

Empowering Marginalised Community Groups for Inclusive Governance in Kenya's Health Service Delivery

Improving Health Service Delivery through Community Participation



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Foreword

The publication “Health Service Delivery through Community Participation: Case for Kisumu County” is a critical pillar in the endeavor for accountability in the delivery quality and equitable health service in Kenya. It encompasses the social accountability model of involving marginalised community members to take part in ensuring quality delivery of health services at public facilities. This report is a catalyst for the realisation of the citizen health rights provided for by the constitution of Kenya and the corresponding responsibility bestowed on the government to ensure that the interest of marginalised groups are taken to account.

The report identifies areas that need to be addressed for the realisation of the objects set under the country’s development blue print and the national health policy. The reports also lays bare the issues to be addressed for the accomplishment of the vision of performance contract between the government of Kenya and the ministry of health including the basis for ensuring efficient and effective health service delivery to Kenyans through a human rights approach to service delivery.

It builds up the fundamental principle of democracy that outlines the citizens’ right to demand accountability and the obligation of public service providers to be accountable. It also highlight on the crucial social accountability actions and mechanisms that communities can use to monitor and hold public officials accountable including the citizen and community monitoring reports and budget analysis. The report lays emphasis on the dire need for community engagement in health service delivery process through citizen reports and community monitoring implementation as a way of documenting their perception regarding quality and other aspects of health service delivery and the bare exposure of various pertinent issues that need to be addressed for the accomplishment of quality health service delivery to vulnerable community members in every county.

Lack of good health is a hindrance to full participation in the governance processes by vulnerable population. The study has therefore identified a number of action points in its recommendations that need to be looked at by both national and county government in a bid to realisation of the aspirations of the many marginalised groups – women, youth, disabled groups and people living with Aids who are presently impaired to effectively engage in the planning, implementation, and the maintenance of a sustainable pattern of community health development agenda.

In conclusion, it is generally agreeable that illnesses reduce incomes and assets, as people tend to spend more money seeking treatment instead of engaging in productive investments. It therefore important that I emphasise on the need to address the health service delivery issues identified by this study within Kisumu County and those that require action by the national government as the health of a nation is a pillar to its economic growth.

Pamela Amondi Omino

Deputy Speaker, Kisumu County Assembly

Preface

The goal of health services provision is to improve health outcomes in the population and to respond to people's expectations, while reducing inequalities in both health and responsiveness. The public healthcare needs are supposed to be met with the best possible quality and quantity of services produced at minimum costs. Healthcare is conventionally regarded as an important determinant in promoting the general physical and mental health and well-being of people around the world. Studies have also shown that good health is fundamental to leading a healthy and productive life. Recent advances in knowledge development emphasise the idea that population health has a significant effect on economic progress, as healthy populations live longer, are more productive, and save more.

Experience over the past decade has shown that to improve community health and reduce morbidity and mortality, efforts should focus on building capacities at individual, family, and community levels to ensure and demand appropriate healthcare, prevention, and care-seeking behavior. In limited resource settings, community-level interventions are potentially effective ways to address the problem at its roots, as decisions to seek and access healthcare are strongly influenced by the socio-cultural environment.

The Citizens Health Rights have been comprehensively provided for under Kenya's new constitutions under its various articles; 26, 42, 43, 53, and 56. However their realisations are pegged on effective empowerment of the vulnerable community members together with the national civil society to understand and actively assume their roles in the health service delivery. Devolved system of governments is therefore a recipe of enhanced service delivery to communities by timely addressing the real emerging challenges in various spheres of their lives.

The intent of devolution in Kenya embrace the recognition of the rights of communities to manage their own affairs and to further their development; protection and promotion of the interests and rights of minorities and marginalised communities. The motivation on health service devolution to the county level has been the promotion of access to health services throughout country while addressing the issue of discrimination of the rural communities, the problems of bureaucracy in matters of health service provision especially procurement related problems, promotion of efficiency in the delivery of health services and addressing the problems of low quality of health services. Therefore, the need for creating right governance and accountability structure for the county health service delivery is critical in making devolution and health service delivery a success. Proximity of county governments to the communities is assumed to have the vantage in involving communities to adjust service delivery models to their specific needs.

I must admit that community members still grapple with a lot of challenges as far as health service delivery is concerned. Among them highlighted by community members during the project training on social accountability include absence of prescribed medications at the facilities, shortages and frequent absence of health service providers, lack of sufficient equipments and necessary facilities for service delivery, distance or inaccessible roads to health facilities, lack of 24-hour delivery services to expectant mothers and insufficient information at the public health facilities.

This project on community participation in health service delivery by CUTS Nairobi has been very instrumental in steering the cultivation of capacity and necessary empowerment for the vulnerable groups so that they can actually engage in social accountability aspects of healthcare services at the county level. It has created a model that can easily be replicated in other counties and communities to greatly enhance health service delivery outcomes in the greater Kenya.

The project through health budget analysis, citizen report card and community monitoring has been very instrumental in identifying a number of issues that need to be addressed both at national level and within Kisumu County in order to realise quality health service delivery and outcomes. Some of these issues may be common to other counties and can be addressed using the same model of stakeholders' engagement. I cannot stress much on the concept of health service delivery social accountability since it has been an eye opener to most of the stakeholders at the county; it is an area that deserves attention in terms of resource allocation and actualisation at the community level within the sub counties by involving community members, health service providers, local and county level leadership in order to identify and conclusively address emerging health service delivery issues.

In conclusion, the assurance of equitable and quality health Service delivery to the marginalised community groups at the county level require a sustained empowerment of the marginalised groups in the community to be able to demand for good governance and accountability in the public health service delivery. This model of community monitoring is therefore critical in the establishment of challenges and constraints bedeviling the delivery of quality public health services and equitability in the distribution of resources in the rural public health facilities in Kenya and can easily be replicated to other counties and community.

Pradeep S. Mehta
Secretary General, CUTS International

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We are grateful to our colleagues, Clement Onyango for his continued support and assistance in taking the project forward, to Martha Getachew and Rosebella Oiro for providing insights into the project study analysis and reviews.

We are grateful for the support from the County leadership led by the Deputy County Speaker of Kisumu County Assembly; Honorable Pamela Amondi Omino and her colleagues, Hon. Salome Kamonya Magare, Hon. Charles Aguko for their unwavering support during the implementation of the Project.

Finally, at CUTS Jaipur (India), we are grateful to George Cheriyan, Rijit Sengupta and Om Prakash for their inputs and insights to the report and social accountability training component of the project, to Madhuri Vasnani and Mukesh Tyagi for helping us publish this report. Our Secretary General, Pradeep S. Mehta has continued to be dependable to us and has put in the Preface of this report.

Acronyms

ATI	Access to information
ANSA-AW	Affiliated Network on Social Accountability – Arab World
ANSA-SAR	Affiliated Network on Social Accountability – South Asia Region
ARVs	Anti Retrovirus
CMR	Citizen Monitoring Report
COMM GAP	Communication for Governance and Accountability Program
CoP	Community of Practice
CSOs	Civil Society Organisations
CUTs	Consumer Unity & Trust Society
DFGG	Demand for Good Governance Learning Network
EMACIGHES	Empowering Marginalised Community Groups for Inclusive Governance in Kenya’s Health Service Delivery
FOIANET	Freedom of Information Advocates Network
GoK	Government of Kenya
GPSA	Global Partnership for Social Accountability
ICESCR	International Covenant on Economics Social and Cultural rights
KNCHR	Kenya Commission of National Human Rights
KEPH	Kenya Essential Package for Health
MTEF	Medium term Expenditure
NACC	National Aids Control Council
NHSSP	National Health Sector Strategic Plan
PHCs	Public Health Centres
PLWHA	People Living With HIV AIDS
SASaNet	South Asia Social Accountability Network
USAID	United States Agency for International Development
WBI	World Bank Institute

Executive Summary

CUTS Nairobi implemented a project entitled 'Empowering Marginalised Community Groups for Inclusive Governance in Kenya's Health Service Delivery (EMACIGHES)' with the support from Akiba Uhaki Foundation. The project goal was to ensure equitable and quality health service delivery to the marginalised groups through community monitoring in Kenya. The project objectives included empowering the participation of marginalised groups (women, PWDs, PLWHAs, vulnerable youths) in demanding better governance and social accountability of public health service delivery in Kenya, enhancing equity and quality of public health service delivery through the use of a replicable community based health service monitoring model and establishing challenges and constraints bedeviling the delivery of quality public health services and equity in the distribution of resources in the rural public health centers in Kenya.

The project had two components comprising national health budget analysis and the Kisumu county level health service provision survey with community members and monitoring of health facilities. The project study was premised on both primary data from interviews with beneficiaries of public health services and key stakeholders, direct facilities observations and reviews of secondary literature including policy documents; reports and articles as well as evidence based primary data from the field.

The study analysed the allocation and expenditures for the health sector in Kenya with the reflection on the specific priority needs of marginalised groups including disabled, youths and women in the national budgetary allocation and the corresponding expenditure over the last 5 years. The study analysed the factors considered in the health sector budgetary allocations including who decides budgetary allocation and expenditure, state of involvement/participation of marginalised groups women, PWDs, PLWHAs, vulnerable youths in the health sector budgetary process, considerations for specific allocations in the health sector, existing parliamentary and departmental (including at the institutional level of county governance) accountability mechanism on allocation and expenditure and effectiveness of the existing accountability mechanism within the health sector.

It also highlighted on the challenges and opportunities for the realisation of equitable and quality health service delivery to the marginalised groups in Kenya through budgetary allocations. The county level component of the project involved community training on social accountability tools and community monitoring process, the perception survey on users of public health services at the community level and the state of play in terms of physical structures, equipments and other infrastructure available within the public health facilities.

Among the key findings is the below par national health budget allocation, lack of participation of community members in the health service decision making, absence of essential health service delivery equipments, medications/ drugs and high disease burden within the Kisumu county. It is therefore necessary that community members are empowered to be able to participate in ensuring accountability within the health sector and that both the national and county health budget to be increased to meet the current health needs in both the county and national level.

1. Introduction

The right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare to every citizen is provided for under chapter 43 (1)(a) of the constitution of Kenya. Under chapter 56 of the constitution, the state has the responsibility of putting in place affirmative action programmes designed to ensure that minorities and marginalised groups have reasonable access to health services. The fourth schedule on the distribution of functions between the national government and the county governments allocate to the County government responsibilities over the county health facilities and pharmacies; ambulance services; promotion of primary healthcare; licensing and control of undertakings that sell food to the public; veterinary services (excluding regulation of the profession); cemeteries, funeral parlours and crematoria; and refuse removal, refuse dumps and solid waste disposal.

The National Health Policy takes into account the health requirements set out in the Constitution together with the long term health goals set out in the country's development blue print- vision 2030. Its overarching goal is to attain the highest possible health standards in a manner responsive to the population needs with the aim of achieving provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans.

The vision of performance contract between the government of Kenya and the ministry of health for the period July 2013 to June 2014 is to realise a healthy and globally competitive nation. Its purpose is to establish the basis for ensuring efficient and effective service delivery to Kenyans in line with the provisions of the Constitution and by requiring Ministries, Departments and Agencies to adopt human rights approach to service delivery and focus on ensuring that systems are established to realise equality among all users of public services; impartiality and fairness in the process of delivery of public services; continuity of public services under all circumstances; establishing systems to enable adaptability of public services to the needs of users; ensuring professionalism and ethics in Public Service is achieved and maintained; establishing systems to ensure promotion and protection of rights of users of public services and public servants as enshrined in the Bill of Rights; institutionalising a culture of accountability, integrity, transparency and promotion of values and principles of public service; ensuring effective, efficient and responsible use of public resources, and responsiveness by public servants in delivery of public services.

The national development plan-Kenya Vision 2030 emphasises the need for community participation in order to meet national development objectives. Good health is the building block for community development and lack of it impair the participation of marginalised groups (women and youths) in planning, implementation, and the maintenance of a sustainable pattern of their development. A critical factor of health-related initiatives in Kenya is the cultivation of the capacity and necessary empowerment for women and youths so that they can effectively engage in social accountability aspects of healthcare services. This can only be realised by empowering them together with the civil society of Kenya to understand and assume their roles in the health service delivery.

The healthcare service in Kenya is defined by the Kenya Essential Package for Health (KEPH), which is based on a life cycle approach to deliver a comprehensive healthcare package across all levels of healthcare. The government is the main provider of healthcare services, despite the existence of other private for-profit and the private not-for-profit providers serving a significant proportion of the Kenyan population.

The country health service delivery system is made up of six levels namely Level 1 comprising of Community health facilities, level 2 made up of dispensaries, level 3 comprising of Health centers, level 4 made up of district (primary) referral facilities where as level 5 and 6 comprise of provincial (Secondary) referral facilities and national (Tertiary) referral facilities respectively.

In a bid to enhance quality health service provision in Kenya, public healthcare policy in Kenya has witnessed many reforms. The Kenya Health Policy Framework of 1994 had an overall goal of promoting and improving the health of all citizens through restructuring of the sector to make all healthcare services more effective, accessible and affordable by 2010 with a focus on increasing community participation in service delivery. It had its implementation segmented in two phases i.e. from 1999-2004, and from 2005-2010.¹

In 1996, the Ministry of Health launched a Community Participation Strategy document with an objective of building the capacity of citizens to demand better services and to know and progressively realise their right to equitable, good quality public healthcare service. The Second National Health Sector Strategic Plan of Kenya (NHSSP-II, 2005-2010) was developed to address health-related challenges so as to reverse the downward trend in health-related outcome indicators with a specific focus to increase equitable access to healthcare services; improve the quality and responsiveness of those services; enhance the efficiency and effectiveness of service delivery; and Increase the financing of the healthcare sector.

Kenya is a state party to a number of international conventions including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the African Charter on Human and Peoples' Rights as well as other human rights treaties. Appreciating that states have different levels of resources, the ICESCR provides that the rights guaranteed by it, including the right to health, are subject to "progressive realisation," meaning that a state should "take steps to the maximum of its available resources" to achieve full realisation of this right. Kenya's Constitution incorporates international law into national legislation in article 2(6) which allows the application of all ratified conventions and treaties. In addition, article 42 provides that "every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare.

Though the national budget has been in constant increase, the ministry of medical services responsible for providing curative services to all the over 40 million Kenyans has witnessed a reduction in budgetary allocation from 22 billion in the 2009-2010 budget to 21 billion. In addition, the health sector budgetary allocation as a percentage of the total budget has seen a drop from 7.0 percent in 2009-2010 to 6.5 percent in the 2010-2011 budget.^{i,ii}

¹ <http://www.smartglobalhealth.org/pages/kenya-mission/kenya-health>

Life expectancy at birth stands at 59.48 for the total population whereas male: 58.91 years and female: 60.07 years (2011est.). However in 2011-2012, the Health Ministry has received Sh85bn, an increase of Sh12.3bn from the previous financial year, to recruit an additional 5,200 health workers, allowances, and construction of more health facilities.

Notwithstanding the reforms by the government and the incremental budgetary figures, there is still evidence of a mismatch between government spending and desirable outcomes. The State of Kenya Consumer Report 2012 has shown that public health service provision present severe challenges to consumers in the country. A similar situation is reiterated by the USAID report on Maternal Health in Kenya³ which indicates that approximately 14,700 women and girls die each year due to pregnancy-related complications while another 294,000 to 441,000 women and girls will suffer from disabilities caused by complications during pregnancy and childbirth each year.

The limited progress in the health related outcomes in Kenya are attributed to a number of factors; key being the deficiency in service delivery to the end users hindering the translation of funds to desired outcomes. Recent studies have indicated that tens of thousands of children in need of anti-retroviral treatment are still not accessing life-saving drugs.⁴

Access to emergency obstetric care is also inadequate, especially for poor women and girls in rural areas⁵. In all cases, and like in both least developed and developing countries, it is the women and youths in Kenya who faces the greatest brunt in terms of inefficiencies and high cost in accessing quality health services owing to their limited disposable income and a less effective public healthcare service delivery system.

Despite somewhat impressive reform, major public health facilities continue in a sorry state. There is hardly information on planning, financing and implementation of services available to the public. There is only just a demand on the part of civil society for good governance and social accountability of health services mainly due to limited capacity to understand the issues of governance and social accountability in the healthcare sector. While there is general laxity or failure on the part of the ministries of health and the institution of local governance to engage all stakeholders (particularly women and youths) in setting priorities and taking part in decision-making process, it is also true that there is no demand for such engagement.

The State of Kenya Consumer Report 2012 exposes general lack of awareness on the part of consumers on their rights and responsibilities as it relates to health service provision and redress process. This has not only retarded the quality of health service provision but has also created room for irresponsible behavior by health service providers in many public health institutions. Therefore, the challenge of enhancing capacity of the marginalised consumer groups with knowledge on social accountability mechanism to enable them take part in demanding quality and accountability in the health service provision in Kenya is timely.

² <http://www.standardmedia.co.ke/?articleID=2000059886&pageNo=2>

³ <http://kenya.usaid.gov/sites/default/files/USAIDKenyaHealthstats%20may10.pdf>

⁴ Human Rights Watch, A Question of Life or Death. Treatment Access for Children Living with HIV in Kenya, December 2008,

⁵ Human Rights Watch, "I am Not Dead But I am Not Living": Barriers to Fistula Prevention and Treatment in Kenya, July 2010

Study by USAID⁶ (2010) on improving resource allocation in Kenya's public health sector, recommended the need to promote women's participation in decision making at the decentralised level while educating political and community leaders about the benefits of women's involvement in planning and management of health service programs. It also pointed out the need for targeted efforts to support and promote female representation in areas with high levels of poverty to encourage compliance with legal mandates for representation. It further echoed the need for further research on key factors that foster women's participation to develop advocacy and support measures to integrate women into decision making processes.

It is on this background that this project to empower women and youths to participate in the governance process in Kenya's health service delivery was conceived and implemented by CUTS Nairobi office with the support from Akiba Uhaki Foundation. The project goal was to ensure equitable and quality health service delivery to the marginalised groups through community monitoring practice in Kenya. The project objectives included empowering the participation of marginalised groups (women, PWDs, PLWHAs, vulnerable youths) in demanding better governance and social accountability of public health service delivery in Kenya, enhancing equitability and quality of public health service delivery through the use of a replicable community based health service monitoring model and establishing challenges and constraints bedeviling the delivery of quality public health services and equitability in the distribution of resources in the rural public health centers in Kenya.

The project had two components comprising national health budget analysis and county level health service provision survey with community members and facilities monitoring in Kisumu County. The project study was premised on both primary data from interviews with beneficiaries of public health services and key stakeholders, direct facilities observations and reviews of secondary literature including policy documents; reports and articles as well as evidence based primary data from the field.

CUTS and its Global Governance Profile

CUTS International (Consumer Unity & Trust Society) established in 1983, is a non-profit, non-governmental organisation working on public interest issues. Governance is one of its programmatic areas of which has realised major successful interventions. Starting its endeavours from state of Rajasthan in India, the organisation moved to the regional level at South Asia and now it is widely recognised as a resource organisation at the global level for its capacity of producing consistent results in the area of enhancing transparency and accountability, expertise in imparting skills to use social accountability approaches and strengthening the practices of social accountability.

