



HSPS II Achievements and Lessons Learned

Health Legislation for the New Constitution

Legislation in Health

As concepts relative to and perceptions of what constitutes and determines health have changed. Science has made an array of increasingly sophisticated technologies available to advance public health. In turn, societies have generally followed suit by adopting legislation that deals with all aspects of health protection and promotion, disease prevention, delivery of health care, and ethics in health care.

In accordance with individual traditions, countries have progressed differently as the process involved the character and enforcement of the legislative instruments. However, as a result of international collaboration, the objectives of health legislation become increasingly harmonised across and between countries.

Health Legislation in Kenya

Discussed for some time, the need to reform and modernize Kenya's health legislation was first recognized in 1996 when a Health Reform Secretariat (now the Unit for Technical Planning and Performance Monitoring) was established, with legislative reform as one of its tasks. The existing Public Health Act was originally introduced in 1921 and has been amended on various occasions, the most recent edition being from 1972.

In 2008, following a new proposal for reform from the Department of Standards

and Regulatory Services, it was decided to undertake a review both of the Kenya Health Policy Framework of 1994 and of the existing health laws and statutes, to which end an Inter-Ministerial Secretariat was established.

The review of the Health Acts was started but unfortunately it did not deliver on its mandate. A Task Force met in March 2008 and meetings with the private sector in the course of 2009 considered various reform issues. The review of the Health

Policy Framework led to the issuing of a report "Towards a New Health Policy for Kenya – a Concept Note".

The circumstances which preceded the adoption of a new Constitution provided a new impetus to legislative reform in the health sector. With the introduction of 'rights to health' and of

specifying the State's duties in this respect, it is time to provide Kenya with a modern Health Law. Also, the decentralisation envisaged by the Constitution dictated revisions of the legal framework for health.

How did HSPS II get involved?

Under a subcomponent entitled 'Support the implementation of SWAp related activities through common basket arrangements', HSPS II supported legislation review. In October 2009, prior to the health-related implications of the new Constitution were known in details,



HSPS II assisted the Ministries of Health (MOH) in holding a succession of workshops to elaborate a review of existing health legislation.

The outcome of the first step of the review was the identification of a number of shortcomings in the existing legislation:

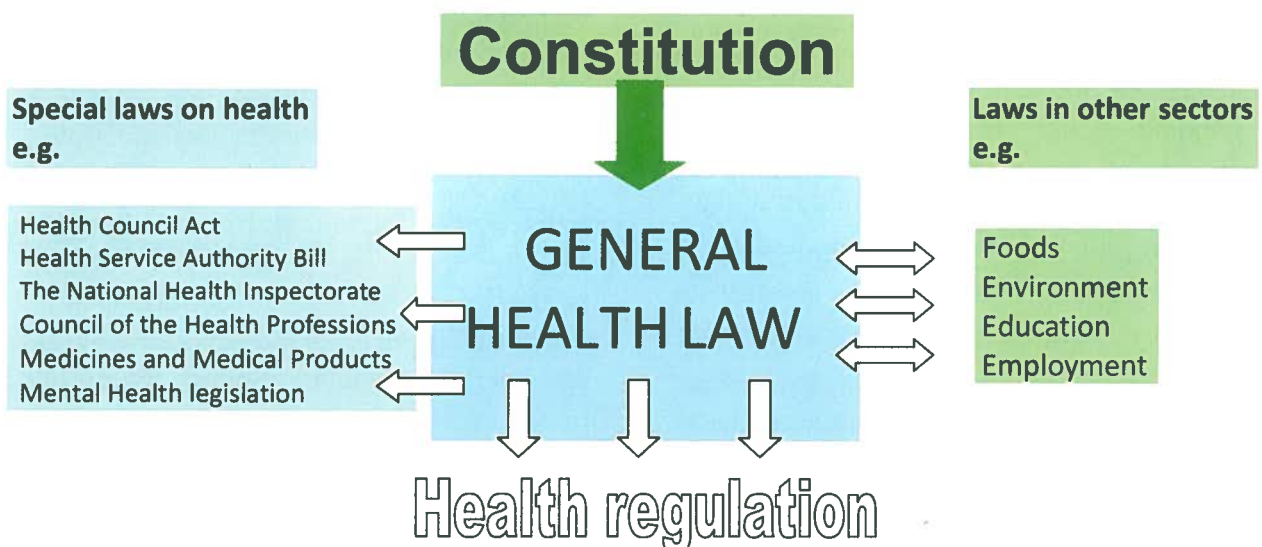
1. A new Kenya Health Policy Act would need to be developed;
2. The Public Health Act needed to be revised and updated;
3. An Act to mandate a strong Public Health Inspectorate was required;
4. A single consistent Act for the Health Professions was needed to replace the numerous individual health professions acts;
5. A specific Medicines Act needed to ensure the efficacy, safety and quality of medicines and certain related product;
6. An Act on the Governance of Health Institutions was required; and finally
7. Provisions for Universal Health Insurance Coverage were called for.

A Roadmap for the legislative reform was given a timeframe covering the period 2009-12.

How was the Legislative Process taken forward?

Following the promulgation of the Constitution on 27th August 2010 and the adoption by Cabinet of the broad framework for its implementation, MOH were requested to

1. Develop a National Policy Frame Work in Line with the Constitution in collaboration with relevant Ministries and stakeholders by April 2011.
2. Develop a Sessional Paper on the National Health Policy to be submitted to Parliament by April 2011.
3. Hold meetings to share with stakeholders for purposes of ownership.
4. Set up an Implementation Team to steer the process of Implementation of the Constitution in the sector immediately.
5. Finalise the Position Paper for the Health Sector through internal ministerial workshops and meetings with stakeholders across the country.



The health policy and legal hierarchy. The Constitution shapes, directly or indirectly via the policy process, the Health Law, which, together with subsidiary legal instruments, mandates or assigns responsibility for specified aspects to the National MOH, County Governments and to various 'institutions'. Subsidiary legislative instruments are at various stages between early draft and final adoption.

