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Improving Universal Primary Health Care by Kenya

A Case Study of the Health Sector Services Fund

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Human Development Network

Universal Health Coverage Studies Series (UNICO)
UNICO Studies Series No. 5

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Improving Universal Primary Health Care by Kenya
A Case Study of the Health Sector Services Fund¹

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The World Bank, Washington DC, January 2013

¹ The Health Sector Services Fund is Kenya's response to expand the supply and strengthen primary health care. The program empowers communities to take charge of addressing their health needs and set priorities responsive to local needs.

² We would like to thank Dr. S. K. Sharif, Director Public Health; Dr. Jackson Songa, Head of the Health Sector Services Fund (HSSF) Secretariat, and colleagues from the Royal Danish Embassy for their constant support of this important initiative. We would also like to place on record the commitment shown by Facility Management Committees and the staff of the Health Centers and Dispensaries for their constant efforts to improve services by making the best use of HSSF grants.

The World Bank’s Universal Health Coverage Studies Series (UNICO)

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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Abbreviations

CBHF	Community Based Health Financing
DANIDA	Danish International Development Agency
DHMT	District Health Management Teams
ESP	Economic Stimulus Package
HCP	Health Care for the Poor
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HSSF	Health Sector Services Fund
K Sh	Kenya shillings
KEMSA	Kenya Medical Supplies Agency
KEPH Services	Kenya Essential Package of Health Services

Executive Summary

This case study describes the Government of Kenya's initiative to expand the supply of health care and strengthen primary health care through implementation of the Health Sector Services Fund (HSSF), which provides direct cash transfers to primary health facilities. This initiative, launched in 2010, is a direct response to challenges identified by the Public Expenditure Tracking Surveys in making funds for operation and maintenance available to the health facilities, and builds on lessons from initiatives supported by the Danish International Development Agency (DANIDA) in the Coastal Region.

The local communities, represented by the facility management committee, manage the funds received, and work closely with the facility staff to improve delivery of primary health services. Currently, the Government of Kenya, DANIDA, and the World Bank are supporting this initiative, which is complemented by ongoing sector reforms to improve the availability of health human resources and essential medicines to further expand service delivery. The program also helps in improving accountability for the use of resources received from different sources, including cost sharing involving local community representatives monitored by independent agencies on a periodic basis. The HSSF initiative is well aligned with the principles of devolution as envisaged by Kenya's new constitution.

This initiative has so far been expanded to nearly 3,000 primary health facilities in the public sector. The administrative data of ministries of health suggest increased utilization of the primary health facilities (from 25.8 million in 2010/11 to 27.0 million 2011/12). The health facilities were able to improve their overall upkeep with the local contractual staff and were able to buy consumables to improve quality of care. A pilot undertaken in applying the principles of performance-based financing suggests that such an approach can help further strengthen the monitoring and evaluation systems and contribute to improvements in quality.

There are, however, some operational challenges that were faced during the first two years of implementation. The most important ones include issuing timely authorizations for incurring expenditures, need for more hands-on support for accounting, and further simplification of accounting at the facility level. These issues are being addressed by the government. The authorization is now done annually, district health management teams are being complemented with accountants to provide better hands-on support, and program accounting requirements at the facility level are being simplified ensuring, full compliance with the government procedures. The ongoing Public Expenditure Tracking Survey Plus will provide more quantitative information, which will help to further fine-tune this initiative and make it responsive to the new dispensation wherein counties will be responsible for the delivery of primary health services.

1. Introduction

This case study describes the Government of Kenya's initiative to expand the supply of health care and strengthen primary health care through implementation of the Health Sector Services Fund (HSSF) launched in 2010. Specifically, the paper presents the key health sector and financing issues, the institutional and implementation arrangements of the HSSF, and complementary reforms in the sector to support the HSSF. It also shares early implementation experiences and ongoing innovations, highlights the pending agenda, and proposes options to enhance on-the-ground effectiveness of the HSSF.

The HSSF is an innovative financing approach to improve the delivery of primary health services in Kenya. It is a revolving fund providing direct cash transfers to primary health care facilities that include dispensaries and health centers. The local communities represented by the Health Facility Management Committee (HFMC) manage the funds received and prioritize their use responsive to their health needs.

The HSSF aims to improve the delivery of quality essential health services in an equitable and efficient manner as envisaged by Kenya Vision 2030 (Kenya's development program covering 2008 to 2030), the Kenya Health Policy framework 1994–2010, and the Ministry of Public Health and Sanitation Strategic Plan 2008–2012. This initiative was a direct policy response by the Government of Kenya to the findings of the Public Expenditure Tracking Survey of 2005 that little or no funds provided for the operation and maintenance of primary health facilities actually reach them and, as a result, the delivery of health services is adversely affected.

The HSSF mobilizes additional resources from the government and its development partners to improve service delivery. It envisages expeditious and direct cash transfers to primary health facilities run by the government and faith-based organizations, and supports an equitable distribution of resources. More importantly, the HSSF empowers local communities to take charge of their health by actively involving them through the HFMCs in the identification of their health priorities, and in planning and implementation of initiatives responsive to the identified priorities. The program also helps in improving accountability for the use of resources received by the facility through both grants and cost sharing.

Thus, the HSSF is well aligned with the principles of devolution and access to services as described in Kenya's new constitution, which expects the state to ensure reasonable access to its services to all parts of the republic.

The Government of Kenya is complementing HSSF with other reforms required to improve service delivery for the rural poor. These include reforms in human resources and procurement, and introducing a pull system³ of distributing medical products.

³ A pull system is a "Manufacturing system in which production is based on actual daily demand..." (<http://www.businessdictionary.com/definition/pull-system.html>).

2. HSSF Institutional Architecture and Interaction with the Rest of the Health System

Brief Description of HSSF

The HSSF is an important initiative under the National Health Sector Strategic Plan II (2005–2012) and the Community Strategy to expand the supply and strengthen primary health care. The specific objectives of the HSSF are to (a) support and empower communities to take charge of improving their health, (b) support capacity building in management of health facilities, and (c) provide financial resources to meet critical gaps for improving quality of health service delivery at the facility level.

The HSSF is a government-led response to effectively address the operational challenges encountered in making funds available to health facilities. It builds on lessons learned from a Danish International Development Agency (DANIDA)-supported program that provided direct funding to health facilities in the Coast and North-Eastern Provinces of Kenya. While the approved scope for HSSF includes public primary health facilities and facilities operated by faith-based organizations, the scale-up is taking longer than the originally envisaged time to ensure adequate fiduciary and accountability mechanisms. The program hitherto has been expanded only to the government primary health facilities, first starting with 722 health centers. Subsequently, the program was scaled up to over 2,000 government dispensaries in FY 2012, and the government is currently in the process of evolving implementation details, including the option of using performance-based financing, for expanding the fund to facilities managed by the faith-based organizations.

The program was formally launched in 2010 by the Government of Kenya and is being financed through domestic resources and support from DANIDA and the International Development Association (IDA) through the Health Sector-Wide Approach (SWAp).

Institutional Architecture of Health Care for the Poor (HCP)

The HSSF has a formal governance structure and is regulated by the legal notice “The Government Financial Management (HSSF) Regulations,” 2007, Legislative Supplement No. 67, gazetted on December 21, 2007, and subsequently updated in June 2009.

HSSF resources consist of funds allocated to the facility from the national level and appropriated by parliament, grants and donations received locally, and user charges generated by the facility. The funds provided from the national level include the resources allocated by Government of Kenya and the development partners supporting HSSF. These funds are credited directly to the bank account of each facility that is eligible to receive HSSF grants⁴, and are managed by the Health Facility Management Committee (HFMC) according to the Financial Guidelines approved by the Ministry of Public Health and Sanitation.

⁴ These eligibility criteria include (a) the health facility has been gazetted formally by the government; (b) HFMC members have been trained; (c) the health facility has an operational bank account; (d) adequate technical staff are available at the facility; (e) an Annual Operational Plan has been prepared; and (f) an accountant would have been appointed for the cluster of facilities where the facility is located, to carry out or oversee the required financial accounting functions.

At the national level, the oversight for HSSF is provided by a seven-member National Health Sector Committee that includes representatives of civil society, the private sector, and the Permanent Secretaries of Public Health and Finance. The Director of Public Health Services functions as the Secretary for the National Health Sector Committee. The eight Provincial Health Teams provide strategic oversight for the fund in their respective jurisdictions including the capacity building for fund management and reporting. With the proposed devolution in the health sector guided by Kenya's new constitution, the counties are expected to take over this function and play a more proactive role.

The District Health Management Teams (DHMT) provide technical and operational oversight at the district level by approving the Annual Operational Plans and Quarterly Implementation Plans prepared by the facilities, and the monitoring the implementation of these plans through integrated supportive supervision. The DHMTs are to consolidate the performance and expenditures reported by facilities in their respective districts and forward them to the national level with a copy to the provincial health team.

The governance at the facility level is ensured by the HFMC. Every facility has seven to nine members (with at least four members selected from the community and four women) that have the responsibility for preparing and implementing the Annual Operational Plans and Quarterly Implementation Plans with budgets. The HFMC will also oversee implementation including supervision and control of all resources raised, received, and managed by the health facility, including HSSF resources.

