Chapter 7

Organization and Management in the Health Sector

This chapter examines the organization of health services and presents an assessment of the management and service delivery capacity of the major provider agencies. The public sector agencies discussed are the Ministry of Health (MOH), including the Division of Family Health (DFH), and the National AIDS and STD Control Program (NASCP), and the National Council for Population and Development (NCPD). Non-profit and for-profit elements of the private sector are presented, with emphasis on their programs in family planning and STDs/HIV/AIDS. The relationship between the public and private sectors is presented in relationship to the changes in roles and relationships which are called for in the Kenya Health Policy Framework (MOH 1994a).

7.1 The Ministry of Health (MOH)

The Ministry of Health (MOH) is responsible for national health policy and is the major actor in Kenya's health care system. It has approximately 44,000 employees and manages almost 2,000 health facilities and offices. Within the MOH, the Division of Family Health (DFH) functions as a planning, management, coordination and training unit for family planning and other essential health programs such as immunization (KEPI), Acute Respiratory Infections (ARI) and the Control of Diarrhoeal Disease (CDD). The National AIDS and STD Control Programme (NASCP) is also currently under the MOH.

7.1.1 MOH Administrative and Management System

The Ministry of Health is broadly divided into four administrative divisions and seven technical services divisions. The administrative division is responsible for budgeting, planning and development. The technical division is in charge of hospitals, health services, nursing, environmental health and training.

The MOH does not have a well-defined structure nor organizational chart. The chain of command is not well defined and the hierarchy of authority within the MOH is not clearly established (GOK 1993b). The key management functions of the MOH are divided between the Permanent Secretary (PS) and the Director of Medical Services (DMS). The division of authority between these two positions is not clearly defined. This has occasionally led to disagreements and management problems in the past. The recent change which upgrades the position of the Permanent Secretary above that of the Director of Medical Services should contribute to the clarification of the authority structure. There has been a high turnover of MOH personnel in many senior management positions including the DMS, the Director of Curative Services, the Head of Division of Family Health and Head of the Pharmacy Division.

Each province has a Provincial Health Management Team (PHMT) led by a Provincial Medical Officer (PMO). The team is broadly responsible for the coordination, monitoring and evaluation of health programs in the province. The members of the PHMT are not involved directly in the management or delivery of health services. The role of the Provincial Medical Office has never been clearly defined and the new Health Policy Framework (MOH 1994a) recommends several changes to increase its role in monitoring, coordination, quality control and the enforcement of standards and regulations.

Health services in the districts are managed by a District Health Management Team (DHMT), led by a District Medical Officer of Health (DMOH). The DHMT is responsible for the planning, coordination, supervision, and the distribution of supplies. Since the introduction of cost-sharing, the DHMT works in cooperation with District Health Management Boards (DHMB) whose main function is to oversee the collection and allocation of revenue generated at health facilities. Members of the DHMT are also in charge of vertical programs such as family planning and KEPI.

7.1.2 Financial Management

Government expenditures follow Treasury guidelines and regulations which are uniform for all Ministries. In these guidelines, the accounting procedures are clearly spelled out and all Ministries are expected to use them. The system, however, has not been adapted to the Ministry of Health's needs for budgeting, financial management and audits.

The accounting officer (the Permanent Secretary) has the authority to oversee disbursements and accounts for the Ministry budget. Most of these functions are delegated to heads of divisions and to the senior officers in the provinces (PMOs), the districts (DMOHs) and in hospitals (the Medical Superintendents). These officers have the "Authority to Incur Expenditure (AIE)" and are ultimately responsible for the management of finances. In practice, the management of finances, personnel and supplies is delegated to a hospital secretary. They control the day to day expenditures, maintain accounts and file financial reports. There is widespread dissatisfaction with the hospital secretaries, and they are often accused of mismanaging funds and other resources.

The system of financial management makes it difficult to determine the cost of operating specific services or cost centers within departments and facilities (MOH 1994a). Separate accounts (or subheads) have, however, been set up by districts and hospitals to account for donor funds.

Those involved in financial management include the hospital secretaries, clinically trained staff (e.g., doctors) and others with general educational backgrounds. In the past, hospital secretaries had special training in administration, but this has been discontinued. Very few DHMT members (and those in charge of hospitals and health centers) have

had adequate training in financial management and other administrative skills. This lack of preparation appears to be one reason the MOH has difficulty in managing its resources. No training or induction courses are organized for officers taking on responsibilities of managing finances for the first time (e.g., young doctors assuming the responsibility of District Medical Officer or Medical Superintendent).

The MOH Curative Services Financing Gap Study (MOH 1994), which was funded by the World Bank, makes a number of comments on the lack of efficiency in the MOH management system. It states:

> The strain on government financing of Curative Services is partly due to inefficient use of resources. The effectiveness of goods purchased is another area of concern. Purchases of goods not fit for the intended purpose are common. . . .

The financial system used by the MOH is mandated by the Ministry of Finance. This system is not well adapted to the MOH information requirements nor is it integrated with other information systems for facilities, health or personnel. Perhaps the weakest area of financial management in the MOH outside headquarters is the preparation of annual budgets for hospitals and districts. Information for basic planning and budget rationalization is lacking.

7.1.3 Cost-Sharing

The MOH, with assistance from USAID, set up the Health Care Financing Secretariat three years ago. This Secretariat has made considerable achievements in establishing the program, training personnel involved in fee collection, training of the District Health Management Boards, adjusting fees, and approving expenditures. The program has generated substantial revenue that has been used to improve government facilities and services. Funds are maintained in a separate account within the districts.

The revenue is generated from two sources -- user fees and National Hospital Insurance Fund (NHIF) reimbursements. The funds from cost-sharing represent about 3 percent of the total MOH budget and are expected to rise to about 12 percent within the next five years (MOH 1994a). Major problems remain, however, and the Secretariat estimates that up to 35 percent of the revenue collected is lost through dishonest procurement practices and fraud. Additional losses are due to the weakness in the financial management practices of the hospitals, and the MOH estimates that NHIF collections are only about one quarter of their potential. Exemptions and waivers granted to those "unable to pay", and civil servants, also reduce the amount of revenue that could be generated through cost-sharing.

The introduction of user fees has increased the need for more personnel trained in accounting and financial management. Cash control and accounting procedures need to

be strengthened, and personnel with these skills are needed in the districts and at hospitals. Only a few of these systems have been computerized.

7.1.4 Personnel Management and Manpower Planning

The MOH has a total manpower of almost 44,000 employees. Expenditure for personnel consumes 70 percent of the annual recurrent expenditure. The Personnel Division is a large and complex unit with offices in Afya House and officers posted to the provinces and the districts. Its major activities are related to appointments, posting, promotions, transfers salaries and other allowances, pensions and complement control. In addition, most major divisions within the MOH (e.g., Nursing, Clinical Officers, Environmental Health) and the DHMTs maintain records on their staff.

The Personnel Division is not well organized and personnel management problems have been a major concern of recent administrations in Afya House. The MOH does not have a clearly rationalized system of job classifications and, until September 1994, could not link personnel with their work stations. Reliable systems for tracking personnel and evaluating their performance have not been established.

The Ministry has a Division of Technical Manpower Planning and Development that has three sections:

- Technical Manpower Planning and Development
- Technical Donor Coordination Section
- Continuing Education Programme

The Division has been headed by a Senior Deputy Director of Medical Services (SDDMS). The Ministry also has a Ministerial Training Committee made up of technical officers whose main functions are to approve scholarships, study leaves and overseas training courses for employees.

A training unit headed by an Under Secretary serves as the Secretariat to the Ministerial Training Committee. In general, manpower planning, training and deployment are not very well coordinated at Afya House. The Ministry will soon complete a study that will be used to revise its national manpower and training policies (Schwarz 1995). The preliminary results indicate:

1. The supply of key health professionals (doctors, clinical officers, nurses, public health staff etc.) has increased at twice the rate of the population during the past 15 years;

2. There is a major shortage of clinical officers needed to diagnose and treat illness at health centers;

3. Priority in personnel deployment is given to hospitals and inpatient services. While most hospitals are adequately staffed, there is a 50 percent shortage of professional personnel at the health centers and dispensaries that provide most of the outpatient services and MCH/FP services;

4. Health personnel are not equitably distributed among the districts and provinces. For example, Western and Nyanza Provinces have less than 90 Key Health Professionals (KHP) per 100,000 population, while other provinces have more than 120 KHP per 100,000;

5. There is a high concentration of health professionals in urban areas in the Government and private sectors. The rural areas do not have adequate professional staff to provide the full range of essential health services.

The development of an accurate and reliable personnel management information system, together with a professionally trained manpower unit are critically needed within the MOH. If, and when, they are established, the MOH will be able to efficiently deploy staff with specialized training (e.g. MCH/FP, STDs/HIV/AIDS) to facilities where their skills are needed, and to identify future training requirements. As currently designed and managed, the personnel management systems cannot provide these data.

7.1.5 Health and Management Information Systems

The Ministry of Health has several, unconnected, health and management information systems that operate at headquarters (including the Division of Family Health), the districts and at health facilities. Most systems are under the responsibility of the Division of Planning and Development. The Health Policy Framework (MOH 1994a) observes that:

> These systems are characterized by a lack of integration, and are disjointed and widely dispersed with no effective central coordination to ensure that the information which they contain is readily available to all who need it.

In regard to Health Manpower Information, it makes the following statement:

> Presently the Ministry of Health has no reliable, accurate, standardized information system for personnel management, planning and budgeting and for evaluating and tracking the performance of employees.

The lack of accurate and timely information hampers the Ministry's capacity for effective management and planning. Recent surveys carried out for the Ministry by Development Solutions for Africa, Ltd. included up to date information on all MOH employees and health facilities (Schwarz 1994). It remains to be seen whether these will be integrated into management systems and updated periodically. Even if the MOH can overcome the

information system problems, it will still have to address the lack of analytical and planning skills among the personnel in the Division of Planning and Development (DPD).

Several donor funded projects have attempted to remedy the information system and planning weaknesses over the past decade but have had little impact. One problem has been the lack of good technical leadership of the Division. Those appointed have been from outside the MOH with no training or experience in the health field. Similarly, almost all DPD professional staff are economists and statisticians seconded to the MOH from the Ministry of Planning and Development. Few have clinical or public health training. The lack of participation of health professionals in the DPD is a major organizational weakness. In addition, MOH employees sent overseas for Masters Degree training in public health have not been deployed to the DPD and most have resigned from the MOH within a few years after they finished their graduate training.

The production of a strategy and plan to reorganize and strengthen the Division of Planning and Development is included in the studies recommended in the Kenya Health Rehabilitation Project (Schwarz and Bertrand 1990). The successful completion of this study and the implementation of the recommendations are critical to the solution of this long standing problem. Until the restructuring of the Division is completed, capacity building opportunities are limited. There is, however, a major need to design and implement health and management information systems for facilities, districts and for the province level. These activities should be included in programs at these lower administrative levels. If successful, they will influence developments at the national level and should accelerate the process of change in a constructive manner.

7.1.6 Education and Training

7.1.6.1 The Kenya Medical Training College (MTC)

The MTC consists of the college in Nairobi and 23 constituent medical colleges spread throughout the country. It has the mandate to select and train paramedical health personnel for the country. Its major programs are for nurses, clinical officers, public health officers and technicians. It also trains laboratory and pharmaceutical technologists, dental technologists, therapists and a variety of other allied health professionals. It conducts pre-service and post-basic educational programs.

In 1990, Parliament passed the "Kenya Medical Training College Act" which gave the college and its centers a semi-autonomous status and laid the foundation for its institutional development. In November 1994, the Medical Training College Board was gazetted and the institution is now a parastatal with responsibility for pre-service and post-basic training. In principle, this new status should enable the MTC to operate more effectively and efficiently. It will now have greater control over its personnel, finances and academic programs.

Some major weaknesses in the MTC are the lack of a teaching and administrative staff with adequate academic credentials, the poor condition of the physical facilities, lack of equipment and supplies, outdated curricula (for most cadres) and limited capacity for planning and management. Few faculty members have university degrees and most faculty who teach diploma level students have only had diploma level training themselves. In recent years, some MTC teachers have completed a post-basic program in medical education,

7.1.6.2 Continuing Education

There is a Continuing Education Unit within the MOH that is located at the School of Nursing. The program began in 1982, funded mainly by SIDA and WHO/UNDP. It caters to the needs of health professionals who receive their pre-service education at the MTCs -- nurses, public health staff, clinical officers, etc. The unit organizes management training in the districts based on requests and budgets provided by the DHMTs. The Continuing Education Unit is also involved in the development of learning materials.

During the past decade, the vast majority of short (less than three months) continuing education courses and workshops for nurses and clinical officers have been organized and funded by donor agencies through the Division of Family Health. The principal ones have been in MCH/FP, KEPI, CDD and ARI. Others on health facilities and equipment have been targeted to public health staff. These courses fill important gaps in the current training system.

7.1.6.3 University Education

Doctors, dentists and pharmacists are the major university trained cadres employed by the MOH. Scientists (biology, entomology etc.) and some senior administrators also have university degrees. These programs are organized under another ministry, and the MOH has little influence on the content of their training, although GOK health facilities are used in training and internship. The University of Nairobi graduates more than 100 doctors per year and has a small Masters of Public Health program. GTZ has a project to strengthen the MPH program at Nairobi University. There is a one year program that leads to a Diploma in Advanced Nursing at the University. Graduates of the program form the core of the leadership for nurses in the MOH and at the MTC.

A new six year training program for doctors began at Moi University in 1990 and will soon begin graduating about 40 doctors per year. The program has incorporated an innovative, problem-oriented approach to training and includes management and behavioral sciences in the curriculum. It is designed to produce doctors with a strong community/public health orientation in contrast to the classic approach used at the University of Nairobi. The University has also established bachelors degree programs in Nursing Sciences and Environmental Health that will begin accepting students in the

next two years. It also has plans for a Master's Program in Health Management and Economics.

Post-graduate medical education is done at the University of Nairobi. Doctors employed by the MOH may apply for these programs but their selection, and the specialties to which they are admitted, are done by the university, and their training is paid for by the MOH. The selection does not, however, take the Ministry's manpower needs into consideration. MOH doctors have opted for private practice oriented specialties of surgery, paediatrics, internal medicine, and obstetrics and gynecology. The less popular and less marketable fields of public health, anaesthesia and pathology have not attracted many candidates. These fields, particularly public health, are crucial for the strengthening of the national health system.

7.2 The Division of Family Health (DFH)

7.2.1 Organization (see Appendix A for organogram of Division of Family Health)

The Division of Family Health functions as an umbrella Division for the management of vertical programs in Maternal and Child Health and Family Planning (MCH/FP). It includes five programs:

1. Family Planning (FP)
2. Nutrition
3. Immunization (KEPI: Kenya Expanded Programme of Immunization)
4. Diarrhoea (CDD: Control of Diarrhoeal Diseases)
5. Acute Respiratory Infections (ARI)

In addition, there is a section for administration.

The major functions of the program offices within the DFH are similar. They include:

- Policy and program formulation;
- Planning and budgeting (annual and five year work plans);
- Training (including the assessment of needs, planning and implementation).
- Coordination of Donor Inputs;
- Coordination of NGO activities;
- Management and supervision:
  - -- program monitoring and evaluation
  - -- financial management
  - -- the management of commodities and logistics.

There is no comprehensive policy or strategy that integrates the objectives and activities of the five programs within the DFH. Each program has its own units for training, supplies, personnel, stores, transport and administration. There is little coordination between the programs, and each develops its own work plans and schedules without reference to the others. Vehicles of different programs may be in the same district at the same time, but programs often do not share vehicles or other resources.

The DFH occupies a building several kilometers from Afya House, the MOH Headquarters. This hinders effective coordination with Division and Department managers in charge of the health professionals in the field.

While the DFH programs train MOH personnel to provide preventive and promotive services, the program managers have no control over the deployment or use of personnel in health facilities. Deployment decisions for nurses are made by the Division of Nursing, for Clinical Officers by their division, etc. This has led to a situation in which

about half the personnel trained through the DFH provide in-patient services and have little opportunity to put their family planning training to use.

The MCH/FP programs of the DFH operate through the District Health Management Teams (DHMT). The District Health Education Officer is responsible for the CDD Program . The District Public Health Nurse is responsible for Family Planning Program and KEPI. They are primarily responsible to the DISTRICT MEDICAL OFFICER OF HEALTH and to their division heads at the MOH headquarters, not to the DFH.

The supervision of DFH programs at health facilities has not been well organized nor highly effective. Supervisory visits are infrequent, do not last long and normally do not include a serious review of performance and results. They are primarily administrative visits.

7.2.2 MCH/FP Services at MOH Facilities

Hospitals and most health centers provide the full range of MCH/FP services, while the pattern in dispensaries is highly variable. The table below shows the percentage of each type of service at MOH health facilities.

MCH/FP Services at MOH Health Facilities

Type of service provided	Percent of facilities providing service
KEPI (Immunizations)	69%
CDD (control of diarrhoeal disease)	48%
Nutrition and Growth Monitoring	68%
Family Planning	62%

Source: Development Solutions for Africa, Ltd.