Current State of Affairs

Based on the new Constitution, the Position Paper, the National Health Policy and the zero draft of Kenya Health Law was developed with support from HSPS II. The Law provides a definition of rights, duties and obligations at all levels in the health sector and introduces structures and procedures to ensure the development, review and implementation of health policies and services.

The draft of Kenya Health Law has, upon presentation to and discussion with stakeholders, been further developed. A review of functions and institutional structures of the two ministries has been carried out and a proposal on the

alignment of the Ministries of Health with the new constitutional framework, at the national and county levels, has been factored into the draft Health Law which is expected to go into a public hearing.

A first draft of the Health Service Authority Bill was generated in March 2012. Several other health-related laws need to be developed such as Health Professions Act, The National Health Inspectorate Act, the Health Council Act, Regulation of Medicines and Medical Products.

Finally, a new health sector strategy is also being developed as part of Government requirements to Ministries towards effective implementation of the Constitution.



A picture from the KICC workshop

What remains to be done?

The amount of work involved for the various documents to be developed, finalised and approved by the relevant authority and for the draft bills to be converted into Acts by Parliament should not be underestimated. However, this is likely to be dwarfed by the task of putting the provisions into practice, bound to

make far greater demands on leadership and governance.

The Health Law Draft One is expected to be placed in the national newspaper to inform and allow the public to comment on the draft before it is finalised. Thereafter, a final draft should be submitted to the Commission for the Implementation of the Constitution for

constitution compliance evaluation. The Ministries will prepare a Cabinet Memo on the Health Law for presentation to the Cabinet. After presentation in the Cabinet, the actual process of transcribing into the legal paragraph format will start.

Sustainability

Further to the preceding reflection, sustainability will depend on the capacity to lead, govern and manage the sweeping changes which must be foreseen to flow from the reform process. The legislative process so far, given its duration and the difficulties encountered, might have been more promising in this respect.

However, the wider political realities are changing, driven not least by the new Constitution itself, but even more so by citizens becoming aware of their rights, generally holding authorities to account, and demanding that health and other services are of good quality. Even if it may take time for these realities to bear on equity, quality and health status, this evolution is perhaps the best hope for the sustainability of the health system of Kenya - and for the health of Kenyans.

Lessons Learned

1. Stakeholder management

By placing eminent expertise at the disposal of the health ministries, HSPS II has made an important contribution to modernising health legislation in general and rendering it in conformity with and conducive to the vision of the Constitution. While not over yet, the process leading up to the finalisation of the various policy documents and legal bills has been laborious and appears to indicate inadequate stakeholder management.

2. Leadership and Governance

The new comprehensive health legislation will eventually produce changes of a scale likely to seriously test the capacity to

implement and sustain the reforms in practice.

From the point of a long-time dedicated development partner, the question remains as to whether the energy, creativity, commitment and skills to overcome the obstacles are on hand.

3. Reforms and devolution

The process of implementation of the Constitution was initially sporadic and problematic across the whole public sector. The lack of wider Government plan for the implementation has caused significant delays in the process.

In all organisations it is well-known that restructuring feeds uncertainties to all staff members in the organisation. In this case we are looking at a three dimensional change at the same time: Two ministries merging to one, devolution of the responsibility of the health care services from the National Government to the County Government, and all the implications of this devolution which calls for new regulatory bodies.

4. Part time commitment

The various officers in the ministries have shown great commitment and interest, but none full time designated personnel were appointed by the ministries to follow the process. This has affected the continuity and the implementation process.

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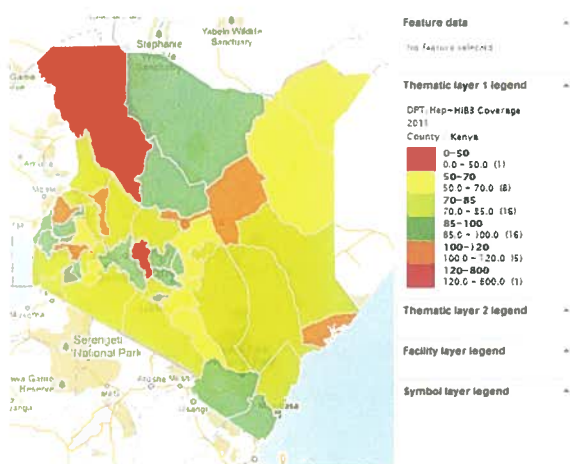
HSPS II Achievements and Lessons Learned

Health Management Information System

Health information: managing knowledge and strengthening evidence for better health

The World Health Organisation's Framework for Action for Strengthening Health Systems builds on an understanding of a health system as consisting of the following six building blocks: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance.

According to the Framework, a well functioning health information system ensures the production, analysis, dissemination and use of reliable and timely health information by decision-makers at different levels of the health system, both on a regular basis and in emergencies. It involves three domains of health information: on health determinants; on health systems performance; and on health status.



DHIS 2 includes Geographical Information System (GIS) which allows viewing selected indicators on maps, such as e.g. immunization coverage.

Based on a variety of operational and strategic data sources, health information helps detect, investigate and contain public

health threats; guide everyday health services management, i.e. by generating data on health services and system resources; and track overall performance.



The DHIS 'team' at the official launch on 15 Feb. 2012.