The planning and monitoring are integrated with regular supportive supervision of primary health services from the district, provincial, and national levels.

Spillover Effects on the Rest of the Public System



The HSSF offers a vehicle for channeling resources directly to the health facilities for the first time in Kenya, using country systems compliant with Government of Kenya fiduciary guidelines. The program promotes transparency, participation of communities in decision making, and better accountability for funds and results. While it is too early to assess the impact, an important initial spillover effect observed was the improved reporting and accounting for the user fee being collected by facilities. Some facilities effectively used the funds to

improve service delivery such as providing electricity to maternity wards to provide much needed 24-hour delivery services and improve facility upkeep by hiring local staff. Also, the

overall accountability is beginning to improve and facilities are disclosing the client charters and services offered free of charge.

The partners supporting the health sector are showing keen interest in using HSSF for improving service delivery, and UNICEF has already started using HSSF to improve delivery of maternal and child health services in a few provinces.



The HSSF design also includes performance-based financing, and the Bank is currently supporting a pilot in Samburu County to test the feasibility of this approach, building on the systems established under the program. The preliminary results from validation of project facilities suggest improvements in prenatal care, deliveries by skilled attendants, and children fully immunized. More importantly, the Health Management Information System (HMIS) reporting has improved from 71 percent to 88 percent and both clinical and overall quality/governance scores have shown steady improvement, highlighting potential benefits of overall systems strengthening (figures 1 and 2).

Figure 1 Average Clinical Quality Scores in Health Facilities under PBF

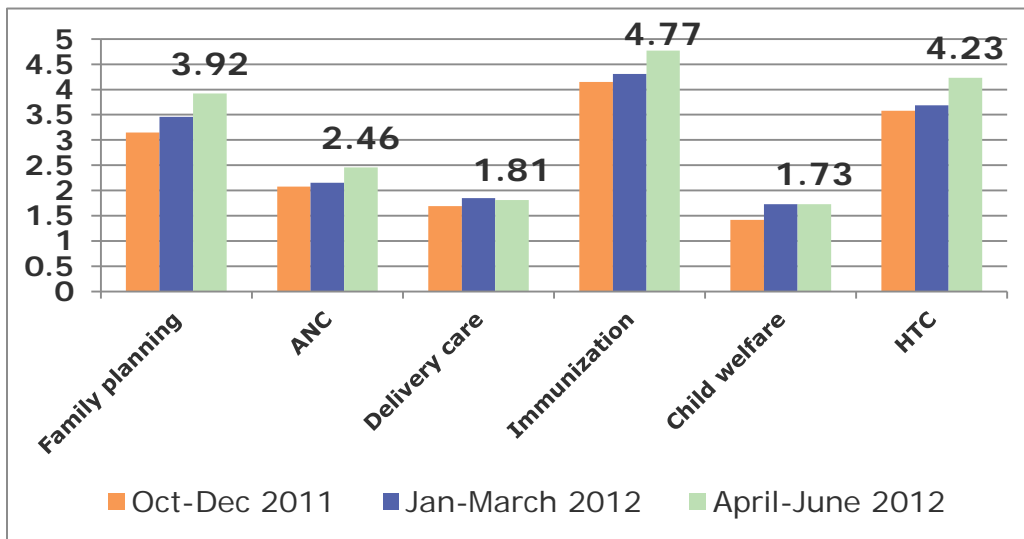


Figure 2 Average Cross-cutting Quality Score Improvements in Health Facilities under PBF



This initiative also noted the weaknesses and inconsistencies in the HMISs and the opportunity for using implementing partners present in the district for verification of data reported by facilities, which will be external to the system and will not significantly add to the costs. The government is contemplating using this approach to contract faith-based organizations, and also to scale-up performance-based financing through other sources of financing including support for health systems strengthening from the Global Alliance for Vaccines and Immunization and Health Results Innovation Trust Fund established at the World Bank with support from the UK's Department for International Development (DfID) and the Government of Norway.

3. Targeting, Identification, and Enrolment of Beneficiaries

Addressing inequities in the access to and utilization of health services is the central goal of the National Health Sector Strategic Plan II. The HSSF supports this goal by targeting services and levels of care where there are still huge inequities. The focus of HSSF is on the first three levels of health care—community, dispensary, and health center—which are most critical for delivering the Kenya Essential Package of Health Services. In addition to supporting improvement of service delivery at the facility level, the HSSF provides resources for the staff to plan regular outreach sessions to address special needs of the underserved populations who do not visit the facilities.

The HSSF design envisaged equity-based resource allocation criteria to provide additional funding to areas where poverty levels are high, population density low, and costs of providing services relatively high. Despite being approved by the parliament, the equity-based resource allocation has still not been made operational due to time taken to ensure adequate accountability mechanisms in the program and improve reporting of expenditures. Meanwhile, Kenya's new Constitution mandated devolution of responsibility to deliver essential health services to counties and introduced equity-based resource allocations for counties covering all sectors. The HSSF program now needs to revisit the originally envisaged equity formula in light of these developments.

The HSSF also aims to support the primary health facilities being operated by the faith-based organizations that still remain the sole providers of health services in some of the poorest and hard-to-reach communities. Channeling HSSF resources to such facilities will help increase access for the poor. Building on the implementation experiences so far, the program is now exploring specific modalities for contracting faith-based organizations, including the option of using performance-based financing.

4. Special Topics Related to the Management of Public Funds in HCP

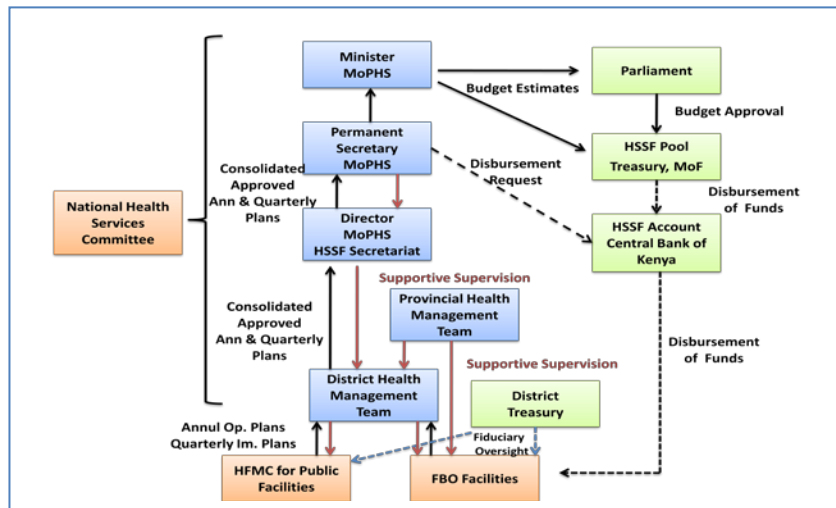
The financial transfers under HSSF are expected to influence the behavior of the two Ministries of Health, development partners, and primary health service providers. The HSSF was set up as a mechanism for pooling resources from the government and development partners through the SWAp and through transferring the resources directly to health facilities to improve the upkeep of facilities and implement locally relevant activities for improving service delivery. All decisions to use the HSSF are expected to be endorsed by the HFMC, which improved participation of users in decisions related to delivery of health services and enhanced accountability in the use of HSSF money to deliver agreed results. More importantly, the HSSF minimized the risk of loss of funds noted in the past when transfers were made through regions and districts, and provided more predictable financing to primary health facilities.

Each facility receives HSSF funds directly into its bank account. At the facility level, the HSSF funds help to improve coverage, quality, and their responsiveness by providing basic operational costs. These costs include supporting staff for facility upkeep and recordkeeping, and operation and maintenance of the facility, equipment, and vehicles. In addition, the fund also supports outreach and community-based services to promote equity and cross-sector linkages.

The planning process is facilitated by a facility stakeholder's forum organized by the facility in charge, consisting of the HFMC, development partners supporting the health sector in the locality, representatives of the constituency development fund, the divisional water officer, the agricultural extension officer, and the head teachers of the primary school. This forum reviews the performance of the facility during the previous year, discusses the implementation challenges and how the facility tackled them, and the government's identified priorities in the sector, and lists the key issues to be addressed by the facility during the next financial year. These key issues guide the Annual Operational Plan prepared by the facility in charge together with the HFMC. After the Annual Operational Plan has been approved by the DHMT, the HFMC prepares the Quarterly Implementation Plan, which describes specific activities to be implemented during each quarter. The Quarterly Implementation Plans are approved by the HFMC and submitted to DHMT.

The facilities requisition funds on a quarterly basis; however, the first two quarters for a new facility participating in the program are released in one installment, and releases for the third and fourth quarters are released only after the facilities prepare and share their quarterly financial reports. After the reports have been approved by the National Health Sector Committee, the money for the next quarter is transferred to the facility bank account (figure 3).

Figure 3 Funding and Disbursement Pathways for HSSF



Thus, the HSSF allows the community to have a strong role in the planning and implementation of health services responsive to their local needs, and ensures provision of funds directly to health facilities. More attention is being paid to compliance with guidelines for community participation in the program and the performance of providers using new tools for supportive supervision.