Various endeavours of CUTS are helping the region in accelerating the speed of such work to improve development outcomes. The global initiative for governments, donors and civil society organisations (CSOs) facilitated by The World Bank called 'Global Partnership for Social Accountability (GPSA)' has recognised CUTS for its work and made it the global partner of GPSA. It has been included in the roster of experts.

⁶ http://www.healthpolicyinitiative.com/Publications/Documents/1115_1_Kenya_Resource_Allocation_FINAL_05_13_10_acc.pdf

The current phase of CUTS' interventions is distinguished for variety of use of social accountability (SAC) approaches at all levels of governance through enhancing voice power of citizens to engage them for obtaining better services, rights and entitlements as well as for improving transparency, combating corruption and improving service delivery through building capacity of people for utilising access to information (ATI). It is now prominently playing the role of mentor among the countries of South Asia, East Asia and Africa. It is anchoring the regional community of practice (CoP) on social accountability (Accountability Solutions) for south Asia and building capacity of representatives of government and CSOs mainly from the south Asian countries.

CUTS International is having affiliations with a number of networks operational at the national and international level including

- South Asia Social Accountability Network (SASANet)
- International Resource team on SAC of the World Bank Institute (WBI)
- Communication for Governance and Accountability Program (CommGAP)
- Demand for Good Governance (DFGG) Learning Network
- Affiliated Network on Social Accountability – South Asia Region (ANSA-SAR)
- Affiliated Network on Social Accountability – Arab World (ANSA-AW)
- Freedom of Information Advocates Network (FOIANET)

2. Project Overview

Project Goal

This project on empowering marginalised Community groups for inclusive governance in Kenya's health service delivery (EMACIGHES) was conceived with a goal to ensure equitable and quality health Service Delivery to the marginalised groups through Community Monitoring in Kenya.

Project Objective

The project was set to realise the following objectives:

Enhancement/empowerment of the participation of marginalised groups (Women, Persons with disabilities (PWD), People living with HIV and AIDS (PLWHA), the Elderly and vulnerable Youths), in demanding better governance and social accountability within the public health service delivery framework in Kenya.

Enhancing equitability and quality of Public Health Service Delivery through the use of a replicable community based health service monitoring model.

Establishment of challenges and constraints bedeviling the delivery of quality public health services and equitability in the distribution of resources in the rural public health centers in Kenya.

Activities

The project had a number of activities undertaken during the period for the realisation of the set objectives. These included:

Budget Analysis: the annual budget for public healthcare service delivery in the Kenya for the last five years was analysed to understand the nature and extent of allocation and corresponding expenditure – to ascertain whether they are as per priority needs of various consumers groups. Other than a quantitative analysis (including a disaggregated analysis of revenue and capital expenditure), there were qualitative analysis of factors such as who decides budgetary allocation and expenditure, how they are decided, existing parliamentary and departmental (including at the institutional level of local governance) accountability mechanism on allocation and expenditure and how effective that mechanism is.

Citizens' Report Card (CRC): is a simple but powerful tool to provide public agencies with systematic feedback from users of public services. By collecting feedback on the quality and adequacy of public services from actual users, CRC provides a rigorous basis and a proactive agenda for communities, civil society organisation or local governments to engage in a dialogue with service providers to improve the delivery of public services.

The pre-defined CRC was used to collect feedback on the quality and adequacy of public health services from the community members within Kisumu County. It involved asking the community members about their perception/level of satisfaction on various services

delivered at the PHCs. The study employed the use of both random and purposive sampling of users of public healthcare services in communities within Kisumu County to score different attributes of those services and what users want to do to improve their quality. It involved face to face interview with regular users of public healthcare services within Kisumu County. Samples of 200 users were interviewed for the purpose of this analysis.

Interviews with potential beneficiaries, Policy Makers and Practitioners: there were informal interviews and meetings with potential beneficiaries (including women who were pregnant or have undergone childbirth in the recent past, or those with small children) to understand their experiences and problems faced, as well as assess the extent to which key services were being delivered. A selected number of policy makers and practitioners were interviewed to understand their views and concerns about improving the governance and social accountability of public healthcare service delivery in Kenya. These interviews focused on the steps to be taken to improve the quality of public healthcare service delivery in the country.

Community-Focused Monitoring Training Workshop: the training involved sharing on the best practice models from India on how community can participate to enhance the quality of public health service delivery. The training focused on the marginalised community groups within the county together with elected representatives of county assembly. There were discussions on the application of social accountability tools and lessons drawn from the experience of CUTS International's work on this subject in India and other parts of South Asia employed. The beneficiaries were then introduced to CUTS documentaries on good governance and social accountability in the health service delivery in which they were able to practically see on how other communities engage in similar situations in India.

Citizen Monitoring Report (CMR): The recipients of the community focused training eventually formed part of the monitoring cell and were engaged in the implementation of citizen monitoring report. The CMR were used to note down the absence/ presence of services and the state of facilities at the various selected public health facilities within Kisumu County during the survey. All the services people are entitled to get at a PHC were mentioned in the CMR.

3. Scope and Methodology

What is Community Report Card?

It is a qualitative monitoring tool that is used for local level monitoring and performance evaluation of services, projects and even government administrative units by the communities themselves. The process is a hybrid of the techniques of social audit, community monitoring and citizen report cards. It is an instrument to exact social and public accountability and responsiveness from service providers. However, by including an interface meeting between service providers and the community that allows for immediate feedback, the process is also a strong instrument for empowerment.

The project had two each at the national and county level. The national level components involved national health budget analysis whereas the county level component involved community health service delivery monitoring training, health service provision survey (CRC) and facilities monitoring (CMR) within selected health facilities in Kisumu County. Under health budgetary analysis, the study involved both quantitative and qualitative analysis of allocation and expenditure for the health sector in Kenya over the last five years together with reflection on the specific priority needs of marginalised groups including disabled, youths and women in the national budgetary allocation over the last five years and corresponding expenditure, qualitative analysis of factors considered in the health sector budgetary allocations including who decides budgetary allocation and expenditure, state of involvement/participation of marginalised groups (women, PWDs, PLWHAs, vulnerable youths) in the health sector budgetary process, considerations for specific allocations in the health sector, existing parliamentary and departmental (including at the institutional level of county governance) accountability mechanism on allocation and expenditure and the effectiveness of the existing accountability mechanism within the health sector together with the challenges and opportunities for the realisation of equitable and quality health service delivery to the marginalised groups in Kenya through budgetary allocations.

The county component of the project involved community training on social accountability tools and community monitoring process, baseline survey involving collection of both primary data through interviews with beneficiaries of public health services and key stakeholders, observations at the public health facilities and reviews of secondary literature including policy documents; reports, journals et al. This was basic assessment on the state of play in terms of public health service delivery, challenges and opportunities for enhancing community participation in Kisumu County of Kenya via community monitoring report and citizen report cards. The main focus was on the perception of users of public health services at the community level and the state of play in terms of physical structures, equipments and other infrastructure available within the public health facilities.

The development of Citizen Report Card employed the use of both random and purposive sampling of users of public healthcare services in communities within Kisumu County to score different attributes of those services and what users want to do to improve their quality. The recipients of public health services including expectant women, new mothers, men, youths, disabled and the old were asked about their perception/level of satisfaction in relation to health services at the community health facilities. Over 201 respondents were

engaged in the CRC survey based on their experience in public health services within their community public health facilities at the county.

The Citizen Monitoring Report implementation was undertaken within twelve (12) public health facilities which were selected on a random sampling basis. Each of the selected public health facilities was observed four (4) times in a span of six days during official working hours by the members of community monitoring cell (CMC) comprising of four (4) unemployed educated members of the community oriented for monitoring. Each monitor was strictly instructed to make unannounced visits to two different health facilities every day. The data was then coded, entered and analysed using statistical package for social science.

Data Collection

The study team prepared structured questionnaires for the three categories of respondents including Citizen Report Card, Community Monitoring Report and key Respondents Feedback which was in line with the study objectives. The study interviewers were then trained on the procedures and contents of the research tools before they were later engaged in a pilot survey of questionnaires in Kisumu. This was vital in acquainting the interviewers with the issue at hand and prepares them to administer the questionnaires more effectively and efficiently in the field. The pilot survey also granted them chance to further interrogate some of the questions in order to gather as much relevant information as possible.

The team engaged in unplanned visits to health facilities for observations on the parameters of study and for interviews with recipients/community members at the health facilities. The research team also scrutinised existing relevant documentations including reports, various policy documents, and newspaper articles and internet sources. The purpose of the documentary review was to collect published data and other relevant information on the subject as a basis for further verification and clarifications during the interview process.

Major documents were obtained from the health sector and health sector stakeholders websites. Other secondary sources of data used in this study included the Constitution, key documentation guiding the health sector in the country, various legislations and reports, publications by various consumer organisations, etc.

Study Limitation

The implementation of the project activities had its share of challenges. Some community members had unfounded fear and refused to disclose information to our research team. Some key respondents also excused themselves on the basis of other prior commitments hence unavailable for the interviews.

The limited financial resources denied the possibility of conducting a comprehensive county level survey on community health issues. The research team therefore randomly and purposively sampled those who were found at the health facilities to gather their perception of the health services.

Difficulty in accessing some health centers during the implementation of CMR and CRC owing to downpour over the period. Our research team had to wait longer for the weather to improve before they could go to those facilities to conduct studies. They also shifted their

plans to deal with those particular facilities were transport system was not so disrupted by the rains.

There were a lot of suspicions by staffs at health centers to an extent that in some centers like Manyuanda health center, our investigators were locked out of the facility. In some instance, one of our investigators was arrested in Manyuanda and locked in a police cell at Kombewa police post on orders by the medical officer in charge at the facility in which he was forced to disclose the contents of the study. The in-charge then went through the filled up questionnaires both CMR and CRC to establish the nature of information that was being collected. It took the efforts of CUTS, Kenya Consumer Organisation representative and the area ward representative to have him released. In mitigating this problem, our investigators had to make unplanned visits while pretending to be patients to make their observations at the same time having discussions with other patients at the facility or outside facilities on their experiences.

In view of the stated limitation, some issues were not comprehensively addressed in this report. Nevertheless the study team managed to detail all the information gathered in reaction to the study objectives. The team managed to establish a number of findings and recommendations to improve the health service delivery at both national and county level.

4. Project Findings

The national health system in Kenya has for long been centralised with key ministries making key decision in policy development, coordinating the work of all sector players while at the same time initiating and taking charge of the actualisation of new policy decisions including implementation of policy guidelines on a range of issues similar to charging of user fees, and undertaking monitoring and evaluation on the impact of policy adjustments at the district level.

The new constitutional dispensation provides for devolution of specific functions to the county governments. Among the functions include the overall responsibility on the running of county primary health facilities, primary health programmes, clinical programs, pharmacies, ambulance services, promotion of primary healthcare at the county level including family planning, maternal and child health, health education, rural health and training centers, nutrition, food safety through licensing and control, veterinary services excluding regulation of the health profession, cemeteries, funeral parlors and crematoria services at the county level. The health service functions now left for the national government include health policy formulation, management of national referral health facilities, veterinary policy formulation, health training institutions, provincial hospitals and HIV issues.

Nevertheless the new county governments have now to grapple with a range of challenges in their quest to provide quality health services to the vulnerable communities. The situation is attributed to the pre-devolution's state of unbalanced development in the country in relation to uneven distribution of health resources including the health facilities, human resources, and poorly developed communication infrastructure in various counties. The disproportionate poverty level across the country is another major hindrance to accessibility of health services by majority of the population owing to high cost.

In the wake of government's commitment to provision of accessible and affordable health services in the country by way of waiving the maternity fees in all the public health institutions, lack of sufficient equipment and drugs has remain a major obstacle in the realisation of quality health services to its citizens. Health workers have constantly voiced their plight in relation to poor remuneration which has led to frequent nationwide strikes jeopardising access to health services in the country. The situation is not made better when women still find themselves in very pathetic situation as some of them are being forced to deliver their babies on the floor in district hospitals. Not to mention is the shocking video footage in September 2013 which showed a woman delivering a baby on the floor of Bungoma District Hospital while the nurses in attendance slapping her to walk to ward to finish the delivery process.ⁱⁱⁱ

The county health budget allocation is also lacking in terms of adequacy of data on the actual requirements for quality health services as they were drawn in record time just to facilitate allocation of funds without effective consultation on the information on the real demands that informs the policy development process at the county level.

For poor patients who seek treatment at lower-level health facilities but cannot be diagnosed or treated there, they are often asked to pay for their own transport to a higher-level health facility. The health system also suffers from lack of properly trained and compensated community health

workers despite the key role they play in reaching out to patients, including children, informing them about healthcare options, and convincing them to seek healthcare for themselves or children in their care. User fees for tests, drugs, and medical procedures are another obstacle for many patients⁷ in access to health services at both county and national levels.

According to the international budget partnership statistics, all the 47 counties in Kenya are below the country's targeted doctor's population ratio of 36 doctors per 100,000 populations. The country is still stuck at 8,600 registered medical doctors – for more than 40 million populations when only 4500 of those doctors in the payroll as per the medical practitioners and dentists board records. Public hospitals in Kenya continue to struggle with the provision of life-saving medical services to a large, mostly poor population of patients, in the wake of persistent standoff between county governments and doctors over the devolution of health services persist.^{iv}

As stated by the secretary general of Kenya medical practitioners and dentist association, over 201 doctors had resigned from public hospitals in protest over the manner in which devolution of health services to county governments has been crammed with mismanagement, nepotism in the hiring of new doctors, frozen promotions and reduced or delayed salaries.

The devolution of health services failed to follow the constitution, which requires the process to be implemented gradually over three years. According to the parliamentary health committee chairperson, the committee review established that devolution of health services to county governments was rushed in spite of their inability. They should have taken the three-year window provided in the constitution to prepare and systematically devolve medical services. This should have allow effective stakeholders consultation on the priority health needs of the community and better devolution process of the health services at the county level.

Key Findings

Country (National) Level

- 1) National health budgetary allocation has been increasing but is still way below the Abuja declaration target of 15 percent of total expenditure. This has seen many public health facilities lacking in terms of basic essential infrastructures, facilities, equipments, prescription medications/drugs, poor remuneration to health workers leading to frequent national strikes as public health facilities and general reluctance of public health workers.
- 2) Actual national health expenditures are much lower than the approved expenditures. This implies possible inefficiencies either in the financial system that hinders release of funds to the health programmes, or the government is not effectively implementing their program work that ensures all expenditures are exhausted.
- 3) All the 47 counties in Kenya are below the country's targeted doctor's population ratio of 36 doctors per 100,000 populations. The country is still stuck at 8,600 registered medical doctors – for the more than 40 million populations when only 4500 of those doctors in the payroll as per the medical practitioners and dentists board records.

⁷ <http://www.hrw.org/news/2011/04/14/kenya-submission-government-health-budget>

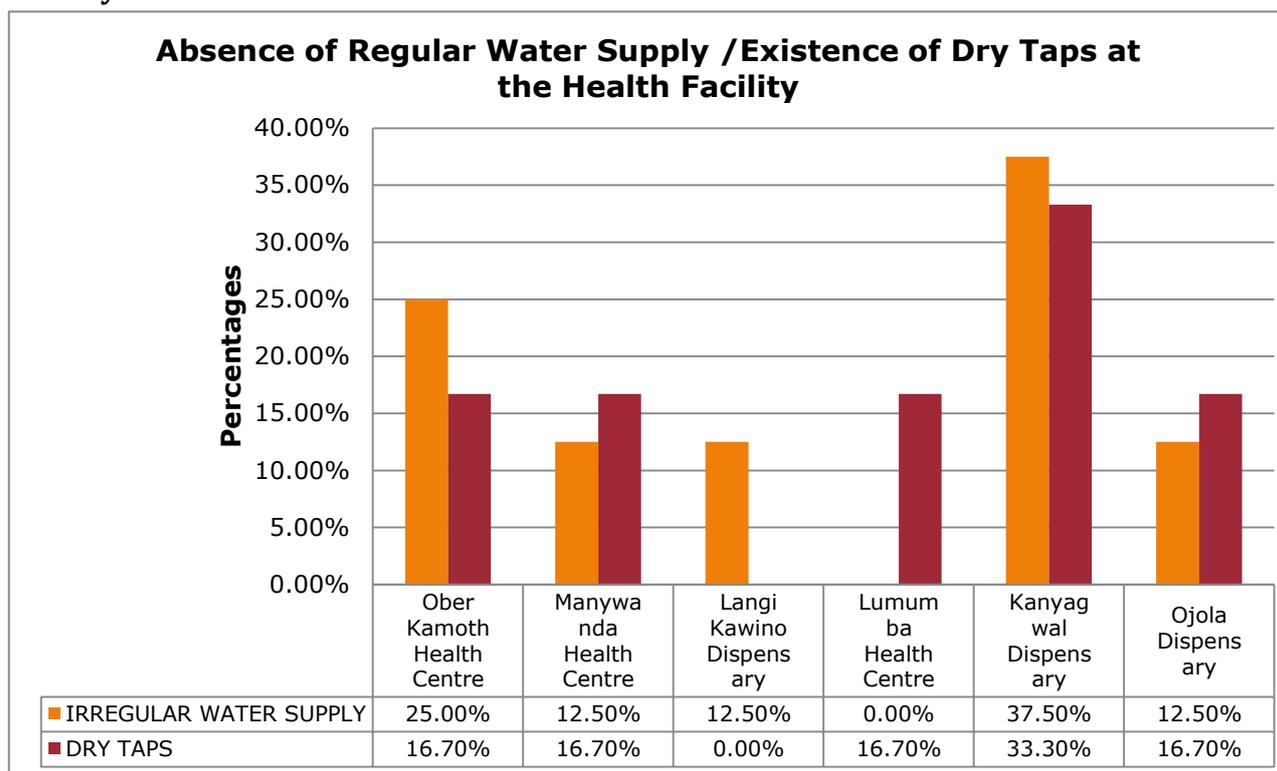
- 4) Most of the county health budgets are lacking in terms of adequacy of data on the actual requirements for quality health services as they were drawn in record time just to facilitate allocation of funds without effective consultation on the information on the real demands that informs the policy development process at the county level.
- 5) Health service devolution to county governments has been rushed without effective stakeholders consultation on the priority health needs of the community and in disregard to the time frame stipulated in the constitution. Other issues raised include nepotism in the hiring of new doctors, frozen promotions and reduced or delayed salaries.
- 6) Expectant women continue to receive cruel treatment by health service providers at Public Health Facilities Across the country.