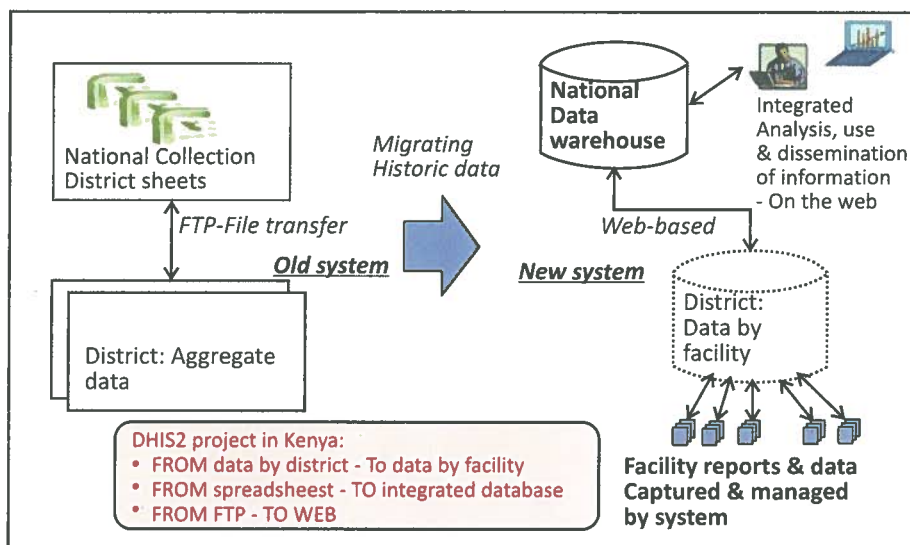
Health Information in Kenya

Over the years, the Ministry of Health (MoH) has assembled an increasing amount of data, e.g. on vital statistics, programmes and activities. However, in addition to problems with the accuracy of such data, the ensuing information was found not to match its individual purposes.

In an attempt to address performance measurement of the health sector a File Transfer Protocol (FTP) was initiated in 2007/08 and reporting rates steadily increased. Reporting forms and registers were revised; data were captured by health facilities, aggregated at district level, and then transferred by FTP (as excel files) to the national level. However, the facility "identity" of data was lost in the process, rendering general and comparative analysis cumbersome. Further, as districts continued to be created, data management became ever more difficult. In response, it was decided to adopt the District Health Information Software

(DHIS2), a free, open source web-based “data warehouse” database application. This software addresses both local and national needs.

funding. Future activities, incl. investments to improve quality and use of data, will henceforth be financed by USAID (via AfyaInfo) and other partners interested in health information systems.



State of Play - March 2012

The DHIS2 is used in all provinces, districts health facilities (hospitals, health centres, dispensaries, clinics) and community units – including non-public institutions - and in an

The development of DHIS2 is coordinated by the Kenya Health Information System with technical support from the University of Oslo. The transition from FTP to web-based system is illustrated in the figure above.

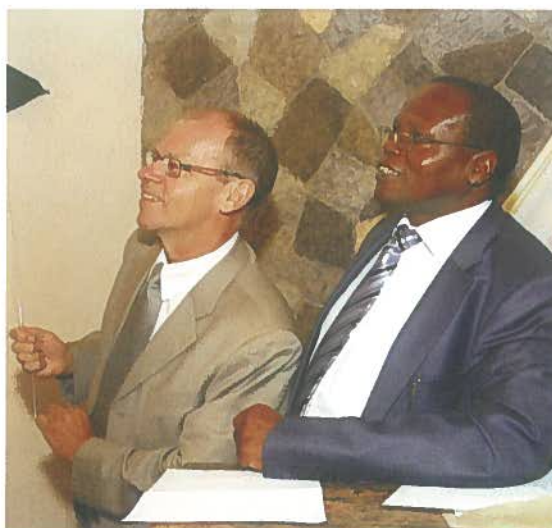
of health centres, for capture, reporting, charting and tabling of data, and also increasingly for more advanced analysis.

Getting DHIS2 operational

Early development and pilot-testing took place in tandem with the building of a strong country team. The DHIS2 was soon found to be operable from a central server, reached by users countrywide by cloud application technology and districts using wireless modems for connectivity. Implementation benefitted from users being already computer and Internet 'literate', familiar with data forms and collection routines.

A rapid rollout to all districts and hospitals, province by province, took place in 2011. A good internet infrastructure allows using so-called cloud computing, the first of its kind in Africa. An immense training campaign, partly funded by DFID, was part of the exercise.

The DHIS2 was launched as Kenya’s official Health Information System on 15th February 2012. This also marked the end of DANIDA



Mr. M. Bor, PS, MoPHS, and Mr. G. Aagaard Andersen, Danish Ambassador, at the DHIS launch.

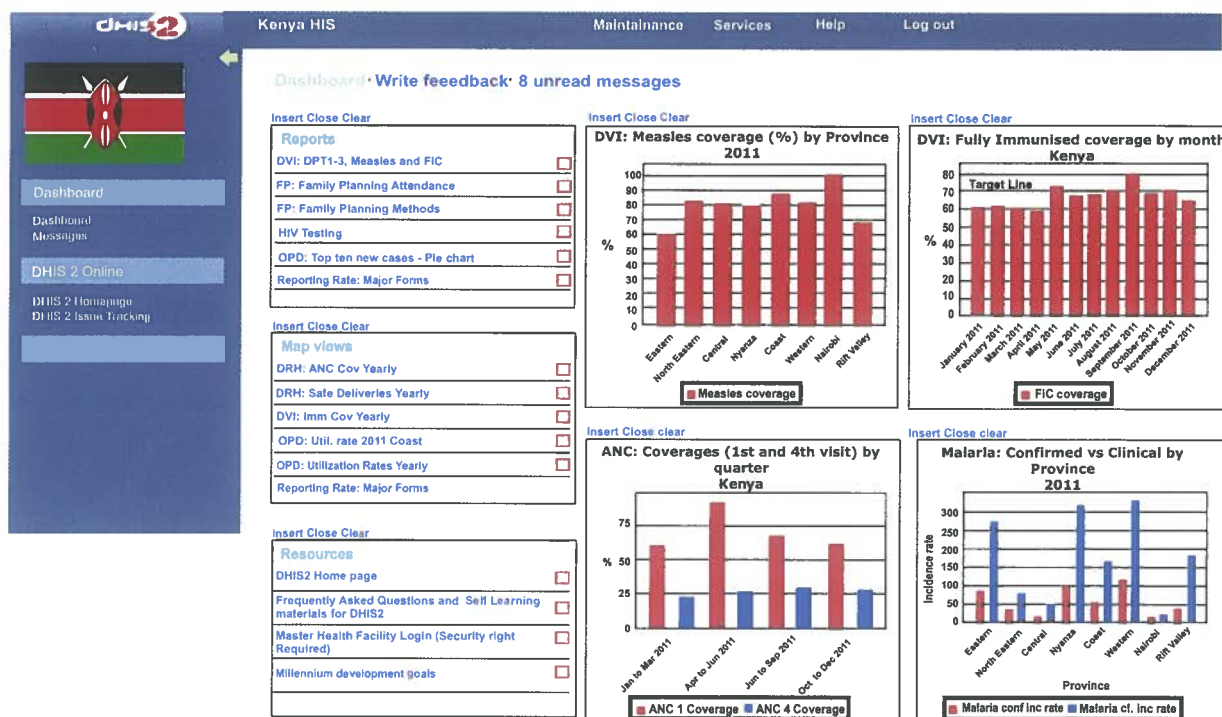
Intense efforts have been devoted to addressing issues as they emerged and to continue developing the system in a modular approach, including off-line data entry capability to compensate for poor connectivity in remote areas. An online server enables system changes to be made interactively and in accordance with users' input.