These data indicate that there is a major shortfall in basic preventive and promotive services at MOH facilities. However, almost 70 percent of the women in Kenya who use contraceptives obtain them from MOH facilities (NCPD 1994a). An increase in MOH facilities offering FP services may produce an increase in the number of women using contraceptives.

7.2.3 MCH/FP Training Programs

A major activity of the DFH has been training of health professionals, mainly nurses and some clinical officers and doctors. While the courses have been called "Continuing Education", they are actually courses in the basics of family planning, immunizations and cold chain management, and clinical management of diarrhoea and acute respiratory infections.

Training activities are organized within each vertical program. While all fall under the rubric of MCH/FP, there is no broad framework or strategy that integrates them. Several evaluations have pointed out that the quality of the training is only fair, and is particularly weak in the area of communication skills. Most trainers do not have good teaching skills and are not adequately trained in pedagogical methods. Training plans are not well formulated and there is little systematic monitoring and evaluation of the results. The following table summarizes the approximate numbers of health professionals who have been trained by the DFH:

TYPE OF TRAINING	YEAR STARTED	NUMBER TRAINED
Family Planning	1972	6,600
KEPI	1980	10,000
CDD	1986	3,500
ARI	1990	230
TOTAL		20,330

Source: Development Solutions for Africa, Ltd.

The health professionals who are trained are from the MOH, NGOs and local authorities. The selection of trainees is not well organized, nor is it based on an assessment of need. The deployment of trained personnel is the responsibility of the DHMTs. And yet, in all districts, one finds that about half the personnel trained in KEPI, CDD and/or family planning are in positions where they are not able to practice the skills acquired in the training programs. Less than half the MOH personnel trained in family planning between 1986 and 1994 currently provide MCH/FP services.

Training (except for a newly revised family planning course) is not competency-based. Participants get certificates for attendance.

In 1990, KEPI training was integrated into the MTC core curriculum for nurses, and there is work in progress to integrate CDD training. However, over 2,500 Kenyan health

professionals are graduated each year without adequate training in the basics of prevention, diagnosis and treatment of the major causes of morbidity and mortality. The family planning course is not integrated into the pre-service curriculum for nurses and clinical officers. Family planning is not covered in the training of public health officers and technicians.

MCH/FP continuing education courses are organized and funded by donors, and the GOK does not provide direct financial support for these activities. They are relatively expensive as many are held in hotels. The DFH cannot sustain these expensive training programs without donor support. Institutional ties to the MTCs and other training institutions have not been established, nor have the curricula been adapted for basic pre-service programs.

The DFH does not train health professionals in nutrition. Karen College (an MTC) has been responsible for Nutrition training since 1967. Short intensive nutrition courses (initially six months, and later nine months in duration) were offered to enrolled nurses and midwives. After 1983, those courses were phased out and replaced by a two-year certificate course in Community Nutrition. A degree program in Nutrition was also established at the University of Nairobi.

7.2.4 Planning and Information Systems

While information systems have been established for the various DFH programs, reporting is irregular and the analysis and use of data in planning and management is weak. The data have not been used to plan for the training and deployment of personnel trained in family planning, nor for the establishment of Service Delivery Points (SDPs). There are great discrepancies between districts in the numbers of FP trained personnel. For example (Schwarz, 1994):

- The districts of Embu, Nyandarua, Lamu and Isiolo have more than 20 MOH health professionals trained in FP per 100,000 residents. In contrast, more than a quarter of the districts have less than six MOH health professionals trained in FP per 100,000 residents.

- In the districts of South Nyanza and Kakamega, more than 70 percent of the MOH facilities offer FP services. In contrast, there are six districts where less than 25 percent of the MOH facilities offer FP services.

These inequities reflect the fact that while a substantial investment has been made to collect and process relevant data, the DFH does not have the capacity to analyze nor to use the information for planning or management decisions.

7.2.5 Funding and Financial Management

The programs within the DFH are the core of the MOH's effort to provide basic, cost-effective health interventions throughout Kenya. None, however, receive adequate funds from Treasury and remain very dependent on donor funds for their vehicles, commodities (all contraceptives), training activities, and operational expenses. Donor funds for DFH programs channeled through Treasury have not been easy to access and accounting for these expenditures by the MOH/DFH has frequently been criticized. Donor support for several key programs has been withdrawn and/or significantly reduced. USAID discontinued funding the DFH to conduct FP training, and instead funds Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) as a cooperating agency to manage training at DFH.

The DFH has not established mechanisms to generate revenues for the programs. Although part of the cost-sharing revenue is, in principle, reallocated to primary health care activities, the amounts are not large enough to support the DFH continuing education programs. In addition, the DHMTs and DHMBs have not yet used locally generated revenue to sponsor training courses for MCH/FP programs.

7.2.5.1 Accomplishments of the DFH Family Planning Programs

Throughout the past decade, external advisors have played a major role in program and financial management and still play key roles in KEPI and Family Planning. The capacity of the overall DFH administration, and that of the individual programs, to manage the programs independently has not been established.

The most important accomplishments of the DFH family planning programs have been financed by donors and implemented by private agencies with expatriate (donor financed) management. These include the management of contraceptive supplies and logistics, the introduction of competency-based training in family planning, and the development of a National Implementation Plan for family planning.

1. Management of Contraceptive Supplies

The management of the supply and distribution of contraceptives is one of the major activities of the Family Planning Program of the DFH. More than seven agencies including the World Bank, UNFPA, SIDA, ODA, FINIDA and USAID provide contraceptives. The GOK does not use government funds to purchase <u>any</u> contraceptives.

USAID initiated support to strengthen the DFH's capacity in logistics in 1988. Because of disappointment with the DFH's ability to manage contraceptives, and to account for them, USAID set up a Family Planning Logistics Management (FPLM) project in 1991. The project has seven employees (including one expatriate project manger). In addition,

17 persons from the DFH are seconded to the project: 2 clinical officers, one nurse and one information system specialist; the rest are administrative (including supplies), clerical and subordinate staff.

The FPLM project was established at a time when the demand for contraceptives was increasing and when the DFH was having serious difficulties in their procurement and distribution. Part of the problem was that the donors who supplied the contraceptives delivered them to the port in Mombasa, and it was up to the MOH to get them to Nairobi and then to the districts. The MOH had difficulty in getting funds from Treasury to pay port fees and storage costs on a timely basis. The administrative process often took up to five months. By the time the check was ready, the storage fees had altered the cost. Supplies expired prior to getting out of the port. Under the FPLM project, the service is "door to door," i.e. from the donor to the Central Supplies Warehouse in Nairobi. Some donors (ODA and SIDA) continue to deliver the contraceptives to Mombasa, and these are experiencing the same delays in getting out of the port as were encountered before the initiation of FPLM.

Prior to FPLM, accountability was difficult to determine. Supplies could be in overabundance, and expiring, in one district, and out of stock in another. The FPLM information system is reducing these problems. There is widespread agreement among the MOH and donors that the FPLM has improved the situation. They agree that the FPLM has been more efficient than the DFH in logistics and management. They do not believe the MOH can overcome the bureaucratic obstacles to manage commodities in the near future and would like to see the project strengthened and expanded.

A major FPLM project objective is to strengthen the capacity of the MOH to manage the system. This is done through training DFH personnel seconded to the project and other MOH staff in the districts. To date, more than 1,900 MOH employees (supplies officers, clerical staff and others) have participated in three to four day courses organized by the FPLM. During the past few years several steps have been taken to strengthen the training including: the introduction of competency-based training, on-the-job training, and the establishment of District Contraceptive Logistics Teams. Still, efficient distribution systems have not been established in all districts. Some districts lack adequate storage facilities and trained staff. The current number of personnel trained in logistics is not adequate to manage the expected increase in the level of contraceptives.

Major problems encountered by FPLM in their "MOH strengthening" activities are the same problems encountered by other donor implementing agencies: the transfer of trained personnel to new work stations (approximately 50%), a shortage of trucks and storage facilities in some districts, theft, and the uneven performance of the District Public Health Nurses (who are in charge of the FP programs within the districts). In addition, they lack information on the proper contraceptive mix for each district and there is a shortage of auxiliary supplies (e.g. gloves, disinfectants, etc.).

2. Competency Based Training

Until recently, all DFH trainees received a "Certificate of Attendance". Merely attending a course was enough to receive a certificate. The DFH had no way of knowing what the trainee had actually learned and could apply to daily work. USAID funded JHPIEGO to revise the FP training to make it "competency based". Trainees skills are tested until they are capable of repeating a procedure correctly several times. JHPIEGO has also introduced training on models so that the trainees can practice a procedure on a model and gain some skill prior to practicing on people.

3. National Implementation Plan

A Task Force has been organized to prepare a National Implementation Plan. The idea for the Task Force originated during an evaluation of FP in Kenya, run by AVSC (a USAID funded international agency) in 1992. A major finding of the evaluation was that Kenya lacked "an overall implementation plan for a Kenya national family planning program:

> . . . . They do not have the specifics of a projected method mix, facilities and equipment needs, supplies and commodities, staffing, training and I&E needs, and projected costs. Policy-makers and providers, both in Nairobi and in the field, felt that these estimated projections are needed for planning and implementation efforts. The donor agencies echoed this need." (AVSC 1992)

The DFH is the lead GOK agency organized to transform the results of the assessment (together with other data from the Demographic Health Survey, NGOs' and donor agencies) into a detailed national plan. The Task Force includes representatives from other GOK agencies (including the NCPD), NGOs (FPAK, CHAK) donor agencies and donor funded projects (e.g. FPMD). USAID is the principal outside agency helping to coordinate the data collection, analysis and production of the plan.

7.2.6 Observations and Comments

General Organization and Management. The current separate and vertical organization of programs within the DFH has continued for many years and little has been done to integrate them at headquarters or within the DHMTs. The scheduled outside evaluation of the organization and management of the DFH in 1991 was canceled. A similar initiative proposed by GTZ was approved and then postponed. The DPM study of the MOH (GOK 1993a) included an assessment of the DFH, but did not adequately address organizational issues.

In 1990, an evaluation of the MCH/FP Training Program was conducted (DFH 1990) which included recommendations for organizational change within the Family Planning

program and the DFH. Those related to strengthening the FP training program are currently being implemented through JHPIEGO, a USAID contractor. The recommendations for organizational change for the Division as a whole have not been addressed.

The past record of the Division of Family Health does not suggest that it is likely to undergo change unless there is outside pressure for reform. This should be preceded by a comprehensive evaluation of its current structure and organization.

7.3 National AIDS and STD Control Programme (NASCP)

The state of the National AIDS Control Programme (NACP) is summarized in the Kenya NACP Three Year Multi-Sectoral Workplan (1994-1996):

> The efforts of the Kenya National AIDS Control Programme have been constrained by lack of funding, limited involvement of other key ministries, inadequate human resources, (and) insufficient coordination between both internal and external organizations involved in the prevention of AIDS throughout the country. In addition, the recommended infrastructure for coordination of activities has taken too long to be fully implemented. The National AIDS Council and related Provisional and District committees are yet to be established.

7.3.1 History and Background

The first case of Acquired Immune Deficiency Syndrome (AIDS) was reported in Kenya in 1984. In 1985, the Government of Kenya (GOK) established a National AIDS Committee within the Ministry of Health. The NACP has mobilized the efforts of the private sector, NGOs and religious groups to participate in AIDS awareness and prevention programs both at national and community levels.

In 1987, the GOK invited the World Health Organization to provide technical assistance to develop a National AIDS Control Programme. This was followed by the creation of an AIDS Programme Secretariat (APS) and the development of the first Medium Term Plan (MTP I for 1987 - 1991).

Main activities proposed in the MTP I were:

1. A "massive" public awareness campaign;
2. Strengthening of laboratory services;
3. Surveillance;
4. Training of Health Workers.

The public awareness campaign has been successful. The 1993 DHS (NCPD 1994a) found that virtually everyone interviewed had heard of AIDS, and that 96 percent of men and 90 percent of women knew that the AIDS virus is transmitted through sexual intercourse; over 75 percent knew that a healthy person could be infected, and over 85 percent knew that a mother could transmit it to her child. It also found that some misconceptions lingered: over 55 percent still believe that the AIDS virus can be transmitted by mosquitos, and over 30 percent believe that it can be transmitted by kissing.

Laboratory services have been strengthened and national screening of approximately 98 per cent of all blood transfusions has been established. Although hospitals can screen blood before transfusion, reports have been made that blood is sometimes improperly screened or not screened all, and that needles and syringes are used without adequate sterilization.

The shortcomings in control have been attributed to a lack of reagents for the testing of blood and a shortage of disposable syringes and needles. There is also a serious problem of disposal of HIV contaminated materials. Contaminated blood, needles and syringes, as well as other hospital and laboratory wastes, have been deposited openly outside hospital compounds where children and others have access to them.

Surveillance sites have been set up at ante-natal clinics in different parts of the country, and the 1994 AIDS Report published the current prevalence rates, as well as their trends over the past five years (These are detailed in Chapter 4).

The MTP II (1992 - 1996) recognized that the NACP had to advance beyond "awareness" if the AIDS epidemic were to be controlled, and therefore proposed:

1. Getting individuals to make use of their AIDS knowledge to change their behavior;

2. Mobilizing human and organizational resources to deal with the social and economic impact of the AIDS epidemic.

The MTP II also recognized the important connections between AIDS and other Sexually Transmitted Diseases (STDs). STD activities have been integrated into the AIDS program, and the NACP was renamed the National AIDS and STD Control Programme (NASCP) (see Appendix B for a description regarding the organization and manpower of the NASCP).

7.3.2 Funding of the National AIDS/STD Control Programme

The National AIDS/STD control programme has received funding from a number of donors as well as the GOK. Unfortunately, despite the worsening of the HIV/AIDS problem in Kenya, funding from donors has decreased:

- Funding from WHO/GPA to the NACP decreased from $2.5 million in 1987 to $800,000 in 1993.

- The GOK contribution has also decreased, and the funds indicated in the printed estimates have not been released to the program in full and or on time due to "cash flow' problems.

- Several donors have decreased or withheld funds due to dissatisfaction with the performance and accountability of the NACP, or until better channeling mechanisms have been worked out. Many of these donors have funded agencies in the non-governmental and private sectors.

The Directorate of Personnel Management (DPM) team that carried out a study of the MOH in 1992, made the following observations on the Aids Programme Secretariat:

> The Study team noted that the programme funds to a great extent are channeled through WHO whereby the funds administrator manages them on behalf of the Kenya Government. This kind of arrangement is costly to the Government because WHO takes 13 percent of the funds as administrative costs. Besides that, the accounting records of NACP are not easily accessed by the Government accounting system making it hard to justify the expenditure of the funds.
>
> The team noticed that the program coordinator for the AIDS program had no access to the programme documents. This situation has made it difficult for the Kenyan Programme Managers to visualize the trend of financial expenditure and activities at National Level. The question of donors being in control of finances to the exclusion of the Kenyan managers is totally unacceptable since the finances under contention have ideally been given to the Kenyan Government. There is also no indication that the representatives of the donors are more honest than the Kenyan officers if honesty in the utilization of funds is the criterion.
>
> Further the study team noted that the expatriate project advisors are given more leeway in determining which project to give priority and fund. (GOK 1993a).

The major current funders of the NASCP are listed below:

WHO/GPA assisted in the development and implementation of the two medium term plans in 1987 and 1992. GPA has provided assistance with training workshops.

educational materials, equipment, reagents and vehicles. It has also provided long term technical assistance in Administration.

UNICEF has sponsored school and community-based AIDS education programs in selected districts. It also supported training service providers, the Know-AIDS Society, and educational materials for youth, truck drivers and the community. Through the Bamako Initiative, UNICEF has expanded community based outreach programs in counselling, home-based care, and condom distribution.

USAID has contributed in several vital areas. It has:

- been the main contributor of condoms to Kenya;
- provided support to the Sentinel Surveillance and IEC programs;
- provided a blood bank data management system to the NPHLS (National Public Health Laboratory Service);
- funded a study on the Socio-economic Impact of AIDS;
- provided management assistance through a long term AIDSCAP Resident Advisor. A large scale AIDSCAP program is planned for three urban areas (Mombasa, Nairobi, Eldoret). The target populations will be adults in their workplaces, STD patients, family planning attenders, and college students. The support for national capacity building in mass media interventions and behavioral research will continue.

UNDP has played a leading role in advocacy through:

- workshops for senior politicians and national and district civil servants;
- assistance in the development of chapters on HIV/AIDS control and prevention in both the District and National Development plans.

UNFPA is conducting pilot programs to integrate HIV/AIDS education into the continuing education in Family Planning.

CIDA has focused on strengthening STD control activities in Nairobi and Nakuru and on improving referral services and national training in STD case management.

The Netherlands had directed its aid to IEC projects targeting adolescents and a training of trainers program in AIDS education and counselling. The Netherlands supports the National Tuberculosis Control Program.

Belgium supports the STD control unit with a resident advisor, the development and printing of treatment guidelines, STD diagnostic reagents, equipment and drugs.

