance, broad representation and at-risk communities. The boardstructure should also be reviewed to ensure it consists of a chairperson from a Non-GoK organisation and a vice chairperson from GoK organisation or vice-versa. There is need for standing committees which implement specific tasks on behalf of the boards. Orientation and capacity building should be a priority whenever a new board has or members have been chosen to raise awareness on their roles especially the oversight/leadership role. This can be done through a series of team building retreats and empowering the board members by clarifying their roles and responsibilities.

7. **The procurement procedure and law should be amended to make it more responsive especially with regard to the procurement of drugs**. This was cited as one of the major causes of drug shortages in the facilities. This reform should also go hand in hand with capacity building at KEMSA and transforming it to an autonomous institution to increase its capacity to withstand interference by MoH and political interests in its operations.

Section 5: The Global Fund (GF)

5.1 Introduction: Brief history of the Global Fund in Kenya

For over seven years, the Global Fund has awarded Kenya ten grants worth $ 274,076,304 (Ksh, 20,555,722,800 estimated at the rate of Kshs 75 per dollar) for prevention and treatment of HIV/AIDS, Tuberculosis and Malaria. The following table gives the details of the grant, the principal recipient, disease targeted, amount approved/ disbursed, the round given and the starting date of the grant.

Table 21: Global Fund grants to Kenya

Round #	Principal Recipient	Grant Assistance Disease	Total Funds Approved/ Disbursed (USD)	Grant Starting Date
R 1	Kenya Network of Women With Aids (KENWA)	HIV/AIDS	220,875	01.04.2003
	Sanaa Art Promotions	HIV/AIDS	2,650,813	01.04.2003
R 2	Ministry of Finance, Government of Kenya	HIV/AIDS	36,721,807	01.12.2003
	Ministry of Finance, Government of Kenya	Tuberculosis	3,299,522	01.11.2003
	Ministry of Finance, Government of Kenya	Malaria	4,640,447	01.10.2003
R 4	Ministry of Finance, Government of Kenya	Malaria	162,173,085	01.02.2006
R 5	Ministry of Finance, Government of Kenya	Tuberculosis	13,499,900	01.09.2006
R 6	Ministry of Finance, Government of Kenya	Tuberculosis	4,206,357	01.04.2008
R 7	Ministry of Finance, Government of Kenya	HIV/AIDS	30,655,749	01.06.2009
	CARE International	HIV/AIDS	16,007,749	01.06.2009
R 9	Agreement Not Yet Signed	-	-	
TOTAL APPROVED/DISBURSED FUNDS			**274,076,304**	

The Global Fund Country Coordinating Mechanism in Kenya (CCM) was established in response to requirements and recommendations of the Global Fund. The CCM, as a policy and decision making body, is a major forum for coordinating GF grants' implementation, sourcing and implementing funds from other sources

The mandate of the CCM is to discuss, approve and submit viable and appropriate proposals to the Global Fund, or to other funding sources identified and agreed by the CCM, and to monitor, guide and support the successful implementation of the projects that are financed as a result of proposals from the CCM. Specifically, the CCM organises and coordinates the proposal development process and shall ensure the efficient and effective implementation of the projects that are financed as a result of the approval of these proposals. In pursuing its mandate, the CCM adheres to the principles of broad and inclusive participation, democratic decision-making, openness and transparency, and efficient operation.

CCM Oversight Role: The CCM is the supreme body responsible for determining how GF activities are conducted in Kenya. It is responsible for ensuring the proposal development process is carried out properly and the awarded grants are implemented efficiently and within the defined principles and addressing the national priorities in scaling up the fight against Malaria, TB and HIV/AIDS. This backstopping role is not clearly highlighted in the CCM governance manual as part of its mandate.

CCM Composition: The membership of the Kenyan CCM has evolved over the years in an effort to ensure wide inclusion and participation of stakeholders; starting with an initial number of 36 and currently stabilising at 26 voting member organisations and 26 alternate organisations. The CCM has taken proactive measures to ensure that membership reflects gender balance, representation of rural areas or cities other than Nairobi and at-risk communities. Each sector selects its representative organisation to the CCM using their selection process. However, the process has to be transparent, inclusive and based on clear criteria.