Functionalities thus introduced include:

- Mobile web interface;
- Users being familiar with Excel, data entry screens were made to capture the minimum data using standardised

by MOH as in FTP 'spreadsheets'

- A data visualizer for dynamic analysis and presentation of data;
- Use of Mapping interface, Geographical Information System (GIS).



The way forward....

A priority will be to create a web portal where processed data, reports, tables, maps, data views, annual reports, policy documents etc. may be disseminated to politicians, media and the general public.

Another task will be to use mobile applications for immediate or emergency data reporting, and to develop especially the inpatient level data module.

Thirdly, the focus should now move beyond just collecting and managing data, to include analysis and use of information. To this end, a major training rollout, this time with participation from executive levels, should be initiated as a matter of urgency.

Fourthly, stable server hosting with a two line connectivity (24/7) is crucial to the sustainability of DHIIS2. This calls for decisions on issues related to human resources, backup, reliable connectivity and network bandwidth, power supply, physical security and disaster recovery plans, and effective, powerful and robust hardware.

Lesson Learned

1. Technological advances

The DHIIS2 has been received with keen enthusiasm by users and most programmes have agreed to abandon stand-alone data collection and, instead, to rely on information provided by the DHIIS2. Without a determined pursuit of appropriate yet

state-of-the-art technological solutions, achievements are likely to have been far less impressive.

The Kenyan DHIS2 has gained repute abroad and national team members are being invited as resource persons, e.g. to relate Kenyan experiences or help define system standards internationally.

2. A strong and committed national team

The above points to another important lesson: the importance of anchoring the system with a national team, in whose members substantial capacity-building efforts have been invested.

Having helped develop this capacity, i.a. by enabling several team members to acquire relevant Master degrees, the HSPSII has provided significant impetus to the technical and institutional sustainability of good health information in Kenya.

3. Partnership and role definition

The approach by the University of Oslo team, i.e. one of partnership rather than a more classical provider attitude, has been a key DHIS2 success factor, as repeatedly underlined by members of the national team as well as evidenced by the continuous and dedicated web-based interaction with and support to users.

The team's receptivity has inspired users' confidence and added significant momentum to the application's adaptation to Kenyan realities.

4. Provision of Technical Assistance

At a more general level, the flexibility and responsiveness with which HSPSII TA has been made available, has encouraged dialogue with the MoPHS/MoMS and thus been conducive to identifying and hiring of suitable and competent expertise.

A proactive TA approach may occasionally – if too dynamic - maintain rather than amend institutional weaknesses. Contrary to any concerns of this nature, both the HSPS II and the DHIS2 have played an essential role in helping host ministries uphold and strengthen capacity during a difficult time.

References

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AbouZahr C, Boerma T. Health Information Systems: the Foundations of Public Health. Bulletin of the World Health Organization. 2005, 83, 8.

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Vision of Health Information System (HIS): To be a centre of excellence for quality health and health - related data and information for use by all.

Mission of HIS: To provide timely, reliable and accessible quality health information for evidence, based decision-making to maximize utilization of scarce resources in the health sector

The DHIS is aligned to:

Mandate: To generate, analyze and disseminate health information to facilitate effective policy formulation, management, planning, budgeting, implementation, monitoring and evaluation of health services and programme interventions in the health sector by all.





HSPS II Achievements and Lessons Learned

Pull System - Appropriate Medicines Use

Pharmaceuticals & Health Care

Since the introduction, by the World Health Organisation in 1977, of the Essential Drugs concept many efforts have been devoted – at international and national levels – to addressing issues related to lack of access to, and irrational use of, medicines – issues which together with poor medicine quality - constitute a serious global public health problem.

The context is the enormous economic impact of pharmaceuticals - especially in developing countries - where spending on pharmaceuticals represents as much as 25 to 66% of total public and private health spending, often leading to household impoverishment.

The Pharmaceutical Supply Chain



Source: *Management Sciences for Health*

In strictly technical terms, neither access nor rational use is complex. However, political, legal, economic, and behavioural circumstances render drug supply vulnerable to poor governance. Financial stakes are high and incentives skewed towards 'consumption'. Drug prices are generally opaque and have repeatedly been shown to be abusive, at governments and individual level. Perceptions play a great role in how health

workers prescribe and how patients take medicines. Most worryingly though, and even if other determinants account for the disparity in access to medicine, corruption carries a major share of the responsibility. Also, counterfeit medicine is an increasing problem in most developing countries. Equally, irrational and inappropriate use of medicines results in wastage of scarce resources and sometimes produces severe public health hazards rather than benefits to patients.