ODA funds are channeled through GPA to NACP and new programs will focus on providing STD treatment, distributing condoms, health promotion and home-based care (through NGOs).

7.4 The National Council for Population and Development (NCPD)

7.4.1 Background

The National Council on Population and Development (NCPD) was created in response to a high population growth rate, and the unsatisfactory results of the Family Planning programme of the MOH. Whereas the population growth rate was expected to decrease from 3.3 percent in 1969 to 3.0 percent by 1979, census results indicated an increase to 3.8 percent.

In 1982, a Task Force was established within the Office of the Vice-President to study the problem. The Task Force was comprised of university professors and representatives of the government and non-governmental agencies, with the support of UNESCO. They developed a plan for a small, independent council to focus on policy and IEC strategies, and to mobilize financial support for a wide range of implementing agencies.

The NCPD was established in 1982 with a broad mandate to formulate population policies and strategies, and to coordinate population oriented activities within a multisectoral framework. It included a Council Board with representation from the Universities, FPAK and other NGO's, health professionals and senior GOK officials. The operation of the NCPD was put in the hands of a Secretariat. The rationale, justification and specific Terms of Reference for the Council are detailed in Sessional Paper No.4 of 1984.

The 16 points mentioned in the Sessional Paper may be grouped in the following general categories:

i. To formulate policy, strategic plans and investment plans;

ii. To plan, coordinate and promote multi-sectoral IEC programs in MCH/FP;

iii. To mobilize resources and coordinate the programs and activities of donors and local organizations involved in population activities;

iv. To review, evaluate and "programme" selected proposals;

v. To provide technical and other support services to participating agencies;

vi. To promote research into social, cultural, economic and technical research;

vii. To monitor and evaluate projects and programs;

viii. To prepare budgets, and "to coordinate and control the receipt and disbursement of all funds required to finance the Council's activities."

The mandate is clear in outlining NCPD's central role in the formulation, coordination and promotion of multisectoral programs and activities. Its role in technical support, monitoring, evaluation and in the coordination of research is also unambiguous. However, its mandate "to coordinate and control the receipt and dispersement of all funds to finance the Council's activities " leaves room for a wide range of interpretation. The original intent was to give the Council control over its own budget. Over the years, this has been interpreted -- by many donors as well as by the GOK -- as the basis for NCPD's role in the channelling of funds to other agencies.

Initially, the civil servants in NCPD were not professionally qualified in health and population. This was remedied through long term training in demography and population for many senior staff. Unfortunately, many who returned to the NCPD after their professional education were transferred to other government agencies or resigned. Throughout the late 1980's and 1990's, there the leadership of NCPD included few individuals with adequate professional education and experience in population. This weakness was exacerbated by the high turnover at senior levels and in the Director's chair -- there have been five directors of NCPD in the past eight years.

In 1993, the NCPD was moved from the Ministry of Home Affairs (MOHA) to the Office of the Vice President and is now in the Ministry of Planning and National Development. This change is viewed by some as a positive step that should strengthen the role of the Council in planning and coordination at the national and district levels. Others disagree with this view and suggest the shift in Ministries will have little impact on its capacity to fulfill its mandate.

During the late 1980's and 1990's, the Council -- with strong donor support -- became increasingly involved in channelling funds to NGOs thereby increasing its role in project management and supervision. According to the World Bank (WB 1994d:18)

> This anomaly could be seen as being mainly responsible for skewing the operational emphasis of NCPD toward family planning service delivery as opposed to its originally envisioned broad population policy and advocacy role.

See Appendix C for an outline of the structural changes of the NCPD within the GOK.

7.4.2 The Organization and Staffing of NCPD

See Appendix C for a description of the organization and staffing of NCPD and an organogram of the current structure.

7.4.3 The Performance of NCPD

The assessment of the NCPD should be viewed in the context of the positive demographic trends and other changes that have occurred in the past ten years. These include the expansion of family planning services, an increased awareness of services and technical options, a decline in the rate of population growth, the increased use of contraceptives and an increasing demand for FP services. While it is difficult to determine the extent to which NCPD's actions have contributed to these positive developments, it has played a definite role in the promotion, coordination and resource mobilization for population programs in Kenya.

One major shortcoming is that the NCPD has not established an effective institutional framework for policy formulation, nor mechanisms for effective interministerial and donor coordination. The accomplishments and shortcomings of the NCPD are examined in the following section.

7.4.3.1 Major Accomplishments and Strengths

1. As a government agency with a mandate in population, the NCPD provides legitimacy and credibility for the national program, including those projects run by non-governmental agencies. This is important because of the need to marshal official support to ensure an enabling environment for family planning and other population activities. The NCPD has served as a central location where plans of many agencies are put together and forwarded to the Ministry of Finance for funding.

2. The NCPD has provided a forum for the discussion of population issues and programs, and helped raise awareness of family planning and other activities. It has sponsored National Leaders Conferences (1984 and 1989) and other workshops. Partly through its efforts, National Development Plans have included chapters on population. Population education and information have been integrated into the activities of other agencies and Ministries. It has improved communication between agencies and its IEC activities have sensitized national, provincial and district administrators. In addition, the NCPD has funded a wide range of IEC projects.

3. The NCPD has functioned as the GOK's agency to channel bilateral and multilateral funds to the public, voluntary and private sectors. The role of NCPD

is critical since some multilateral donors (e.g..the World Bank, UNFPA) can only work through the GOK.

4. The NCPD extended its activities to the district level through the training and deployment of 14 District Population Officers. While the reviews of their performance are mixed, DPOs have promoted programs and, in selected districts, improved coordination of population activities.

7.4.3.2 Major Shortcomings and Weaknesses of the NCPD

While the NCPD "coordinates" a wide range of agencies and programs, its effectiveness in carrying out this function is hampered by several obstacles over which it has little control. They include:

- A tradition within the GOK that looks at policy and planning issues in sectoral rather than multi-sectoral terms;
- The central role of the DPM and the Public Service Commission (PSC) in the selection, deployment and promotion of personnel.;
- The complex, inefficient and time-consuming tasks of financial management;
- The lack of an appropriate organizational structure. As a department within a ministry, it does not have the autonomy nor the flexibility to resolve many of the personnel and financial management problems listed below.

Recent attempts to overcome these obstacles are discussed in the final section of this chapter.

1. Policy, Planning and Coordination

The NCPD does not have the institutional capacity needed to formulate policy and program strategies. Population policies have not been updated, nor has a strategic plan been produced. This was expressed by Professor Okoth-Ogendo, Chairman of the NCPD Council during the Nakuru Workshop. He states:

> NCPD has not built the institutional capacity it requires to carry out the enormous responsibility of population formulation and program coordination .... There is a lack of a national strategic plan to guide and coordinate implementation of the population policy and programme. There is also a lack of clear objectives and updated targets to reflect recent demographic developments in fertility, mortality and morbidity, and inconsistency between government policy and legal provisions on sensitive

issues .... As NCPD we need to revise policy guidelines. (Okoth-Ogendo 1993)

The NCPD's approach to population issues has focused too heavily on family planning services. In its Mid-Term Review, the UNFPA concluded that:

> Kenya's population policy "focuses largely on ... family planning ... the broader aspects of population related to the development efforts ... have been largely unexplored." (UNFPA 1994:28)

Many observers stated that this is the most important current problem, and that the NCPD should focus on multisectoral coordination and the relationship between population policy and development. They state that service delivery should be coordinated and managed by the MOH and other agencies with clinically trained personnel, and that the NCPD has become too involved in project management.

Although it has a large professional staff, the NCPD depends on donor resources and outside technical assistance to develop projects and programs. Its "plans" are essentially a collection of proposals formulated by NGOs and the donor agencies and appear to be "donor driven."

The NCPD has had only limited success in the coordination of donors and local organizations involved in population activities. There are many agencies, including many NGOs, using different strategies and working with sectors of the population they have independently identified. The UNFPA Mid-Term Review report notes:

> It is questionable whether all these [population activities] have common nationally approved procedures ... since each player virtually seems to be doing his own thing ... donor driven projects abound in the system. (UNFPA 1994:29).

The NCPD does not have an effective working relationship with the Ministry of Health. Its emphasis on service delivery conflicts with the role of the MOH. The MOH has a clear mandate, and clinically trained staff, to organize and deliver family planning services. NCPD personnel have neither the clinical training nor experience to manage or evaluate service delivery programs. This is true from the national to the district level where the roles and relationship between district MOH personnel and the District Population Officers remain undefined.

2. Financial and Project Management and Assistance

The financing of NCPD's development program is through bilateral and multilateral grants, and IDA credits. The grants cover 100 percent of project costs while the credits cover 80 percent. NCPD has no source of generating funds to finance its operations and

maintenance, including salaries and benefits. Without donor funding, it will be completely dependent on the Exchequer for its finances.

The GOK budget and accounting process with its fixed expenditure ceilings for specified time periods is seen as a major constraint to the efficient utilization of donor resources. According to the GOK Task Force (GOK 1994d:20), the problem has manifested itself in the following ways:

- the difficulty in getting budget allocations sufficient to cater for the priority activities of the population programme;
- the difficulty in ensuring that the activities covered are fully reflected in the printed estimates; and
- the difficulty in getting the actual release of the funds allocated in the estimates.

In addition, each donor agency has its own accounting requirements which often are not compatible with those in the GOK and the NGOs.

The NCPD functions as a donor agency *vis a vis* the implementing agencies but it does not have the appropriate authority to efficiently administer the funds allocated to the projects. This has resulted in delays in getting funds to the implementing agencies and has had a negative impact on their ability to carry out their projects as designed. In addition, GOK funds to meet recurrent costs and counterpart funds for donor funded projects were often not readily available. In short, the current financial procedures are not well adapted to the needs of a rapidly changing population program.

The NCPD has not been effective in project management and technical support. The NGOs and donor agencies are critical of NCPD's ability to get the required paperwork through its parent Ministry and Treasury. There are delays in transferring funds to NGOs, and there are problems in financial management and accountability. NCPD's poor performance in financial management and technical support has led some donors to withdraw funds from NCPD and allocate them to local and international NGOs. Audit reports detail NCPD's difficulties in accounting for funds allocated for its own activities and for the NGO projects it manages. USAID now refuses to channel any funds to NCPD. A recent World Bank Mission notes that:

> NCPD has not proven to be an effective manager of NGO grants, with major problems arising both in the flow of funds to NGOs and in fund accountablilty (WB 1994d:18).

The World Bank recently removed funds from NCPD and reallocated them to the MOH. Another recent report noted that "NCPD may be perceived more as a bureaucratic obstacle than as an aid to effective operation within projects" (Price 1994:5).

The NCPD has not established the capacity to monitor and evaluate projects and research proposals. A GOK Task Force stated that the large number of committees " . . . militate against making important, timely decisions on population project proposals." (GOK 1994d:13).

NCPD's monitoring and evaluation activities focus on progress reports and accounting statements from implementing agencies, but there is no formal review process nor feedback to the implementing agencies. Some NCPD officers supervise their projects, but do not appear to have the professional skills required to analyze data and evaluate project results. The 1994 UNFPA Mid-Term Review states that the NCPD has not developed systems, nor manuals to track policy development and programs. The report states:

> . . . there is no evidence of a comprehensive management information system or network. There is no central data bank to keep track of population materials. . . . the routine field monitoring functions of the NCPD staff seem to be dormant at the moment (UNFPA 1994:31-32).

A recent World Bank review mission noted with concern "that the NCPD still has not developed a capability to plan and manage research activities in population." (WB 1993b:12).

3. Information, Education and Communication (IEC)

The NCPD has not provided leadership in IEC activities. The NCPD still does not have professional staff skilled in IEC, nor has it produced a comprehensive IEC strategy. At the 1993 Nakuru Conference, the Chairman of the NCPD Board, Professor Okoth-Ogendo stated, "NCPD should be a national resource center in IEC. However, this has been an area that NCPD has been particularly weak. . . ." (Okoth-Ogendo 1993)

The NCPD has not been able to recruit communication specialists to develop and lead this critical program area, and in 1994 the IEC Division was headless. In the World Bank Mid Term Review (1993), the authors noted that ". . just a few [staff] have been exposed to population communication skills." (WB 1993c) The World Bank mission was particularly critical of the NCPD's activities in IEC and noted:

> that neither the functioning nor the morale of the IEC Division has improved in any significant manner over the past few years and therefore offers little hope for improvement in either carrying out creative IEC activities or inspiring NGOs/other Ministries associated with the ongoing population projects. . . . (WB 1993b).

The NCPD does not have a comprehensive IEC strategy nor guidelines for the production of materials. The UNFPA Mid-Term Review said that in Kenya:

> . . . there has developed a situation of overlapping, sometimes contradictory unrelated and uncoordinated [IEC] activities. The need to bring these together in a coherent, programmatic way is obvious. The delay in doing this is regrettable (1994b:82).

Past attempts to address the situation have not been successful. For example, several years ago the UNFPA provided NCPD with help to develop an IEC strategy. The draft document, "National Population Information Education and Communication Strategy" was judged to be inadequate. According to the UNFPA's experts,

> It [the strategy] lacks coherence and structure and simply does not state categorically who does what with whom, when, where and how; it merely 'calls for clear demarcation of duties, roles and responsibilities among all the actors in population IEC nationally' (UNFPA 1984:92-3).

The NCPD has not designed IEC messages targeted to specific groups, nor has it promoted debate on sensitive issues such as abortion and reproductive health services for the youth. Messages developed to date have been directed for wide audiences and viewed by some as "ineffectual." Baseline and other surveys needed to develop messages targeted to specific audiences have been delayed, and interagency coordination in IEC has not been well established. In 1993, a World Bank document stated:

> The mission is surprised to find that the NCPD, so many years into its life, now asserts that most of its IEC activities have not been community or target specific. It is difficult for the mission not to regard this as a virtual indictment of the Division's capacity to formulate or guide IEC activities in any reasonably competent manner (WB 1993b).

While the NCPD plays an important role in the production of IEC materials, a recent World Bank Mission concluded that NCPD's ". . overall function has been more one of controlling 'what NOT to say,' than providing assertive guidance to developers on promotion and targeting of certain groups." (WB 1994d:16)

7.4.4 Recent Events that Address the Status and Future of the NCPD

Two recent events had important implications for the future of the NCPD. They were:

(1) The NCPD/UNFPA Nakuru Conference: The Present and Future of the NCPD held in April 1993; and

(2) The GOK Task Force on the Restructuring of the NCPD, which responded to the recommendations of the Conference.

The Nakuru Workshop brought together a wide range of participants from within and outside government, including the current and past directors of NCPD. Their diagnosis of NCPD's problems was comprehensive and the workshop report suggests a consensus on the direction and content of structural reform and organizational change. The made many excellent recommendations to revitalize the NCPD and strengthen its internal operations and relationships with other agencies. Appendix D presents a summary of the workshop and major recommendations.

7.5 Kenya Medical Research Institute (KEMRI)

The Kenya Medical Research Institute is a parastatal of the Kenya Government. The mission of KEMRI is to conduct health sciences research and generate research findings to be applied towards the improvement of the health status in Kenya.

In line with GOK objectives, KEMRI's research is targeted first and foremost towards generating new information on the prevention, control, management and treatment of diseases of public health importance in Kenya; and secondly, towards increasing the awareness of the individual Kenyans and the community in avoiding health risks and leading better health styles.

The thrust of KEMRI's research work is consequently on communicable diseases that afflict the majority of Kenya's population. The institute also directs significant attention to non-communicable diseases such as cancers and cardiovascular diseases whose prevalence in the Kenyan population is rising.

7.5.1 JICA's Support of KEMRI

JICA has been a major donor to KEMRI for almost 15 years. The most recent KEMRI/JICA project (1990 to 1995) is one of JICA's largest health projects in the world, and the largest source of donor funds for KEMRI. The Project has made many major contributions of both direct and indirect impact to the improvement of the health status in Kenya. Some of the most outstanding contributions are:

1. Strengthening of the national health manpower and research capacity through training, and through development of modern facilities for health research and the provision of research equipment and materials;

2. Transferring technology through Japanese experts involved in the Project;

3. Screening of transfused blood with KEMRI Hepcell Kit developed locally;

4. Evaluating effects of immunizing newborns against Hepatitis B in Kenya;

5. Developing early diagnosis and treatment of hepatocellular carcinoma, a major cause of death among young Kenyan males secondary to Hepatitis B infection;

6. Evaluating efficacy of Cereal-Based Oral Rehydration fluids in Kenya using home-grown cereals;

7. Enhancing community awareness to disease prevention and control through community-oriented research programs (such as Kwale schistosomiasis Project);

8. Disseminating data and information through publications, workshops and seminars for application in health care delivery services.

7.5.2 Organization and Staffing of KEMRI (See Appendix E)

7.5A Strategic Implications: The Public Sector

1. **Activities to strengthen public sector organizations should be incorporated into the programs and projects under the Joint Strategy.** The MOH, the NASCP and other government agencies currently have weaknesses that will negatively affect the long term sustainability of the proposed projects and that need to be addressed. Give attention to the organizational development aspects of public sector agencies. Advocate for organizational reform within government agencies.