The HFMCs have the full responsibility for preparing and implementing the Annual Operational Plans and Quarterly Implementation Plans, including their budgets to oversee implementation and supervise and control all the resources raised, received, and managed by the Officer in Charge, including HSSF resources. The HSSF has a well-developed results chain, which links the inputs from HSSF to services and intermediate health outcomes and uses selected indicators to assess the performance of a facility in order to reward performance. Intensified supervision of services is provided under the HSSF program whereby every quarter, all facilities are visited by the DHMT at least once.

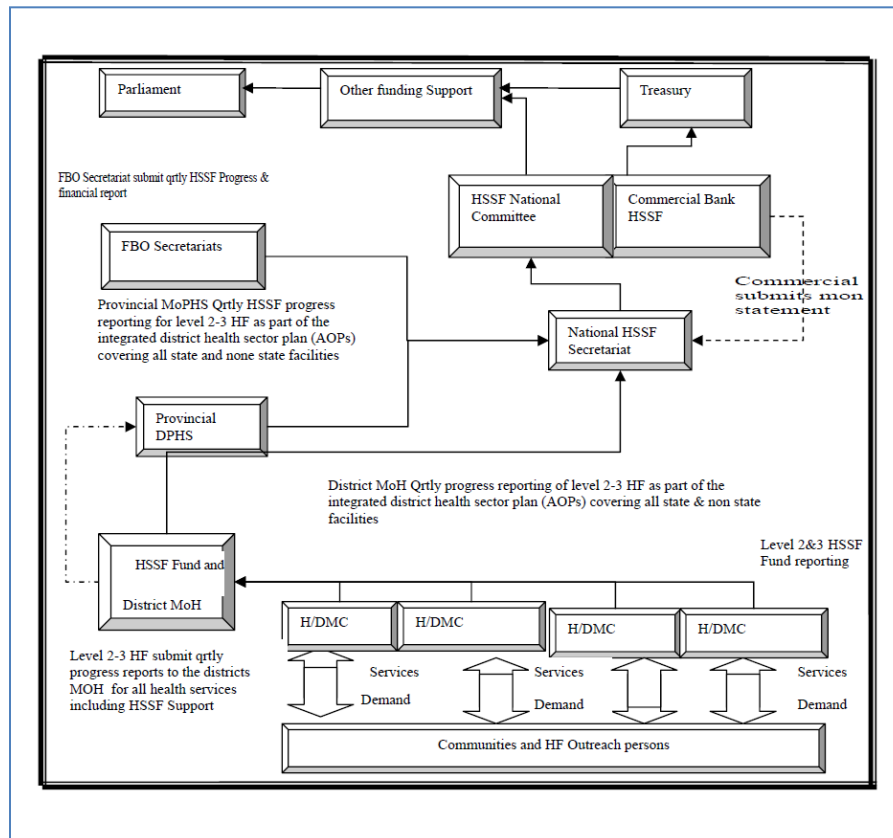
The Service Delivery reports compiled monthly by the officer in charge of the facility on behalf of the Health Center/Dispensary Management Committee are sent to the DHMT. All spending units of the program (HSSF secretariat, Provincial Health Management Team, DHMT, and facilities) prepare and submit a Monthly Expenditure Return and a Quarterly Financial Report.

Each facility receiving HSSF grants prepares a monthly financial report using the standard format and shares it with the DHMT within the prescribed deadline for review and consolidation. The DHMT submits the consolidated monthly financial report, which includes reports from both the facilities and the DHMT to the Ministry of Public Health and Sanitation head of accounting unit through the HSSF secretariat. The HSSF secretariat, in turn, produces a summarized and consolidated HSSF-wide financial report, which it uses to prepare its interim financial reports and annual accounts. Copies of these reports are submitted to the Health SWAp for monitoring purposes (figure 4).

The fund has facilitated improvement in the delivery of quality essential health services in an equitable and efficient manner. The HFMCs at the health center and dispensary levels have proved that these funds can be managed fairly well in low-resource settings and that the impact is perceived to be highly positive. Further, HSSF also helped eliminate operational bottlenecks in

providing financial resources to the primary health facilities that predominantly faced delays in receiving funds from the Ministry of Health.

Figure 4 HSSF Reporting Process



5. Management of the HCP’s Benefits Package

Despite Kenya’s strong commitment to achieving universal coverage with the Kenya Essential Package of Health (KEPH) Services, several supply-side constraints still exist in its health system. (See Annex 2 for the plan to improve delivery of KEPH Services.) The three most important challenges in delivering the KEPH Services for all Kenyans are:

- Access to resources to maintain facilities and deliver quality services
- Availability of competent human resources to deliver the package
- Availability of an adequate supply of essential medicines and medical supplies.

While the HSSF is aiming to address the first challenge, the Government of Kenya has initiated efforts to address the remaining two challenges.

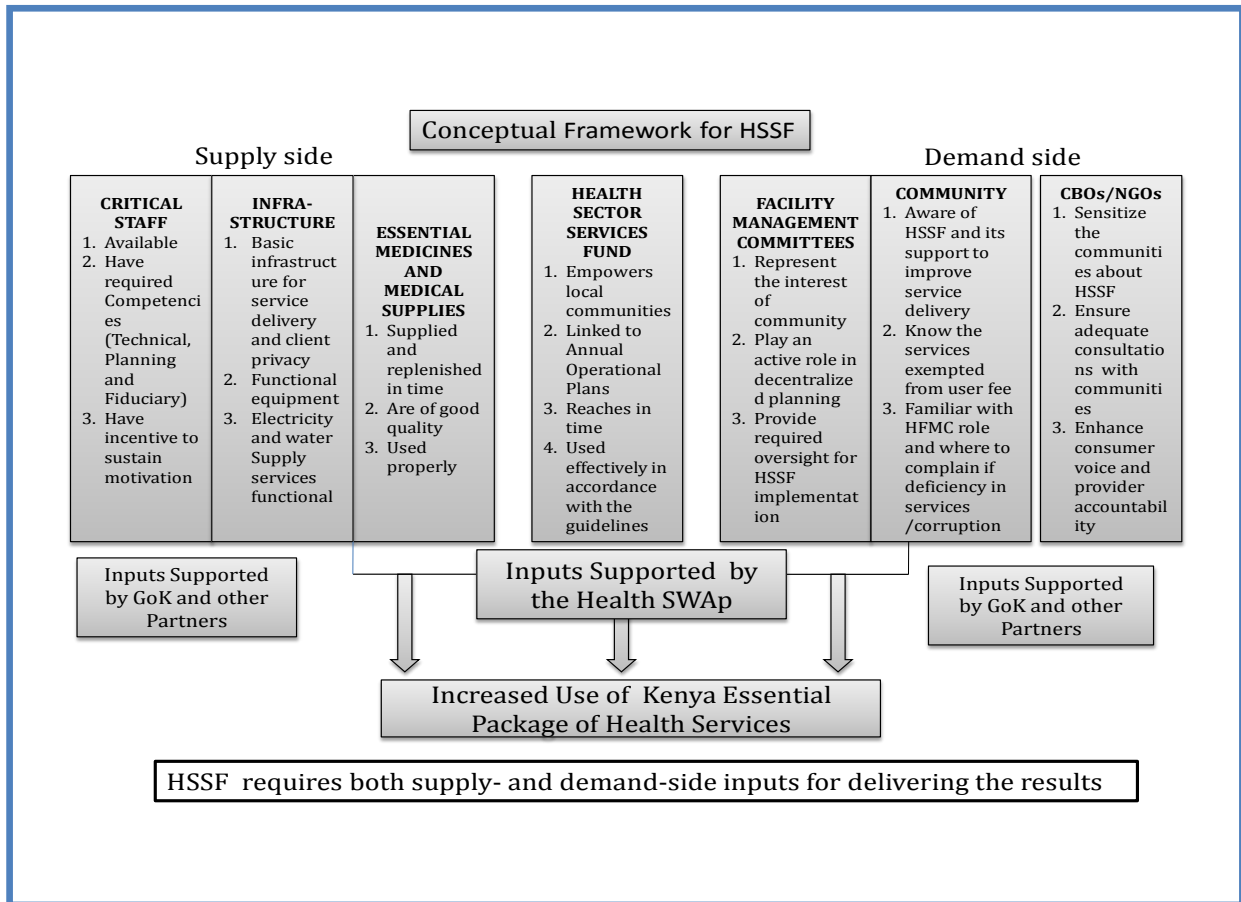
The HSSF supports improved delivery of the KEPH Services. The KEPH is organized by birth cohorts, as shown in table 1.