Kisumu County Level

- 7) The community members are over burdened by curative diseases at 47.26 percent followed by child health at 26.71percent.
- 8) Despite pre natal clinic registration, only about 41 percent made substantive visits of between 4 to 9 times to prenatal clinics before delivery with majority of about 30 percent making only 4 visits.
- 9) About 11 percent of the expectant women were not taking the supplements in spite of attending prenatal services.
- 10) Despite attending the prenatal clinic, 19.23 percent of women were not exposed to any laboratory check-up for blood or urine related tests regardless of its benefits in detection of possible infections including HIV and other medical complications such as high sugar/protein level and opportunity for earliest possible medical intervention.
- 11) Over 19 percent of community members do not have the knowledge on membership of community health committees.
- 12) Over 37 percent of community members reported absence of prescribed medication at the facilities.
- 13) Over 47 percent of community members are either dissatisfied or partially satisfied with public health service delivery in Kisumu County.
- 14) Over 7 percent confirmed having engaged in payments of bribes to secure health services at the public health facility.
- 15) About 69 percent of the bribe payment was demanded by health service providers while 31 percent were voluntary bribe to facilitate action by health service providers.
- 16) Majority of respondents (over 33 percent) paid Kshs. 100 for bribe, 20 percent paid Kshs. 500 whereas over 13 percent paid Kshs. 200 for health services. The remaining component of respondents paid varied amount in the range of kshs.50- 450 for the health services.
- 17) There is general apathy by community members on the issue of complaints as majority (over 73 percent) have never complained about poor health services provision in the county. This general apathy may be attributed to lack of awareness or lack of confidence by community members on the existing institutions or systems of redress relating to health service issues.
- 18) Over 52 percent of the complaints either had delayed or no response from the relevant officers.
- 19) There is greater preference (94 percent) to public health facilities by community members as opposed to other alternatives (5.97 percent) in the neighbourhood.

- 20) Over 38 percent of the respondents held the feeling that medical equipments within public health facilities are either inadequate or not good enough to perform their functions.
- 21) Irregular water supply or existence of dry taps is a major challenge to most of the public health facilities in the county.

Figure 1: Absence of Regular Water Supply/Existence of Dry taps at the Health Facility



- 22) Communication system remains a challenge among many public health facilities at the county. Over 80 percent of the health facilities either lacked the telecommunication equipments or they were out of order or relied on personal mobile phones for health service providers.
- 23) Emergency preparedness remained a key challenge to most of the public health facilities as they continue to lack basic necessities including gloves, post-delivery sanitary pads, ambulance facility, under five years vaccine and their storage facility/ fridges, lacked proper waste disposal mechanisms.
- 24) Some health facilities were lacking on basic requirements in terms of sick bed, inpatient's beds, laboratory and its equipments and reagents.
- 25) Either there was no clear information displayed on charts or they were not displaying sufficient information enough to properly guide patients on the services offered and where to get them at the facilities
- 26) existing information chart failed sort in defining the ministry's, core functions, services offered, commitments, obligations, customer's rights and obligations, mechanisms for complaint and redress for any dissatisfied community member.
- 27) The health system also suffers from lack of properly trained and compensated community health workers despite the key role they play in reaching out to patients, including children, informing them about healthcare options, and convincing them to seek healthcare for themselves or children in their care.
- 28) User fees for tests, drugs, and medical procedures are another obstacle for many patients⁸ in access to health services at both county and national levels.

⁸ <http://www.hrw.org/news/2011/04/14/kenya-submission-government-health-budget>

- 29) Serious structural imperfections in Kenya's health system as access to healthcare are often compromised by a dysfunctional referral system between health facilities.
- 30) Poverty as another major challenge to access of health services by majority of the population.
- 31) User fees for tests, drugs, and medical procedures are another obstacle for many patients in access to health services at both county and national levels.

Key Learnings

The community monitoring training was very useful in capacity development, awareness creation and getting insights into some of the challenges faced by beneficiaries at the health facilities. It provided a platform for consumers, providers and county leadership to engage directly on issues bedeviling community in health service delivery.

Implementation of Citizen Report and Monitoring Cards has been very useful in exposing the state of play in the health service provision. This background will be very useful in the development of a model that will help address the current issues affecting the system of health service delivery in Kisumu County and that which can be replicated in other counties.

Interviews with key stakeholders at the county level have been very useful in terms of getting their views on the health services at the county level. This will be considered while developing recommendations for improving the health service provision to the vulnerable community groups.

5. Lessons Learnt

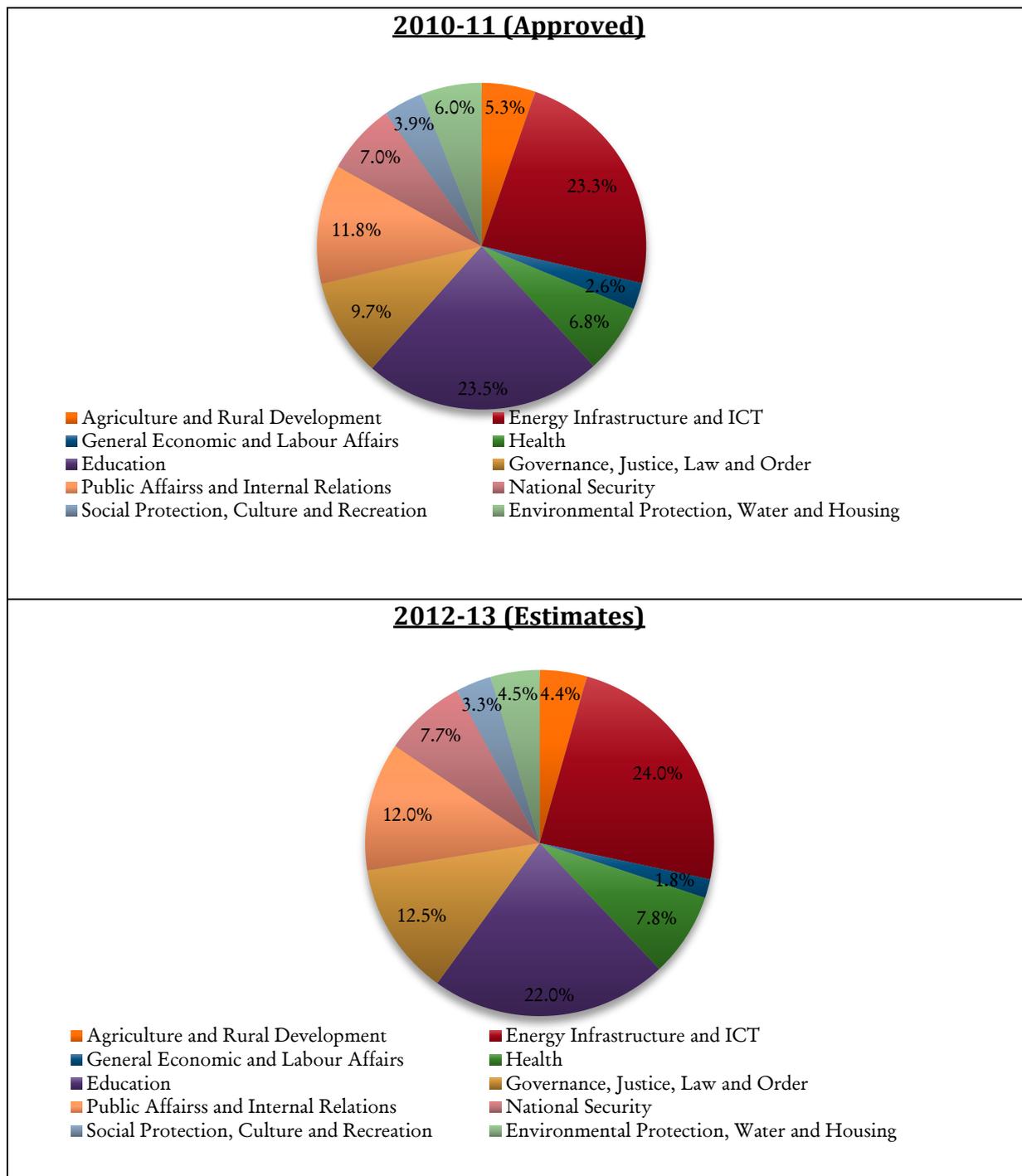
- More time and resources needed to have been allocated for effective implementation of community monitoring and citizen report card at the county level.
- Community monitoring trainings needed to have been planned to cover the sub-county and at location levels where local health facilities are established and where majority of vulnerable groups can be met to benefit and apply the knowledge. This would lead to a greater impact on the beneficiaries. Therefore more resources are necessary to realise the same in line with requests from county leadership made during the pilot training in Kisumu.
- There is value in using frequent visitors and common recipients of health services in administering citizen monitoring card to avoid suspicion, hostility and non-cooperation by health service providers.
- It is a good practice not to divulge any indicative information or prior hint into possibility of undertaking such activity at the health facilities over time to health service providers in order to achieve a true representation of the reality at the facilities.
- These lessons have been discussed internally among the staffs involved in this project at CUTS and will be seriously considered in subsequent interventions. We will therefore seek for more resources to undertake devolved training on community monitoring at sub county and location level to create a greater impact.

6. National Health Sector Budget

Kenya Health Sector Budget Analysis

The health sector spending in Kenya (i.e. Ministry of Health and Sanitation and Ministry of Medical Services) has been increasing gradually as shown in Figure 1. Education and Energy, Infrastructure and ICT sector receive the largest allocation in the last three years.

Figure 2: Sectoral Budgetary Allocation



Source: Budget Policy Statement (Various)

The health sector ranks sixth in terms of amount of budget allocated to the sector as a proportion of total government budget in 2010-11. In 2012-13 the sector moved one step higher to the fifth rank. Even though the health budgetary allocation has been increasing, it is still way below the Abuja declaration target of 15 percent of total expenditure. Table 1 further provides detailed health sector actual expenditures for the last five years.

In 2007-08 the actual total health spending was approximately 26.6 billion, this amount increased to 51.5 billion according to the 2010-11 approved estimates. Recurrent expenditure still constitutes a large portion of total health expenditure, even though it is decreasing. In 2007-08, recurrent expenditure constituted approximately 72 percent of total health expenditure, this reduced to 60 percent in 2011-12. Actual development expenditure has more than doubled between 2007-08 and 2010-11.

The health sector spending as a proportion of total government expenditure has averaged 5.5 percent during the same period. The non-wage component of approved health spending increased from 43 percent in 2007-08 to 70 percent in 2011-12. This implies that there are more health inputs being used in services delivery. A lower wage component could also mean that the healthcare personnel are stretched. Currently there are 0.2 physicians per 1000 in Kenya as compared to Cuba with 6.7 per 1000, World Bank (2010). Health expenditure reduced in 2007-08 by 40 percent from the previous financial year.

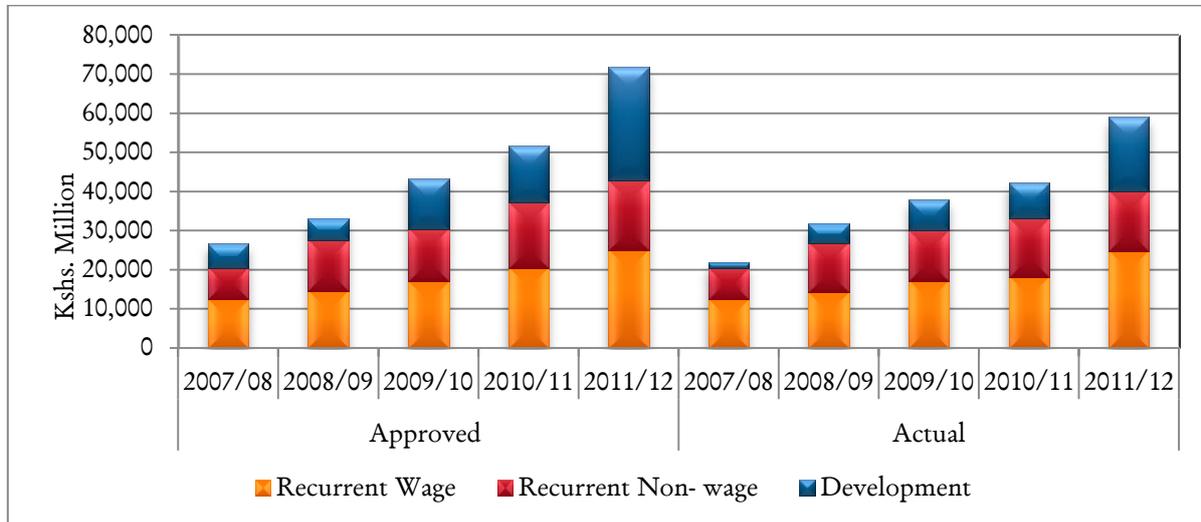
Table 1: Recurrent and Development Health Expenditure (Kshs. Millions)

	Approved					Actual				
	07/08	08/09	09/10	10/11	11/12	07/08	08/09	09/10	10/11	11/12
Recurrent	20,430	27,632	30,443	37,149	42,830	20,257	26,927	30,001	33,111	40,016
Wage	12,457	14,670	17,062	20,447	25,060	12,451	14,245	17,194	18,142	24,885
Non- wage	7,973	12,962	13,381	16,702	17,770	7,806	12,682	12,807	14,969	15,131
Development	6,137	5,313	12,897	14,429	28,922	1,461	4,870	7,836	9,089	18,888
HEALTH	26,567	32,945	43,340	51,578	71,752	21,718	31,797	37,837	42,200	58,904
Total GOK						534,842	595,719	725,201	819,624	947,777
Wages/ HEALTH	29.6	39.3	28.6	24.3	30.4	32.2	34.9	53.4	29.6	42.3
Non-wage/ HEALTH	42.9	42.0	41.7	47.7	69.6	67.8	65.1	46.6	70.4	25.7
Recurrent/ HEALTH	72.4	81.4	70.2	72.0	59.8	81.4	84.5	77.2	67.9	67.9
Development/HEALTH	27.6	18.6	29.8	28.0	40.2	18.6	15.5	22.8	34.0	25.7
HEALTH/Total GOK						5.5%	5.4%	5.4%	5.7%	6.2%

Source: GOK Estimates (Various)

Figure 2 compares actual and approved expenditures. The actual expenditures are much lower than the approved expenditures. This implies that there are inefficiencies either in the financial system that hinders release of funds to the health programmes, or the government is not effectively implementing their program work that ensures all expenditures are exhausted.

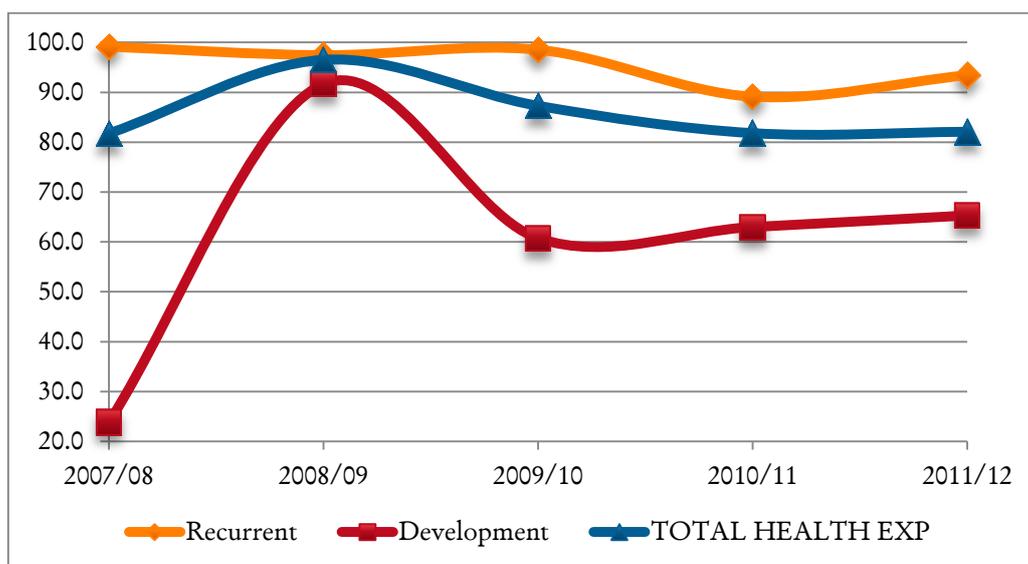
Figure 3: Health Sector Recurrent and Development



Source: GOK Estimates (Various)

The health sector absorption rate given by the proportion of actual to approved expenditure remains mixed as shown in figure 3. The absorption rate of health spending increased during the period 2007-08 to 2008-09 where it stood at 96.5 percent. This increase in absorption particularly the development expenditure can largely be attributed to increase in health spending associated with the drought that saw increased spending, in order to mitigate the health related outcomes of the drought. Recurrent expenditure absorption rate has been increasing with 2010-11 recording 89 percent absorption.

Figure 4: Health Sector Expenditure Absorption Rate



Source: GOK Estimates (Various)

Table 2 further gives a summary of health sector spending by economic classification. The government has allocated more finances to curative health as compared to preventive health. More funding allocated to curative healthcare could imply that the government has geared its health policy towards curative healthcare; on the other hand it implies that curative healthcare demand is driven by the population's disease burden. This implies that the government policy is geared towards curative healthcare or the healthcare situation is driven by the health curative health needs of the population.

Table 2: Recurrent and Development Health Spending by Economic Classification (Million)

	Actual			Approved	Estimates
	2008-09	2009-10	2010-11	2011-12	2012-13
General Admin. & Planning	2,315	2,356	9,885	8,667	9,119
Curative Health	17,507	19,203	17,874	17,527	25,736
Preventive Medicine & Promotive Health	4,428	5,203	5,519	15,766	18,096
Health training and research	1,162	1,180	2,394	2,394	3,131
Medical Supplies Coordination Unit	457	460	459	471	482
Referral Hospitals	4,649	4,940	8,763	8,411	7,664
Disease Control services	114	141	147	280	322
Primary Health services	1,271	5,657	7,442	10,332	14,714
Technical support services	39	166	100	174	172

Source: GOK (Various)

Preventive medicine and promotive health expenditure quadrupled between 2008-09 and 2012-13 as compared to curative health, which increased at a much lower rate. This increase can be largely attributed to the Kenyan government increased focus on preventive medicine especially after the financial year 2010-11. The government also increased expenditure on primary health services, which increased from 1.3 billion in 2008-09 to an estimated value of Kshs.14.8bn in 2012-13. This increase can be attributed to the health sector strategic focus on essential package for health which is community driven health strategy, which focused on provision of essential health package to the community level where both government and communities work together to ensure increased geographical access to health services and improved healthcare.

Budgetary Allocation Process in Kenya

The budgetary allocation process in Kenya owes its existence to chapter 12 on the Kenyan constitution. The budget includes estimates of revenues and expenditures that are normally submitted to parliament. The Budget is prepared under the Medium Term Expenditure Framework (MTEF), which is a transparent planning, and budget formulation process that attempts to link government policy priorities to the limited resources available in an efficient

manner that will produce optimal outcomes. The MTEF seeks to provide a comprehensive framework from which public expenditure can be planned and managed in order to increase predictability of resources. In the MTEF also seeks to ensure that priority areas of development receive adequate funding through the estimation of actual costs. Table 3 provides the main budget activities in the budget process.