2. **Resource management of public sector agencies should be carefully monitored and improved.** The experience of JICA, USAID and other donors has shown that GOK health and population agencies have limited capacity for financial and other resource management tasks. Develop training activities that strengthen planning, management and evaluation skills.

3. **Health and management information systems related to Joint Strategy projects need to be coordinated and integrated into the implementation strategy.** The current information systems in the public sector are weak and cannot provide adequate data nor the professional analyses required to measure progress and impact.

4. **Integrate management training into project activities and institutionalized at the MTCs.** Mangement training can be part of the basic, post-basic and continuing education programs for health professionals.

5. **Strengthen the capacity of the public sector agencies to work effectively with NGOs and the private sector.**

6. **Introduce computer technology into basic, post-basic and continuing education programs at the MTC.** If the MTC is to prepare health professionals for the next

century, it is essential to increase the level of computer literacy of the students. The training will enable students to use information technology in patient management and administration.

7. Encourage the MTC to review the academic requirements for entrance into Certificate and Diploma courses. Currently, the diploma courses require an aggregate of "C pass" or credits in three subjects at the school certificate level. Certificate courses require a "D+ or a pass" in two relevant subjects. These requirements seem low given the complex nature of clinical and public health tasks which graduates are required to perform.

7.6 The Private Sector

This section examines the role of the private sector in providing general health services and management in family planning and STD/HIV/AIDS. The intent is to provide a comprehensive assessment of the private sector's management and service delivery capacities as well as their contributions to public health in Kenya.[1]

Editors note: **This section of the report is based on several USAID consultants' reports produced during the past year. The terminology used in the reports are clearly explained in the text but differs from those in the earlier sections of the Joint Strategy document which are based on those used by the MOH. The major differences are:**

1. **"Private providers" in this section includes private (for profit) groups and individuals, and the NGO/Mission agencies.**

2. **"Facilities" in this section includes pharmacies, clinical laboratories, and shops where pharmaceutical products are sold.**

3. **"Personnel" in this section includes chemists, community health workers, traditional healers and traditional birth attendants.**

Harmonization of the conceptual frameworks and terminology for health subsectors, agencies, facilities and personnel should be addressed in the next stage of planning for the joint strategy.

7.6.1 Overview of Private Health Provision in Kenya

Kenya has a pluralistic health system. Health services are produced by the government and a host of non-governmental providers. "Private providers" consist of private and non-government health care service delivery suppliers within the health care system. Other non-governmental organizations in this

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[1] [illegible]

sector include single purpose organizations such as the Family Planning Association of Kenya (FPAK) and community based providers. In the for-profit sector are health facilities owned by sole proprietors and partnerships, companies and parastatals, pharmacists and traditional health practitioners. Together these privately provided services are a rather large, and growing, part of the national health delivery system of Kenya.

While the public provision sector has been well studied and is fairly well understood, very little is known of the non-government health sector. Assessments of the non-government sector are hampered by its diversity in terms of providers and facilities. In fact, there are over 20 different types of providers in Kenya.

7.6.2 Types of Private Providers

Non-Profit: Among the non-profit religious/mission organizations are Protestant and Catholic hospitals, health centers, clinics and dispensaries; and Mosque-affiliated clinics, dispensaries and pharmacies. Among other non-profit NGOs are family planning clinics, community health workers, community pharmacies, and other non-profit hospitals.

For-Profit: These providers include individual- and group-run hospitals and clinics with doctors and nurses; privately-owned maternity and nursing homes; employer-provided clinics and pharmacies; and individual pharmacies/chemists, clinical laboratories, stores, shops, and such traditional practitioners as herbalists, bonesetters, diviners, and birth attendants. Among for-profit facilities and services, a distinction is made between modern and traditional systems of treatment and medicine.

Parastatals and Employer-Based Services: Although parastatal and employer-based services may be found in the public sector, these services are most commonly found in Kenya's private sector. Parastatals which currently offer family planning and other health services include Kenya Post and Telecommunications, Kenya Ports Authority and the Coffee Research Foundation. Employer-based services can be found throughout Kenya in industries such as Bata Shoe Company, Kenya Breweries Ltd., Pan African Paper Mills, Del Monte and Goldsmith Seeds.

7.6.3 Distribution of Private Health Facilities by Ownership

It is important to have an understanding of the distribution of private health facilities by type of owner. Private health facilities are owned by a variety of agencies and individuals. Each of these owners pursues a different set of objectives. For some, the objective is to maximize profits, for others it is to reduce production losses from ill

workers, and for religious groups the driving force may be philanthropic. Thus, in order to put the following discussion regarding locational patterns in context, it is appropriate to briefly discuss the distribution of private health facilities in Kenya by ownership.

As of October 1994, there are 1,446 private health facilities in Kenya. Of these, 47.3 percent are in the mission sector, 51 percent in the private/company sector and the remaining 1.7 percent are owned and operated by the Family Planning Association of Kenya (FPAK). In terms of the distribution of types of health facilities by ownership, the mission sector owns more than two-thirds of the hospitals, 86.6 percent of the health centers and 42 percent of "other" health facilities. The private/company sector owns slightly more than 30 percent of the hospitals, less than 15 percent of the health centers and more than half (55%) of the "other" health facilities. This evidence suggests that the mission sector is the largest non-governmental provider of curative care.

7.6.4 Geographical Distribution

Evidence regarding the distribution of mission facilities as of 1994 suggests that missions concentrate their health facilities in areas with large concentrations of Christians. This pattern of location results in non-Christian areas being underserved in terms of relatively good quality mission-provided health services. It is difficult to characterize mission facilities in terms of their urban/rural distribution. However, it is a generally held view that they are mostly active in the rural areas of Kenya.

Although mosque-affiliated health institutions are found in predominantly Moslem areas, there does not appear to be a visibly conscious choice of a location as is observed with mission facilities.

Most company and for-profit health facilities are concentrated in the urban areas although some may be found on plantations and at parastatal sites in rural areas. The for-profit providers in this group are influenced by profitability conditions, i.e. the size of the market, patients' willingness and ability to pay. Employers are, on the other hand, driven by the need to provide employees with health services in order to reduce production losses. Rift Valley Province has the highest concentration of private/company health facilities followed by Nairobi Province. Nairobi and Rift Valley Provinces together account for more than 50% of all private hospitals. Northeastern Province has the lowest number.

Of the 290 pharmacies and chemists in Kenya as of July 1994, Nairobi has the largest concentration (47%), followed by Rift Valley (13.8%) and Coast (10.3%). These three provinces together account for 71 percent of all pharmacies in the country. TBAs and community health workers are more commonly found in Nyanza, Eastern and Western Provinces.

7.6.5 Assessment of Private Sector Performance

Religious Organizations

There are two main religious organizations active in the provision of health services in Kenya. These are a) the various denominations of the Protestant church and b) the various orders of the Catholic church. There are also mosque-affiliated health facilities and reported cases of health facilities associated with Hindu and Buddhist religions. The involvement of Christian missions in health services delivery dates back to the latter part of the eighteenth century. The purpose of the early medical institutions was to proselytize among the African population. With time, this has become less important. The activities of these health institutions are coordinated by two different groups, Kenya Catholic Secretariat (KCS) and the Christian Health Association of Kenya (CHAK) which reflect the two broad divisions of the Christian church.

Christian Health Association of Kenya (CHAK)

CHAK coordinates the activities of approximately 230 health facilities in Kenya operated by various protestant denominations such as the Seventh Day Adventist Church (SDA), Presbyterian Church of East Africa (PCEA), Church of the Province of Kenya (CPK) and the African Inland Church (AIC). Each hospital member of CHAK is autonomous and makes its day-to-day operational decisions independent of CHAK and other member-facilities. CHAK exists to represent its member-institutions on common issues before the GOK, disburse grants for the GOK to member facilities, to coordinate the activities of the facilities on issue of mutual concern and to be the repository of aggregate information on the health activities of member-facilities. These member units include 183 dispensaries, 32 health centers and 15 hospitals located in rural districts throughout the country. In conjunction with its Catholic counterpart, CHAK provides over 30 percent of all health services in Kenya. With family planning as part of these integrated health services, the CHAK member units are responsible for a large number of rural family planning users.

CHAK facilities depend mainly on direct cash payments and minimally on employer purchase of services. CHAK facilities are less likely to depend on the NHIF as a source of revenues and grant very few exemptions to the indigent. In a 1994 study, 80% of CHAK facilities respondents said they would need incentives in order to provide public health services while another 70% would like to be given incentives in order to provide additional curative services. Family Planning Management Development is presently assisting CHAK in improving its management systems at the Secretariat level and enhance its ability to provide the necessary support to their member health facilities.

Kenya Catholic Secretariat (KCS)

There are approximately 354 Catholic-affiliated health facilities. Catholic health facilities are, like CHAK, autonomous in their day-to-day operations. They are largely

supported by volunteers and donations from abroad. The KCS performs the same duties for its members as does CHAK. KCS facilities (14 in total) appear to be very dynamic. Judging from the plurality of payment instruments these facilities report to accept, they appear to attract patients from different segments of society. Cash payment was the most commonly reported payment instrument, followed by employer reimbursement and the NHIF especially for inpatient services. KCS facilities also report granting more fee exemptions to the indigent.

KCS facilities are generally regarded to be of very high quality and all things being equal should be expected to attract more NHIF patients than CHAK facilities.

Crescent Medical Aid (CMA)

Mosque-affiliated health facilities are run and operated by the Crescent Medical Aid (CMA). There are approximately 12 mosque health facilities in Kenya. The CMA, unlike CHAK and KCS, directly runs the facilities for the individual mosque owners.

Family Planning Association of Kenya (FPAK)

As a leading non-governmental family planning service provider, FPAK plays a key role in meeting the GOK's national targets. Preliminary findings from the 1993 Demographic Health Survey show that FPAK provides 5 percent of Kenya's family planning services. From Family Planning Management Development, FPAK receives assistance in the areas of strategic planning and management, MIS, and resource expansion. This will allow FPAK to better plan and manage activities, expand its service delivery, and continue to be a major contributor to the national plan.

Employer-Provided Health Services

Employer-provided health services are an important source of care for many; although, there are no identifiable estimates of the number of employer-provided health facilities in Kenya or the number of Kenyans who benefit from such services. Some employers own and directly operate their own health facilities; those who do not, purchase health services for their employees from private health care providers. There appears to be some co-payment for health services rendered since both company reimbursement and direct cash payments are important payment instruments in these facilities.

7.6.6 Growth of Private Providers

The government of Kenya relaxed restrictions during the 1970s on MOH doctors working in the private sector, then in the 1980s tried to reimpose the restrictions. The result was that many doctors resigned from public service. The government has since permitted MOH doctors, nurses and clinical officers to work in the private sector. Now, it is not

unusual to find a private dispensary that is owned by a physician who works for the MOH, but run by a medical assistant or nurse, with the doctor keeping part-time hours.

Today, with the public health system over-burdened and unevenly distributed, the government has a new interest in the possible contributions that private health providers can make to national health goals. Kenya now has a pluralistic health system, because it has permitted a large and diverse private sector to develop.

Community-based services are especially critical. In line with government efforts to increase overall health services in rural areas, more community-based and community-owned services are being found in rural areas. The number of private community clinics and pharmacies is growing.

Because the growth of the private, especially for-profit, sector has been both uneven and rapid, it is increasingly difficult to track new facilities, analyze their financing, and the type and quality of their service delivery. This is especially true since there is a scarcity of information on private services.

7.6.7 Utilization of Private Providers

Kenyans seeking care have a nominally wide range of providers from which to choose. Detailed breakdowns of source of patient care are provided in surveys undertaken by the Health Care Financing Project (KHCFP) in 1993 in six districts, and by AMREF in 1994 in three districts. Estimates from the KHCFP data suggest that utilization of private and mission facilities for outpatient care together amounts to 20 percent of total utilization. When the purchase of over-the-counter drugs is added, the private sector contribution rises to 42 percent, with traditional medicine and herbs contributing a further 5 percent of total utilization. Government facilities, on the other hand, were used in 40 percent of visits.

In contrast to informal and anecdotal evidence, surveys show very low levels of use of traditional healers and low-to-moderate use of herbal treatment. To the extent that this reflects under-reporting of use of this sector, it may be an artifact of the questionnaire design. In any case, it is clear from the evidence that private sources of curative care are very important in Kenya.

7.6.8 Factors Affecting Private Health Services

There are factors of both supply and demand which affect private health services. Supply factors affect the provision of service and demand factors affect people's use of services.

Demand-Side Determinants:

The demand for private services is high. The consumer's use of private and mission services is at least 20 percent of total health-care utilization. Adding the purchase of over-the-counter drugs, total modern private sector use rises to at least 42 percent of total use.

- **Income:** According to both for-profit and non-profit providers, household income is the greatest constraint to the use of services. Where there is evidence of household income, great differences are found in private service use by different economic groups. The poor are most likely to use drug sellers, small individual providers, traditional providers, and mission/mosque facilities; while the larger urban facilities, both public and private, serve more of the affluent classes.

- **Education:** People with more education are more likely to seek health care and higher-quality care. The higher the level of education, the greater the use of private services. For mothers, the more education they have, the more likely they are to seek modern antenatal care and care for their children.

- **Residence:** Urban areas are more able to support full-time private and for-profit services because of economies of scale, generally higher incomes, greater formal sector employment, and better access to transportation. There is a great potential for development in rural areas, especially for the church-based, non-profit sector. However, non-profits providers in the poorer areas often have trouble covering their operating costs.

- **Quality of Services:** Studies find greater patient satisfaction with "good treatment" at mission and private facilities than with "poor quality" government facilities. Reasons for private provider preference include cleaner and friendlier environment, better trained and more courteous staff, more time with doctors and less time spent waiting.

- **Health Insurance:** Kenya has a social insurance scheme and a form of employer insurance/cost coverage scheme. Insurance tends to promote greater use of private for-profit providers. However, insurance coverage is limited.

- **Cost-Sharing:** Kenya has begun to charge user fees (cost-sharing) for certain public services. This may lead to greater demand for private health care services, and increase the competition between private and public providers.

Supply Side Determinants:

MOH services have deteriorated with falling real government funding -- resulting in drug shortages, lack of essential supplies, over-crowding, and long delays. Despite the difficulty in obtaining financial credit, the economic and political climate generally favors the growth of private health services. Governments' legalization or reduced restrictions

on private providers have contributed to their expansion in many countries. Now, the greatest constraints of providers are lack of access to capital and credit, high taxes on imported drugs and medical equipment/supplies, and lack of training for medical personnel.

- Capital: The trend toward more open economic environments has encouraged private sector provision of health services; however, there do not appear to be specialized financial institutions that lend to health providers. One result is that private sector growth is dominated by small clinics. Lending to the health sector is not attractive to banks and other financial institutions because of the general lack of collateral and the low liquidation values of such specialty services.

- Taxes: The government's high taxes on imported drugs and equipment have restricted private sector development.

- Personnel: There are occasional shortages of doctors, nurses, pharmacists, and technicians. The greatest lack is in rural areas, as most doctors choose to work in urban areas.

In addition to the above cited constraints, other constraints on private sector development, particularly in rural areas, are high transport costs, low rural income base, poor rural infrastructure, lack of training facilities, and weak coordination with and little information from the MOH. While government policies and regulations and their licensing and certification processes, have not necessarily constrained the growth of private providers, they have impacted the urban concentration of private providers.

7.6.9 Problems Confronting the Private Sector

Much more is known about the constraints and problems faced by the mission sector than any other types of private provider. For this reason, only mission facilities are treated in this section.

There are three major problems facing most mission facilities. The first is financial, the second is the lack of management and administrative skills, and the third is the lack of places in local medical institutions for them to train their paramedics. These problems appear to be especially serious for CHAK affiliated hospitals, three of which were recently taken over by the GOK in keeping with the policy to assume full responsibility for any failing church health institutions. A management study identified the following as the major constraints facing CHAK facilities:

i. lack of a system of controlling and managing drug supplies, and

ii. lack of a system for monitoring the purchase and use of food in the hospital kitchens.

Fourteen percent of the facilities studied had no inventory system while 40 percent of the small units had no drug inventory system.

Finance is also a problem. The GOK has not subsidized the activities of mission health institutions, although it does from time to time make outright grants to them. This amount has been decreasing in recent times. Non-profit health institutions can also petition for a 50 percent reduction of foreign trade taxes on imported items. In order to make up for their financial shortfalls, some church-affiliated facilities have decided to make a deliberate effort to attract more NHIF patients.

Finally, the lack of places in local institutions for the training of paramedical staff is a serious problem confronting the mission health sector. KCS for example, reported that all attempts in recent years to get training places at the Medial Training College for two of their qualified candidates have not been successful.

7.6.10 Insurance

Insurance affects the demand for private services by lowering the cash cost of health care at the time of illness. In so doing, it makes a greater variety of providers financially accessible to the patient, thus increasing the patient's choices of providers. In Kenya there are two broad types of formal insurance: the National Health Insurance Fund (NHIF), and private health insurance. In addition, there is an informal risk-sharing arrangement know as *harambee*.