Table 1 Kenya Essential Package of Health Services

Cohort	Service Package
Cohort 1 Pregnancy and newborn (up to 2 weeks of age)	<ul style="list-style-type: none"> ▪ ANC and nutritional care, Intermittent Prophylactic Treatment for Malaria, Tetanus Toxoid Immunization ▪ Use of skilled birth attendants, clean delivery, BCG vaccination ▪ Postnatal care, breastfeeding support, supplementary feeding ▪ Family planning services ▪ Insecticide Treated Net promotion and use ▪ Indoor Residual spraying ▪ Prevention of Mother to Child Transmission of HIV ▪ Micronutrient supplements (iron) ▪ Hygiene, water and sanitation
Cohort 2 Early childhood (2 weeks to 5 years)	<ul style="list-style-type: none"> ▪ Community integrated management of childhood illnesses and insecticide treated net promotion and use ▪ Appropriate nutrition, extended breastfeeding, growth monitoring, Expanded Program for Immunization, provision of vitamin A, zinc ▪ Psychological stimulation, physical/cognitive development ▪ Exercise and recreation
Cohort 3 Late childhood (6–12 years)	<ul style="list-style-type: none"> ▪ Essential school health program ▪ Adequate nutritional care ▪ ITN promotion and use ▪ Exercise and recreation
Cohort 4 Adolescents (13–24 years)	<ul style="list-style-type: none"> ▪ TT2 in schools ▪ Reproductive Health and HIV/AIDS/STI (sexually transmitted infections) counseling ▪ Substance abuse counseling ▪ Adequate nutritional care ▪ Accident prevention ▪ Reproductive Health and Family Planning services ▪ Exercise and recreation
Cohort 5 Adults (25–59 years)	<ul style="list-style-type: none"> ▪ Annual screening and medical examinations ▪ Accident prevention ▪ Reproductive Health and Family Planning services ▪ Healthy lifestyles (exercise, recreation, nutrition, etc.)
Cohort 6 Elderly	<ul style="list-style-type: none"> ▪ Annual screening and medical examinations ▪ Exercise and the promotion of general hygiene ▪ Social/emotional/community support

The HSSF alone will not be able to improve service delivery in isolation. However, it addresses one of the important bottlenecks in service delivery. The program, therefore, requires complementary reforms and actions to improve availability of human resources for health and improved supply of essential health products. The conceptual framework of HSSF presented in figure 5 considers these issues.

Figure 5 Conceptual Frameworks of HSSF



A health sector Community Strategy has also been developed and launched. The main objective of this strategy is to “strengthen the community to progressively realize their right to accessible and quality care and to seek accountability from facility based health services.” In addition, the strategy proposes strengthened linkages and dialogue with the formal health sector through Community Health Workers, who are volunteers supervised and supported by Community Health Extension Workers. In principle, the full implementation of the community strategy would need 4,000 extension workers and 70,000 Community Health Extension Workers, but the Community Strategy will be implemented only gradually due to financial constraints (box 1).

Reforms are also underway in human resources for health. In particular, new human resources for the health strategic plan have been launched, and the Ministry of Public Health and Sanitation has undertaken a devolved recruitment exercise, with the resources made available through the government’s fiscal stimulus package. In recent years, the shortfall of staff in the health services has been ameliorated by employing contract staff under a funding arrangement with Development Partners. Many of the staff hired on contract have been posted to the most deprived, underserved provinces. The contract health workers have helped improve the service coverage and quality of care. However, shortfalls still remain, especially among nurses, clinical officers, and laboratory technicians in many deprived districts. Although current human

Box 1 Recruitment of Health Workers under the Economic Stimulus Package (ESP) Program

The Kenya ESP was initiated by the Government of Kenya to boost its economic growth. It was introduced in the 2009/2010 Budget Speech and its aim was to jump-start the Kenyan economy toward long-term growth and development, after the 2007/2008 postelection violence that affected the Kenyan economy, a prolonged drought, and an escalation in oil and food prices. Investment in health was one of the major elements of the ESP, and the budget allocation was envisaged to cover, among others, public health centers in all 210 constituencies. Employment of 20 nurses on a contract basis per constituency was one of the aims of the project.

The process is decentralized, with recruitment panels at the district level and the management of the data centered at the Ministry of Public Health and Sanitation headquarters. After interviews are conducted in the districts, the lists are forwarded to the headquarters where they are compiled and the names forwarded to the Public Service Commission for approval and issuance of appointment letters.

The staff hired under the package include nurses, Community Health Extension Workers, Public Health Officers, and Public Health Technicians.

ESP Phase 1: In 2010, under the ESP program, the initiative set out to employ 4,200 nurses (20 for each of the 210 constituencies) under contract. The total number recruited was 3,776, of which 3,497 reported to stations.

ESP Phase 2: In 2011, under ESP Phase II, 6,300 health workers were earmarked for recruitment. Under Phase II, the numbers of health staff authorized were 3,150 nurses, 2,100 Community Health Extension Workers, and 1,050 Public Health Officers/Public Health Technicians. The total number of health workers recruited in this phase was 4,827, which included 2,129 nurses, 2,099 Community Health Extension Workers, and 599 Public Health Officers/Public Health Technicians.

coordination with Development Partners including through a major review meeting in March 2010.

However, there are still challenges in ensuring effective distribution of procured commodities and institutionalizing the pull system. With support from the development partners, KEMSA is currently focusing on strengthening and integrating its logistic systems to ensure timely availability of all supplies (including those supplies made through national programs) based on the facility drawing rights established and disease burden. The existing centralized procurement and distribution arrangements need to be revisited in light of the ongoing devolution, ensuring that facilities and counties have autonomy to order essential medicines based on their needs and have alternate options to do so while ensuring principles of economy, quality, and rational use.

resources management is overcentralized, there are ongoing efforts to devolve human resources management to the counties.

Discussions are also ongoing to introduce new allowances for health workers in remote areas, and there are plans to set up campuses for postgraduate training programs in the provinces to retain health professionals in their work locations.

Progress has also been made in reforming and strengthening governance of the Kenya Medical Supplies Agency (KEMSA). There are already signs of efficiency improvements in KEMSA. In particular, KEMSA's procurement function is now generally in compliance with the Public Procurement and Disposal Authority provisions, and the prices for health commodities obtained by KEMSA compare favorably with other suppliers, mainly due to high volumes and improving procurement standards. KEMSA's throughput also increased by almost 37 percent in 2009 compared to 2008, with only a marginal increase of 9 percent in supply chain costs. KEMSA has improved its

6. The Information Environment of the HCP

Health information systems at the Ministries of Health collect routine health data through a network of community units comprising 6,190 health facilities (government, faith-based, nongovernmental, and private). Other key contributors to health information are the Civil Registration Department of the Ministry of Immigration, the Kenya National Bureau of Statistics, research institutions, and the African Network for Health Management.

A core set of process and governance indicators has been identified to monitor the implementation of HSSF. HSSF uses information from two sources to assess the performance of a facility: the HMIS and a quantifiable supervision checklist. Both the HMIS and supportive supervision by the DHMTs are well-established strategies of the Ministry of Public Health and Sanitation to assess facility performance.

The HMIS remains the main source of information for the Annual Operational Plan. However, like most developing countries, there are challenges in getting reliable information in time from the HMIS. The major challenges include inconsistencies in data reported compared to actual sources of data, weak capacities of HMIS staff, lack of integration among the many parallel data collection systems, and inadequate coordination. While HSSF resources can be used for the recruitment of records clerks, depending on need, the supportive supervision role of DHMT can be more effectively used building on the new checklist introduced by the Department of Primary Health Care, which helps to objectively assess the performance of facilities.

In addition, an independent integrated fiduciary review agency has been contracted to monitor on a quarterly basis HSSF's fiduciary compliance, performance, governance arrangements, and value for money covering a nationally representative sample. Some of the positive findings from the first two reviews are that (a) the program funds were generally well used and there were visible improvements in overall service delivery at the sampled health facilities; (b) the HFMCs were generally well constituted and involved in decision making and oversight functions; and (c) the sampled facilities received Essential Medicines and Medical Supplies from KEMSA, quarterly. Reported instances of Essential Medicines and Medical Supplies stock-out decreased from 49 percent in September 2011 to 46 percent in December 2011.

The key challenges identified are (a) delays in the release of HSSF funds and authorizations to incur expenditures, thereby adversely affecting the implementation of planned program activities; (b) poor recordkeeping at facilities due to heavy workload, capacity constraints, and inadequate support from accountants; (c) despite having adequate storage and inventory records, updating of bin cards used for recording pharmaceutical stocks was not being done regularly; and (d) 27 instances of inappropriate use of HSSF funds were reported.

The Ministry of Public Health and Sanitation has started measures to address the identified weaknesses of the program. All cases of inappropriate use of HSSF funds reported were investigated and acted upon, and feedback is being provided to facilities on their specific areas of weakness. The HSSF fiduciary records are being further simplified while maintaining compliance with Government of Kenya requirements. The authorization to incur expenditure is now being issued on an annual basis, which allows facilities to readily access available funding.

Finally, DANIDA has agreed to support government efforts to have one accountant in each district to provide sustained handholding and capacity building of health facilities as a full member of the DHMT.

7. Key Conclusions

Health centers and dispensaries are the major source of primary-level care for communities, particularly in the rural areas of Kenya, where over 80 percent of the population resides. Public health services at these lower levels of care where the poor mainly seek their care are particularly weak. Unreliable funds flow and unavailability of essential medicines and medical products are known common weakness in public primary health care facilities. According to a 2009 client satisfaction report by the Ministry of Medical Services, a majority of public health facility clients reported unavailability of essential drugs and medicines. In addition, the findings of the 2005 Public Expenditure Tracking Survey revealed that little or no funds actually reach primary health care facilities. The manifestations of such weakness at the service provision level have included, among others, inadequate and poorly maintained equipment and infrastructure.