5.1.1 Key Findings on the Global Fund

5.1.1.1 Ministries of Health tussle over GF

According to AIDSPAN, an independent watchdog of the Global Fund, Kenya is on average almost one year behind schedule in implementing and reporting on GF grants with some activities more than three years behind. This admission strengthens the position of Dr Hatib Ndihie, a Global Fund Consultant. Kenya's recent application for Round Nine was rejected on technicalities. From the interviews with stakeholders at various levels, over 58% of the respondents identified the Global Fund as a key contributor to the HIV/AIDS, Malaria and TB kitty in the country. Meanwhile the Ministry of Medical Services has expressed intimidation and frustration from the GF. The GF has not sent any money because the ministry does not have clear structures on how the money will be utilised, managed and accounted for. Recently Kenya was denied Kshs 47 billion because of the lack of proper accountability mechanisms to ensure efficient use of the funds. In contrast the Ministry of Public Health and Sanitation has assured Kenyans of the full support it is receiving from GF in the implementation of its programmes. The ministry is implementing activities that were funded by Round Seven worth Kshs 10.4 billion. The first disbursement of Kshs 3.5 billion has been received and the ministry is awaiting the next disbursement.

5.1.1.2 CCM Challenges in Performing its Oversight Role

The CCM is faced with many challenges in backstopping the GF grant implementation activities in Kenya. Some of which are inherent to its structure and sectors of representation. These challenges are evident as explained by CCM members and GF staff interviewed. CCM has failed to distinguish its day to day management and oversight roles. The CCM is largely seen as an administrative unit as opposed to a backstopping organ. This is also partly attributed to the fact that most CCM members are not aware that the CCM is expected to play an oversight role in the implementation of the GF grants. The CCM has experienced many oversight challenges in many areas including the following: lack of clarity on its roles and responsibilities; power struggles and personality clashes among the members; interference by the Global Fund; and poor communication throughout the Kenya GF System.

5.1.1.3 Global Fund New Funding Approach-NSA

The study established from key stakeholders that the transition from the GF Round-based planning approach to National Strategic Planning Approach (NSA) has not been well designed. The process was hurriedly done, stakeholders were not given enough time to understand and adopt the changes. Only a few people (facilitators) were flown to GF-Geneva to be trained on NSA but they never had any impact on the key stakeholders and beneficiaries. The big challenge noted with the new approach is that it does not include community participation in the process. It is a well known fact that the main objective of the GF was to bridge the existing gaps in funding for healthcare. Therefore, the NSA proposals were complimentary to the ongoing MoH activities.

Kenya as a country needs to re-organise GF programmes and re-strategise by meeting the required GF standards. The country has experienced delays due to organisational weaknesses. In Round Two Kenya lost a whole year and in Round Four funds' transfers from Treasury to MoH took a long time due to a change in the mode of transfer from a cheque payment system to wire transfer.

The country has experienced loss of money from dollar exchange rates. In a recent case, during the application they used Kshs 76 per dollar but received funds at an exchange of Kshs 75 during the disbursement thus creating a shortfall in budgetary allocations for implementation. The loss of one shilling per dollar will lead to losses running into millions or billions of shillings at the end of the funding period.

The Global Fund does not have a country level manager for the fund and previously CCM and FMA (Financial Management Agency) have been used for oversight and this has suffered a great loss. It has proven worthwhile to appoint a country level manager for example the Global Vaccination Initiative (GAVI), a leading health services financier in Kenya has appointed the World Bank and UNICEF as country managers of its interventions in Kenya. For funding to the Malaria Control Programme, DFID has appointed WHO as its country manager. In the procurement of drugs and other supplies, USAID/PEPFAR have appointed MEDS as its procurement agent. With the existence of these systems, the country has experienced great successes and minimal challenges that others can learn from. The Global Fund both in the government and CSOs have many pending cases of misappropriation of funds and other resources that have not been accounted for. One of the reasons for such cases is the poor monitoring and evaluation system and lack of reports on the ongoing activities. The impact of the watchdog units such as the Parliamentary Health Committee (PHC) in overseeing health resources and issues in the country is hardly felt. The procurement and supply chain of medical inputs, materials and supplies for GF projects are not transparent as currently KEMSA is experiencing challenges. Supplies procured are not received on time and are not in the right quantities as per the procurement orders.

5.1.1.4 Governance Issues at CCM

The Global Fund's country governance structure is unclear. The Country Coordinating Mechanism (CCM) that helps in compiling country applications for the Global Fund is not yet recognised in the current legal framework and has limited oversight capacity. Members to the CCM represent large groups of stakeholders including MoH departments, CSOs, the private sector, institutions of higher learning, research institutions and people with disabilities who also have a stake in the Global Fund. Members of the CCM, for instance the senior government officials, have several other commitments and may lack sufficient time to study and understand their roles and responsibilities clearly. The technical performance of the members is low as per the required commitment and tasks to be performed based on the CCM manual which members rarely make reference to. Finally, frequent changes of representatives to the CCM are a big challenge to the unit and performance of the team.

5.1.2 Key Recommendations on the Global Fund Health Financing Facility

1. **Global Fund (GF) headquarters and country contacts should organise a GF programme evaluation in the country** that will cover: governance, participation, leadership, systems and structures. The lessons and experiences learnt will be documented, shared and inform subsequent management of GF in the country.