NHIF

The NHIF is a mandatory contributory scheme for government and formal sector employees which has been in existence since 1966. It finances inpatient treatment costs in both public and private facilities and has become an important source of financing for the non-government hospital sector, including both for-profit and non-profit hospitals. Currently, the NHIF is estimated to effectively cover 6 million people.

Presently, the NHIF suffers from a variety of problems which impair its role as a successful risk-sharing scheme and make it difficult to assess its overall impact on the private sector. Among these problems are: payment mechanisms which create incentives for expansion of private bed capacity but not for quality improvement or cost control. high transaction costs in claims processing, limited ability to control fraud and abuse. and differences in benefit use for high and low income contributors.

NHIF and Consumer Incentives

Models of insurance predict that insured patients will consume more health services than they otherwise would have because insurance largely frees them and the physician from the discipline of cost. Receipts and benefits paid out have been rising, particularly since

1989/90 when NHIF contribution rates were revised. In that year, the flat contribution rate which had been in place since the NHIF was founded was replaced with a graduated contribution schedule. Workers contribute 2 percent of their monthly income but no more than KSh 320 per month. Since 1990, benefits paid have risen while revenues have changed little. This would be consistent with increased consumer use of health care under insurance.

There are competing explanations for these trends. The revision of reimbursement rates in 1989 could have resulted in an increase in total benefits paid out even after controlling for the increase in the number of institutions making claims. There has also been an increase in the number of facilities claiming from the Fund. This may include newly-registered providers.

Another factor that may explain the decline in net revenues is the fact that GOK facilities are now making increased efforts to claim from the NHIF. Previously they had no incentives to pursue NHIF claims because all such revenues collected were returned to the Treasury. With the introduction of cost sharing in government facilities, the GOK has permitted these facilities to retain collected revenues for their own use in a facility improvement fund. This is reflected in vigorous efforts by these facilities to mobilize revenues, including those from the NHIF.

Private Health Insurance

The second type of formal insurance is private insurance, taken out by individuals or by employers on behalf of their employees. There are no reliable estimates of the number of Kenyans covered by private insurance schemes. Evidence from a recent study of the insurance market suggests that, as in the case of the NHIF, private insurance coverage is largely limited to those in formal sector employment. Insurance companies report that the majority of clients are located in urban areas, and 80 percent of all insurance agents operate in urban areas.

Although formal private insurance is emerging as an important source of financing for upper income Kenyans and those employed in the formal sector, it is unlikely to become a very important source of health financing for the majority of the Kenyan population in the medium term. Two factors constrain the scope of private insurance. First, it has a predominantly urban bias, and second, it is generally employment-related, thus its availability is likely to remain limited to those in formal employment. Incomes in most other sectors remain too low to support the cost of insurance.

The Harambee Movement

A third, informal type of insurance is provided by the "Harambee" movement. This is the practice of communities voluntarily pooling together their funds for private or public projects. In addition to contributing towards infrastructure investment, raising Harambee funds is a relatively common way to assist families facing catastrophic illness. Harambee

is a fund raising, financing mechanism which represents risk-pooling. The incentive for individuals to contribute to Harambee fund-raising lies in their expectation that they, too, would receive the same assistance were it needed. By increasing households' access to cash for paying medical bills, the Harambee movement probably increases utilization of private health care providers.

7.6.11 Linkages Between the Private and Public Sectors

There are three main linkages between the private and public health sector: (1) laws and regulations; (2) communication and coordination: and (3) service delivery.

- **Regulation:** Laws concerning the private health sector mainly regulate the quality of inputs -- such as minimum standards of entry. The laws governing entry into practice of private health care tend to be enforced weakly and do not have their intended effect. Generally, the government has little capacity to assure the quality of medical practice and ensure equitable distribution of access.

- **Coordination:** The MOH is formally supposed to coordinate public and private health services at the level of the district and the province; however, actual coordination often falls short of intentions.

- **Service Delivery:** Both public and private health services tend to be more curative than preventive. However, the non-profit mission sector offers services that deliberately try to reach rural areas with preventive health care. Data in Kenya shows active private sector involvement in national health problems.

Overall, budget allocations for public health systems are declining and the systems are struggling to provide equitable access to care and prevent deterioration of the national health status. Both private and public services are heavily concentrated in urban areas. Public health decision-making is over-centralized and slow to respond effectively to health needs. Communication and coordination of public and private services are both weak. The private sector has little opportunity to contribute to public health policy. Interviews suggest that there is very little consultation between the MOH and the private health sector either in terms of policy formulation or in terms of coordinating responses to specific health problems.

In recognition of the importance of private health providers in Kenya's health system and the need to use available resources more efficiently , a new office responsible for coordinating the health activities of the private sector and the government was recently created in the MOH. While the mandate of this new office is still being developed, it is expected to work very closely with the private sector and serve as a clearing house for all their requests and policy recommendations to the GOK.

7.6.12 Private Provision and the Public Health Agenda

When considering the potential for increasing the role of the private sector, it is critical to understand the contribution of the private providers to public health services. In this section we consider program areas of public health significance in Kenya, presenting evidence from a variety of sources about the magnitude of the role played by different types of private providers.

Reproductive Health Services

Kenyan private providers, including missions and other NGOs, make a major contribution to the supply of family planning services. Many types of private providers are involved -- hospitals, clinics, for-profit providers, donor-assisted projects, national associations, employer-provider services, pharmacies, shops, and others. Private providers are sometimes more important suppliers than public providers for certain contraceptives, especially condoms.

Household-level data from the DHS (NCPD 1994a) indicate the magnitude of the contribution of the private sector to family planning service provision. Of current users of all modern methods of contraception, 24.7 percent were supplied through private medical sources and 68.2 percent supplied through public sources. Private providers are relatively more important suppliers of IUD's and female sterilization (31.1% and 33.2% respectively) than other methods. IUD insertion and female sterilization are mostly provided in private hospitals and clinics, and FPAK clinics. Public sector sources, on the other hand, are used by more than 70 percent of users of pills and injections. Private sources are more important suppliers of condoms. Analysis by the DFH Logistics Unit suggests that condom distribution by an "average" private outlet is up to six times greater than by an equivalent public unit.

Community-Based Distributors of contraceptives (CBDs) are yet another private source of family planning services. A recent review of CBD activities in Kenya enumerated at least 14 major implementing agencies (NGOs) with over 4,000 distributors based in 1,200 sub-locations. While following a variety of program designs, all use community-based structures to provide clients with family planning information and services.

Communicable Disease

- **Immunization:** Recent immunization coverage rates provide evidence regarding private sector contribution to EPI activities. Out of 359 children sampled, 81 percent were immunized in public facilities and 18 percent in private facilities. The contribution of the private sector was marginally higher in rural areas. This statistic fails to capture the IEC, awareness creation activities in which the private sector may engage.

- **Tuberculosis:** Of the 20,000 cases of TB diagnosed in the general population, it is estimated that 20-30 percent were treated in mission facilities. Up to an additional 10-20 percent of cases may be diagnosed in mission facilities and then referred to public sector facilities for treatment. A rise in the cost of TB drugs in the private market is believed to have caused a reduction in the number of cases treated in the private sector. As in the case of the mission sector, the role played by private providers may be greater in diagnosis than in treatment.

- **HIV/AIDS:** The contribution of the private sector to AIDS treatment and prevention activities is difficult to assess; however, more than 60 NGOs are involved in HIV/AIDS activities in Kenya. A broad range of activities are undertaken by NGOs, including HIV/AIDS education and the production of education materials, counselling, provision of STD/AIDS education and alternative income generating opportunities for sex workers, home-based care, and AIDS orphans support. It appears that the contribution of the NGO sector to HIV/AIDS prevention and education activities is significant.

- **Malaria:** Although data is unavailable, the private sector facility use for malaria is likely to parallel that of the public sector. Private chemists and pharmacies provide a wide range of anti-malarials, including those designated as second-line drugs. The private sector contribution to prevention activities, through the provision of bednets for example, is not well documented. Anecdotal evidence suggests that very few pharmacies/chemists sell bednets.

  There are a number of NGOs engaged in malaria-related activities in Kenya. AMREF is involved in a number of projects including research into the effectiveness and socioeconomic impact of impregnated bednets and community financing of malaria prevention activities. Many other NGOs include malaria treatment and prevention activities as part of their community-based health care (CBHC) programs.

Childhood Illnesses

The public sector remains the dominant source of ORS (69%). However the private sector contribution is significant with shops providing ORS in 8.8 percent of cases, pharmacies in 6.7 percent and mission facilities in 5.6 percent. The private sector contribution is higher in urban than rural areas (35% vs. 29%). The bulk of ORS consumed in the country is produced by local private pharmaceutical companies. Because of import taxes on raw materials and packaging, locally-produced ORS is nearly twice as expensive as its imported equivalent.

While 55-70 percent of children taken to government hospitals, health centers and posts receive ORS, only 22 percent of children taken to private pharmacies and 24 percent taken to private hospitals and clinics receive ORS. Thirty-five percent of children taken to private doctors and 34 percent taken to mission facilities receive ORS. The likelihood

of being treated with antibiotics appears to be higher in private hospitals/clinics and pharmacies, although this is not the case for private doctors or mission facilities. Lack of information on the part of private providers about appropriate treatment of diarrhoea, or lower profit margins on ORS are possible explanations for this treatment pattern. Absolute numbers taken to private facilities are smaller, and some caution must be used in interpreting these findings.

A large proportion of diarrhea/vomiting cases are treated with drugs purchased over the counter. This suggests that pharmacies may be an important source of inappropriate drugs for treatment of diarrhoea. The use of private providers for treatment of fever and cough in under-fives lies in approximately the same range as that for diarrhoea. Overall, 26 percent of cases are treated in the private sector.

7.6A Strategic Implications

1. **Private sector expansion in rural areas** with particular focus on the church-based non-profit sector and NGOs to include the development of cost-recovery schemes and the development of incentives to encourage trained personnel to work in rural areas.

2. **Advocacy with GOK to review taxes imposed on imported drugs and medical equipment and supplies**; and to establish mechanisms which improve private providers' access to capital and credit.

3. **Improved access to training for private practitioners located in rural areas** with particular emphasis on the placement of mission paramedics in local medical institutions.

4. **Advocacy with MOH to coordinate input from the private health sector** for policy formulation and the development of coordinated strategies to respond to specific health problems.

5. Support the expansion of **condom social marketing.**

6. **Increase the role and capacity of Community-Based Distributors** particularly in rural areas (to include HIV/AIDS awareness messages and referral for long-term FP methods).

7. **Continued development of IEC activities through the private sector**, with particular emphasis on the role of NGOs in HIV/AIDS/STD prevention and control, FP and child survival.

8. **Improve family planning service delivery in the private sector** reviewing the role of the private sector in the delivery of pills and injectibles.

9. **Training for pharmacists in basic MCH diagnosis and treatment** with emphasis on malaria, the management of diarrhoea and ARI.

Chapter 8

Japan's Overseas Development Assistance Policy

The Government of Japan (GOJ) has clear policy and program guidelines for its Overseas Development Assistance (GOJ 1992,1993, 1994). It has strategies for its involvement in population and development (JICA 1992b), and population and AIDS (JICA 1994). In addition, JICA has written a basic strategy for its development assistance to Kenya which includes sections on population, health care and medical services (JICA 1992a). This section outlines the major elements of the Japanese approach to development assistance and the strategy for population and AIDS.

8.1 The Philosophy of Japan's Official Development Assistance (ODA)

The Japanese government places a great deal of importance on policy dialogue with the recipient country. ODA projects must be developed on the basis of views and objectives shared by both groups. These policy dialogues are designed to convey the philosophy and principles of ODA and to ensure they are reflected in the projects and programs developed in conjunction with the recipient nation. The GOJ takes a similar approach in its relationship to international and multilateral institutions.

The ODA Charter outline four basic points that must be taken into account in the planning of development assistance:

1. The relationship between development and the conservation of the environment;

2. The prohibition of ODA for military purposes and the aggravation of international conflict;

3. The monitoring of military expenditures, arms production and exports and the allocation of national resources for social and economic development; and

4. The promotion of democracy, market-oriented economic reform and basic human rights.

Countries in which human rights are seriously violated and/or reforms towards democratization are reversed may have their ODA suspended. Exceptions to this are made for emergency and humanitarian assistance.

8.2 Characteristics of Japan's Aid Policy

Japan's approach to ODA takes into account the conditions of social, economic and political development within each recipient country. It selects priority areas and integrates ODA loans, grant aid and technical assistance into its country strategy. Japan's ODA takes a broad perspective and uses a combination of strategies that include economic assistance, trade, direct investment and debt relief. It also takes a "balanced approach" to development in the following ways:

1. A balance between conventional areas (e.g., economic infrastructure and basic human needs) and new areas of assistance (e.g., environment and population);

2. A balance between large scale projects (e.g., physical infrastructure) and small ones (e.g., grass-roots level); and

3. A balance between "hardware" type assistance (development of physical capital) and "software" type aid (human resource development and institution building).

A cross-cutting theme in Japan's approach to ODA is the relationship between technology transfer and human resource development. It embodies the idea that transfer of appropriate technology is a critical element in development, and that to be sustainable, there must be a parallel effort to develop the human resources and institutional capacity to use and maintain the technology effectively.

Japan's ODA initiatives are based on detailed surveys, plans and policy dialogues designed to ensure that projects are suitable to the needs and capacity of the beneficiary countries. They include internal evaluations conducted by the Japanese government and the implementating agencies, and external evaluations by third party and/or joint teams.

8.2.1 The "New Frontiers" of ODA

Japan's ODA has recently expanded its perspective on development issues and strategies. This includes global issues such as the environment, population and AIDS. The "Global Issues Initiative on Population and AIDS (GII)" is part of this new direction. Other areas are: (i) Support for democratization and the introduction of market economies: (ii) Women in Development (WID) and; (iii) South to South cooperation.

8.2.2 Local Participation and Promotion of Understanding

The Goveernment of Japan is trying to extend its ODA program to include Japanese and local NGOs in developing countries. It has also increased its efforts to inform the Japanese public and the citizens of the recipient countries about ODA projects and programs.

8.3 Population and AIDS

Japan's assistance to population in developing countries takes a multisectoral and comprehensive approach. It includes the expansion of family planning programs along with other measures that address the fundamental causes of high population growth -- high infant mortality, poor sanitary conditions, low education levels, poverty and the low status of women. It includes project type assistance for MCH/FP projects (IEC and Training), and demographic information. Research and interventions to control endemic and epidemic diseases are part of Japan's population and AIDS strategy.

Japan's approach to HIV/AIDS focuses on cooperation in Information, Education and Communication activities aimed at preventing the spread of the disease. It includes technology transfer for medical testing and blood screening. Surveys and various types of HIV/AIDS research are also supported.

Population and AIDS issues are closely linked to environmental conditions. Japan's ODA takes this into account through programs to improve public health and sanitary conditions. It includes projects such as urban development, community development, water supply, sewage and waste disposal systems. In Africa, this effort focuses on safe water supply to households.

Japan's ODA strategy also addresses the need to strengthen the capacity of developing nations to analyze and utilize information on health, population, AIDS and environmental conditions. This involves improving the capacity of governments to collect and interpret appropriate data, and to formulate policies and cost-effective plans. Increasing the capacity of the recipient nation and communities to manage, and to monitor and evaluate projects is part of this effort.

Japan's ODA strategy in the population field includes assistance to strengthen and improve:

i. **Basic health and medical care, especially for women and children.** This includes studies and education in public health, the construction and provision of equipment for health facilities (health centers, pediatric and maternity hospitals), the training of nurses, and the control of endemic diseases.

ii. **Basic education, literacy and the social status of women.** This includes school construction, teacher training, production of educational materials and vocational training for women.

iii. **Maternal and child health and family planning.** This includes family planning services and IEC programs.

Japan's ODA takes a long term perspective on development assistance. It involves attention to a project's impact on human welfare as well as its long term sustainability.

The education of health professionals and projects to improve the capacity of training institutions feature prominently in the ODA strategy

8.4 Japan's Strategy for Development Assistance in Kenya

The Country Study Group organized by the Japan International Cooperation Agency (JICA) prepared a report that outlines the rationale and strategy for development aid to Kenya (1992). It follows the principles and development guidelines for overseas development assistance presented in the sections above and adapts them to the social, economic and political conditions in Kenya. The policy identifies several implementation issues, however, that need to be considered in its development assistance to Kenya. They include:

1. **The shortage of local resources.** Options include the absorption of local costs under certain conditions and cooperation with other donors.

2. **The shortage of counterparts.** This will be managed by agreements on counterpart obligations, incentives and prior counterpart training.

3. **Project sustainability.** This is addressed through attention to project quality rather than size, flexibility in project extensions, and the monitoring of structural reforms that contribute to sustainability.

Japan's ODA strategy towards Kenya includes the strengthening of their development assistance implementation structure. This will involve:

1. **Strengthening a field oriented implementation structure.** This includes an increased Japanese role in all phases of the project cycle, increased Japanese and local staff, increased cooperation with local institutions, and the formation of a "monitoring group."

2. **The expansion and improvement of the structure to collect and analyze information.** It includes strengthening their capacity to collect and analyze data, sector studies and improved project monitoring.