The Government of Kenya regards primary health care facilities as a critical pillar of the health system for delivering the essential package of health services for all Kenyans. In an effort to address the challenges faced by these facilities, various reforms have been implemented to ensure that primary health care facilities offer quality services. One of the key reforms has been the establishment of the HSSF, which helps to transfer funds expeditiously and directly to rural health facilities, particularly Level 1, 2, and 3 facilities, to enable them to improve services to local communities. In addition, strategies to remove the supply-side constraints and expand primary health care have been developed. The introduction of the demand-based pull system approach (box 2) of supplying essential medicines and medical supplies has ensured reliable availability of health commodities at the lower-level health facilities. In addition, to address the shortages in health workers, a devolved recruitment exercise was undertaken under the Economic Stimulus Package. This helped in locally recruiting and deploying nurses, community health extension workers, and public health officers and technicians to work in the rural and underserved areas.

Since its rollout in 2010, the HSSF has proved to be a successful strategy for ensuring that funds reach the periphery of the health system, with minimal bureaucratic interference. An early evaluation of the HSSF program by the Kenya Medical Research Institute highlighted the fact that direct financing made an important contribution of facility funding, and was also perceived to have a positive impact on staff motivation, use, and quality of care. Notably, there has been remarkable improvement in the quality of services provided at the primary health care facilities. One of the most recent key finding on the implementation of the HSSF program by DANIDA and the World Bank is the significant number of people visiting the health centers.

Box 2 The Pull System of Supplying Essential Medicines and Medical Supplies

The “pull system” is a demand-based approach for ensuring the reliable availability of health commodities at all service delivery points within a health system. In Kenya, under the National Health Sector Strategic Plan II (2005–2012) the government (Ministry of Health) has established virtual “drawing rights” for health facilities to move toward the “pull” system of supply in which facilities order their required supplies and commodities based on actual need rather than receiving centrally determined numbers of medicine kits (referred to as the “push” system of supply).

Drawing rights for Level 2 and 3 facilities: Each public rural health facility has annual drawing rights established by the ministry through the above-mentioned resource allocation criteria. In 2011–12, new resource allocation criteria for rural health facilities were developed, and the allocation of drawing rights is done at two levels—national to district and district to health facilities

National to district: Allocation criteria are based on district workload, district population, number of Rural Health Facilities in the district, and the district poverty index. Each component has individual weights.

District to facility: The allocation criterion is primarily based on the facility workload.

The process of transition from the push to the pull system for the Rural Health Facilities began at the end of 2005, and pilot projects were undertaken in the Coast and North Eastern provinces. The pilot ended in December 2006. In 2007, a phased rollout for the rest of the country was planned, with Nairobi province and its environs brought on board. The next counties to be included in the system were the Lower Eastern, including Machakos, Makeni, and Kitui counties. However, there were challenges on the supply side, particularly in the processing of orders, since the processing was based on individual orders. During the same period, the KEMSA board was dissolved and a task force formed to investigate the matter.

With these developments, the enrollment of Rural Health Facilities in the system was stopped. In late 2009, a new board was formed and a new road map on KEMSA drawn.

In the first quarter of 2011, KEMSA put more facilities into the pull system for the remainder of the Central and Eastern provinces. Between October 2011 and February 2012, two provinces were placed onto the pull, namely Western and Nyanza provinces. The entire country is expected to move to pull system by the end of FY 2012 from accounting departments.

Early results from the pull system include: (1) wastage and expiry of drugs has been reduced; (2) stock-out reduced and there is reliable availability of health commodities, and (3) equity in resource allocation improved.

The HSSF is currently covering 721 health centers and 2,296 dispensaries in the public sector. The administrative data of the Ministries of Health suggest an increase in utilization rates of health facilities. During the first nine months of fiscal 2011/12, nearly 27.9 million individuals used primary health services compared to 25.8 million in fiscal 2010/11. Over half of these users (16.3 million) were female. In addition, nearly 0.8 million eligible children were fully immunized, with marginal improvements in coverage levels in the North Eastern province. Other early benefits of the HSSF noted are that facilities were able to improve their upkeep and buy consumables to improve quality of care, and HFMC members are actively participating in decision making and are supporting the facilities.

Early results from the pull system indicate that in the districts currently using the new pull system, wastage and expiry of drugs have been reduced. Furthermore, there is reliable availability of health commodities as reflected in reduced stock-outs at health facilities.

The HSSF aims to improve delivery of quality essential health services at the sub-district and community levels,

in an equitable and efficient manner through (a) generating and providing sufficient resources for implementing each facility's Annual Operational Plan to address preventive, promotive, and curative services at Levels, 1, 2, and 3 and to account for them in an efficient and transparent manner according to the government systems; and (b) supporting capacity building in the management of health facilities.

Each facility receives funds four times every financial year, and the funds are credited directly to the beneficiary's bank account. At Level 2 and 3 health facilities, the HSSF funds help in improving coverage, quality, and responsiveness by providing basic operational costs. These costs include supporting staff for facility upkeep and recordkeeping; and operation and maintenance of the facility, equipment, and vehicles. The fund is also used to ensure uninterrupted electricity and water, communication, and supply of consumables and stationery.

In addition, the fund improves services at Level 1 through outreach and community-based services to promote equity and cross-sector linkages by applying resource allocation criteria. The specific activities it supports include outreach services such as reproductive and child health provided by facility staff; mobilizing communities, and promoting cross-sector linkages and other community-based innovative activities including maintenance of water sources and sanitation (Annex 1).

To ensure proper management of the fund, management committees have been established and trained at the district, provincial, and national level. The committees provide oversight functions, but day-to-day management is in the hands of facility committees.

8. Pending Agenda

Like most developing countries, Kenya faces major challenges in ensuring universal health care coverage. Access to affordable and quality health care remains a major challenge for most Kenyans. Income and geographic inequalities still predominate in accessing and using health services, with low utilization of essential services among the poor and those residing in arid and semi-arid areas.

The poor benefit far less from government subsidies to health care. Ill health is concentrated among the poor, but the poorest 20 percent lay claim to just 14 percent of government health care expenditure compared to 27 percent of the benefit received by the richest 20 percent. Both the quality and efficiency of public health services remain low. While many guidelines and policies exist, there is no systematic approach to assessing, monitoring, and improving the performance of health services, at least not according to consistent, defined standards.

Health workers are unevenly distributed around the country, with greater numbers in hospitals and in urban and non-arid areas. Further, there is a general decline in the number of health workers in all provinces. Although the recruitment of health workers under the ESP addressed the shortfalls in human resources, policies to attract them to underserved areas mostly remain ineffective. Moreover, it is still unclear how the status of more than 3,000 staff recruited under the ESP program will be regularized.

Significant progress in efficiency has been observed in KEMSA, but stock-outs of essential medicines, and in particular medical supplies, are still frequent. The overall government allocation for pharmaceuticals remains low and this, coupled with poor supply chain management, forces medicines and medical supplies to be bought locally, as a result of which prices are higher and effective quality oversight suffers.

Despite recent improvements, the health sector continues to face governance challenges. Accountability needs to improve at all levels of the health system, in terms of both service delivery and financial management. Community ownership and involvement in the planning and monitoring of health services have improved following the establishment of community HFMCs, but the complaint redress mechanisms that give voice to citizens remain weak and lack efficiency and transparency.

9. Proposed Way Forward

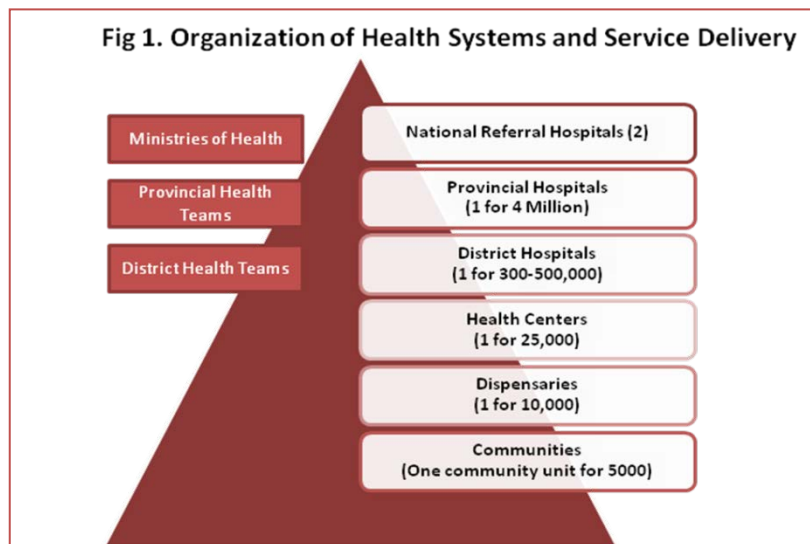
The way forward could include the following:

- Improving delivery of the Kenya Essential Package of Health Services and strengthening systems will be critical for further improvements in health status, especially for poor people. The money being spent on health care could deliver better health outcomes by improving the efficiency of existing systems. Kenya Vision 2030 recommends scaling up output-based approaches that would enable disadvantaged groups to access health care from preferred institutions. The ongoing supply-side innovations such as the HSSF need to be complemented by innovations that more strongly focus on results, such as performance-based financing and demand-side innovations. The Government of Kenya is currently working with its partners to study the applicability of performance-based financing and vouchers in the health sector, building on the successful foundation provided by the HSSF.
- The devolved health care system envisaged by the new constitution provides a huge opportunity for offering more responsive and accountable health services, addressing some of the equity and efficiency concerns about the centralized system. However, it is also important to ensure that countries sustain successful initiatives such as the HSSF and pull system. This requires more stringent assessment of the impact of these initiatives on service delivery, covering both equity and quality dimensions.
- Ongoing reforms need to be further deepened to enhance the citizen's role in health service delivery, through active participation in planning, facility management, complaint redress, and validation of reported results.
- A strong national commitment is required to support counties in addressing the unequal distribution of human resources. While incentives linked to performance remain critical, the creation of an enabling work environment for health care staff in underserved areas remains equally important.
- There is also a need to focus on sustained commodity supply by scaling up the pull system. This involves building on the economic and efficiency benefits of centralized procurement, while improving facility-level commodity management and rational use, led by county and facility health management teams and creating strong competition.