More than half of all medicines are prescribed, dispensed or sold inappropriately, and half of all patients fail to take them correctly. WHO estimates that approximately ten million lives could be saved every year through the improvement in access to essential medicines and vaccines.

The Kenyan Situation

In 2005, the kit system used to supply dispensaries, health centres and most hospitals with pharmaceutical products was replaced by a requisition-based 'pull' system, which pilot tests in North Eastern and Coast provinces had found successful. By 2007, the new system was widely seen as a success and was expanded to include the district and provincial hospitals across the country. The following year a start was made to enrol dispensaries and health centres in Nairobi, Central and Eastern province, but this was soon halted as it became clear that Kenya Medical Supply Agency (KEMSA) was no longer able to cope with demand. By the end of the programme 1,911 public facilities, including all hospitals, i.e. about 40%, were on pull system.

How did HSPS II get involved?

Danida has a long history of supporting the health sector in Kenya including the provision of pharmaceuticals, through supporting actual procurement of supplies, support to KEMSA, supply systems development and capacity building. One of the components HSPS II was conceived to 'strengthen support systems to deliver KEPH at primary levels. In this

context, support for the nationwide roll-out of the 'pull' system for essential medicines and medical supplies (EMMS) was seen as logical extension of Danida's prior involvement in the subsector. Assistance went to capacity building, training, monitoring and supervision and to Appropriate Medicines Use (AMU) in support of the roll-out of the "pull" system.



Dispensing in circumstances of limited supply?

What actually happened?

Following a comprehensive review of the pharmaceutical sector in 2003-05, an update of the Kenya National Pharmaceutical Policy (KNPP) took place in 2006-08. It sets out to revitalize the pharmaceutical sub-sector in terms of policy direction and strategies touching on pharmaceutical products, personnel for provision of pharmaceutical services and the key institutional framework and

processes required to ensure access to medicines for the population. In 2009-10, a draft Pharmaceutical Master Plan (PMP) for implementation of the KNPP was then developed, which stretches the role of addressing organisational and institutional issues relative to the decentralization and other reforms. The latter includes autonomy of KEMSA, the Pharmacy and Poisons Board and the National Quality Control Laboratory.

It further focused on capacity building, strengthening pharmaceutical management, planning and financial management, on appropriate medicines use, as well as on bolstering information, monitoring and evaluation.

A sessional paper on KNPP was later developed and presented to Cabinet in early 2011 and consented in December. This provides the Government

commitment to the much needed reforms in the pharmaceutical sector.

In addition to contributing to the above, HSPS II was instrumental in helping the Ministries of Public Health & Sanitation /Medical Services carry out an 'Evaluation of the Pull System for EMMS in Kenya' and a 'Status Assessment of AMU in the Public Health Sector', both carried out in 2010.



The Situation early 2012

At present, it is unclear to what extent the wider provisions of the KNPP or the recommendations regarding the AMU are being taken forward. The training for the pull system was conducted in the rest of Kenya late 2011 and beginning of this year in line with the performance of KEMSA, which has improved considerably since early 2010. Therefore, the pull system is expected to be introduced nation-wide in the course of 2012.

Sustainability

Implementing the KNPP and moving forward on the recommendations of the Master Plan and regarding the pull system and AMU are indispensable to sustainability. Without progress on these dimensions, public health services will be unable to attract clients also for other services and essential medicines will remain beyond the reach of many, in particular the rural poor; as a result, many will die from easily curable illnesses.

In fact, the financial and economic losses incurred render the present situation unsustainable.

Lessons Learned

1. Medicines are Important

Essential medicines, vaccines and other supplies constitute a vital element of health services. Many lives are lost due to the non-availability of medicines; health services without such commodities lose their credibility, forcing patients to change their health-seeking behaviour; and one of the most frequent complaints heard when speaking to health workers is that 'we have no drugs'.

2. Leadership and Governance

As plainly set out above, the pharmaceutical sector is particularly vulnerable to weak leadership and governance. While financial malfeasance is not per se implied, Kenya is not immune to corruption, as demonstrated in the context of the National AIDS Control Council (NACC) (2005) and the education sector (2010).

3. The Supply Chain

The roll out of the pull system was postponed for some time due to the lack for supply capacity in KEMSA. Most of the recommendations from the evaluation of the pull system in 2010 have so far not been addressed. The evaluation identified five root causes of the pull system's constraints:

- Insufficient funding for EMMS procurement
- Lack of specific budget line for EMMS procurement
- Drawing Rights are not maintained and in line with available funding
- Too many items included in the pull system
- No safety stocks kept at any level.

4. Aid Effectiveness

According to the principles of the Paris Declaration on Aid Effectiveness, developing countries i) will set their own strategies for poverty reduction, improve institutions and tackle corruption (=ownership), and (ii) with donors shift focus to results, and measure results.

While the split-up of the MOH has made 'ownership' and 'result-orientation' the in public health sector more elusive, the apparent lack of progress on pharmaceutical policy is disappointing. Moving forward in this area will be a focal area of future cooperation.

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HSPS II Achievements and Lessons Learned North Eastern Province Infrastructure

Access to Health Services

Irrespective of their pledge to re-orient health system towards Primary Health Care (PHC), many countries – in Africa as elsewhere- continue to allocate relatively few resources, in terms of investment as well as recurrent budget, to primary care. A recent WHO study of national health accounts found that African countries spent an average of 75% of their recurrent health budgets on hospitals and only 25% on non-hospital care.

The emphasis on primary level of care is justified on grounds of cost-effectiveness, feasibility, and equity. An important dimension of equity is access, and achievement of the MDG health goals

cannot escape redressing the often massive disadvantage rural people, when compared to their fellow urban citizens, face in accessing health care.