Table 3: Activities in the Kenya Budget Process

Institution	Responsibility
Commission on Revenue Allocation	<ul style="list-style-type: none"> i. Recommend the basis of equitable sharing of revenue between national and county governments. ii. Recommend the basis of equitable sharing of revenue raised by national government among counties. iii. Recommend on matters concerning the financing of both national and county government. iv. Recommend on matters concerning financial management of both national and county government. v. Define and enhance revenue sources of national and county government. vi. Encourage fiscal responsibility of national and county governments vii. Provide recommendations to parliament on issues dealing with revenue sharing and financial matters for devolved governments. viii. Provide policies that identify marginalised areas.
National Assembly	<ul style="list-style-type: none"> i. Determine the allocation of revenue between governments ii. Review estimates of the judiciary, legislature and executive before approval. iii. Appropriate funds for expenditure by national government iv. Exercise oversight of national revenue v. Approve national budgets
Senate	<ul style="list-style-type: none"> i. Determine allocation among counties ii. Exercise oversight over national revenue allocated to the County
Government Departments	<ul style="list-style-type: none"> i. Revenue allocation among government programmes ii. Budget execution
Judiciary and the Legislature	<ul style="list-style-type: none"> i. Preparation and submission of estimates of expenditure to the national assembly
Controller of Budget	<ul style="list-style-type: none"> i. Oversee implementation of the budgets by authorising withdrawals from public funds. ii. Prepare reports on the implementation of budgets
Auditor General	<ul style="list-style-type: none"> 1. Audit accounts of government and debt

Source: GOK (2011)

The MTEF budget cycle is made up of five interrelated process that ensure that the development priorities of the country are the central focus of the budget planning:

1. **Policy Development-** This is obtained from government documents that priorities key areas of development.
2. **MTEF Budget Process-** this is the process of setting priorities, reviewing previous expenditures and providing budget estimates, which are approved by national and county assemblies.
3. **Budget Implementation-** This is the implementation of programmes approved by national and county assemblies.
4. **Account monitoring-** internal audit is undertaken to ensure ensures procedures are followed when implementing the budget.
5. **Evaluation and audit-** Achievements of objectives are measured and audit and oversight by national and county national assemblies.

The MTEF budget process is undertaken in three main stages Macro target setting/estimation of the overall resource envelope; Review of sectoral priorities and Financial Programming. Macroeconomic target setting involves setting targets for economic growth, inflation, money supply and fiscal targets such as revenues, expenditures and debt levels. With this estimates, it is possible to come up with the resource envelope as shown on table 4.

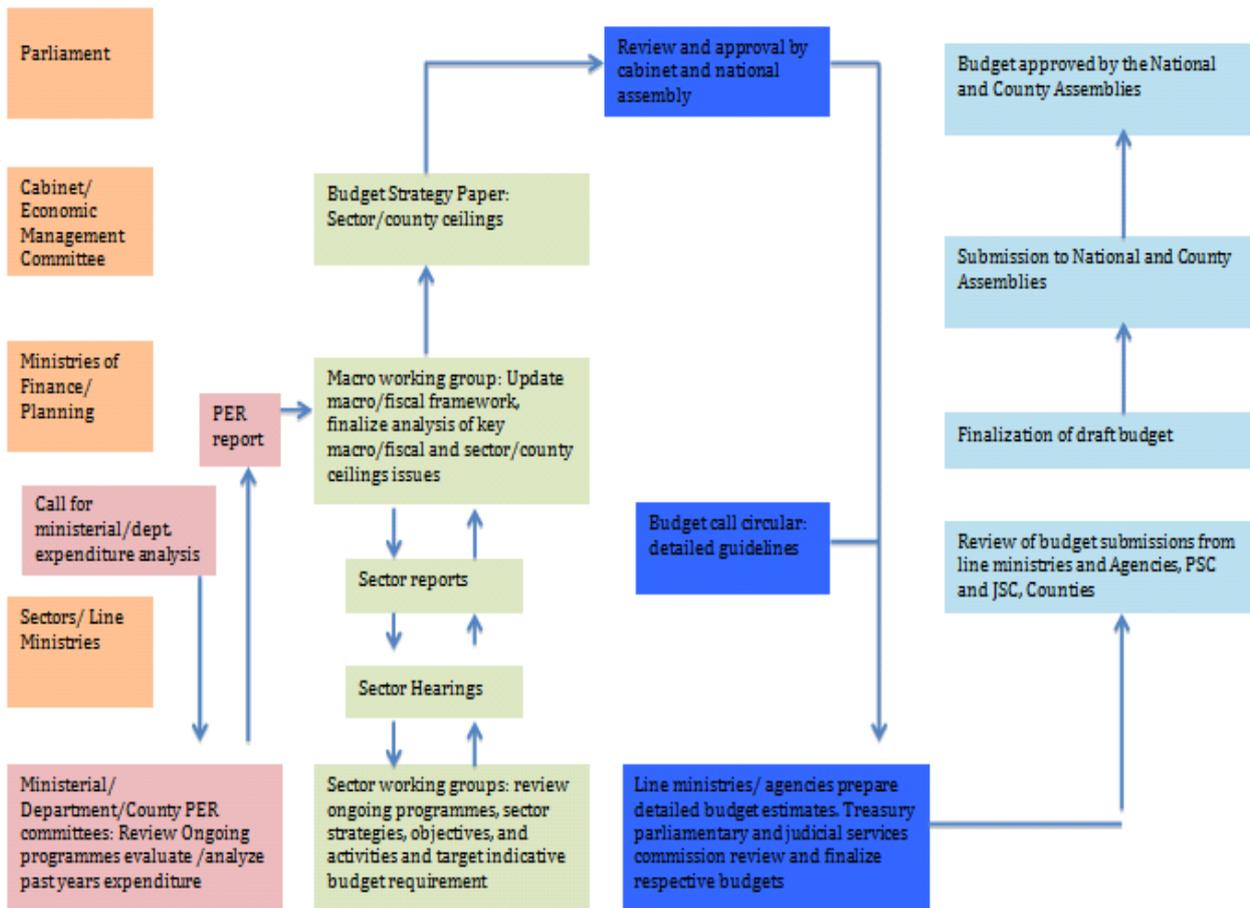
Table 4: Resource Envelope in Kenya (Billion)

	2012-13	2014-15
Total Available Resources	1,147.5	1,298.1
Revenue (Including AiA)	922.6	1034.9
External Grants	47.2	48.4
External Loans (net)	100.1	107.6
Privatisation proceeds	0.0	0.0
Net Domestic Borrowing	77.6	91.3
External Commercial Financing	0.0	15.9
Total Expenditure	1,147.5	1,289.1
Recurrent	782.7	
Development	364.8	

Source: BOPA Presentation (Various)

The process of setting up sectoral priorities and financial programming is shown in figure 5. At this stage, the ministry of finance sends out circular for expenditure analysis by ministries/departments/counties. The respective ministries/ departments/ counties evaluate the ongoing programmes and expenditure analysis and produce a public expenditure review (PER) report. PER report feeds into macroeconomic working group that works on the macro/fiscal sector/county issues. The macro sector group produces the budget strategy paper (BSP), after undertaking sector working group consultations and public sectoral hearings. The BSP is reviewed and approved by the national assembly and the cabinet. Once approved, the Ministry of Finance and Planning sends circulars to departments/ministries/counties to provide detailed budget estimates. The Ministry of Finance reviews the submissions of detailed budgets by ministries, parliamentary service commission, judiciary service commission and the counties. This is the submitted to the national and county assemblies for approval.

Figure 5: The MTEF Budget Process



The Health Sector Budgetary Allocation

The health sector budgetary allocation process follows the progression shown in figure 5. The health sector-working group undertakes a review of the sectors performance, achievements and the resource requirements for the next financial year. Previously the health sector was made up of three subsectors: medical services, public health and sanitation and research and development. The medical services subsector has inpatient malaria mortality, births attended by skilled medical personnel and access to anti-retroviral drugs as the main indicators while the public health and sanitation sub-sector include: child and maternal mortality, immunisation coverage and prevalence of HIV and AIDS. The research and development sub-sector indicators include: number of publications in peer-reviewed journals, new research protocols developed and approved new research findings translated into policy, number of scientific and health conferences held and number of students trained.

The expenditure analysis for the health sector is undertaken using tables 1 and 2. The estimated versus actual expenditure are analysed over the past three years to ensure the expenditures are consistent with health priorities. An important aspect of expenditure analysis is the absorption of expenditure allocation, which is obtained by the proportion of actual to approved expenditure. A higher ratio implies that there was implementation of programmes while a low absorption implies implementation of programmes challenges or slow disbursement of funds. Expenditure analysis will remain a challenge in the coming years due to changes in expenditure reporting framework as shown on table 5. Each expenditure element has both recurrent and development component.

Table 5: Expenditure Reporting Format

Before 2012-13	2012-13	After 2012-13
<ul style="list-style-type: none"> • General admin and planning • Curative health • Preventive and Promotive health • Health training and research • Medical Supplies • Coordination Unit • Referral Hospitals • Disease Control services • Primary Health services • Technical support services 	<ul style="list-style-type: none"> • National government • Devolved government 	<ul style="list-style-type: none"> • Curative health • Preventive and Promotive health • Research and Development

Health sector programmes are ranked in order of importance as follows:

1. Preventive and Promotive health- reduced incidents of preventable diseases and ill health
2. Curative health- reduced incidence of curable disease and ill health
3. Research and Development- reduced disease burden due to communicable and non-communicable disease.

These programmes have sub- programmes whose objectives have been set in line with Vision 2030 as shown on Table 6.

There are several criteria used by the health sector working group in allocating resources in the following order:

1. Priority is given to non- discretionary expenditure such as personnel costs, grants to parastatals and transfers.
2. Purchase of medical drugs and non-pharmaceutical commodities.
3. Operations and maintenance of ministries
4. Resource is allocated to on-going development projects.
5. Focus on GOK counterpart funding to development projects.
6. Ministerial budget committees and procedures.

Table 6: Health Sector Programmes and Objectives.

Programme	Sub-programme	Specific Objectives
Preventive and Promotive Health	General administration and planning	To provide support to enable the provision of quality and effective preventive healthcare services
	Disease prevention and control	To reduce the burden of communicable and non-communicable disease.
	Primary health services	To provide essential healthcare services to mother and child
	Preventive medicine and Promotive health	To support technical programmes and mechanisms in designing the necessary information for advocacy to the general public on disease and injury prevention and control
	Technical support	To provide the essential health support systems necessary to execute the various healthcare interventions
Curative Healthcare Services	Administration and support services	To provide support to enable the provision of quality and effective curative healthcare services.
	Curative healthcare services	To provide integrated and quality curative and rehabilitative services.
	Health training, standards and regulation	To develop human resource capacity in health and enforce standards and regulations

Programme	Sub-programme	Specific Objectives
	Technical support	To ensure effective procurement and supply of essential medical supplies.
Research and development	Research	To conduct research in human health and disseminate and translate research findings in health for evidence based policy formulation and implementation
	Capacity Building and Training	To collaborate with local universities to develop postgraduate training curricula in tropical medicine and infectious diseases graduates and produce postgraduates with high degree of professionalism, innovativeness and motivation.
	Products and services	To produce pharmaceutical products, diagnostic kits for enhancing blood safety and disinfectants for enhancing Infection Prevention
	Management and administration	To strengthen management and administration of research and development through provision of human resources, research infrastructure and support services.

Source: GOK (2012)

Under the promotive and preventive health programme, the preventive and promotive health sub- programme deals with services provided to vulnerable groups such as pregnant women and children which include antenatal healthcare, use of insecticide treated nets by women and children, immunisation of children below one year are under disease and treatment of tuberculosis. The disease and services control sub-programme includes treatment of persons with HIV/AIDs. Under the curative health programme, treatment of diseases such as malaria and HIV/AIDs are operationalised under the curative health services sub-programme. Table 7 further provides the budgetary allocation for the programmes identified in table 6. Preventive and promotive healthcare remains the top priority going by the amount of monies allocated.

Table7: Health Sector Programme and Sub-Programme Budgets FY 2012-13 to 2015-16

Programme		Estimates	Projected		
			2012/13	2013/14	2014/15
Preventive and Promotive Health					
	General administration and planning	7,069	11,603	19,381	35,059
	Disease prevention and control	17,987	29,753	48,568	88,020
	Primary health services	319	1,074	1,282	1,429
	Preventive medicine and Promotive health	15,279	24,329	35,185	55,982
	Technical support	171	326	394	471
Curative Healthcare Services					
	Administration and support services	1,958	4,838	5,578	6,431
	Curative healthcare services	20,444	49,904	57,859	67,074
	Health training, standards and regulation	4,027	9,931	11,460	13,225
	Medical Supplies Coordinating Unit	3,407	8,292	9,626	11,173
	SAGA's	11,720	22,826	23,321	24,903
Research and development					
	Research and Development	6,696	33	8,767	8,997
	Capacity Building and Training	38	687	34	36
	Products and services	292		721	757
	Management and administration	1,428	2,538	2,656	2,676

Source: GOK (2012)

7. The Special Needs Groups (Women, Children and PLWHA) Challenges and Opportunities

The former Ministry of Public Health and Sanitation (2008) has acknowledged that there are socio-cultural barriers associated with low literacy levels, religious beliefs and gender bias, which hinder certain groups such as women, children, and adolescents, the disabled and other vulnerable and marginalised groups from accessing public health services. While this is the case, the ministry does not have a specialised budgetary allocation process that explicitly deals with the youth, orphans, women, and other vulnerable and marginalised groups. The ministry however works closely with other sectors in order to improve these groups access to health services.

In order to improve access to public health services for these specialised needs groups and PLWHAs, the Ministry of Health works closely with the former Ministry of Gender, Sports, Culture and Social Services and the National Aids Control Council (NACC). Malaria prevention has been dealt with as a cross cutting issue that affects women, children and PLWHA in the 2012-13 budget under the preventive and promotive health sub-programmes.

The special female health needs are largely associated with reproductive health, prenatal and post-natal healthcare. The main challenges include high maternal mortality rate per 100,000 births, which stood at 360 by 2010. Most maternal deaths are attributed to excessive hemorrhage since skilled birth attendants do not attend to women at childbirth, low prevention of mother to child HIV/AIDs transmission, malaria transmission during pregnancy and unmet family planning needs. These challenges have been largely addressed in the MTEF 2013-14 budget through the prioritisation of these health challenges in the health programmes as shown on table 7.

The primary health services sub programme under the promotive and preventive health services is focused on essential healthcare for mother and child. The projected allocation in 2013-14 has more than doubled from the allocation of Kshs. 319 million in 2012-13. The challenge of malaria in pregnancy and use of skilled birth attendants has been addressed under curative healthcare services sub-programme (under the curative healthcare programme).

Child health forms a very important component of any healthcare system. According to the Kenya Integrated Household Budget Survey 2005-06, the infant and under five mortality stood at 60 and 92 per 1,000 live births respectively. While there is improvement from the 2003 Kenya Demographic Health Survey, these figures are above the millennium development goal targets of 26 and 33 per 1,000 live births respectively. Secondly, child nutritional status has remained low in Kenya, so that by 1998, stunting, underweight and severe malnutrition rate of children under the age of 5 was 33, 21 and 6 percent respectively. Poor child nutrition has been found to cause 8 percent of child mortality, UNICEF (2009). The current budget 2013-14 is more focused on immunisation of children under one year as compared to initiatives that are geared towards nutritional improvement.

The Kenya National AIDs Strategic Plan 2009-10 to 2012-13 seeks to achieve the following four impacts by end of this year 2013: reduced the number of new infections by at least 50

percent; reduced AIDs related mortality by 25 percent; reduce HIV related morbidity and reduce the socio-economic impact of HIV at household and community level. The 2013-14 budget has allocated resources under disease prevention and control sub-programme which is focused on increased availability of anti-retroviral drugs (ARVs), under the preventive and promotive health programmes, the budgetary allocation will ensure preventive treatment and care activities of HIV/AIDs through Voluntary Counseling and Testing (VCT), prevention of mother to child transmission services and distribution of condoms. Under the promotive and preventive health sub-programme promotes preventive HIV/AIDs measures that will reduce the incidence of HIV/AIDs.

8. Accountability Mechanism for the Health Sector Budgetary Allocation

Accountability is an important component of any success strategy since one is able to monitor progress of what is happening, or review any development projects or political pledges or any action taken. In Kenya, there are several national mechanisms available for ensuring accountability in the health sector:

Ministry of Health

This is the line ministry that is held accountable in ensuring that health outcomes improve over time. The core function of the Ministry of Health is to provide primary care services at the community, dispensary and health center levels. The Ministry is mandated to support the attainment of the health goals of the people of Kenya by implementing priority interventions in public health based on its mandate and guided by the strategic framework developed GOK (2008).

The Health Sector Working Group

This working group analyses the health sector performance, achievements and resource required for the 3-year MTEF period. This working group produces an annual report that provides stakeholders with information that is required to make appropriate policy and funding decisions. This working group includes stakeholders working in the three priority programming areas.

The National Assembly

The national assembly plays an important role in allocating resources, enacting laws, overseeing the implementation and representing the views of the vulnerable and marginalised groups. They shape policies, approve budgets and hold the executive branch into account. In the case of ministry of health, they play a vital role in ensuring the health needs of vulnerable and marginalised groups are met by creating an enabling environment through legislation and policy and budget support.

The Departmental Committee on Health: The National Assembly

This committee investigates and enquires into all matters relating to the programme and policy objectives of Ministry of health and departments. This committee investigates, inquire into, and report on all matters relating to the effectiveness of the implementation of policies on health, medical care and health insurance. This committee has the authority to summon officials of the ministry of health and to parliament in order to answer any queries arising from running the ministry.

Kenya National Human Rights Commission (KNCHR)

The Kenya National Commission on Human Rights is an autonomous institution established under article 59 of the Constitution of Kenya 2010, with the core mandate of the promotion

and protection of human rights in Kenya. KNHCR acts as a watchdog over government to ensure that it does not violate human rights and provide leadership in towards moving the country to a human rights state. The main goals of KNCHR are:

1. To promote the respect and observance of human rights standards in public institutions.
2. To increase the application of human rights principles and standards in mechanisms of justice.
3. To enhance the realisation of economic and social rights in Kenya.
4. To enhance the efficiency and effectiveness of the Commission.

The KNCHR works with marginalised communities, disabled people and internally displaced persons to ensure that government pays attention to their needs and incorporates them in the national development process.

The National AIDS Control Council (NACC)

The mission of NACC is to “To provide Policy and a Strategic framework for mobilising and coordinating resources for prevention of HIV transmission and provision of care and support to the infected and affected people in Kenya”. This mission is achieved through the following objectives:

1. Provision of policy and a strategic framework
2. Mobilisation and coordination of resources
3. Prevention of HIV transmission
4. Care and support for those infected and affected by HIV and AIDS

NACC works with both state and non-state actors in achieving the objectives set under a multi-sectoral national response approach, which includes public sector, private sector, non-governmental organisations and development partners. NACC has also developed a comprehensive National HIV and AIDS Monitoring, Evaluation and Research Framework (M&E Framework) to coordinate stakeholders towards one agreed country-level monitoring and evaluation system. This approach will ensure non- duplication of efforts and a more integrated approach for combating HIV/AIDS, which has greater impact.