The development strategy outlined above will be used in the design and evaluation of the projects to be implemented as part of the Global Issues Initiative.

8.5 Current Strategies and Development Assistance Projects in Health, Population and AIDS in Kenya

Japan's ODA is implementing two projects in health and population and is in the planning stage of a third one. The projects are:

1. **The Population, Education and Promotion Project (PEPP).** This is an IEC project to produce and promote the dissemination of audio-visual materials, and use of mass media.

2. **Research and technical cooperation with KEMRI.** This involves technical assistance and support for research on several tropical diseases.

3. **Rehabilitation of the Medical Training College.** This new project will include the physical rehabilitation of nine MTCs, the provision of equipment and supplies, planning and curriculum reform. It involves the training of faculty and administrators and other capacity building activities.

Chapter 9

USAID's Development Assistance Policies and Activities in Population and Health

9.1 USAID's Development Assistance Policy

USAID's development assistance philosophy under the current Clinton Administration emphasizes that *people* are central to development. Development is envisioned as a process in which people take control of their lives and improve the conditions and prospects for themselves and their families.

USAID recognizes that its success will ultimately be determined by the way it approaches its development mission and responds to urgent humanitarian needs. Therefore, it employs certain operational methods in all its endeavors, namely: support for sustainable and participatory development, an emphasis on partnerships, and the use of integrated approaches to promoting development.

USAID programs are undertaken in three types of countries:

- Countries where USAID provides an integrated package of assistance;
- Countries that have recently experienced a national crisis, a significant political transition, or a natural disaster, where timely assistance is needed to reinforce institutions and national order;
- Countries where USAID's presence is limited, but where aid to non-governmental sectors may facilitate the emergence of a civil society, help alleviate repression, meet basic humanitarian needs, enhance food security, or influence a problem with regional or global implications.

Within these nations, USAID will support four programmatic areas that are fundamental to sustainable development:

- Population and Health
- Broad-Based Economic Growth
- Environment
- Democracy

Progress in any of these areas is beneficial to the others.

9.2 USAID's Strategic Approach to the Population and Health Sector

USAID's population and health goals are mutually reinforcing. Specifically, USAID will contribute to a cooperative global effort to stabilize world population growth and support women's reproductive rights. Consistent with United Nations projections, this effort should result in a total world population between 8 billion and 9 billion by the year 2025, and less than 10 billion by the year 2050, with very low growth thereafter. Over this decade, USAID also will contribute to a global health goal of halving current maternal mortality rates, reducing child mortality rates by one-third, and decreasing the rate of new HIV infections by 15 percent. To achieve this, USAID will concentrate its population and health programs on two types of countries. Those countries which contribute the most to global population and health problems, and countries where population and health conditions impede sustainable development.

At the program level, USAID's operational approach is founded on the following principles and objectives:

- Promoting the rights of couples and individuals to determine freely and responsibly the number and spacing of their children;
- Improving individual health, with special attention to the reproductive health needs of women and adolescents and the general health needs of infants and children;
- Reducing population growth rates;
- Making programs responsive and accountable to the end-user.

The types of programs USAID supports vary with the particular needs of the individual country and the kind of approaches that local communities initiate and support. However, most of USAID's resources are directed to the following areas:

- Support for voluntary family planning systems;
- Reproductive health care, including prevention and control of sexually transmitted diseases, especially HIV/AIDS, and improved prenatal and delivery services;
- The particular needs of adolescents and young adults;
- Infant and child health;
- Education of girls and women.

USAID collaborates with other donors, host country governments, development agencies, universities and academic organizations, the private sector, PVOs and NGOs. Where

appropriate, USAID will pursue and practice joint planning and allocation of resources, sharing of methods, and pooling of technical resources. This will extend from the institutional level to the field.

9.3 USAID's Strategy for Development Assistance to Kenya

The goal of USAID's country program in Kenya is to assist the government and people of Kenya to achieve sustained and broad-based economic growth so that current and future generations can enjoy increased opportunities, higher standards of living, and greater security in meeting their basic human needs. This is to be accomplished by:

1. reducing the rates of fertility and population growth; and

2. increasing production, employment, income and foreign exchange from the private sector.

USAID/Kenya contributes to reducing fertility and population growth rates by promoting increased contraceptive use. This, in turn, is to be accomplished by improving the supply of contraceptive services and increasing the demand for contraceptive services. USAID/Kenya contributes to increasing production, employment, income, and foreign exchange earnings from the private sector by increasing private investment for Kenya as a whole and increasing farmer net income.

This overall strategy is directed towards developing and improving an "enabling environment" by reducing restrictions on the private sector and by fostering production and marketing conditions that will serve as inducements for greater crop production.

9.4 Current USAID Assistance to Kenya's Population and Health Sector

9.4.1 Strategic Objectives

The strategic objective of USAID/Kenya's Office of Population and Health is to reduce fertility and the incidence of HIV. An integrated approach inclusive of activities in family planning, HIV/AIDS and health care finance has been adopted in an effort to successfully achieve these objectives.

Family Planning

The primary focus of USAID/Kenya's population and health activities is family planning service delivery. The strategy employed to achieve improvements in this area include:

- increasing access to family planning information and services
- meeting unmet needs for family planning

- increasing contraceptive prevalence
- reducing fertility
- reducing the population growth rate
- improving maternal and child health
- extending the women's right to control fertility
- promoting sustainable economic growth

HIV/AIDS Prevention

USAID/Kenya's secondary focus is on the prevention of HIV/AIDS. This strategy seeks to:

- promote behaviors which minimize the risk of transmitting/acquiring HIV
- increase condom use
- improve STD prevention and treatment
- integrate HIV/AIDS/STD services into family planning/Maternal and Child Health programs

Health Care Finance

The thrust of the health care finance component is to achieve policy reform and the implementation of reforms which promote the sustainability of health services. The strategy is to:

- increase local resources for health care (particularly primary and preventive health care) through user fees;

- increase NHIF and other insurance reimbursements;

- reallocate existing public health resources away from curative to preventive approaches; and

- improve efficiency of health services.

9.4.2 Implementation Portfolio

The current USAID Population and Health portfolio consists of four elements, each implemented in an effort to achieve a reduction in both fertility and the incidence of HIV. The portfolio is as follows:

- Four bilateral projects with length-of-project funding of $89 million which focus primarily on family planning services and secondarily on HIV/AIDS prevention

and health care finance policy reform -- Family Planning Services and Support, Private Sector Family Planning II, Contraceptive Social Marketing, and the Kenya Health Care Financing Project;

- An AIDS Technical Support Project implemented by Family Health International/AIDSCAP. Kenya is considered a "priority" country for which approximately $2.15 million in bilateral and central funding are allocated;

- A centrally-funded portfolio of approximately 25 different activities which focus mainly on family planning;

- A growing number of regionally-funded activities complimentary to the USAID/Kenya Population and Health portfolio.

9.5 Constraints to USAID as a Donor Agency

The following items have been identified as constraints to USAID both as a donor agency and as an agency involved in and committed to activities in the population and health sector:

- Current USAID "Buy America" policies render the procurement and provision of pharmaceuticals, HIV/AIDS testing kits and reagents and contraceptives, non-competitive and therefore, costly.

- The tendency to spread country resources across all agency priorities (e.g. environment, population and health, economic growth, democracy) results in too many on-going activities with too few resources. This makes it difficult to achieve national level impact in any one area.

- Population and health sector activities are heavily dependent on USAID/Washington core funds. These funds are granted to a host of cooperating agencies who manage and implement population and health projects. Because activities are spread across a range of implementors, it becomes difficult to attribute impact. This makes focusing and coordinating national efforts difficult as each implementor has its own agenda and range of activities.

- USAID policy supports 5-year funding and planning horizons yet what the organization attempts to achieve in its strategic objectives require at least 10 to 20 year long-term investments.

- In the past eight years, USAID has reduced its technical staff by nearly half, specifically in the sectors of population and health, agriculture, and education. This reduction has resulted in the remaining technical staff concentrating much of

its time and energy on management issues, USAID procedures and processes, and an increased reliance on contractors.

The population and health component of USAID's Kenya country program respond to needs and problems as they are defined locally -- emphasizing an integrated approach to expand reproductive choice and rights, help slow population growth, decrease maternal and child mortality, and reduce the spread of HIV/AIDS and other sexually transmitted diseases.

Chapter 10

Joint Strategy

10.1 Overview

The Joint Strategy provides a framework for the implementation of coordinated development assistance between the Governments of Japan (GoJ) and the United States (USG) in accordance with the population and health initiatives of the U.S.-Japan Common Agenda and the Government of Japan's Global Issues Initiative on Population and AIDS (GII).

The strategy reflects the policy, priorities and technical assistance mechanisms of the GoJ's ODA and USAID. It responds to needs identified in the population and health sector during a joint Japan-U.S. sector assessment conducted in December 1994. The Joint Strategy takes into account the new health policy of the Government of Kenya and the activities of other donors in the population and health sector.

The Joint Strategy suggests an approach that includes collaboration in program planning, design and evaluation of projects which address the health and population needs in Kenya. Implementation will be through projects managed independently by the GoJ and USAID, either directly or through cooperating agencies. The agencies will establish mechanisms to share the results of their individual efforts and will collaborate on project monitoring and evaluation.

The GOK and non-governmental partner agencies have and will continue to be involved throughout the planning, implementation and evaluation process of the Joint Strategy.

The strategy outlined in this document should be viewed as the first step in the planning process. Additional discussion between representatives of the respective governments will be necessary to finalize activities.

The Joint Strategy described below highlights the complementarity of USAID's new population and health program "AIDS, Population and Health Integrated Assistance" (APHIA) and on-going and proposed activities for support by the GoJ under the GII.

Building upon the results of the *Joint Japan-U.S. Sector Assessment*, the GoJ and USAID are cooperating to identify and plan population and health projects in Kenya. The GoJ has participated in the design of USAID's new APHIA program. APHIA will have a five year life beginning in September 1995. The total estimated cost of the program is $100 million.

The GoJ will begin framework design of new population and health activities under the

GII/Common Agenda in fiscal year 1995 (April 1995-March 1996). This process will be followed by basic design studies for individual components to be carried out throughout the GII cooperation period (1994-2000). USAID is expected to participate in both the framework and basic design of new GoJ supported projects which, in keeping with the GoJ's commitment to the GII, will represent a significant expansion of Japan's portfolio in the population and health sector.

The findings of the *Joint Japan-U.S. Sector Assessment, USAID/Kenya's O/PH strategy and the formulation of APHIA* suggest that the following broad categories are critical factors in addressing the immediate family planning and health needs of Kenyans and building Kenya's capacity to sustain health and population services over the long-term:

- strengthen the capacity of the public sector to plan, design, implement and evaluate appropriate population and health services;
- strengthen the capacity of the private sector to plan, design, implement and evaluate appropriate population and health services.

The strategy will also involve strengthening the capacity of public and private sector agencies to deliver essential curative and preventive services. While Population and HIV/AIDS are the target areas for intervention under APHIA and the GII in Kenya, the proposed projects utilize an integrated approach which includes family planning, HIV/AIDS/STDs and maternal and child health.

The organization of activities specific to these needs provides a framework for a full description of the complementarity of USAID and GoJ supported activities.

10.2 Public Sector Service Delivery

The GoJ and USAID will collaborate in the design of programs to strengthen public sector capacity to plan, design, implement and evaluate appropriate family planning and health services. Both agencies have extensive international experience in health and family planning that can be used to accomplish this objective.

Kenya's national health delivery system is still at a formative stage. The system continues to be weak in centrally-coordinated support functions fundamental to improving quality and access to integrated services such as policy analysis, planning and coordination; research, monitoring and evaluation; logistics; training and Information, Education and Communication (IEC).

10.2.1 Policy

Policy is the foundation of development. The formulation of sustainable policies requires an open dialogue and capacity for data collection and analysis. APHIA will focus on broadening participation in policy dialogue in Kenya and strengthening the capacity of the GoK in policy analysis. Recognizing that policy dialogue is an important tool in promoting sustainable development, USAID and the GoJ will work together to promote policy issues of mutual concern and interest.

10.2.2 Program Planning and Coordination

Program planning and coordination is a key element to long-term sustainability of health sector service delivery. Through APHIA and the GII, the U.S. and Japan will provide support to build Kenya's capacity to conduct program planning including research, monitoring and evaluation activities.

Both USAID and JICA will continue to support research in the population and health sectors. Under APHIA, USAID will continue to support operations and behavioral research. Under the GII, JICA will support feasibility and basic studies for newly proposed project ideas. Consultation on the design, implementation and results of these research activities will benefit Kenya, the GoJ and USAID.

10.2.3 Research, Monitoring and Evaluation

In addition to providing assistance to build national capacity for research, monitoring and evaluation, the GoJ and USAID will closely monitor and evaluate the activities and projects funded under the Joint Strategy. While each project may have its own internal assessment and evaluation component, the GoJ and USAID programs should include a plan for collaborative evaluation. The plan should include interim, end-of-project and post-project evaluations with teams composed of the GoJ, USAID and outside experts.

Through the Kenya Medical Research Institute, JICA is providing on-going technical cooperation for research of several diseases which affect Kenyans. JICA is considering the possibility of expanding their technical assistance to include clinical research in HIV/AIDS. Collaboration on the design of this new research activity will provide an opportunity to ensure complementarity with USAID's on-going research interests.

10.2.3.1 HIV/AIDS Research and Surveillance

Surveillance is a key component of any national HIV/AIDS prevention and control program. USAID is providing technical assistance to strengthen Kenya's national sentinel surveillance system. However, a chronic shortage of HIV test kits jeopardizes the successful operation of the sentinel surveillance system.

A USAID funded project has developed low cost, HIV rapid testing technology. The project helped to set up the manufacture of testing kits in Thailand, and could assist Japan to produce them in other countries in which JICA has development assistance programs. Japan already manufactures excellent, but more expensive, rapid tests which could be used for confirmation testing.

In the short-term, the GoJ may consider the possibility of procuring HIV test kits using non-project assistance/debt relief grant or counterpart funding. These kits, if procured, would complement USAID's assistance to the national sentinel surveillance system on a short-term basis.

10.2.4 Logistics

Chronic shortages of essential drugs, medical supplies and contraceptive commodities continue to be a major weakness of the Kenya public health sector. Shortages are due mainly to problems in public sector tendering and weaknesses in the management information system (MIS) which makes the accurate forecasting of national requirements difficult.

In 1991, with assistance from USAID, the MOH created a parallel national contraceptive commodities logistics system. The USAID-funded Family Planning Logistics Management Project (FPLM) has assisted the MOH establish an effective contraceptive commodities system which facilitates national supply forecasting, ordering, delivery, warehousing and distribution to meet essential national contraceptive supply requirements. Currently, contraceptive supplies are maintained at a 90-95 percent adequacy level at the national level, and 70-90 percent at the district level.

The extension of an efficient and reliable logistics management system for other essential commodities in the health sector is essential to meeting the health and family planning needs of the Kenyan population. Through APHIA, USAID will continue its on-going support to strengthen the contraceptive logistics management system, pursue the goal of increasing self-sufficiency in contraceptive supply and explore the potential of expanding the logistics management system to include STD drugs.

The GoJ will consider the possibility of providing project-type technical assistance or an individual JICA expert to strengthen the logistics management system and grant-aid for the

construction of warehouses in some districts and the supply of small trucks and vehicles to distribute contraceptives, drugs and medical supplies.

Close coordination between GoJ and USAID will maximize the impact of their independent support for this essential component of the public sector service delivery system.

Until the World Bank and other donors are able to provide large quantities of condoms, it will be important to maintain the supply. Together, USAID and the GoJ can provide leadership among the donors in the population and health sector to determine the contraceptive commodities needs and coordinate to meet this need. A suitable donor coordination mechanism is already in place in Kenya. USAID will continue to procure contraceptives for distribution under the public (MOH) and private sector (social marketing) distribution systems. The GoJ may consider the possibility of procuring contraceptives. Contraceptives procured by the GoJ with non-project assistance or special material support could be distributed through the public (MOH) or private sector (social marketing) distribution systems. This topic deserves further attention and discussion.

10.2.5 Infrastructure Support

JICA has received a request from the GOK for grant-aid for the rehabilitation of Western Provincial and/or Coast Provincial Hospital and will examine the feasibility of this project during fiscal year 1995. In addition, GoJ considering the possibility of extending grant-aid to strengthen the infrastructure of and provide equipment to health centers, dispensaries and district and provincial hospitals.

Preliminary results of a maternal mortality survey in Kenya indicate that nearly 500 maternal deaths result from every 100,000 live births in Kenya. This means that approximately 7000 women die every year from factors related to pregnancy and childbirth. These deaths are largely preventable with known packages of essential services. The district-level hospital is often a focal point for the prevention of maternal deaths as essential obstetric services and skills are appropriately located at this level.

APHIA's district-level focus component will address the ability of community-based health workers to recognize risk factors associated with pregnancy and labor and delivery. However, additional skills and equipment are needed at the district-level facilities to ensure that those who do reach the district hospital are treated promptly and appropriately. Indeed, research from a variety of settings has shown that many maternal deaths occur after a woman has reached a health facility due to lack of proper training and equipment.