Community-based services feature strongly in PHC. However, access to PHC implies proximity of health infrastructure, i.e. dispensaries, maternities, and health centres, complemented by hospital care, e.g. for obstetric emergencies and other acute care.

Thus, while the case for re-orienting expenditure between levels of care remains valid, an even stronger case can be made for remedying access to care by investing in rural health infrastructure.



Building for better access to health care in NEP...

The Kenyan Situation

As a result of uneven investments over time, the distribution of health facilities in Kenya remains consistent with the description above. Construction of dispensaries, health centres and hospitals has not been subject to coherent demographic or geographic needs analysis. Politics and security have played a role in this, as have the particular geographical preferences of external donors.

In 2006, North Eastern Province (NEP) and parts of Coast Province were among the areas which had seen the least investment

in infrastructure to provide basic health services. Consequently, numbers of health facilities, hospital beds and cots per 100,000 people were among the lowest in the country relative to other provinces, and distances between facilities were sometimes several hundred kilometres. To compound this, NEP also had the poorest road network, and its poverty levels were among the highest, in the country.

The comparison of NEP and national health indicators from Kenya Demographic and Health Survey starkly testifies to the consequences of this imbalance, e.g. deliveries in hospital: 17% versus 44%.



Health seeking behaviour is influenced by access to and quality of care.

How did HSPS II get involved?

During HSPS I (Coast and North Eastern) surgical facilities were established with Danida support at Garissa General Hospital (GGP) and Wajir District Hospital, to improve their referral capacity. When HSPS II took over in 2007, only DKK 7 mill, was allocated

for the infrastructure of seven referral centres, including the construction, furnishing and provision of equipment of new wards, theatres, renovation of existing buildings, upgrading of Health Centres to hospitals and various civil works in health facilities. Policy-wise, these construction activities were

concentrated on the higher levels of the health pyramid, as a way of guaranteeing a viable and operational referral system, to allow the provision of basic emergency obstetric care in NEP, thus addressing well-known serious maternal health problems. At the time of planning, activities were foreseen to be finalised by June 2008.

However, as the HSPS II got underway and the wider programme environment underwent change, the need to adapt its strategy became increasingly apparent. The outpatient department at GGH having been destroyed by fire in 2008 and Health Sector Services Fund (HSSF) seeing disbursements delayed, combined to justify reallocations of HSPS II funding. Approved in the course of 2009-11, this allowed an expansion of the NEP health infrastructure investments. Therefore, in addition to the works at the GGH outpatient department, the programme

took on the (re-)construction of ten district hospitals in Mandera, Elwak, Takaba, Bute, Griftu, Wajir, Habaswein, Modagoshe, Bura and Masalani. These were all built or expanded, with female and paediatric wards, theatres, maternity and outpatient department, and equipped with beds and medical equipment, to enable managing obstetric emergencies.

Further, in 2011 the Steering Committee decided to utilise the foreseeable unspent funds for the construction of 54 double unit staff quarters to facilitate the hiring and retention of health staff at dispensaries, health centres and hospitals where most needed.

In total, expenditure for construction in NEP expanded to DKK 52 mill. (KES 760 mill) from the original DKK 7 mill. (KES 100 mill), and works continued till the very end of the programme period.



The Paediatric ward, Madogashe District Hospital

Sustainability

Sustainability and utilisation of the infrastructure created depends on GOK being able and willing, with external partners, to allocate the necessary resource to operate these.

Hiring qualified health workers and other civil servants for remote rural areas is a long-standing and well-known problem. Better working and housing facilities are only one way to help retain staff, other benefits may be needed to ensure proper staffed facilities in NEP.

Unquestionable though, the last years' significant improvement in NEP health service indicators owes much to better

access. Sustaining funding will depend on keeping up progress and demonstrating its impact on health status.

Lessons Learned

1. Accessibility is important

Health seeking behaviour is influenced by access to and quality of care. As nomadic clinics and static health infrastructure have enhanced access to care, utilization of services has grown to approach national levels.

2. Closer to achieving MDGs.

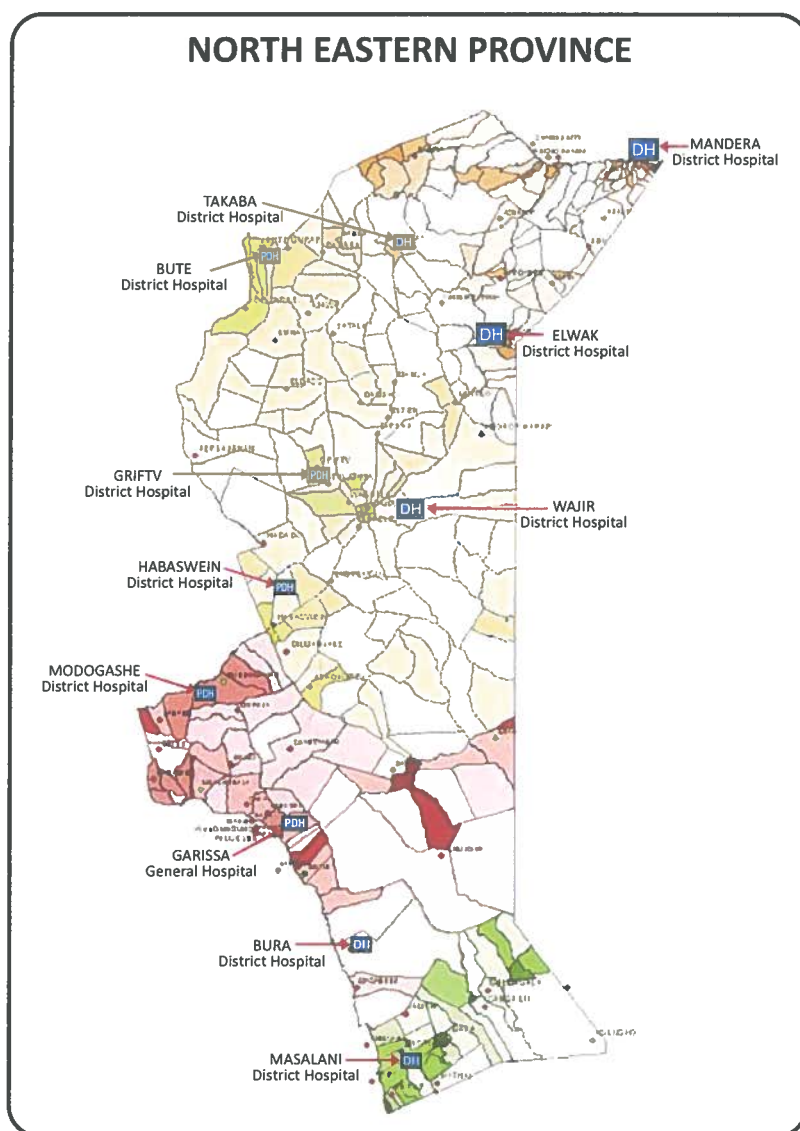
Beyond the ethical arguments for paying attention to those whose health status is particularly poor, extending basic services to the underserved is often a cost-effective way of improving overall health status and achieving the MDGs. The under-five mortality rate has with the last 5 years been reduced by 50%.