9. Consumer Feedback on Health Service Provision

Citizen Report Card

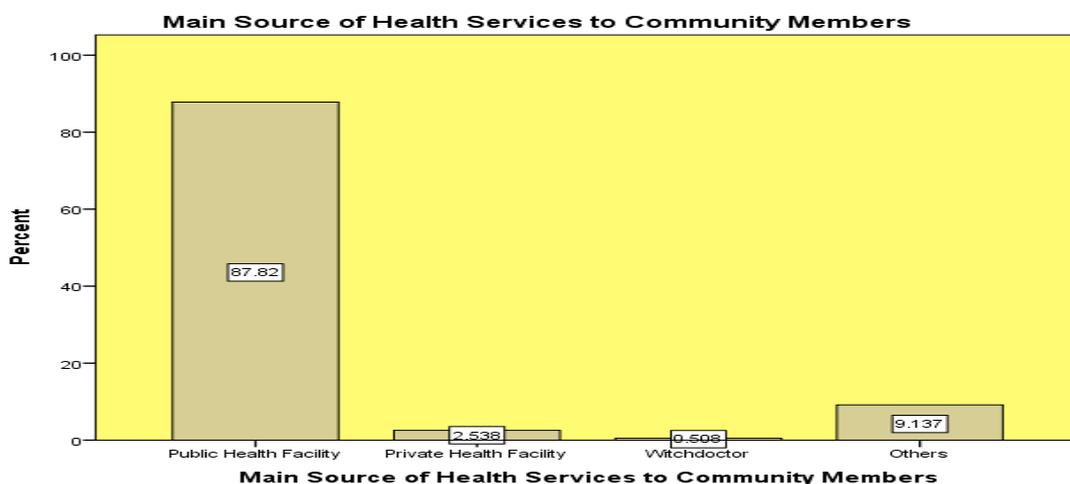
This report card was generated by asking the community members about perception/level of satisfaction on various services delivered at the PHCs. The study employed the use of both random and purposive sampling of users of public healthcare services in communities within Kisumu County to score different attributes of those services and what users want to do to improve their quality. It involved face to face interview with regular users of public healthcare services within Kisumu County. Samples of 201 users were interviewed for the purpose of this analysis.

Figure 6: Gender Distribution



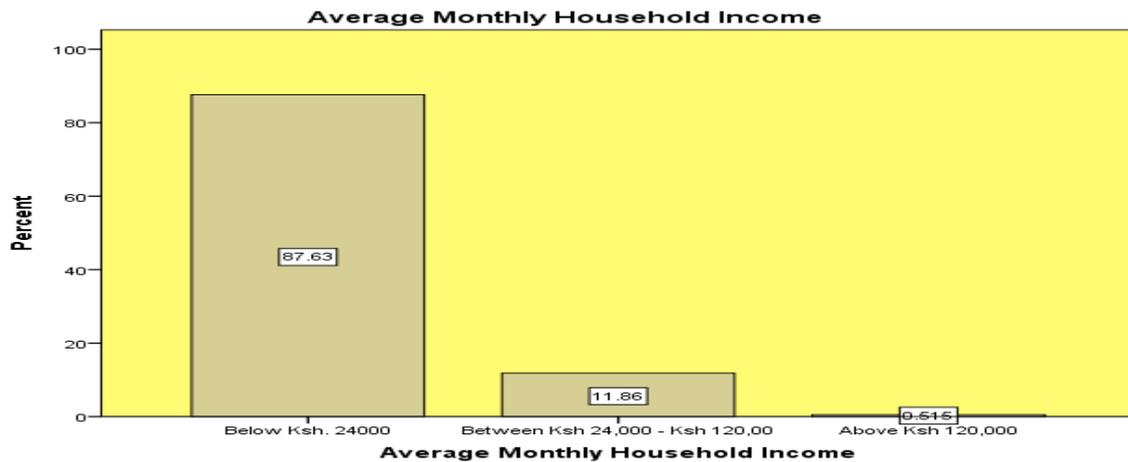
The composition of the respondents included 67 male (33 percent) and 123 females (67 percent).

Figure 7: Main Sources of Health Services



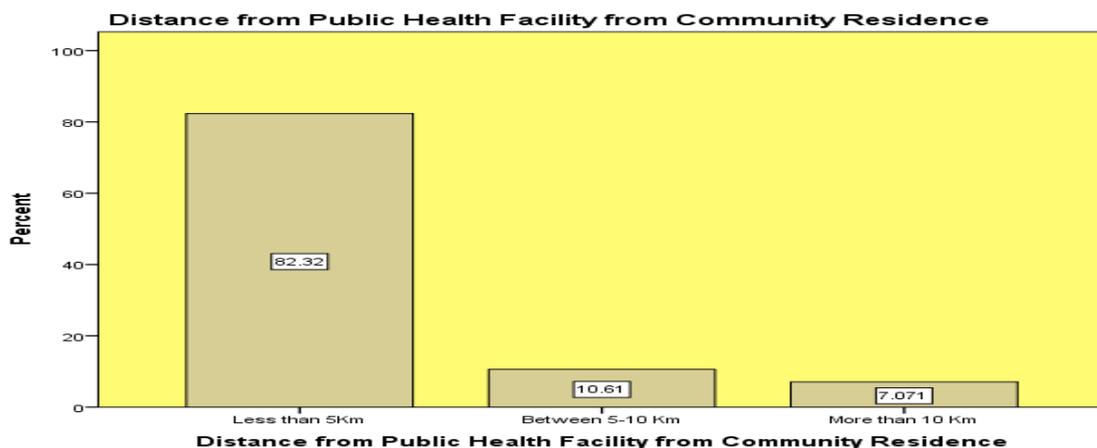
From the feedback, 87.82 percent of respondents rely on public health facility for their health needs while a paltry 2.54 percent resort to private health Facilities. The other segments of about 10 percent rely on other alternative health service remedies. These confirm the dire need to improve public health facilities in terms of accessibility, availability of staffs, prescription medicine, laboratory service and testing equipments and emergency services/ ambulance facility to cater for the needs of the community members.

Figure 8: Average Household Monthly Income



The above graph confirms that the lesser economically empowered one is, the higher the probability of using public health facilities as majority of the respondents in the survey (84.6%) were found to derive less than Kshs. 24,000 income per month where as 11.4% earn monthly income of between Kshs.24, 000 and Kshs. 120,000. Only one of the respondents was found to have a monthly income of above Kshs.120, 000.

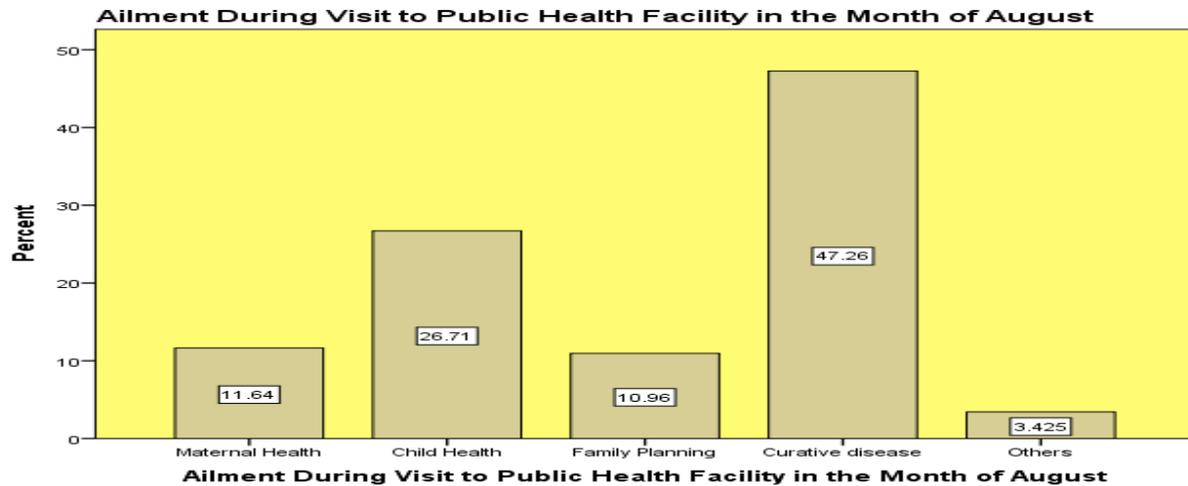
Figure 9: Distance from the Nearest Public Health Facility to Community Residential



In relation to proximity of the health facility to community residence, majority of respondents 82.32 percent have the health facility located in less than 5kms from their residence where as 10.61 percent of respondents live within the range of 5km to10kms. 7.071 percent of respondents live in more than 10 kms from the nearest public health facility. This is an indication of governments' commitment to bringing health services closer to the people

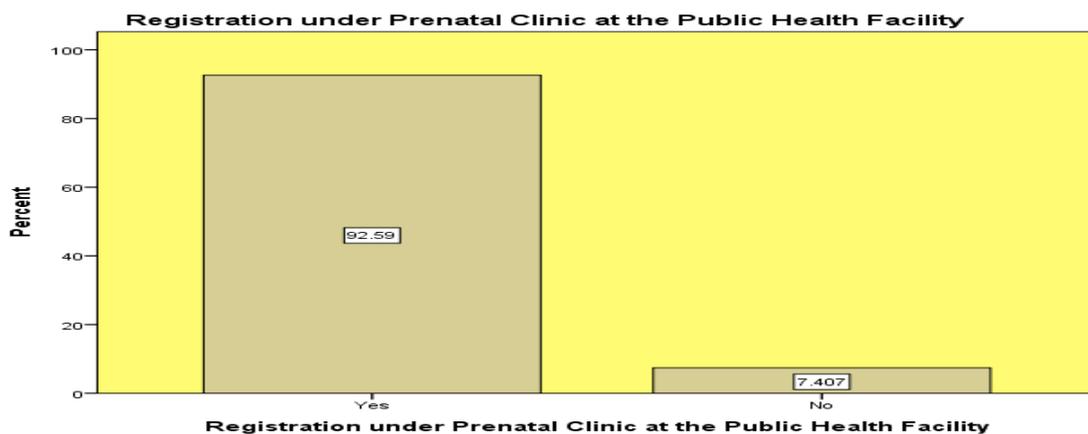
probably through devolved funds including constituency development fund projects. The county government can only do much by ensuring that those facilities are up to task in delivering quality and timely health services to the communities they purpose to serve.

Figure 10: Common Ailments upon Visits to Public Health Facility in August



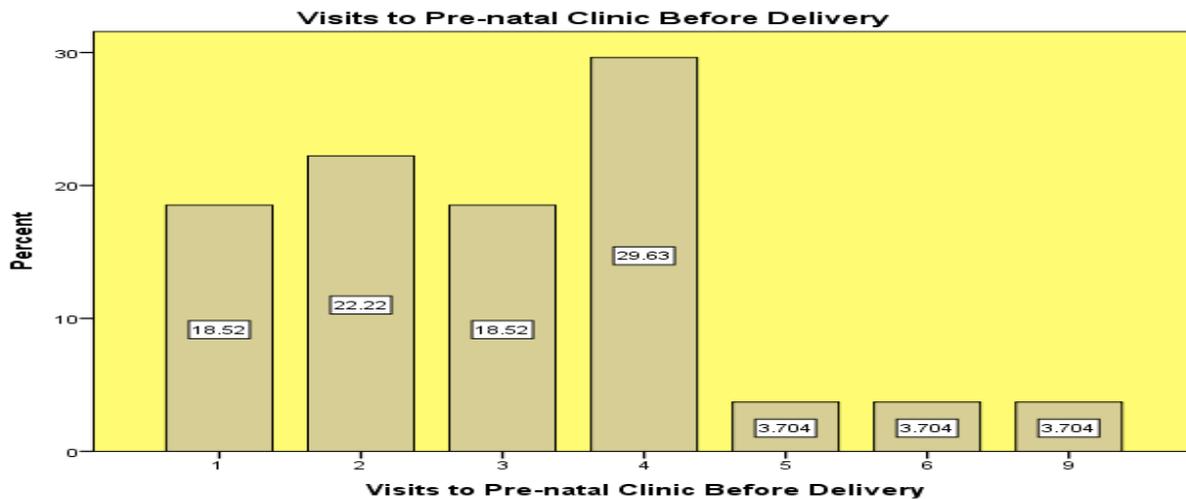
From the findings, the community is over burdened by curative diseases which affected about 47.26 percent of respondents followed by child health which affected about 26.71 percent of the respondents. Maternal and family planning ailments are at 11.64% and 10.96% respectively where as other ailments combined add up to 3.425 percent. The feedback present an array of ailments that are inclined to women and children hence an appropriate health policy should be developed to address them.

Figure 11: Maternal Healthcare Service Delivery in Kisumu County



It is impressive picture as 92.6 percent of women who attend the pre-natal clinic are registered at the facility. However there is need for more efforts to have all expectant mothers at the county registered under prenatal clinic to facilitate proper coordination and follow up for medication by community health workers for the benefits of the mothers and the unborn baby.

Figure 12: Visits to Pre-natal Clinic Before Delivery



Generally it is agreeable that during pregnancy, expectant mothers should make about 4-5 visits to pre-natal clinic at least once during 1st trimester; twice during 2nd; and probably 2-3 times during the last trimester. Lesser visits could imply general lack of information on the importance of prenatal clinics to the mothers, their inaccessibility in terms of proximity or probably lack of resources that may be required. On the other hand higher number of visits could be an indication of some kind of risks or complications expected or being experience by the expectant mothers.

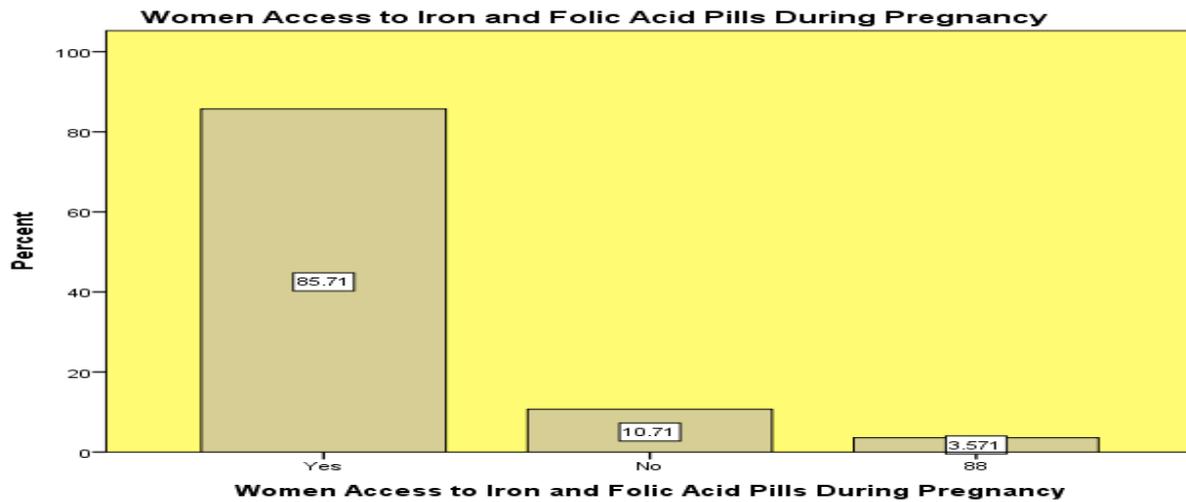
From the study, it is disturbing to note that despite the registration for pre natal clinic, only about 41 percent of those registered made substantive visits of between 4 to 9 times to prenatal clinics before delivery with majority of about 30 percent making only 4 visits. However, it is again rather worrying finding to have a staggering 22% of respondents attending the services only twice and close to 19% only once.

Therefore, there is need for more awareness to the community on the need for attendance of pre-natal check-ups at the facilities for medical advice and treatments to avert dangers and to improve on the health status of the unborn babies.

Women Access to Iron and Folic Acid during Pre-natal Visits at Public Health Facilities

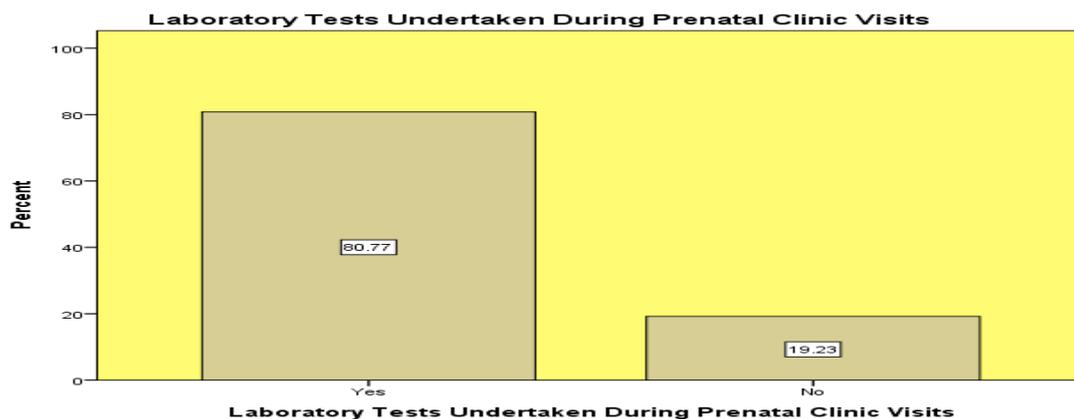
Access to folic acid pills among expectant women is quite useful for both the mother and the unborn in facilitating many body processes including cell maintenance and repair, synthesis of DNA, amino acid metabolism and formation of red and white blood cells. Some studies even have indicated that it assists in inhibiting possibility of colon cancer as well as preventing heart disease^v. There is also a possibility of iron pills in preventing some of the risk factors for pre-term delivery and subsequent low birth weight, and possibly for inferior neonatal health.

Figure 13: Women Access to Iron and Folic Acid Pills during Pregnancy



It is impressive that 85.71 percent of women at the community were able to access the vital iron and Folic Acid pills during their pre-natal clinic visits at the public health facilities. However close to 11% of the expectant women were not taking the supplements in spite of attending prenatal services. Therefore, the county leadership should therefore prioritise the need to ensure enough supply of these pills at the public health facilities so that women from the neighboring community can continue to have access to them during their pre-natal clinic visits for the health benefits to mothers and the unborn babies. Health service providers should also enhance awareness to expectant women on the benefits of taking supplementary pills during pregnancy at the public health facilities.