2. **Country Coordinating Mechanism (CCM) orientation and capacity building:** CCM members need to be aware of their roles and responsibilities particularly the oversight/leadership roles. This can be done through a series of team retreats and empowering of the CCM members by clarifying their roles and responsibilities.

3. **Development of a communication strategy that will ensure all the stakeholders are constantly updated to promote openness and transparency.** This should ensure that relevant agenda documents (guidelines) are circulated in a timely manner to all members. This to some extent will minimise high levels of suspicion among the stakeholders and enable the CCM to make informed decisions when overseeing grant implementation. The strategy should also ensure important information is disseminated to the general public through the media.

4. **De-linking the CCM secretariat from the MoH:** The secretariat should be independent of the MoH with its own budget and should recruit its own staff. The CCM needs to emerge as an independent entity, not as a department of the MoH, as it is impossible to distinguish the CCM secretariat from the MoH. This will restore member confidence in the CCM and build a closer working relationship, information sharing and ownership by the CCM by members.

5. **Operationalisation of the CCM Governance Manual:** The CCM has developed a governance manual which clearly defines the relationships between GF and Kenyan entities, and outlines their roles and responsibilities. This manual should be adopted and members need to start using it as a guide/reference tool. The adoption should be done in a manner that will orientate/inform the new members of the rationale/process used

in developing the manual. During the orientation, members should also be encouraged to point out shortcomings that have been experienced and improvement plans. The monitoring and evaluation tools should be disseminated and a clearly defined M&E framework laid out including mechanisms for support supervision.

Section 6: Overview of Intergrity in the Health Sector

Health services' roles	**Health sector actors**	**Transparency** *(Rules and procedures in place and public reporting)*	**Accountability** *(Technical and financial audits; sanctions applied and complaints handled)*	**Anti-corruption** *(Internal and external anticorruption tools applied)*	**Users Participation** *(Consultation, right and possibility to complain)*
Policy making ▪ Allocation rights ▪ Separation of powers	▪ Ministry of Health ▪ Ministry of Finance ▪ Financial Management Agencies (FMAs) ▪ Local government ▪ Parliamentarians ▪ Professional Boards/Councils ▪ Hospital/Health Facility Management Boards ▪ NGOs/Civil Society Organisations ▪ Efficiency monitoring Unit	▪ Service charters ▪ Complaints and suggestion boxes ▪ Authority to Incur Expenditure ▪ Procurement policies ▪ Flow of funds/disbursement ▪ Recruitment /hiring , planning and deployment- public advertisements ▪ Decentralisation of the recruitment process	▪ Internal audit unit ▪ Display service charters ▪ Supportive supervision ▪ Accountability structures: approval of budgets/expenditure for FIF, etc ▪ External audit ▪ Records and reports ▪ Efficiency monitoring	▪ Service charters ▪ Policies pertaining to governance ▪ Customer care/relations' desks ▪ Suggestion boxes ▪ Anti-corruption policies ▪ Existence of anti-corruption agencies	▪ Community representation in Health Facility Management Boards ▪ Customer care/relations' desk ▪ Clients have a right to complain ▪ Service charters ▪ Governance structure
Regulation ▪ Independence ▪ Enforceable	▪ Ministry of Health ▪ Parliamentary Select Committe on Health	▪ Code of conduct ▪ Professional ethics ▪ Councils ensure operation within regulations and	▪ Regular reporting ▪ Training of staff on efficiency ▪ Procurement/tenderin g regulations and	▪ Research and investigation of cases	▪ Complaint mechanisms ▪ Customer care/relation desk

Health services' roles	Health sector actors	Transparency *(Rules and procedures in place and public reporting)*	Accountability *(Technical and financial audits; sanctions applied and complaints handled)*	Anti-corruption *(Internal and external anticorruption tools applied)*	Users Participation *(Consultation, right and possibility to complain)*
control mechanisms	▪ PPOA ▪ Division of Standards and Regulations ▪ Professional Boards /Councils ▪ Hospital management boards ▪ Health facility management boards ▪ NGOs/Civil Society Organisations ▪ User/Client/Patient ▪ Business community ▪ Private sector ▪ Local government	standards ▪ Accreditation and certification of health professionals ▪ Supportive supervision ▪ Audit	procedures ▪ Human resource management – however staff rationalisation is a challenge ▪ Service provider behavior ▪ Regulation by professional bodies ▪ Contracting recruitment services ▪ Assurance and improvement/ learning are dominant ▪ Assurance purpose emphasises adherence to the legal, regulatory and policy framework; professional service delivery procedures, norms, and values; and the quality of care standards and audits.	▪ Police engagement	▪ Open door policy ▪ Service charters ▪ Minimal role ▪ Poor information flow to community for awareness and decision making ▪ Community is represented in the Health Management Board/ Committee ▪ Mechanisms for educating the community on governance required