Annex 1 General Health System Overview of Financing and Delivery

General Health System

Health services in Kenya are provided by a wide range of players, and the public services (see figure below), which mainly cater to the poor, are particularly weak at the lower levels. Health care providers include the government, faith-based organizations, other not-for-profit organizations, for-profit service providers, and traditional healers. About 40 percent of the services are provided by the private sector, which is broadly defined.



Health services in Kenya are provided through a network of over 4,700 health facilities countrywide, with the public sector system accounting for about 51 percent of these facilities. At present, the public health system consists of the six levels, as shown in figure A1.1: the national referral hospitals (Level 6), which provide sophisticated diagnostic, therapeutic, and rehabilitative services; provincial general hospitals, which provide specialized referral care (level 5); district hospitals, which provide

referral care in priority areas for the district (Level 4); health centers offering a well-defined package of preventive and curative services including delivery (Level 3); dispensaries, which are the first point of contact with the formal health system with priority focus on preventive and promotive care (Level 2); and the community (Level 1).

Basic primary care is provided at the lowest levels of care, including health centers and dispensaries. The main programs in primary care settings include malaria, HIV/AIDS, TB, child health including immunization and birth deliveries, and reproductive health programs. For these programs, health workers use a population-based list of names to monitor program implementation. These programs have earmarked funding, which is more predictable than for the rest of the public health system, although the recent reduction of financing from the Global Fund for HIV/AIDS, Tuberculosis and Malaria could affect the predictability of commodities. There is a small user fee for primary care services (10 K Sh for a dispensary and 20 K Sh for a health center). However, all services for children under five, pregnant women, and national priority health programs are exempted from a user fee. Generally, HIV/AIDS, malaria, TB, and child health are very strong programs. However, for various reasons, they still tend to get implemented vertically, especially to meet donor requirements, resulting in unnecessary duplication.

Health Financing

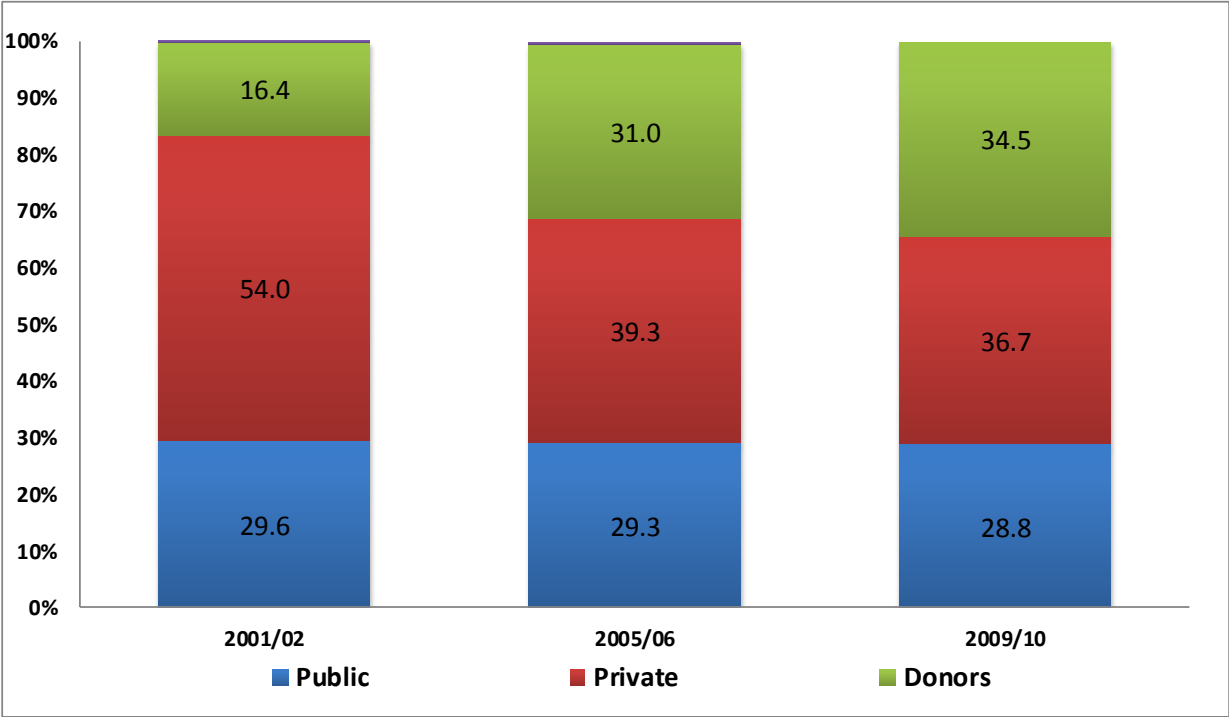
The sources of health financing include government, households, the private sector, and donors that pool resources and pay for services provided by public and private providers. The main players of health financing in Kenya are:

- **General tax financing:** This mainly consists of tax-financed “free” health care services in public health facilities, later modified by the introduction of user fees.
- **National Hospital Insurance Fund:** This was established in 1966 to finance health care in public and private facilities. The scheme is mandatory for formal sector workers earning more than K Sh 1,000 per month. As of June 2010, the National Health Insurance Fund was able to reach 6.6 million beneficiaries (about 18 percent of Kenyans), with 2.8 million principle members, which makes it by far the largest health insurer in the country.
- **Private health insurance:** This has developed over the years, becoming more visible in the early 1980s, with the introduction of health maintenance organizations and the growth in health insurance portfolios for insurance companies.
- **Employer self-funded schemes:** Employers provide health benefits as incentives to their workers and dependents through self-insured in-house medical schemes.
- **Community Based Health Financing (CBHF) schemes:** These have emerged over time to meet the health care financing needs of low-income earners who traditionally have been largely left out of private insurance and the National Health Insurance Fund. There is no specific regulation for CBHF, and most are registered by the Ministry of Gender and Youth Affairs.
- **Out-of-pocket health spending:** Like many developing countries, out-of-pocket spending has been very high in Kenya. Out-of-pocket spending is a major barrier to accessing health care services and drives households into poverty through the sale of assets and the diversion of meager income into health services.
- **Development partners and nongovernmental organizations:** Various development partners and nongovernmental organizations have traditionally contributed significantly to health care financing and provision.
- **Other mechanisms:** These include HSSF, which is a form of supply-side financing to lower-level health facilities and the Output-Based Approach Reproductive Health Voucher, which is a form of demand-side financing that targets the poor. The poor buy the health vouchers at token prices and the voucher is redeemed with a specific service provider network for specified health services.’