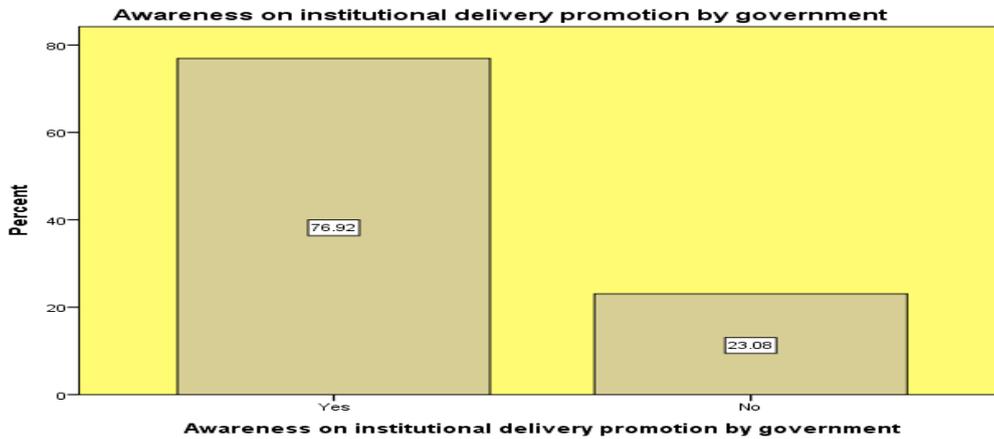
Figure 14: Laboratory Tests Undertaken during Prenatal Clinic Visits



The study reveals that close to 81 percent of the expectant women had laboratory test done during their prenatal clinic visits. This is quite impressive owing to its benefits in detection of possible infections including HIV and other medical complications such as high sugar/protein level and opportunity for earliest possible medical intervention. It is surprising that despite attending the prenatal clinic, 19.23 percent of women were not exposed to any laboratory check-ups for blood or urine related tests. The health service providers therefore need to take the issue seriously by ensuring that all women who attend the prenatal clinics undergo all

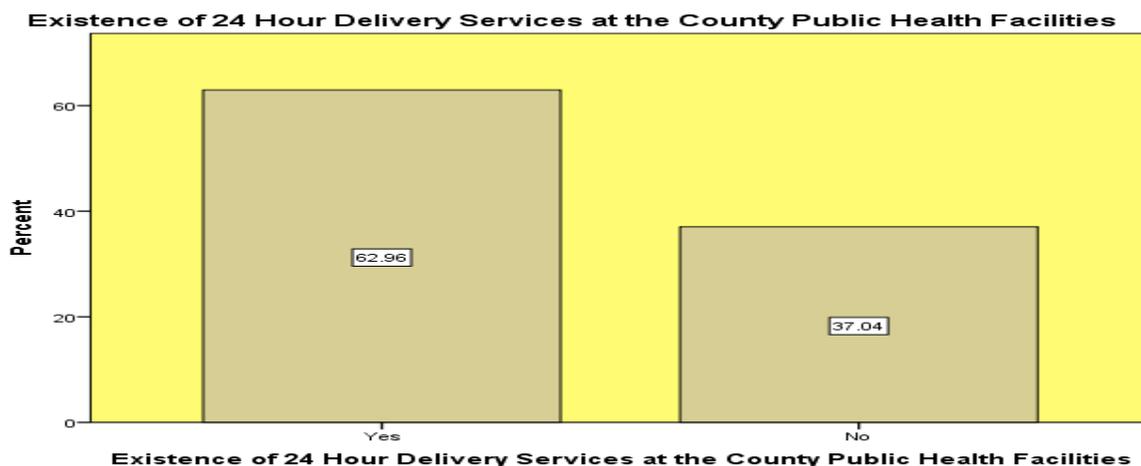
required tests and advised accordingly for the betterment of both mother and unborn baby. There is need for enhanced awareness to the community by health service providers and community health workers on the importance of prenatal laboratory tests.

Figure 15: Awareness on Institutional Delivery Promotion by Government



It's worth noting the recognition on government efforts to promote institutional delivery across the country as 76.92 percent of respondents confirmed awareness on the need to deliver at the health facilities. However, these efforts should be sustained through increased campaign by county leaders, public health officers and community health workers in a bid to ensure that all women get the information and take advantage to deliver their new born babies within the existing health facilities.

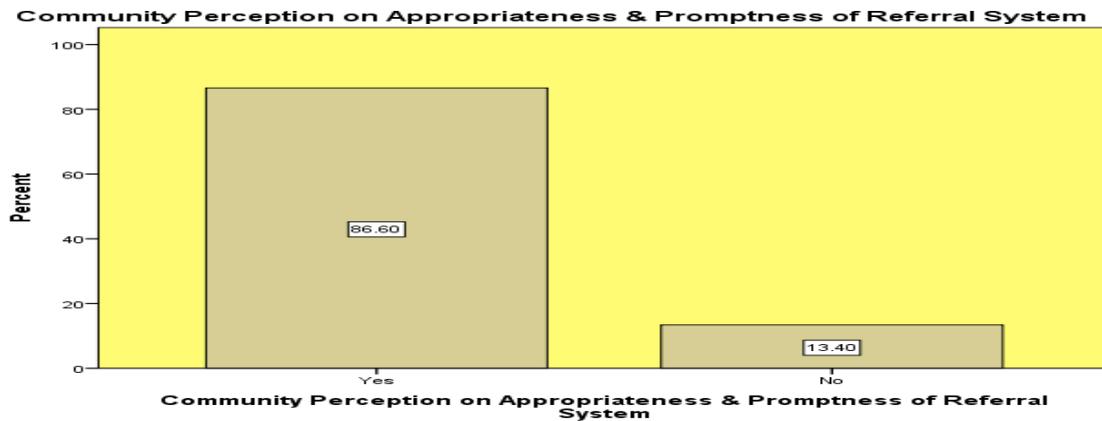
Figure 16: Availability of a 24 hour Delivery Services for Expectant Mothers at the Facility



According to the study, 62.96 percent of respondents confirmed availability of a twenty four (24) hour delivery services for expectant women in their neighborhood, where as a significant thirty seven (37.04) percent had a contrary view for a 24 hour delivery services for expectant mothers in their neighbourhood public health facilities. The latter situation poses greater risk to expectant mothers within the community and therefore the county

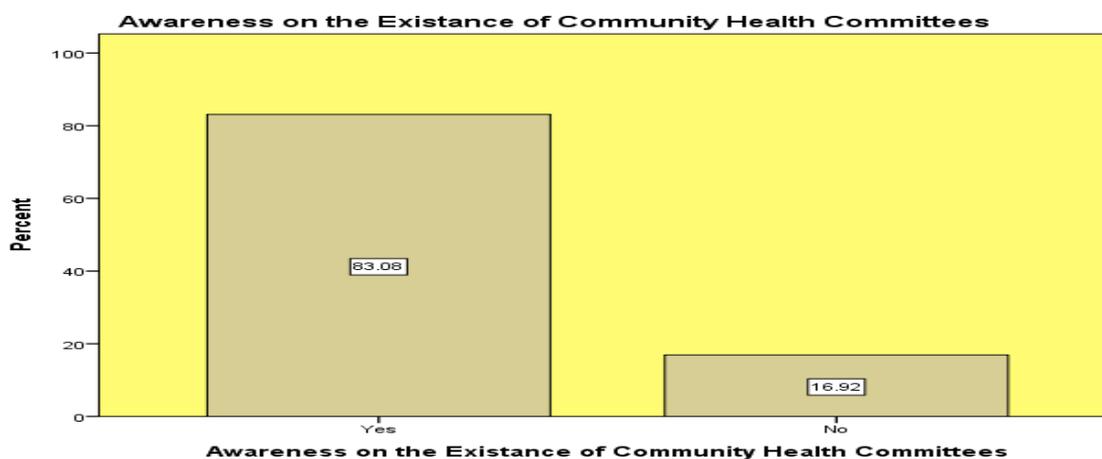
government needs to take drastic measures to ensure that a 24 hour delivery services for expecting mothers are available in all the health facilities in a full time basis.

Figure 17: Respondents Perception on the Referral System at Public Health Facilities



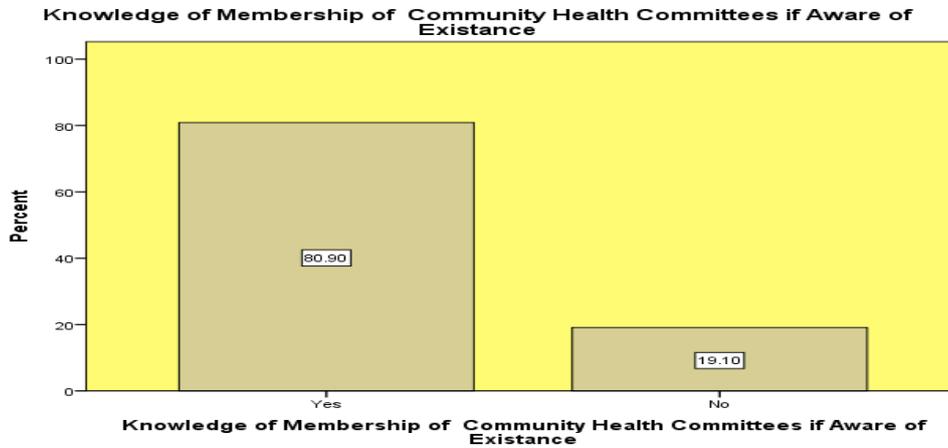
From the study, majority of the respondents (86.6 percent) are in agreement that the referral systems in the neighbourhood health facilities are quite appropriate and prompt. Only 13.4 percent held a contrary view on the appropriateness and promptness of referrals systems at the county health facilities. Therefore the county health service providers should therefore take up the challenge and ensure community members get deserved prompt referrals to help save lives by a voiding health complications arising from possible delays.

Figure 18: Knowledge on the Existence of Community Health Committees



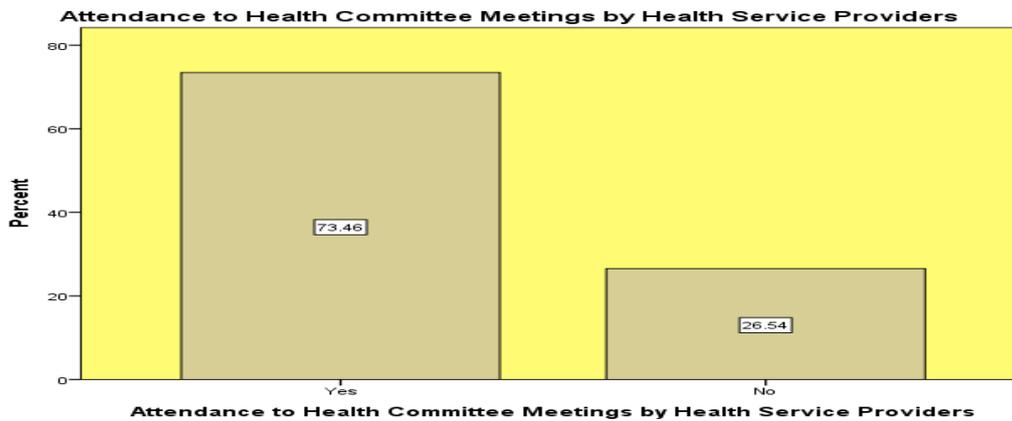
In terms of their knowledge on the existence of health committees in their areas, over 80 percent are aware while only less than 20 percent are not aware of their existence. It is therefore important for the community health committees to publicise their presence for the community to take advantage and engage them as concerns health issues affecting them.

Figure 19: Knowledge of Members of Village Health Committees for those Aware of their Existence



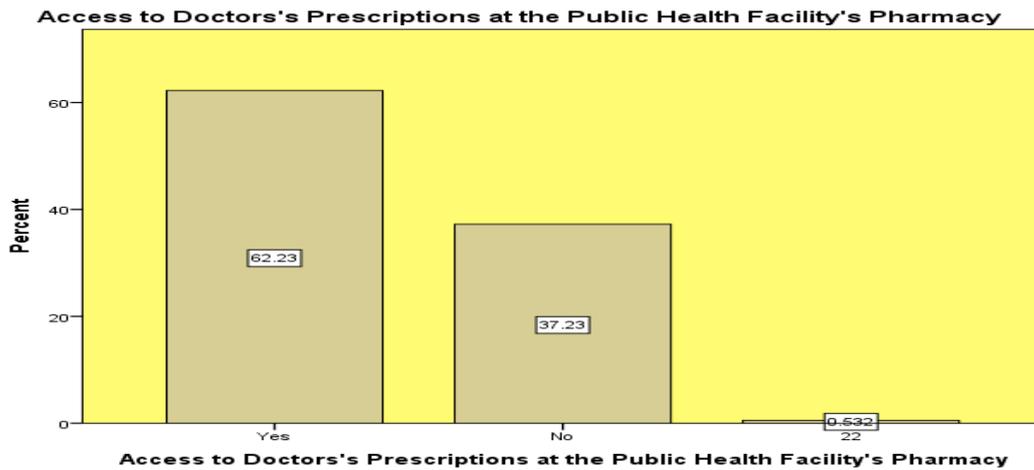
Among those who are aware of the existence of village health committees, an impressive 80.9 percent know the members of such community health committees whereas only 19.1 percent do not have the knowledge of who are those members.

Figure 20: Attendance to Health Committee Meetings by Health Service Providers



The study indicate impressive figure on the attendance of health committee meetings by health service providers as 73.46 percent of respondents confirm their presence in such meetings. This gesture should be sustained to enhance their understanding on the health challenges facing community and also help in bringing on board some other challenges faced by health service providers which must be addressed by the committee.

Figure 21: Availability of Doctor’s Prescription at the Health Facility Pharmacy



Among the respondents, about 62.23 percent confirmed accessing the prescribed medication from the health facility, while about 37.23 percent mentioned absence of prescribed medication at the facilities. There is need for a well-coordinated effort by the management to ensure supply of medicine to avoid shortages.

Figure 22: Level of satisfaction with Public Health Services at the County



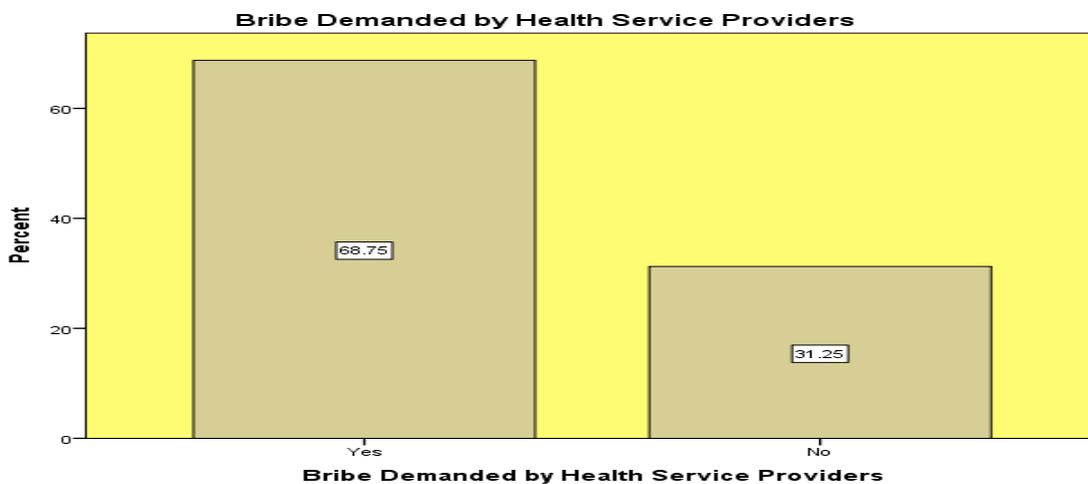
In terms of satisfaction, only 51.26 percent of respondents confirmed their satisfaction whereas the 39.20 percent were partially satisfied. 8.54 percent confirmed their dissatisfaction with the health services at the public facility. Among the key reasons for dissatisfaction included in availability of prescribed drugs, limited or unavailable laboratory services, inadequacy of staffs and resources, high cost of health services, laxity among health service providers, lack of good medical facilities, long queues, and poor /bad treatment by nurses.

Figure 23: State of Corruption at the Public Health Facility



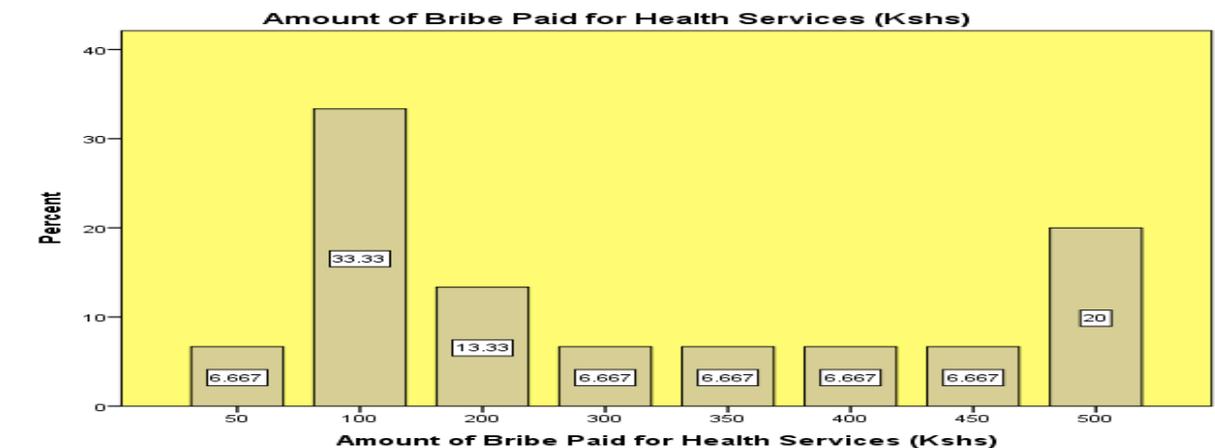
From the feedback it is worthy to note the fact that most health service providers have not been engaged in corrupt practices as confirmed by over 92.63 percent of respondents. However few respondents, (7.368 percent) confirmed payments for bribe to secure health services at the facility.

Figure 24: Bribe Demanded by Health Service Providers



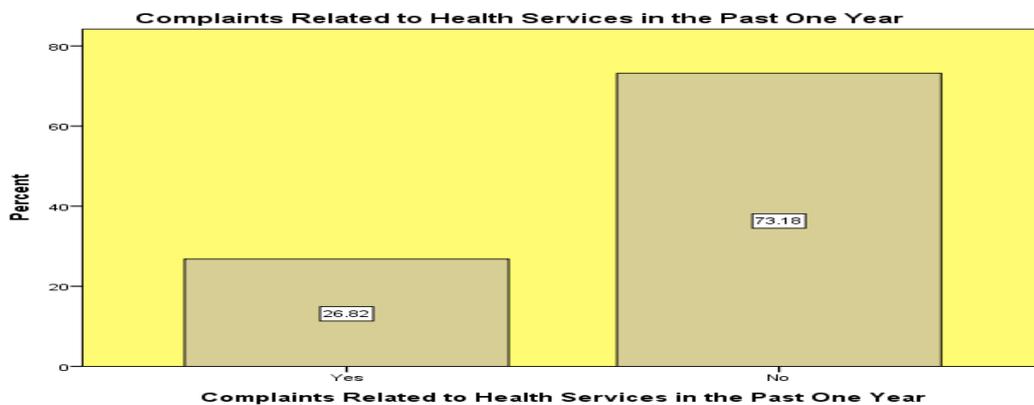
Among the confirmed bribe payments, 68.8 percent said the amount was demanded by health service providers while 31.2 percent said they made voluntary bribe to facilitate action by health service providers.

Figure 25: Amounts of Bribe Paid by Community Members



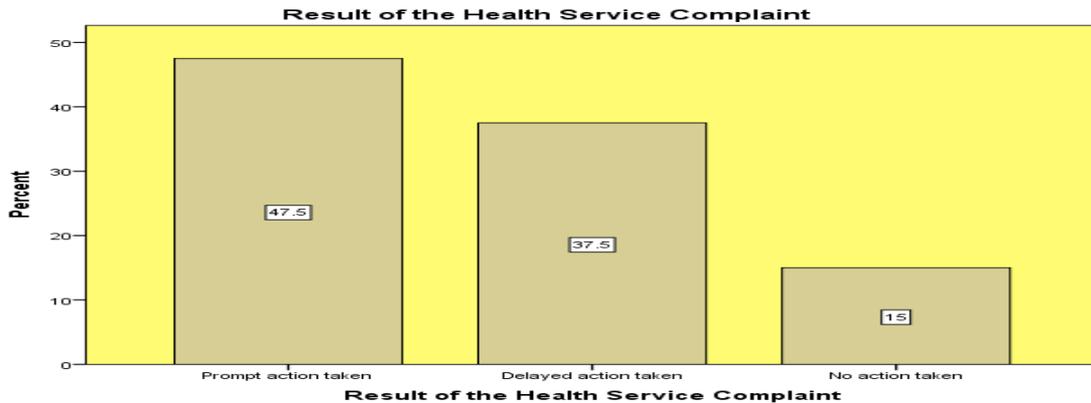
Majority of respondents 33.33 percent paid Kshs. 100 for bribe, followed by Kshs. 500 paid by 20 percent of respondent and Kshs. 200 paid by 13.33 percent of respondents for health services. The remaining component of respondents paid varied amount in the range of kshs.50- 450 for the health services.