The essential package of safe motherhood services at the district level facility has been defined through expert consultation and is available from the World Health Organization. APHIA will support the promotion of safe motherhood services at the district level through:

- the provision of in-service training and tools for the early detection and management of serious obstetric complications;
- strengthening referral mechanisms from the community and the health center to the district hospital including the skills to recognize the need for referral and resources to do so;
- the provision of in-service training and resources for safe, clean delivery by trained personnel and training of health personnel in life-saving skills; and
- the in-service training for the early detection and treatment of postpartum hemorrhage or infections in the mother and newborn.

Essential to the effective implementation of these services is the appropriate equipment. With assistance from the Government of Japan, safe motherhood equipment could be purchased for the district hospital located in each district targeted under APHIA. This assistance would ensure that women have access to a complete package of safe motherhood services at the district level and would directly complement district level efforts implemented through APHIA.

10.2.6 Training

There are approximately 80,000 people directly employed in the health sector. Nearly half of these are in administrative, maintenance and subordinate positions, creating a critical lack of personnel able to diagnose and treat disease in MOH dispensaries and health centers. The lack of qualified health care providers at MOH dispensaries and health care centers is often cited as a reason to bypass this level of care and seek treatment at larger (and more costly) hospitals.

The sustainability of quality health services in Kenya depends on the success of human resource development and institutional capacity building. Training activities are therefore a critical element of the Joint Strategy.

10.2.6.1 Medical Training College Rehabilitation

The centerpiece of JICA's training activities is the on-going rehabilitation of the Medical Training College (MTC) facility in Nairobi. JICA is currently investigating the possibility of expanding this activity to include technical assistance for staff management training and basic curricula development through project-type technical cooperation. The MTC is the primary provider of pre-service training in Kenya. JICA will introduce a Basic Health Services approach into the educational programs at the MTC. Family planning, human reproductive health and STD/AIDS will feature prominently in the curricula.

With support from JICA, the MTC could also build its capacity to offer short courses in

family planning, reproductive health and STDs/HIV/AIDS to health professionals in the GOK, the NGOs and the private sector. Basic curricula and continuing education courses on the management of commodities and equipment could also be developed for use in other MTCs and shared with Rural Health Training Centers (RHTCs) training activities supported by USAID. The development of these courses could be informed by the experience of the USAID-funded FPLM project and coordinated with APHIA's RHTC training activities. JICA support to strengthen the capacity of MTCs will also include assistance in management and planning which will support the objective of the National Manpower Training policies of the GOK.

10.2.6.2 RHTC Rehabilitation

USAID will play a major role in the organization and implementation of in-service and continuing education programs in family planning, HIV/AIDS and maternal and child health through support to the Rural Health Training Centers (RHTCs). USAID has redesigned a six week course in family planning and has developed training programs for HIV/AIDS. GoJ will consider the possibility of providing grant-aid for the rehabilitation of some RHTCs.

Both USAID and JICA's training activities will address the need to strengthen management as well as technical capacity within the population and health sector. These components of the Joint Strategy may provide opportunities for project level collaboration. For instance, curricula and other training materials can be jointly developed, tested and evaluated as appropriate.

10.2.6.3 KEMRI: Training of Research Scientists

Capacity building at research institutions and the training of research scientists is another important part of the training component. To address these issues, JICA will continue its support for research projects and human resource development for scientists and technicians at the Kenya Medical Research Institute (KEMRI). This will include the continuation of its current tropical disease research and a possible expansion to include HIV/AIDS research.

10.2.6.4 KNH Lactation Management Training

A national-level training center for the promotion of lactational management has been established at Kenyatta National Hospital. Initiated with the support of USAID/W, this unit was to provide training of trainers for facilities throughout the country. UNICEF was to have provided the clearly defined set of materials for the conduct of these training sessions. UNICEF has since withdrawn its offer to provide these materials. Possible Government of Japan support for the re-initiation of these activities--with a targeted focus on the district level--would be a clearly beneficial and complementary Common Agenda activity.

10.2.6.5 KNH Equipment Management Training

Based upon the findings of an on-going activity with Kenyatta National Hospital, JICA is considering the possibility of providing training to strengthen the medical equipment management system. Training could be provided through project-type technical cooperation, in-country training or training in Japan. This activity will help strengthen the capacity of the public sector service delivery system to plan and manage resources more effectively.

10.2.6.6 National Blood Bank System

At the request of the GoK, JICA will explore the possibility of providing grant-aid and project-type technical cooperation to strengthen the institutional capacity within the public sector to sustain a national blood bank system. JICA's support to strengthen the national blood bank system will provide a second opportunity for complementarity with USAID's HIV testing and counselling activities.

10.2.7 Information, Education and Communication (IEC)

This is a critical area that has not received adequate attention nor adequate funding by the GOK or the donor agencies. There is little institutional capacity for national planning for IEC in health, population and AIDS. The World Bank addresses this issue in its proposed Sexually Transmitted Infections (STI) project.

Lack of information on family planning continues to be cited as a major reason for non-use of contraceptives. Information on the dangers of HIV/AIDS and its transmission through sexual intercourse is well disseminated among the population (over 90%). Radio programs and information from friends and relatives are the major sources of information. However, half the population still believes that HIV can be contracted from mosquito bites. Less than one quarter of Kenyans identified condoms as a means of protection against HIV/AIDS.

10.2.7.1 PEPP

USAID/Kenya funds U.S. cooperating agencies to develop and implement IEC projects in family planning and AIDS through NGOs. Through APHIA IEC materials will also be developed for the public sector. JICA has an on-going IEC project in population and AIDS in several countries including the Population Education Promotion Project (PEPP) in Kenya.

Under the Joint Strategy, JICA and USAID could collaborate in a needs assessment and preparation of a plan for the development and testing of electronic and print materials, and for the dissemination of high quality materials that currently exist.

JICA is considering the possibility of restructuring the extension of PEPP to work with the MOH. Close coordination between APHIA and the restructured PEPP project will be critical to the success of each project.

JICA's role in capacity building, training and dissemination of IEC materials through PEPP will continue to focus on building public sector capacity, while USAID will work primarily through Cooperating Agencies and NGOs.

Both USAID and JICA will focus on strengthening capacity in Kenya to produce quality integrated family planning and health IEC material. Collaboration in the design, production and dissemination of IEC material under PEPP and APHIA will maximize the impact of both projects.

10.2.7.2 HIV/AIDS Testing and Counselling

Japan's ODA has AIDS projects in countries such as Thailand, Zambia and Ghana that include testing, treatment and education components. USAID has extensive experience in AIDS projects in Kenya and throughout Africa. USAID also has several years of experience in the development and management of HIV testing and counselling centers in Uganda. In addition, a USAID funded project has developed low cost, HIV rapid testing technology. The project helped to set up the manufacture of testing kits in Thailand, and could assist Japan to produce them in other countries in which JICA has development assistance programs. Japan already manufactures excellent, but more expensive, rapid tests which could be used for confirmation testing.

Under the Joint Strategy, the GoJ and USAID will support an integrated strategy for the prevention and control of STD/HIV/AIDS. In addition to HIV/AIDS IEC, complementary activities will include support for HIV testing and counseling centers, clinical research, surveillance and commodities.

APHIA will provide technical assistance for the establishment of HIV testing and counseling facilities. The GoJ will consider the possibility of providing HIV test kits to support these testing and counseling facilities. Several possibilities for the provision of HIV test kits will be considered by the GoJ. Test kits may be procured through non-project assistance. The GoJ may consider the possibility of conducting a feasibility study regarding the long-term production of rapid HIV test kits through KEMRI. HIV test kits procured with assistance from the GoJ could provide complementary support to APHIA's testing and counselling component or APHIA's support to the national HIV sentinel surveillance system.

10.3 Private Sector Service Delivery

NGOs, missions and the private (for profit) sector provide general health services and manage programs for family planning and STDs/HIV/AIDS. The demand for private sector services is high. Consumer use of private and mission services is at least 20 percent of the total-health care utilization. In addition, the distribution of resources in the private sector is more equitable across regions than the public sector.

The GoJ and USAID will collaborate in the design of programs to strengthen private sector (NGO) capacity to plan, design, implement and evaluate appropriate family planning and health services.

In 1994 under the Grants Assistance for Grass Roots Projects (GAGRP), the Japanese Embassy awarded six grants totalling $210,000 to Kenyan NGOs currently funded by USAID/Kenya. The Japanese grants are primarily for the procurement of STD drugs, HIV testing kits, health center equipment and minor renovations to facilities. This level of support is expected to continue during the LOP of APHIA and will complement the technical assistance provided through USAID.

The GoJ's GAGRP is awarded on a yearly basis. The GoJ will consider applications for additional GAGRP to support other USAID funded NGOs to integrate HIV/AIDS/STDs within existing family planning programs. In addition, the GoJ will consider providing GAGRP to USAID supported NGOs for the small scale construction of facilities which will promote long-term self-sufficiency.

JICA will discuss the possibility of placing one or more Japan Overseas Cooperation Volunteers (JOCV) in a USAID supported NGO to provide assistance in developing capacity building skills e.g. management and training.

Both agencies will explore the use of the private sector in the development and dissemination of information at the national and local levels. Through the PEPP project, JICA is already promoting community health education in five districts. PEPP is using district and community level health facilities to distribute IEC materials. APHIA will also promote the production and distribution of IEC materials in the private sector including the capacity to utilize social marketing techniques.

10.4.1 NGO Self-Sufficiency

USAID will continue to provide technical assistance to NGOs to improve their management systems, strengthen health-cost sharing programs and expand alternative health financing options.

As part of its on-going PEPP project, JICA is supporting pilot income generating activities within a community and an NGO. APHIA will also be supporting income generating activities to promote NGO self-sufficiency. Experiences and results from these activities should be shared and disseminated.

Appendix A

A.1 DFH Organization

The DFH is led by a Director and Deputy Director. As a Division, the major function of the DFH is the planning and coordination of MCH/FP programs. While there have been several well qualified and committed DFH Directors, turnover has been very high -- five directors in the past seven years. This has made it difficult to establish effective inter-program coordination.

The authority and control over programs within the DFH are in the hands of the program managers, not the Director of the Division. Each program is an autonomous unit, which depends on donor support for its activities. In contrast to the high turnover of DFH Directors, the leadership of the individual programs has been relatively stable. For example, between 1987 and 1992, there were few changes in the leadership of the KEPI, Nutrition, CDD and Family Planning programs.

A.1.2 Staff of the DFH

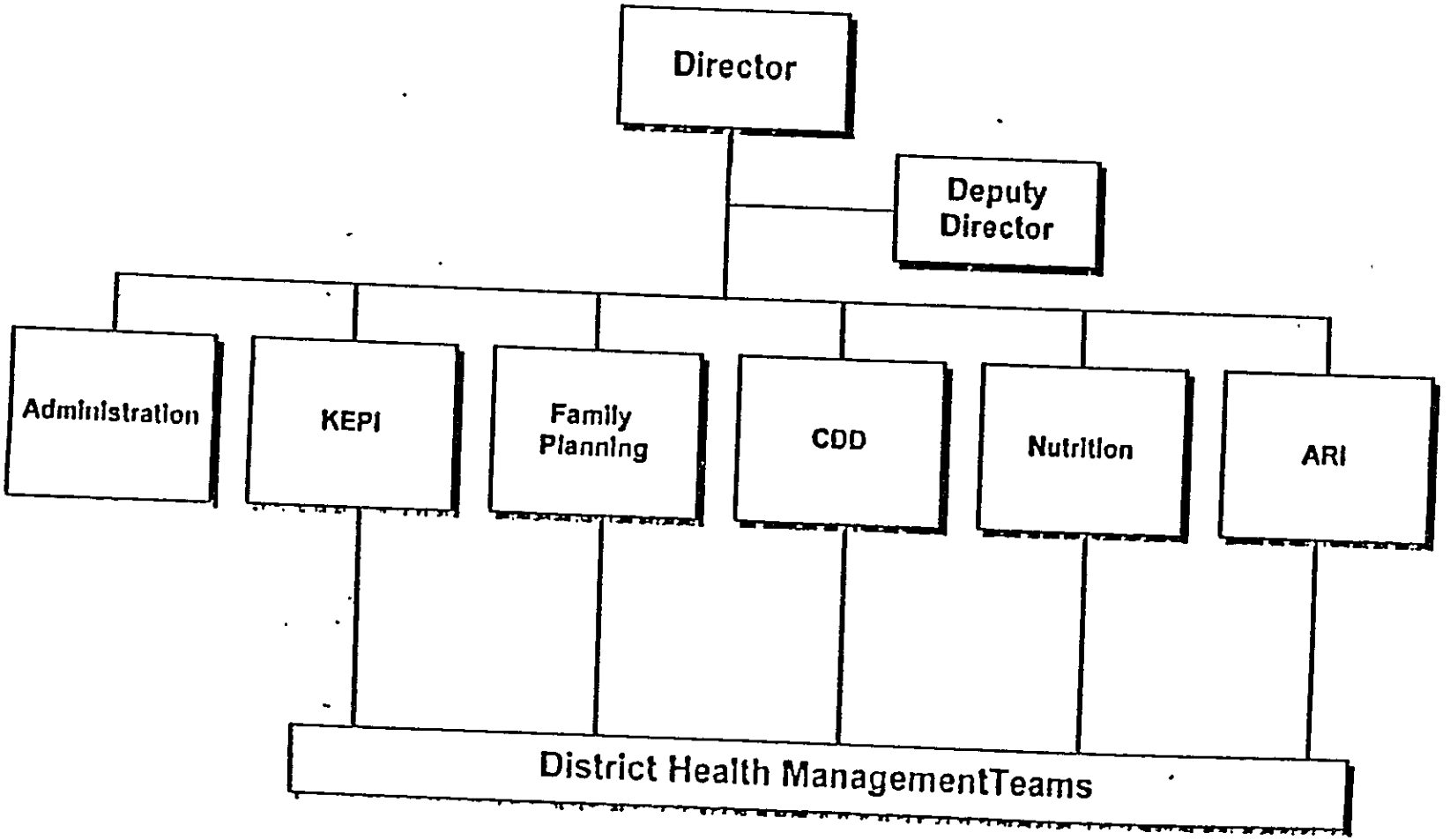
The Division of Family Health has a 38 professional staff, 37 administrative personnel, and 68 people in maintenance, support and subordinate positions. The breakdown of positions and numbers within each is presented below.

Doctors	5	Nurses	17
Clinical Officers	6	Public Health Officers	4
Other Prevent/Prom.	5	Laboratory	1
Administration	37	Maintenance	27
Subordinate	41		

The 38 professional staff in the five DFH programs carry out the full range of management, training and other functions of the Division. They conduct supervisory visits in the districts. They supervise and assist the DHMTs in planning, coordination of NGOs, training and the provision of equipment and supplies.

Several donor funded projects organized to help the DFH have expatriate as well as Kenyan staff. In addition, DFH personnel are seconded to work with them. GTZ, Danida and USAID have project staff and offices at the DFH headquarters. GTZ has a CBD Team Leader, Danida has a Senior Advisor for KEPI, and USAID has project managers for contraceptive logistics (FPLM) and FP training (JHPIEGO). Until September 1993, PRITECH (with USAID funds) provided a manager for a CDD project. Other donor agencies provide part time technical support, funds and/or supplies to DFH programs (e.g., JICA, SIDA, ODA, UNFPA, UNICEF, WHO, and the World Bank).

DIVISION OF FAMILY HEALTH



Appendix B

B.1. Organization and Manpower of the NASCP

The NASCP is in the Ministry of Health. It is run by the National AIDS Secretariat, which has been constrained in its effectiveness by staffing and organizational problems. Recently, the position of Program Manager was elevated to the level of Assistant Director of Medical Services, who reports directly to the Director of Medical Services (DMS). The new Manager is working to upgrade the competence of the staff, and to reorganize the NASCP into a small and efficient group of professionals concentrating on policy, monitoring and evaluation, and coordination.