Funding for the health sector is increasing but still falls short of the needed amount. According to the National Health Accounts undertaken in 2009–10, the Total Health Expenditure in absolute value increased from K Sh 82.2 billion (US\$1,046 million) in 2001/02 to K Sh 122.9 billion (US\$1,620 million), in 2009/10, an increase of 49 percent. Total Health Expenditure per capita increased from K Sh 2,636 (US\$34) in 2001/02 to K Sh 3,203 (US\$42) in 2009/10, a 24 percent increase. However, the Total Health Expenditure as a percentage of gross domestic product has

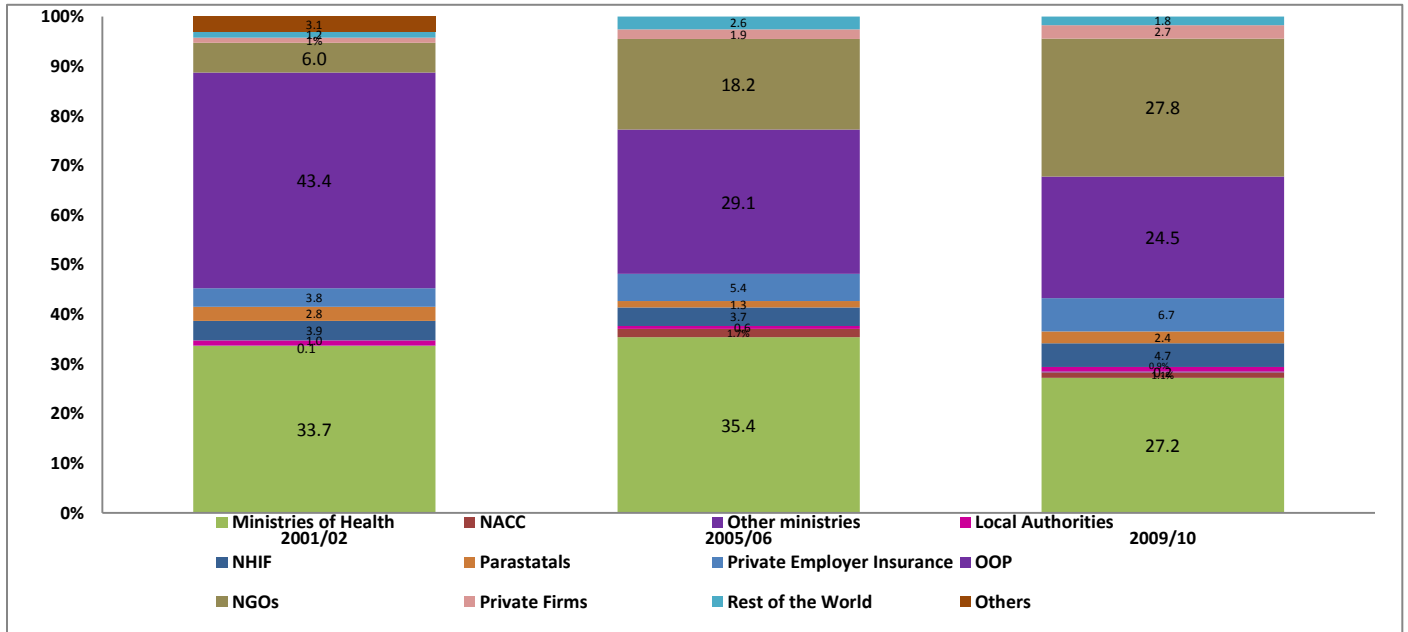
remained nearly constant, at 5 percent since 2001/02. What is more worrisome is the decline of government health expenditures as a percentage of total government expenditures from 8 percent in 2001/02 to 4.6 percent in 2009/10 (figure A1.2).

Figure A1.2 Distribution of Financing Sources, 2001/02, 2005/06, and 2009/10, Kenya



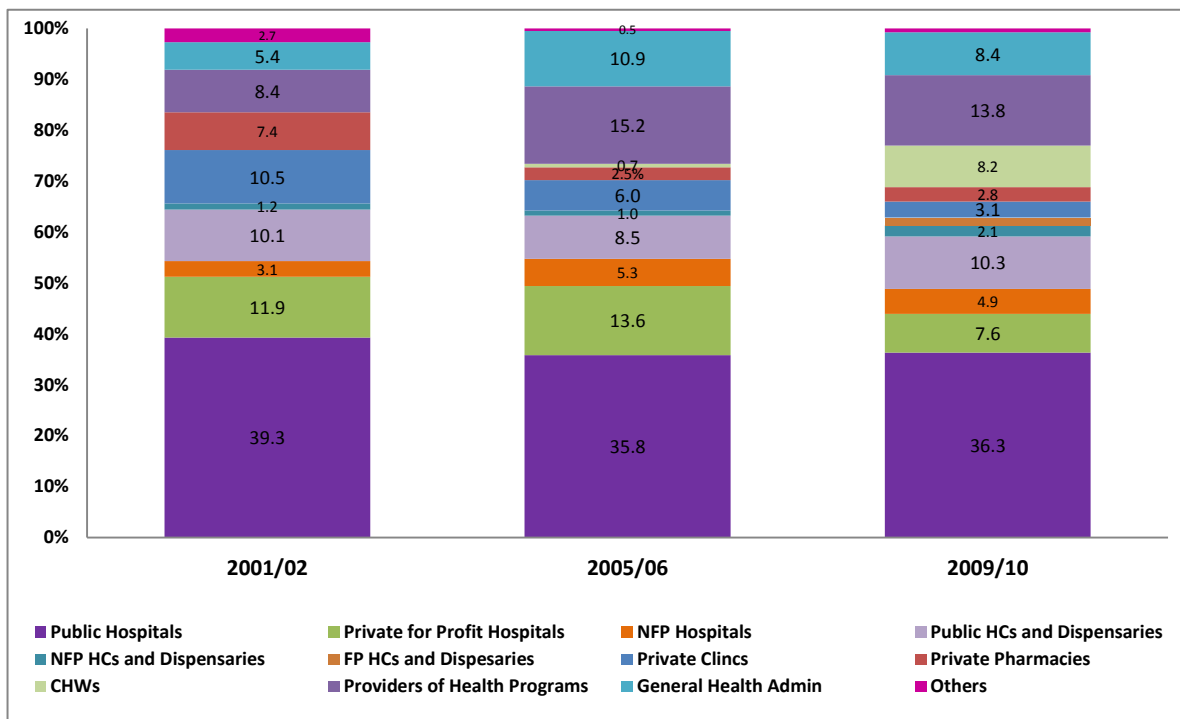
The health sector continues to be predominantly financed by private sector sources (including by household out-of-pocket spending), as depicted in figure A1.2. However, the private sector share has decreased from a high of 54 percent in 2001/02 to 37 percent in 2009/10, while public sector financing has remained constant over the last decade, at about 29 percent. The contribution from donors has more than doubled, from 16 percent in 2001/02 to 35 percent in 2009/10 (figure A1.3).

Figure A1.3 Distribution of Financing Agents, 2001/02, 2005/06, and 2009/10, Kenya



In terms of uses, the public sector entities are estimated to have managed 37 percent of Total Health Expenditure in 2009/10 compared to 43 percent in 2001/02. Similarly, resources managed by the private sector decreased from nearly 50 percent in 2001/02 to almost 30 percent in 2009/10. There has been a steep increase in resources managed by nongovernmental organizations and donors, which nearly quadrupled from 2001/02 (figure A1.4).

Figure A1.4 Distribution of Providers, 2001/02, 2005/06, and 2009/10, Kenya



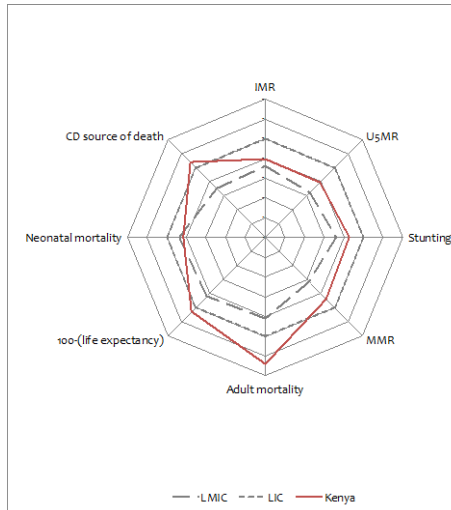
Annex 2 HSSF Activity Planning

Objective: To improve the delivery of Kenya Essential Package of Health (KEPH) Services at the facility and community levels, especially for the poor.

Purpose and Expenditure Category	Activities	Inputs (with intermediate-level account codes)	Indicative Share	Output
Improving coverage, quality, and responsiveness of Level 2 and 3 health facilities by providing basic operational costs (K Sh 450,000 per health center/K Sh 110,000 per dispensary)	<ul style="list-style-type: none"> • Support staff for facility upkeep, recordkeeping, security, etc. • Operation and maintenance of facility, equipment, and vehicles • Uninterrupted electricity and water • Communication • Supply of consumables and stationery 	<ul style="list-style-type: none"> • Casual wages for temporary staff (f2110200) 	20–40%	<ul style="list-style-type: none"> • Fully functional Level 2 and 3 facilities delivering KEPH Services and responsive to clients • Increased use of facilities for preventive health services (immunization, Intermittent Preventive Treatment, pre- and postnatal care, Voluntary Counselling and Testing, Prevention of mother to child transmission), promotive health services (skilled birth care, growth monitoring, vitamin A, contraceptive promotion), curative care (treatment of the sick child, TB diagnosis and DOTS [directly observed treatment, short-course], and outpatient and inpatient care, referrals) • Enhanced transparency and accountability (decentralized planning involving Health Facility Management Committees, disclosure of information on funds received and used, timely expenditure reporting)
		<ul style="list-style-type: none"> • Utilities—electricity, water (h2210100) 	10–20%	
		<ul style="list-style-type: none"> • Communication, supplies and services— mobile, Internet, and courier services (h2210200) 	5–10%	
		<ul style="list-style-type: none"> • General office supplies and services (h2211100) 	5–10%	
		<ul style="list-style-type: none"> • Repairs and routine maintenance—vehicles and other transport equipment (h2220100) • Repairs and routine maintenance of equipment and other assets (h2220200) • Fuel and lubricants (h2211200) • Other operating expenses—bank services, contracted guard, and clearing and transport costs (h2211300) 	10–20%	
Improving Level 1 services through outreach and community-based services to promote equity and cross-sector linkages by applying resource allocation criteria (K Sh 225,000 per health centre/K Sh 55,000 per dispensary)	<ul style="list-style-type: none"> • Outreach services provided by facility staff: <ul style="list-style-type: none"> ➤ reproductive and child health ➤ nutrition ➤ communicable disease and noncommunicable diseases ➤ school health clinics • Mobilizing communities and promoting cross-sector linkages • Other community-based innovative activities (e.g., maintenance of water sources, sanitation) 	<ul style="list-style-type: none"> • Accommodation and domestic travel (g2210300) • Advertising, awareness, and publicity campaigns (h2210500) • Fuel and lubricants (h2211200) 	20–30%	<ul style="list-style-type: none"> • Planned outreach activities held • Improved coverage for community-based services (immunization, prenatal care, vitamin A distribution, use of Long Lasting Insecticidal Nets, community management of diarrhoea, malaria and acute respiratory infection, nutrition rehabilitation, contraceptive/condom distribution) • Enhanced cross-sector linkages— access to safe drinking water, sanitary latrines, school health
		<ul style="list-style-type: none"> • Performance incentives 	30–70%	

Annex 3 Spider Web

I. Outcomes comparisons: Kenya and Low Income Countries

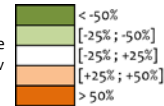


Note on interpretation:

In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average low income country value.