Figure 26: The State of Complaints and Redressal System at Public Health facilities



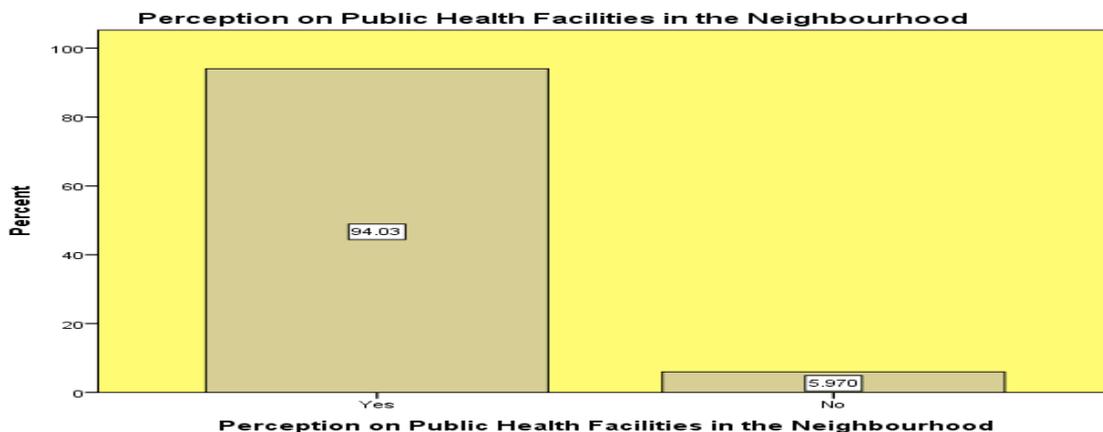
When asked whether they have made complaint related to health service provision, only 26.82 percent confirmed having complained where as 73.18 percent have never made any complaint about health service provision. This general apathy may be attributed to lack of awareness or lack of confidence by community members on the existing institutions or systems of redress relating to health service issues.

Figure 27: Actions on the Complaints against Health Services Provision at the Public Facilities



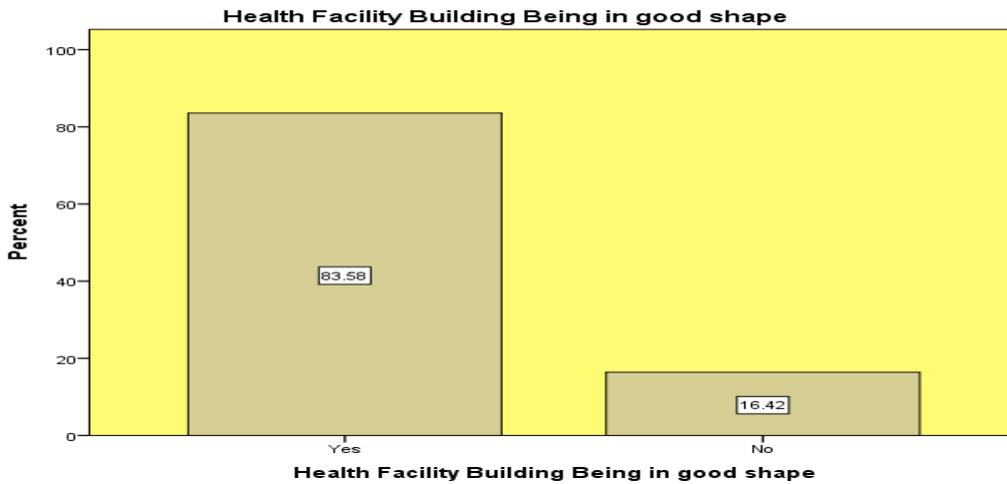
Even for the 26.82 percent of respondents who managed to complain about poor health services, only 47.5 percent had their complaints addressed promptly where as 37.5 percent had a delayed action while 15 percent had no action taken at all. The county leadership together with public health institutions management therefore needs to have in place a system that will ensure that all complaints related to health service provision are timely addressed to enhance quality and confidence on the health services by community members.

Figure 28: General Perception of Community on the Public Health Facilities in the Neighbourhood



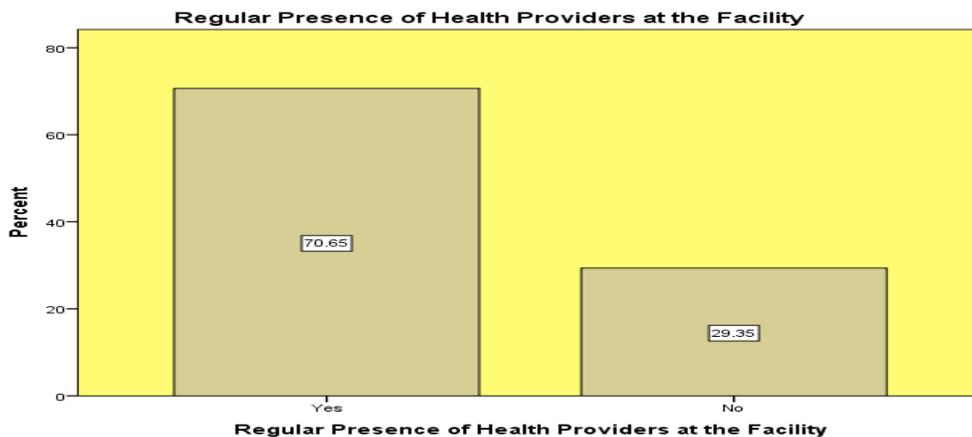
When asked whether they like going to the public health facilities, majority of respondents, 94 percent confirmed their preference for the public facilities as opposed to other alternatives in the neighborhood where as only 5.97 percent had a contrary preference to other health facilities as opposed to public health amenities. This is probably due to their proximity and possibly affordability by members of the community whose majority are below poverty level.

Figure 29: Health Facility Building being in Good Shape



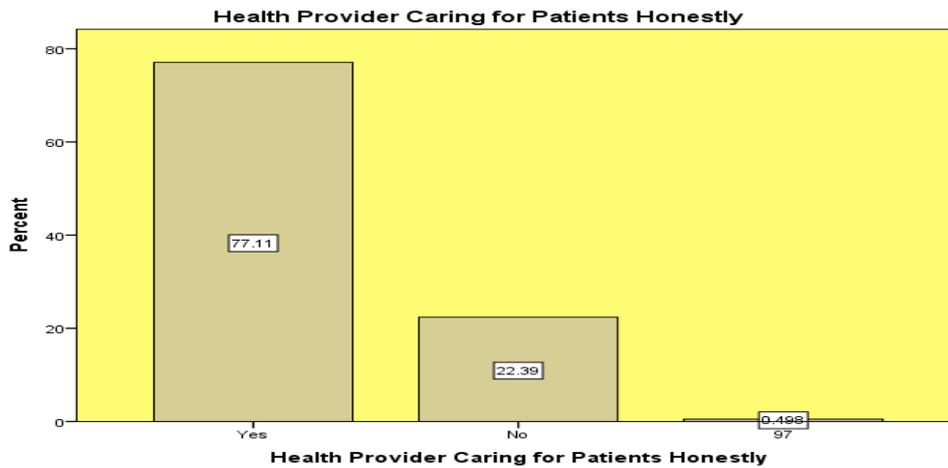
There is a feeling of satisfaction/content with most of the respondents in relation to the status of the buildings at the health facility as confirmed by 83.6 percent of responses who like the status of the building at the facility. Only 16.4 percent of the respondents hold the contrary view that the buildings are in poor shape. The acceptability of the state of the building is likely as a result of the refurbishment of most of the facilities as well as the new structures put up by under the devolved development funds.

Figure 30: Regular Presence of Health Providers at the Facility



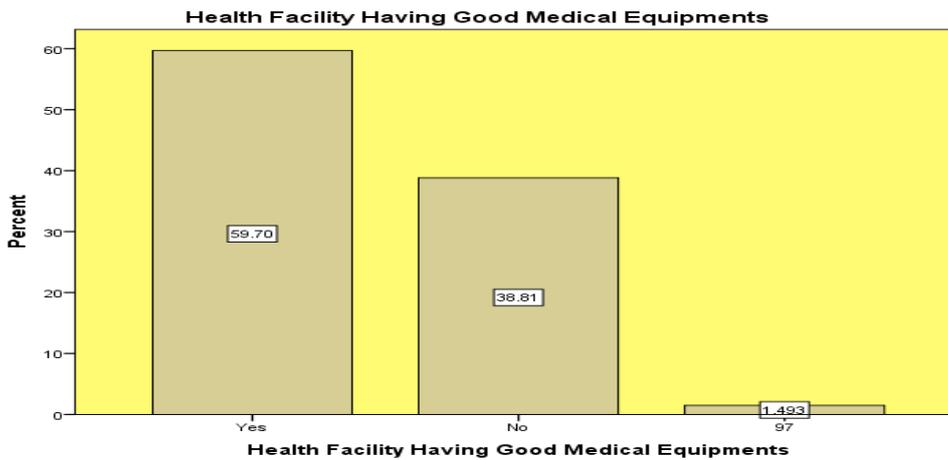
Majority of respondents, 70.65 percent felt that public health service providers have remained present and regular at the facilities where as 29.35 percent of respondents felt that there have been a lot of cases of absence of service providers or irregular presence at the facilities from time to time. The public health service management at the county should therefore pull up their socks to ensure that all public health facilities have sufficient number of staffs at all time to enhance quality and timely health service provision to the community members.

Figure 31: Health Provider Caring for Patients Honestly



Over 77percent of respondents remain positive about honesty of health service providers whereas over 22 percent of them feel that health service providers have not been delivering their services to patients as required by the law.

Figure 32: Health Facility Having Good Medical Equipments

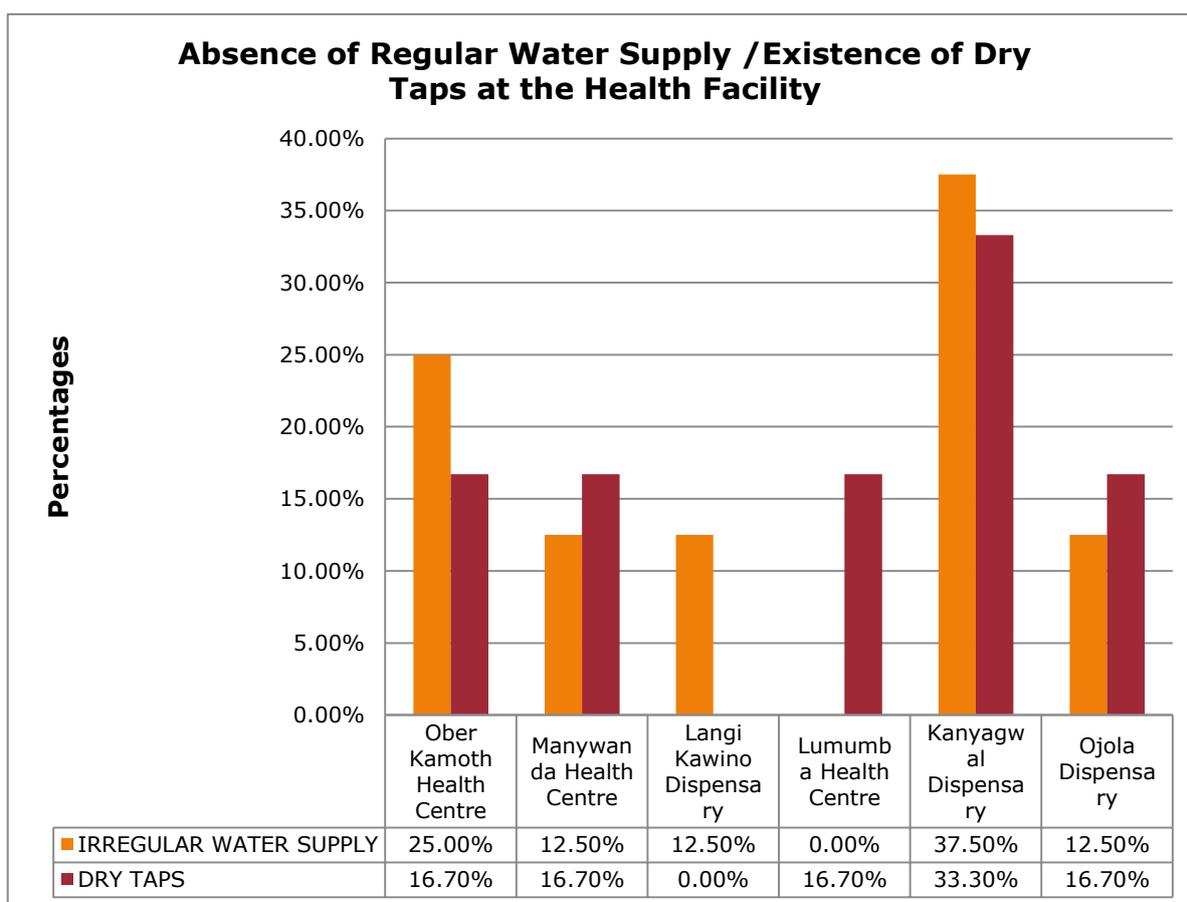


Majority of respondents, 59.7 percent hold the view that public health facilities have good medical equipments where as a significant percentage of respondents (38.8 percent) hold the feeling that medical equipments within public health facilities are either lacking, not adequate or not good enough to perform their functions. The performance of health service providers can only be enhanced when they have all the required equipments for health service delivery. Therefore it is upon the county leadership to give focused attention to the medical equipments before quality health services can be realised in most health facilities at the county level.

Community Monitoring Report

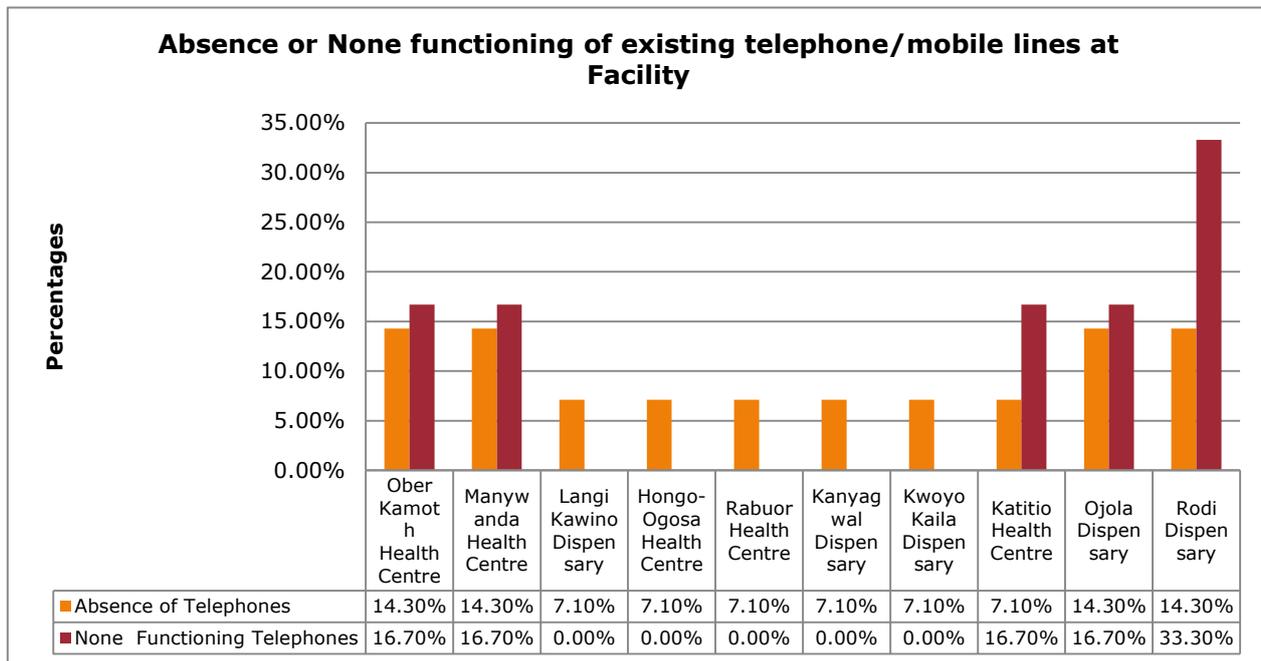
The monitoring of health service provision was undertaken within twelve (12) public health facilities which were selected on a random sampling basis. Each of the selected public health facilities was observed four (4) times in a span of six days during duty hours by the members of community monitoring cell (CMC). The CMR consisted of four (4) unemployed educated members of the community oriented for monitoring purposes. Each monitor was strictly instructed to do monitoring in two different health facilities every day.