3. Flexibility and Adaptability

The ability to adapt strategy and reallocate funding in response to changes in the programme environment was vital to expanding the NEP infrastructure component. This allowed exploiting an opportunity to modify HSPS II's approach in accordance with local stakeholder's wishes and needs.

References

MOH public documents
HSPS II internal reporting.





HSPS II Achievements and Lessons Learned

Nomadic Clinics

Pastoralism and Health

Always precarious, pastoralism or nomadic livestock herding has, in recent years, become even more so, due to climate change and the resulting decrease in rainfall in the lands usually inhabited by people engaging in pastoralist livelihood. Although inhabiting vast areas, nomadic people constitute a minority - perhaps 25 million in global terms. Of these, 18 million live in Africa. Their relative lack of resources renders them 'voiceless', which - combined with the often fierce competition for meagre resources - often leaves them unnoticed by politicians and policy makers. Low population densities, migration, and extensive geographical dispersion with long distances are unfavourable to standard

fixed-point delivery models. Thus, the provision of basic services, including health care, social services and education, is fraught with complexity.

Therefore, when compared to other population segments in their home countries, nomads are usually the most underserved. As a result, their general struggle for survival is often compounded by ill-health, illiteracy and poverty.

Yet, despite this being 'common knowledge', it is striking how little is published in the international health services research literature on the topic. In fact, even the key question of whether mobile clinics perform better than static ones - or vice-versa - seems to remain unanswered.



Camel 'train', NEP.

Nomad Health Care in Kenya

An estimated six million Kenyans, i.e. about 15% of the total, are considered pastoralists, inhabiting perhaps as much

as 60% of the total land area, even if the potential of alternative forms of land use in these areas is limited due to low rainfall or extreme temperatures.

Table 1: Health Indicators NEP/Kenya (KDHS 2003/NASCOP and KDHS 2008/9)

	NEP	National	NEP	National
Immunization coverage	6%	57%	48%	77%
Contraceptive prevalence	<1%	39%	3,5%	46%
Deliveries in hospital	7%	42%	17%	44%
Infant mortality rate	91	77	57	52
Under five mortality rate	163	115	80	74
Maternal mortality rate	1000	414		448
HIV prevalence rate	< 1%	6.7%	0.9%	6.3%

No figure for maternal mortality in NEP was available for 2008.

As in most countries with pastoralists, Kenyan nomads' access to and utilisation of health services are poorer than that of other population segments (table 1). While access to care is only one of many health determinants - in the case of nomads all unfavourable – the dismal health status unquestionably reflects deficient services. The Ministry of Public Health & Sanitation – in collaboration with faith-based services or NGOs – has attempted to amend some of the shortcomings of nomad health services. Yet, at the time of the conception of the Danida-financed Health sector Programme Support phase II (HSPS II) Sept. 2006, North Eastern Province (NEP) relied solely on Government of Kenya (GOK) health services. And the province - one of Kenya's poorest, with an estimated 60-70% of the population engaging in pastoral farming - continued to show very discouraging health indicators (table 1).

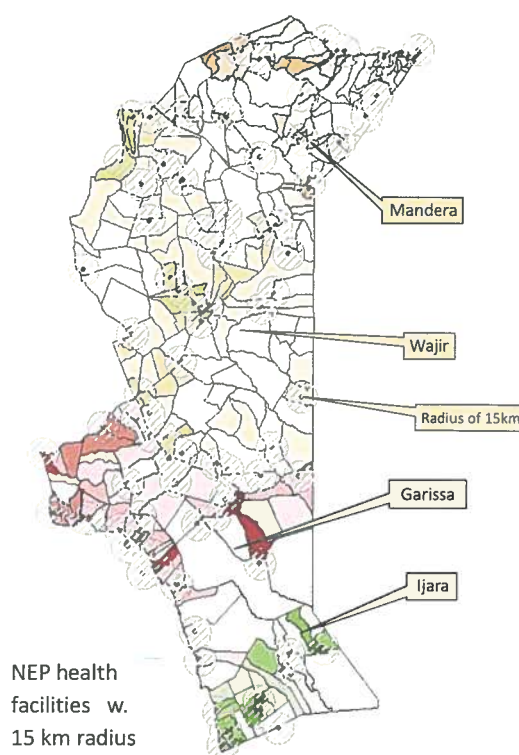
How did HSPS II get involved?

HSPS II was designed to include a health systems research component as a means to test and document modalities for providing the minimum Kenya Essential Package of Health (KEPH) to the nomadic population in NEP. Work would be closely linked with the Ministry of Health (MOH) to ensure that findings would be used to

adjust the national allocation formula, to accommodate the extra cost of providing health services to nomadic populations.