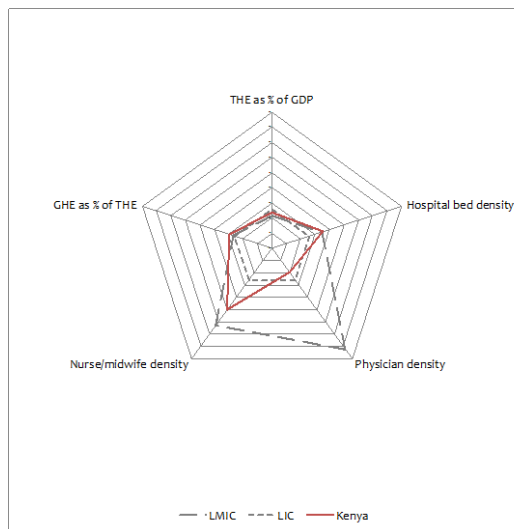
The table below summarizes outcome comparisons with the average low income country (LIC).



Country Data	Kenya	LIC	% Diff.
GNI pc (2000 USD)	401.9	258.2	55.7%
IMR	55.1	69.7	-21.0%
U5MR	84.7	107.9	-21.5%
Stunting	35.2	41.0	-14.1%
MMR	360.0	410.0	-12.2%
Adult Mortality	379.7	296.6	28.0%
100-Life Expectancy	43.5	41.2	5.7%
Neonatal Mortality	28.0	33.5	-16.4%
CD mortality	72.0	67.0	7.5%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]; Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

II. Inputs comparisons Kenya and Low Income Countries

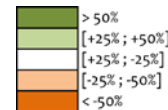


Note on interpretation:

This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average low income country value.

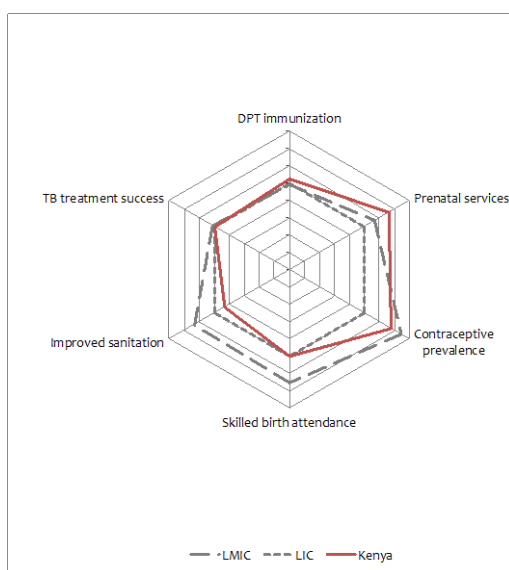
The table below summarizes inputs comparisons with the average low income country (LIC).



Country Data	Kenya	LIC	% Diff.
GNI pc (2000 USD)	401.9	258.2	55.7%
THE %GDP	4.8	5.3	-11.1%
Hosp. bed density	1.4	1.0	46.9%
Phys. density	0.1	0.2	-31.5%
Nur./midwife dens.	1.2	0.5	121.7%
GHE %THE	45.7	38.7	18.1%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

III. Coverage comparisons Kenya and Low Income Countries

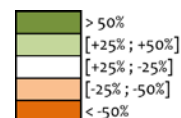


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average low income country value.

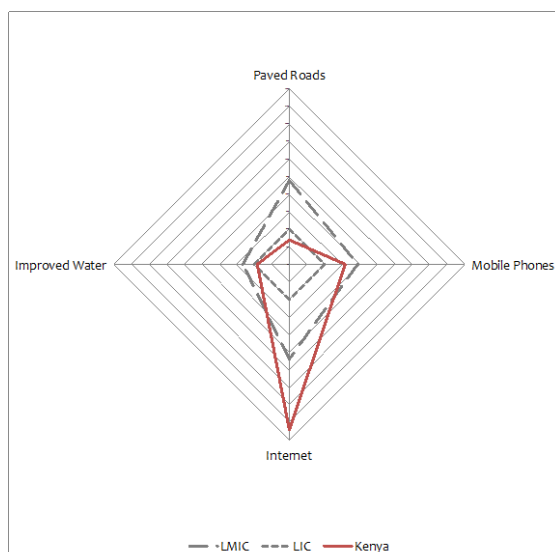
The table below summarizes coverage comparisons with the average low income country (LIC).



Country Data	Kenya	LIC	% Diff.
GNI pc (2000 USD)	401.9	258.2	55.7%
DPT	83.0	79.5	4.4%
Prenatal	91.5	68.9	32.7%
Contraceptive	45.5	33.6	35.4%
Skilled birth	43.8	43.6	0.5%
Sanitation	32.0	37.0	-13.5%
TB success	86.0	86.0	0.0%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

IV. Infrastructure comparisons Kenya and Low Income Countries

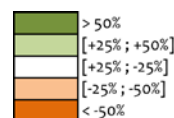


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average low income country value.

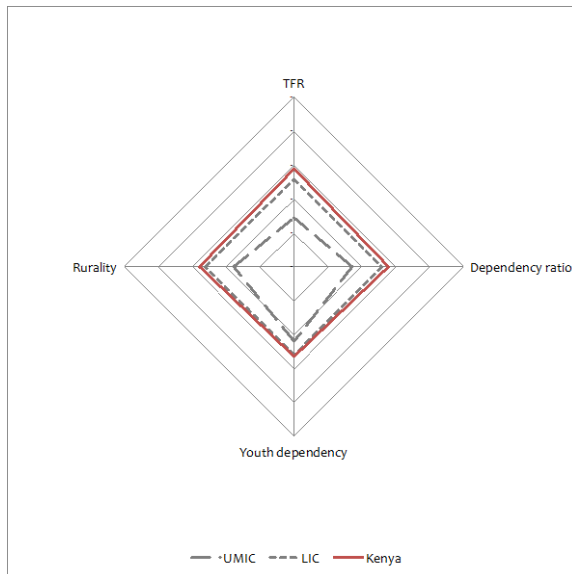
The table below summarizes infrastructure comparisons with the average low income country (LIC).



Country Data	Kenya	LIC	% Diff.
GNI pc (2000 USD)	401.9	258.2	55.7%
THE %GDP	4.8	5.3	-11.1%
Hosp. bed density	1.4	1.0	46.9%
Phys. density	0.1	0.2	-31.5%
Nur./midwife dens.	1.2	0.5	121.7%
GHE %THE	45.7	38.7	18.1%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

V. Demography comparisons Kenya and Low Income Countries

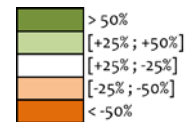


Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average low income country value.

The table below summarizes demographic indicators comparisons with the average low income country (LIC).



Country Data	Kenya	LIC	% Diff.
GNI pc (2000 USD)	401.9	258.2	55.7%
TFR	4.7	4.1	15.7%
Dependency (Total)	82.1	75.1	9.4%
Youth share	94.2	91.5	2.9%
Rural pop.	77.8	71.7	8.5%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

VI. Inequality comparisons Kenya and Low Income Countries

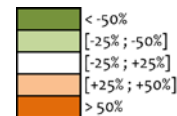


Note on interpretation:

In this plot 'higher' is 'inequal' and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average low income country value.

The table below summarizes inequality indicators comparisons with the average low income country (LIC).



Country Data	Kenya	LIC	% Diff.
GNI pc (2000 USD)	401.9	258.2	55.7%
IMR Q1/Q5	1.2	1.7	-31.8%
U5MR Q1/Q5	1.4	1.8	-20.9%
Stunting Q1/Q5	1.9	1.9	0.8%
ARI Q1/Q5	2.1	1.2	77.7%
Diarrhea Q1/Q5	1.6	1.3	21.8%

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats (<http://data.worldbank.org/data-catalog/HNPquintile>).

The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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