Figure 33: Observation on Absence of Regular Water Supply/Existence of Dry Taps at the Facility



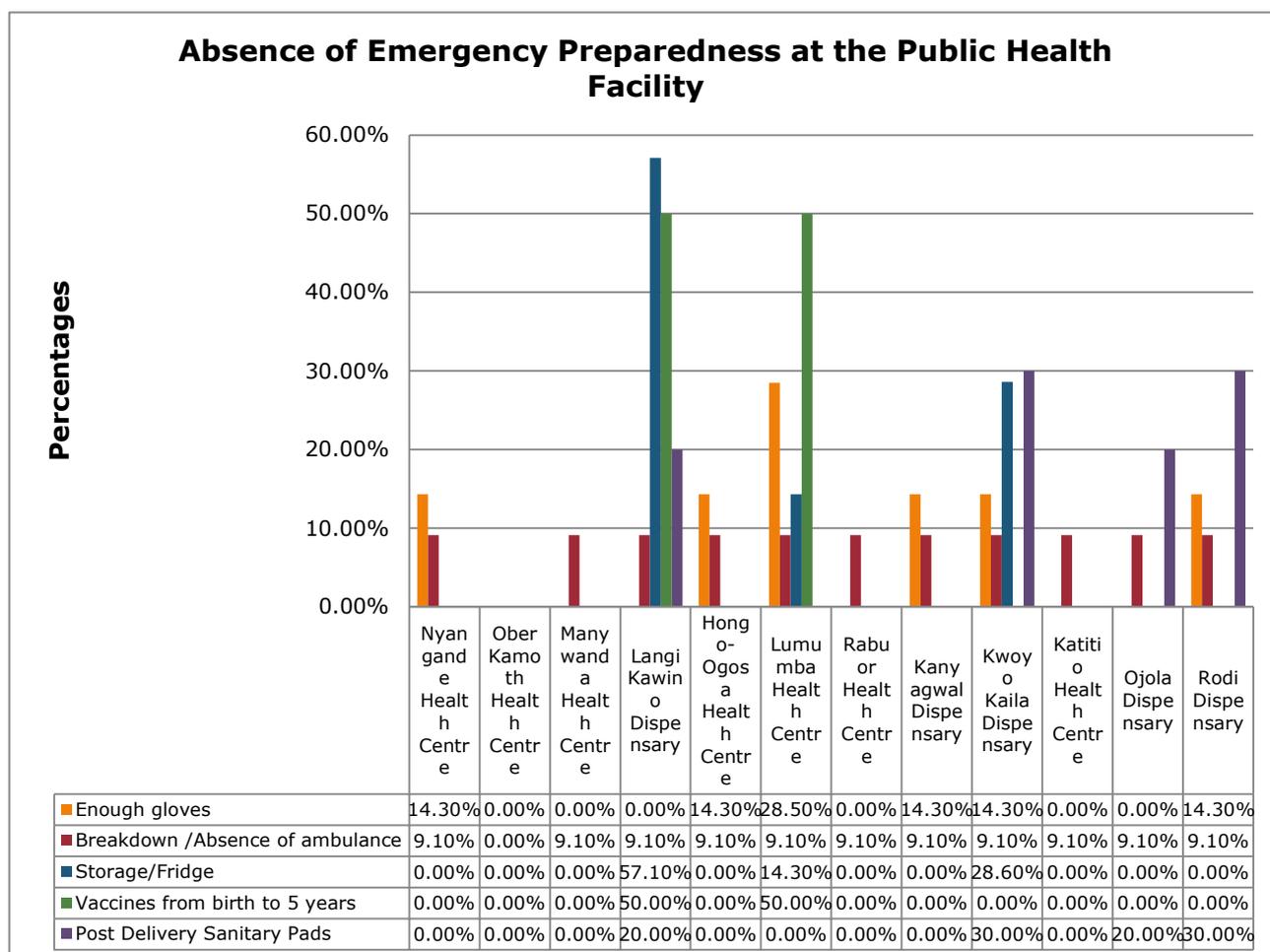
The Result of the monitoring process indicates the major challenge of irregular water supply or complete absence of water at the public health facilities. The most affected during the observation period being Kanyagwal Dispensary at 37.5 percent on absence of regular water supply and at 33.3 percent for dry taps followed by Ober Kamoth at 25 percent and 16.7 percent respectively. Langi Kawino was however at 0.0percent for the dry tap observation.

Figure 34: Observation on Absence or Existence of Non Functioning Telecommunication Equipments at Public Health Facility



Communication system remains a challenge among many public health facilities at the county. Over 80 percent of the health facilities either lacked the telecommunication equipments or they were out of order. In some case the Medical Officers or Nurses were engaging their own mobile phones for communications. Whenever these personal phones were switched off, then there was literally no communication with the facility. The absence of telecommunication facility was highly observed in Ober Kamoth, Manywanda Health Centers, Ojola and Rodi dispensaries all at 14.3 percent of all the observations made within the 12 health facilities visited. There was complete absence of telecommunication devises in five (5) of the observed health facilities including Langi Kawino, Hongo-Ogosa, Rabuur, Kanyagwal and Kuoyo Kaila during the period of observation/monitoring.

Figure 35: Observation on the Absence of Emergency Preparedness at the Public Health Facility

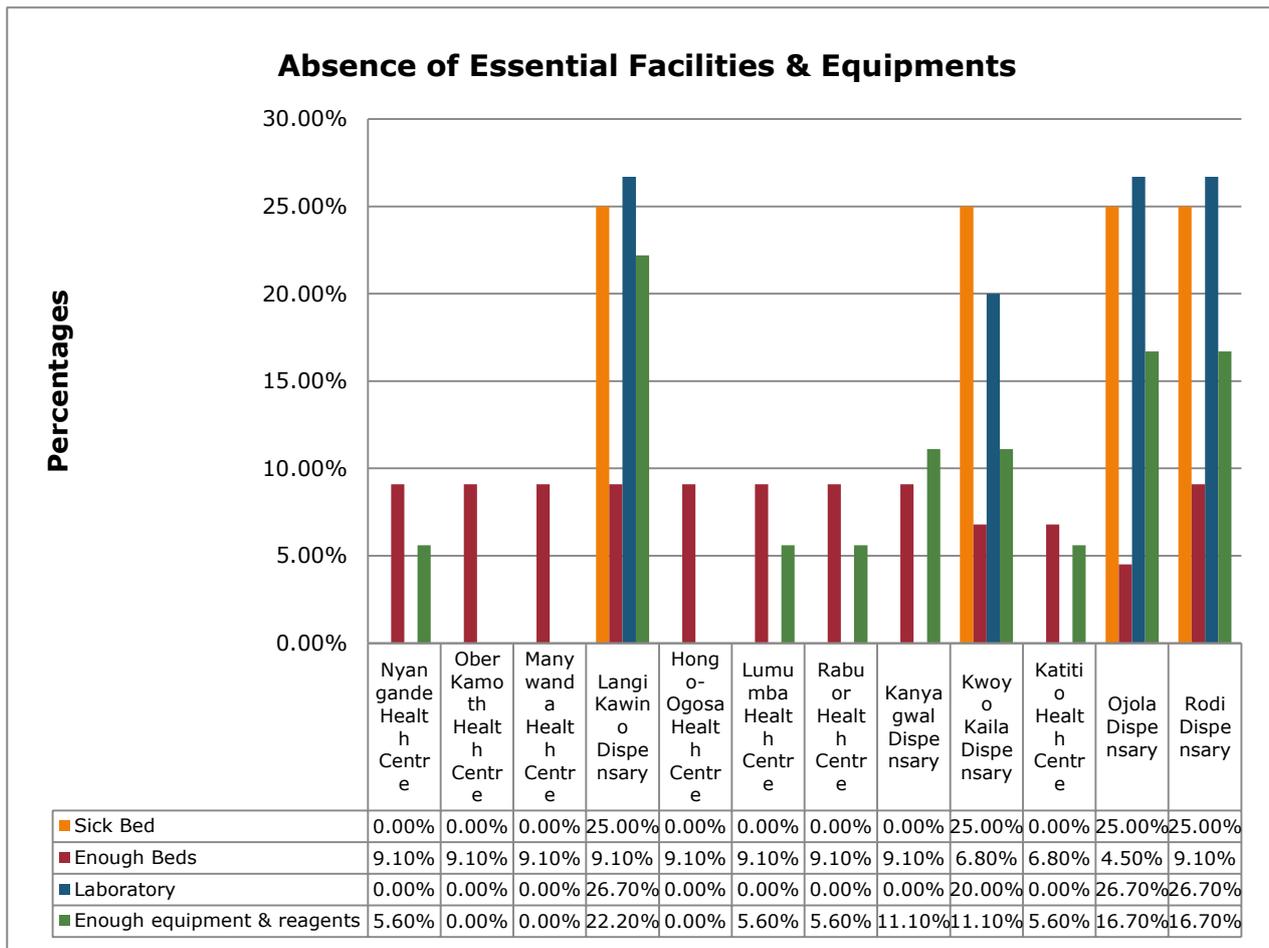


Many health facilities failed the test of emergency preparedness as they were found to be missing basic necessities including gloves, post-delivery sanitary pads, ambulance facility, under five years vaccine and their storage facility/ fridges. They apparently lacked proper waste disposal mechanisms. In terms of absence of gloves at the health facilities, Lumumba Health Centre was the most affected taking up 28.6 percent of all the observations.

Kanyagwal, Hongo, Rodi and Nyangande Health Centre followed with each at 14.3 percent. With the exception of Ober Kamoth, the rest of the health facilities either had none or malfunctioned ambulance in all the observation. Langi Kawino dispensary had the highest occurrence of missing vaccine storage facility/ fridge at 57.1 percent followed by Kwoyo Kaila at 28.6 percent and Lumumba Health Center at 14.3 percent. However, the absence of vaccines for children from birth to 5 years was only recorded in Langi Kawino and Lumumba Health Center at similar frequency of 50 percent.

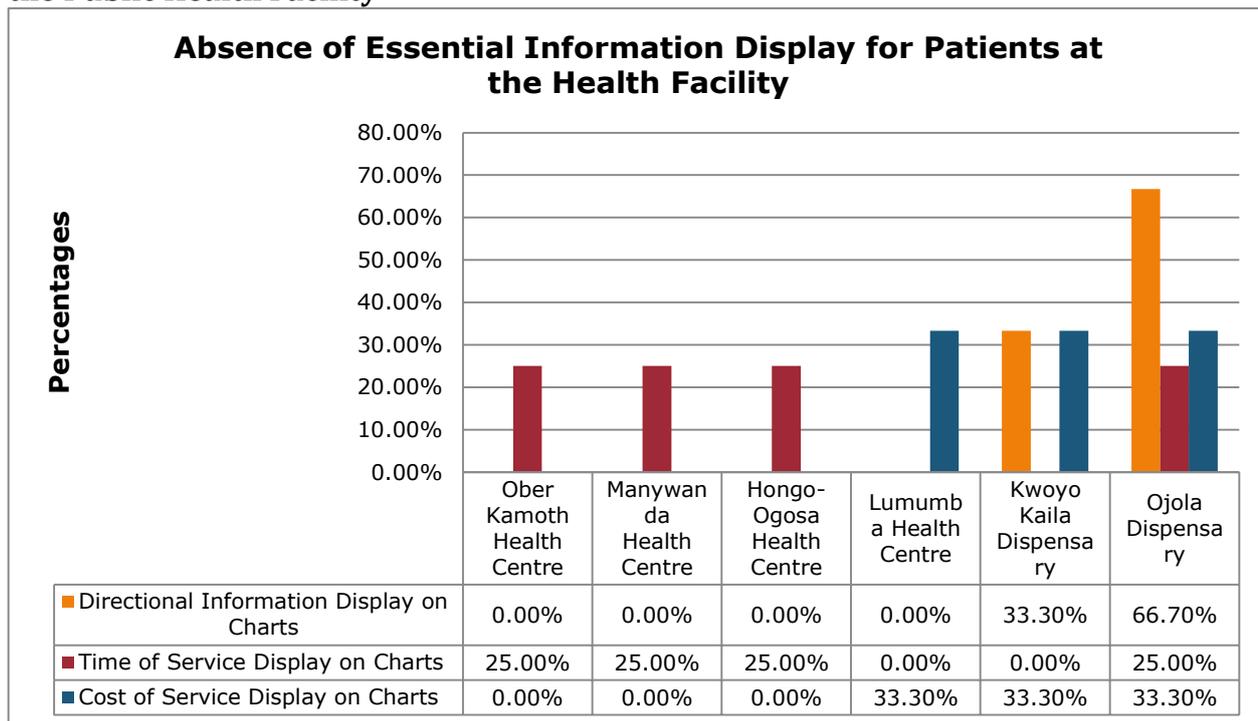
The post-delivery sanitary pads for women were found to be missing over the observation period in Langi Kawino, Kwoyo Kaila, Ojola and Rodi dispensaries. This appeared to have been a cross cutting issue in all dispensaries at the county and that needs to be addressed by the county leadership in a bid to ensure dignity to newborn mothers in the community in the post delivery services.

Figure 36: Observation on the Absence of Essential Health Facilities and Equipments



Some health facilities were lacking on basic requirements in terms of sick bed, inpatient's beds, laboratory and its equipments and reagents. Sick bed was notably missing in Langi Kawino, Kwoyo Kaila, Ojola and Rodi dispensaries during the observation with each having equal observable 25 percent. All health facilities recorded insufficient inpatient's beds whereas laboratory was missing in most of the dispensaries including Langi Kawino, Kwoyo Kaila, Ojola and Rodi dispensaries. Apart from Ober Kamoth, Manywanda and Hongo Ogosa health center, the rest of health facilities lacked enough laboratory equipments and reagents.

Figure 37: Observation on Absence of Essential Information Display/ Service Charter at the Public Health Facility



The existing information chart failed sort in defining the ministry’s, core functions, services offered, commitments, obligations, customer’s rights and obligations, mechanisms for complaint and redress for any dissatisfied customers.

For the period of study, either there was no clear information displayed on charts or they were not displaying sufficient information enough to properly guide patients on the services offered and where to get them at the facilities. These were only noted in Kwoyo Kaila and Ojola dispensaries with ojola taking the lead with 66.7 percent while Kwoyo Kaila following at 33.7 percent of the observations.

It was not possible to know how long the service take from the available displayed information in four facilities including Ober Kamoth, Manywanda, Hongo Ogosa and Ojola health facilities with each having 25 percent of the observations. The cost of health services was not noticeable in Lumumba, Kwoyo and Ojola with each having 33.3percent of the observations. This lack of sufficient information display render new patients confused within the facility and a lot of time is taken while trying to establish what is going on in various blocks or rooms. Consumer’s right for information is therefore violated in the process.

10. Conclusion and Recommendation for Policy Advocacy

There have been commitments by government to ensure provision of accessible and affordable health services in the country among them being the allocation of funds for free maternity programme covering both normal delivery and caesarean section, together with those who end up in intensive care unit and those who undergo renal dialysis. The government through the ministry of health had by December 2013 disbursed Sh1.7 billion to health facilities for the course which has consequently yielded increase of deliveries conducted in public health facilities.^{vi}

However, this particular study has highlighted a number of challenges which continue to affect the realisation of equitable, affordable and quality health and related services at the public health institutions and the attainment of highest health standards within Kisumu County and generally in the country as a whole. The major challenges in the health sector are mainly attributed to limited budget allocation by the national government which is far below the Abuja declaration of 15 percent of national income. This has seen public health facilities lacking in terms of basic essential infrastructures, facilities, equipments, prescription medications/drugs, poor remuneration to health workers leading to frequent national strikes as public health facilities and general reluctance of public health workers.

The other challenge is on the inadequacy of data on the actual requirements for quality health services as the county health budgets were drawn in record time just to facilitate allocation of funds without effective consultation with the communities and other key stakeholders on the information on the real demands that informs the policy development process at the county level. The study also indicates serious structural imperfections in Kenya's health system as access to healthcare is often compromised by a dysfunctional referral system between health facilities. Study also indicates poverty as another major challenge to access of health services by majority of the population.

Majority of poor patients who seek treatment at lower-level health facilities but cannot be diagnosed or treated there, are often asked to pay for their own transport to a higher-level health facility of which they hardly afford. The health system also suffers from lack of properly trained and compensated community health workers despite the key role they play in reaching out to patients, including children, informing them about healthcare options, and convincing them to seek healthcare for themselves or children in their care. User fees for tests, drugs, and medical procedures are another obstacle for many patients in access to health services at both county and national levels.

Not least is the alleged rushing of devolution process of health services to county governments smeared with elements of mismanagement, nepotism in the hiring of new doctors, frozen promotions and reduced or delayed salaries.

Recommendations

Therefore, in addressing the challenges in the health service delivery at both national and county government, the study recommends a raft of measures to be undertaken by both the national and county governments as follows:-

1. While there is increase in the amount of expenditure being allocated to the health sector, this amount is way below the Abuja Declaration target of 15 percent. There need for a strong advocacy for increased budgetary allocation that meets the 15 percent target. The health sector allocation should match and even surpass the education sector budget. For this to happen there must be political will and commitment both at the county level and national level as has been seen in the education sector.
2. The health sector has a comprehensive budgetary process within the larger budgetary making process in Kenya. The sector allocations by programmes and detailed budget lines are undertaken at the sector working groups. There is need for effective stakeholders' engagement at the development stage of the health sector position paper to influence health sector allocation that positively affects women, children, disabled groups and people living with HIV/AIDs. The position paper presents an analysis of the context, sector performance, achievements and the resource requirements for the health sector.
3. In the health sector, budgetary allocation is highest in the curative and preventive and promotive health sub-programmes. These are the core programmes that deal with the health needs of women, children and PLWHAs. While the government has made tremendous efforts to prioritise the health needs of these groups, there is need to ensure improvements in child nutritional needs are catered for. This has not been well addressed in the current 2013-14 budget.
4. The country has moved to a devolved system of government, however, from the programme budget approach, it would be important to disaggregate the health sector budget to what is done by the national and county government. In this way it will be possible to hold the right institution accountable for health outcomes.
5. There are several institutions that play a role in ensuring accountability in the health sector. These institutions are largely involved in health services provision or providing the legislative or operational framework that will ensure the interaction of stakeholders produce positive health outcomes. However, while this is the case, none of these institutions have the mandate to enforce accountability, meaning that accountability in the health sector is largely hinged on political good will of stakeholders. There is need to for the national government to develop a more accountable framework with enforceability mechanisms to ensure greater leaps towards achievement of health related millennium development goals.
6. In the realisation of the constitutional provision under Article 43(1)a (2) and (3) on (2) on the health standards rights, emergency health service provision, and the need for state provision of appropriate social security to persons who are unable to support themselves and their dependents. The national government should undertake the establishment of emergency medical treatment fund to cater for the emergency health needs of the poor. This particular fund should be able to reimburse both the public and private sector for the emergency health services rendered to the deserving poor.

7. In a bid to deal with the challenge of inaccessibility to quality health services resulting from disparities on income/poverty prevalence across the country, the government needs to undertake radical reform within the existing National Hospital Insurance Fund (NHIF) to become a universal national insurance scheme (a single payer system) where population healthcare is publicly funded by national government with both private and public delivery mechanisms.

In this case, the national government becomes the primary reimburse (payer) of healthcare services as the county governments take up the primary responsibility of managing, funding, and governing healthcare with funds from national government. The county governments can either serve as the main purchasers of care from providers, or they devolve this responsibility to other entities. The national government will therefore use the national taxes to reimburse the payments of health services through counties. The full medical cover under the proposed universal national scheme should prioritise the deserving vulnerable groups of women, children, youths, the old and people with disabilities.

This new system will be able to grant the choice of patients visiting public institutions or private physician for health services at predefined cost limits for each individual over time period. Those in employment can have the advantage of supplementary voluntary health insurance provided by employers to cur son against possible time delays while seeking health services within public facilities.

8. Based on the principles of good governance that require public service delivery to be performed with integrity and high level of transparency and accountability and the object of devolution requiring participation of the people in the exercise of the powers of the State and in making decisions affecting them; to recognise the right of communities to manage their own affairs and to further their development. Therefore, the county assembly need to prioritise community involvement in the whole process of health service delivery through the following actions:
 - a. County assembly need to develop programme for routine meeting with members of community to educate them on their health rights, responsibilities and to gather their views in relation to quality of health service delivery, challenges and views on addressing those issues to promote standards of public health service delivery and to improve the general state of the health facilities.
 - b. County assembly to set aside minimal resource allocation by county government to facilitate capacity development on good governance and social accountability tools to the community and routine implementation of community health report card and health facility monitoring report to keep on check the quality and level of absence of health service. This will therefore provide a rigorous basis and a proactive agenda for communities, civil society organisation or local governments to engage in a dialogue with service providers to improve the delivery of public services.
 - c. County assembly to develop county based health service delivery citizen reporting and community monitoring toolkits to help gather community views in relation to public health service delivery to be implemented through the village council and whose reports to be made public and handed directly to county representatives in a community baraza/ forum for appropriate action. This will therefore act to enhance

performance by health service providers and action on lacking equipments or poor facilities within public health centres.

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12. Endnotes

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