Primary Level Health Services in NEP

NEP has a land area of 127.000 km² (22% of Kenyan total) and a population of 2.5 million (6% of total; 2010).

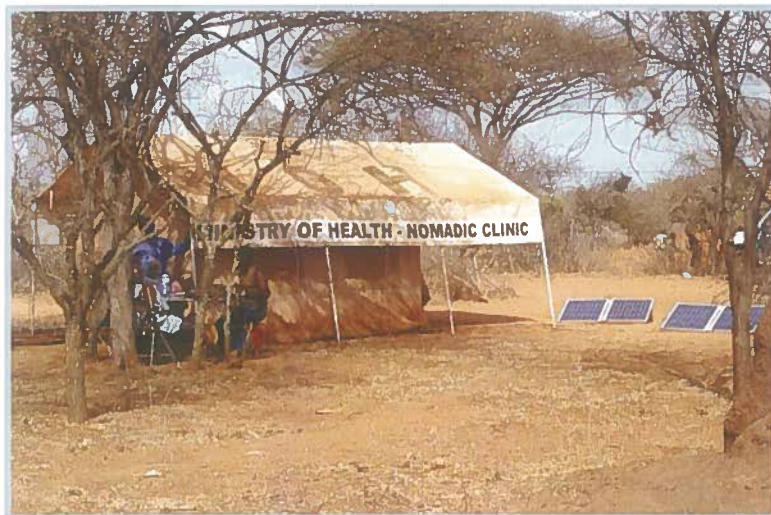


The map above shows NEP health facilities existing in 2008, each with its effective - 15 km radius - catchment area – indicated. Comparatively speaking, 82% of Kenyans live within 5km of a health facility; in NEP the majority resides outside a 5km zone.

What did HSPS II set out to do?

Three nomadic, mobile clinics were initially established in 2006-7. Each functionally linked to a static clinic, they would operate a rotational schedule, offering at each location two weeks' access to services equivalent to level 2 dispensaries, including immunisation and antenatal care. Subject to a deliberate flexibility, each location would be visited on average every 2-2½ months.

The clinics would operate from a moveable tent equipped with basic technology, incl. solar-powered refrigeration and communication, and a motor cycle. The clinic was to be dismantled and transported by the district vehicle to the next site.



The clinics first established were for the zones of Amuma, Tabaka, Sabuli. In 2009 the nomadic service was extended with six other clinics in NEP and two clinics in Tana River, and in 2011 additional three nomadic clinics were established in NEP. To ease transport, by the district vehicle, of the clinic from one site to the next, a closed trailer was developed to serve as carrier for all the tents and equipment. When on site, the trailer serves as a store room.

All the nomadic clinics are now registered as individual clinics with their own

accounts to receive supplies of EMMS directly from KEMSA and funds from HSSF.

What did the Study find?

The study, carried out in early 2009, compared the three nomadic and three static clinics, the latter matched with regard to level of service, catchment area, and various location criteria.

The findings include that the three nomadic facilities, since their start, had served 23,432 patients, against 10,785 for the three 'statics' over the same period. Also immunisation coverage appeared higher in nomadic clinics, although the observation period was too short (7-10 months) to verify this. As regards antenatal care, 1085 women had

registered (first visit) at nomadic facilities against 550 at static ones. Assisted deliveries were 3.2 times more frequent at nomadic facilities.

Although the study intended to document impact on health status, the duration of the nomadic clinics' operation period was – at the time - too short for meaningful and verifiable conclusions to be made.

As for cost-effectiveness, it was unsurprising, given additional recurrent cost for staff allowances, fuel and transport, to find that nomadic clinics were more costly to operate, by a factor of 1.28, than static ones. More important, however, is the finding that average cost per patient contact at a static dispensary, at KSh 379, was 1.64 times higher than the KSh 231 per contact in a mobile facility. Both clients and staff generally expressed approval of the nomadic facilities.

Sustainability

Ultimately, sustainability depends on the GOK and the host ministry being able and willing, with external partners, to allocate the funding necessary to operate this health service.

However, the study of the nomadic model is a classic 'policy experiment', which - by capturing and substantiating one important aspect of overall sustainability: i.e. reaching pastoral populations and offering them basic health services are

possible at non-prohibitive cost – should assist the decision-making by GOK.

Partly a result of the nomadic clinics and partly due to other infrastructure created with HSPS II support, utilisation of services in NEP has, as table 2 amply demonstrates, increased markedly in recent years, bearing out the 2009 study findings.

In terms of institutional sustainability, all nomadic clinics established with HSPS II assistance have been gazetted under the MOPHS.

Table 2: Evolution of Health Service Statistics NEP 2008-11)

Year	2008	2009	2010	2011
Antenatal Visits (1 st)	32,070	27,182	31,164	34,407
Out-Patient Attendances	226,057	228,517	288,446	751,703
Occupied Bed Days	98,422	133,273	133,777	123,331
Caesarean Section	435	642	772	734
Fully Immunised Children	23,748(48%)	28,560(52%)	31,213(54%)	34,407(59%)

Lessons Learned

1. Nomadic healthcare

The HSPS II has made an important contribution to how to bring health services to itinerant people, having demonstrated that proximity is an important access parameter, to which clients respond and that such services can be provided cost-effectively.

It is time to complement the study of 2009 to verify the findings, assess impact on health status, and publish findings internationally.

2. Going to Scale

A recurrent question in the health development discourse is how interventions can be scaled up to strengthen health systems' capacity to deliver on the MDGs.

Is having been taken to scale in NEP a lesson learned for other parts of Kenya?

3. Policy Experiments

Once a main paradigm of development assistance, the policy experiment modality has given way to broad programmatic and budget support-type approaches to development aid.

However, an important lesson learned is that operational research should keep a place in, and be accommodated in current mainstream development assistance.

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