Service development ▪ Intervention criteria concerted with national policies and local actors	▪ Ministry of Health ▪ Ministry of Finance ▪ Ministry of State for Planning, National Development and Vision 2030 ▪ Ministry of Special Programs ▪ Health professional training institutions ▪ Professional associations ▪ Donors/ Funding agencies ▪ Local government/ Councils ▪ Parliamentarians ▪ Private sector ▪ NGOs/Civil Society organisations ▪ Health management boards ▪ FBOs ▪	▪ Authority to Incur Expenditure ▪ Financial reports ▪ External audits ▪ Decentralisation of staff recruitment/ deployment ▪ District development plans ▪ Vision 2030 ▪ National Integrated Monitoring and Evaluation System	▪ Management Information System ▪ Supply data ▪ Monitoring and evaluation framework ▪ Mid Term Evaluation Framework (MTEF)	▪ Suggestion boxes ▪ Customer care desks ▪ Supervision ▪ Service charters ▪ Complaint mechanisms ▪ Staff rationalisation	▪ Participation in health facility management ▪ Formal complaint procedures ▪ Need prioritisation

Health services' roles	**Health sector actors**	**Transparency** *(Rules and procedures in place and public reporting)*	**Accountability** *(Technical and financial audits; sanctions applied and complaints handled)*	**Anti-corruption** *(Internal and external anticorruption tools applied)*	**Users Participation** *(Consultation, right and possibility to complain)*
Service provision ▪ Organisational structure and asset management	▪ Ministry of Health ▪ Hospital management boards ▪ Health facility management teams ▪ DHMTS ▪ Healthcare provider ▪ Health service users/patients/client ▪ Health facility committee ▪ Village health Committees ▪ Community based organisation ▪ NGOs/Civil society Organisations ▪ FBOs ▪ Private Sector	▪ Revenue collection procedures ▪ Documents for verification ▪ Financial reports ▪ Authority to Incur Expenditure ▪ Banking slips and statements ▪ Receipts for payments made for services received	Cost accounting/budgeting for: ▪ Personnel Operations ▪ Pharmaceuticals/ supplies ▪ Definition of basic benefits packages ▪ Contract/procurement oversight ▪ Service delivery equity/fairness ▪ Transparency ▪ Responsiveness to citizens ▪ Service user trust ▪ Dispute resolution	▪ Improved management information systems ▪ Training/capacity building on accountability for stakeholders	▪ Strong partnership /collaboration at community level ▪ Clear governance structure ▪ Integration management approach

Section 7: Key Constraints of the Study

1. Most of the key staff in public health facilities were reluctant to provide the required information, especially those in Nairobi province.

2. The timing of the study was not appropriate as it was conducted at the beginning of the year when most people were travelling back from the holidays and schools were re-opening for the first term.

3. Sensitising key stakeholders on issues of quality, access, reliability amongst other issues was difficult as they are accustomed to the existing systems which have not been as effective.

4. The researchers only met two community monitoring groups as TI Kenya citizen monitoring system had just been introduced at the time of the data collection, therefore the groups were not well developed and coordinated as they are now.

5. Some contacts on the ground, demanded money and other benefits to participate in the study.

Glossary of Terms

Cadre: A small, unified group organised to instruct or lead a larger group

Health workers/Health providers: Trained technical staff ranging from enrolled nurses, registered nurses, clinical officers, doctors, laboratory technicians, pharmacists amongst others.

Healthcare system: Is a complex of facilities, organisations and trained personnel engaged in providing healthcare to a target population.

Health professional: An organisation or person who delivers proper healthcare in a systematic way professionally to any individual in need of healthcare services.

Kenya Essential Package for Health (KEPH): An approach that defines the various life cycle cohorts or age groups and the health service delivery levels.

Level of health facility: These are classified in levels 1-6 as follows - Level1: Community; Level 2: Dispensary; Level 3: Health Centre; Level 4: District Hospital; Level 5: Provincial Hospital; Level 6: Tertiary/referral hospital. Classification is as per the services provided.

Ministry of Health (MoH): This ministry of the Government of Kenya was originally run as a single ministry but currently consists of the Ministry of Medical Services and the Ministry of Public Health and Sanitation. The term as used in this report therefore refers to the two ministries.

National Public Account: National Health Accounts (NHA) is a tool currently used in more than 50 low- and middle-income countries as a framework for measuring total public and private national health expenditure. The NHA methodology tracks the flow of funds through the health sector, from their sources, through financial institutions, to providers and functions.

Norms and Standards: Minimum and appropriate mix of human resources and infrastructure that are required to serve the expected population at different levels of the system with the defined health services.

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