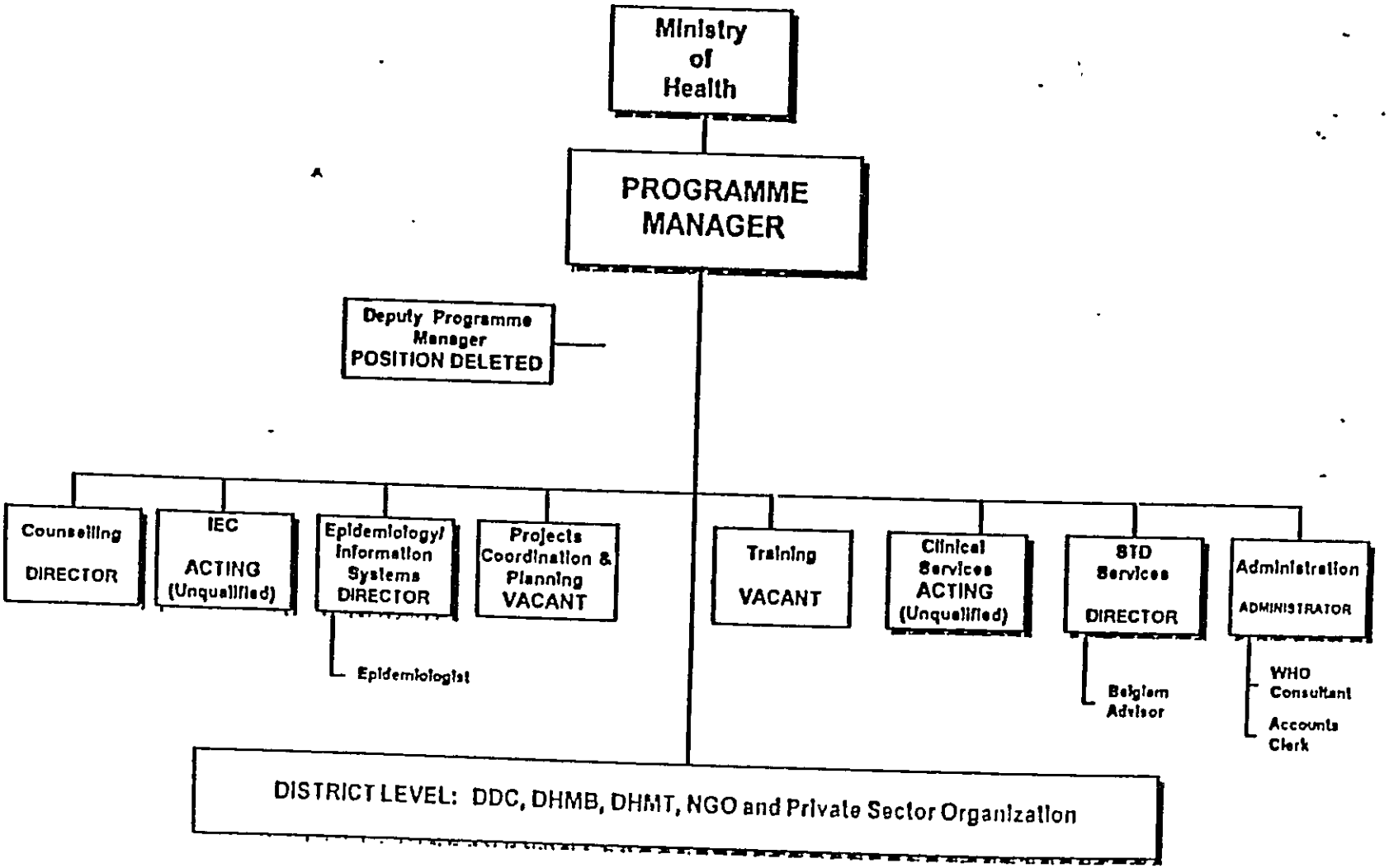
Historically, the identification and deployment of technical personnel into the NACP does not appear to have been based on any defined criteria. As a result, the program has experienced a serious shortage of competent technical staff. The organogram on the next page illustrates the current structure of the program.

Out of nine key positions in the program only four are adequately filled. In a proposal to the World Bank prepared by Senior program staff in May 1994, the following observations were made:

> It is imperative to establish a new structure for AIDS/STD control in view of the state of AIDS/STD in the country. It is very important to have the right officers who can plan, monitor and evaluate activities. To perform these National tasks demands that officers should be of high calibre, skilled and have experience capable of deliberating on concept, strategies, policies and coordination of activities.
>
> To continue having junior staff at National level will put 'AIDS Secretariat in the trap of implementation and execution of activities and it will lower its status. It is suggested that junior staff be re-deployed in Departments and districts for implementation of AIDS/STD programs since they are not of much value for planning and coordination of AIDS activities. (WB 1994c)

National AIDS Secretariat

Actual Staff in Post



Appendix C

C.1. The Organization and Staffing of the NCPD

The NCPD is a department of the Ministry of Planning and National Development. It is organizationally divided into a Council Board, a Council and a Secretariat (*see organogram on the following page*).

The Council Board has about 20 members who represent major government agencies, NGO's involved in population activities, other leaders and scholars. Technical Committees and sub-Committees have the responsibility to develop policy, formulate research issues, assess proposals and allocate resources. Committee meetings are, however, irregular, and key decisions on proposals and other activities are often delayed. Criteria for decisions and procedures are not well defined. There is criticism that there are too many Committees and Sub-Committees; that they give excessive attention to decisions on proposals, not enough attention to the broad policy and programmatic issues. The Board has also been criticized for a "lack of commitment and seriousness," and the competency of some of its members questioned.

The NCPD Council was established to promote interagency collaboration, formulate policy and sponsor IEC campaigns. It serves as a forum for the discussion of a broad range of issues from a diversity of individual and institutional perspectives. Major operational problems of the Council are that it does not meet quarterly and that it often gets involved in operational details to the detriment of the broader policy and coordination issues.

The Secretariat is responsible for the interpretation and execution of population policies and strategies. It is led by a Director who is responsible to the Permanent Secretary of the Ministry. Other senior executive positions include two Deputy Directors and two Senior Assistant Directors. At present, only two of the four senior executive positions are filled, both by lower level personnel serving in an "acting" capacity.

Professional expertise in the field of population does not appear to be a criteria used in the selection of NCPD Directors during the past decade. Leadership functions have suffered from the lack of professionally trained and experienced population experts in senior administrative and technical positions. The use of part time consultants to fill these gaps has not always been particularly effective.

The NCPD Director reports to the Permanent Secretary of the Ministry and to the Executive Committee of the NCPD Council. Since the Board Chairman is not the PS, the structure makes the Director of the NCPD Secretariat accountable to two individuals. The functions of these different bodies are not clearly delineated, which contributed to role conflict between the Council and the Office of the Permanent Secretary in the former Ministry (the MOHA).

NCPD: Current Structure

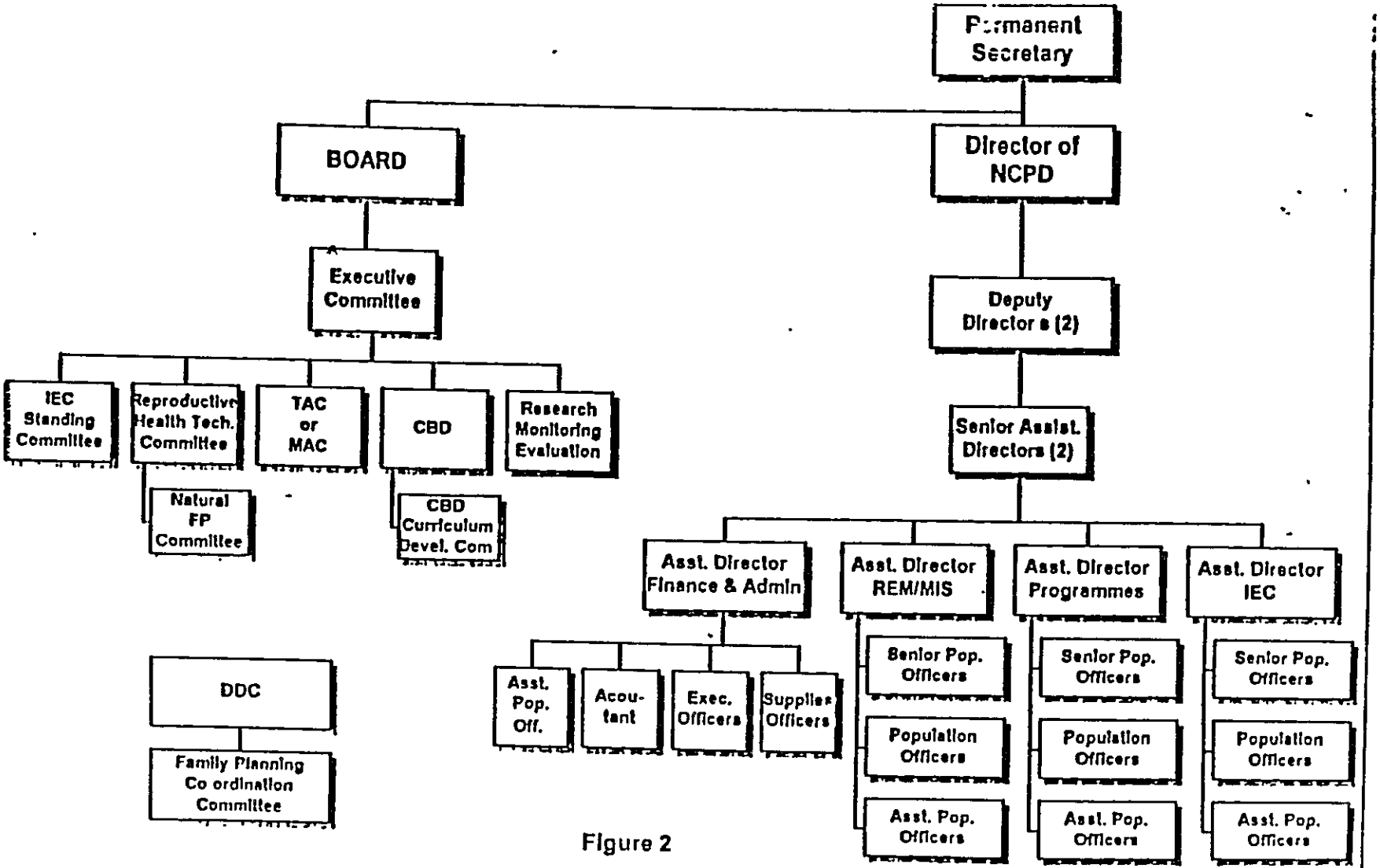


Figure 2

The Secretariat has four major Divisions. They are responsible for:

(1) Finance and Administration
(2) Programs
(3) Information, Education and Communication (IEC)
(4) Research, Monitoring and Evaluation, which includes a Management Information System (MIS) unit.

The roles of the four major Divisions of the Secretariat are not clearly defined. For example, the role of the Programs Division is not well differentiated from that of the IEC Division, nor from the role of the Planning, Research and Evaluation Division. Some Programs Division staff are involved in research activities. In addition, there is no clear linkage between the Secretariat, the District Population Offices and the agencies which implement programs in the districts.

The roles of the Divisions also often overlap with those of the Committees as the roles and functions of the Board Committees are also poorly defined.

The Secretariat has an establishment of 188 posts, and approximately 140 are currently filled. Eighty-five of the 188 posts are for professional staff. About 45 are actually filled, but approximately one-third are away in long term training. The donors have provided extensive support to train NCPD's younger professional personnel. In fact, civil servants find the NCPD an attractive agency to be assigned to because of the opportunities it provides for long term, overseas training. However, those who benefit from overseas training frequently leave the NCPD after their studies are completed or are transferred to other government departments.

In addition to its headquarters staff, there are 14 District Population Officers (DPOs) based in the Districts. The NCPD also utilizes the services of many political, professional and management experts.

The large number of professionally trained staff within the NCPD has attracted the attention of NGOs and other employers who offer higher salaries and benefits. They have recruited many NCPD employees, adding to the high staff turnover. This has seriously reduced the continuity of management and the effectiveness of NCPD operations. The lack of professional mobility within the NCPD, and the low pay scales are often cited as the reasons for the high attrition and lower level of morale among its officers.

The failure of the NCPD to implement the Scheme of Service for Population Officers written in 1989 has contributed to its personnel problems. Many observers believe the NCPD is too large and that it requires fewer, but more highly qualified personnel, to be effective.

The Position of NCPD within the GOK: 1982-1994

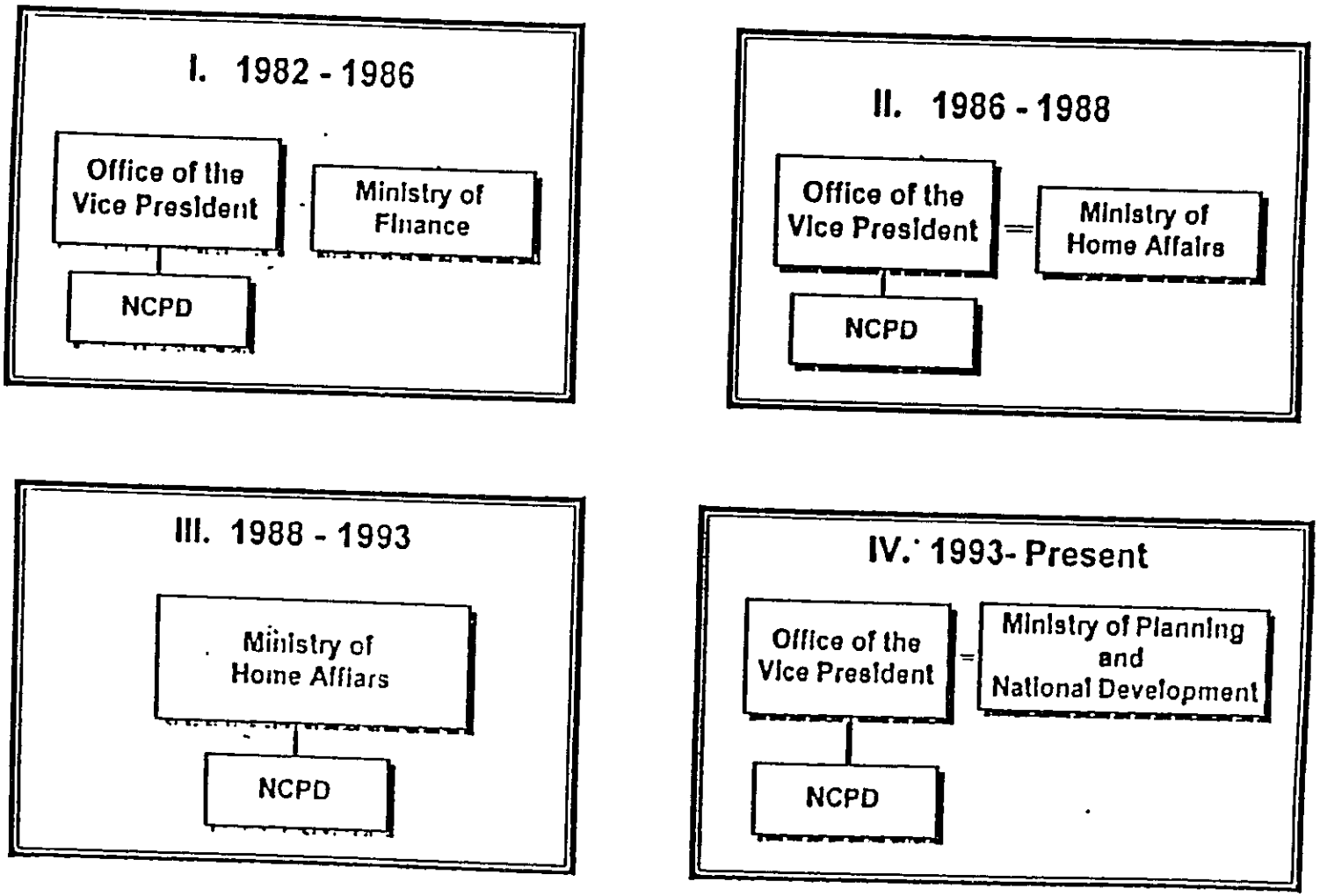


Figure 1

Appendix D

D.1. The NCPD/UNFPA Nakuru Conference: A Summary of Recommendations

A. MANDATE AND ROLE OF NCPD

1. NCPD should acquire the necessary capacity to anticipate the future, help plan for it and shape it in all matters pertaining to population and development.

2. NCPD should act as an advocate on specific population programs to resolve sensitive issues such as abortion, adolescent health including family planning services to targeted youth groups, FLE, etc.

3. NCPD should formulate guidelines, co-ordinate and mobilize support for the National Population Program.

4. The question of where family planning service delivery should belong should be the subject of further discussion between the Ministry of Health and NCPD.

5. NCPD should act as a facilitator in issues relating to donors, the Government of Kenya and providers; removing administrative and logistic constraints; liaising with participating agencies and; evaluating and monitoring programs.

6. NCPD should work to raise the status of women, act as an advocate for women's reproductive rights and individual choices, and generally strive to place issues on the national agenda.

7. NCPD should facilitate the involvement of additional agencies and service providers in the national population program, drawing from the public and private sectors as well as NGOs.

8. HOWEVER, NCPD should not act as an implementor of programs but should contract out most or all of its functions that can be done by competent implementation agencies, e.g. research, evaluation and monitoring, IEC, training, etc.

9. NCPD should not "control" NGOs or implementing agencies but should co-ordinate, give guidance on and facilitate their work.

B. STRUCTURE AND MANAGEMENT

10. The present NCPD should be replaced by a National Commission on Population and Development set up by an Act of Parliament.

11. The form, size, structure and internal organization of the proposed Commission should be the subject of expert study.

C. FINANCIAL and LEGISLATIVE ASPECTS

12. NCPD's system of financing and accountability should be such as can adequately serve its new mandate and functions. In particular, it should enable NCPD to: receive adequate funding; cut down on bureaucracy and; allow efficient management, disbursement reporting and accountability

13. Donors should work towards alleviating the problems associated with slow disbursement of funds by NCPD to implementing agencies by considering alternatives. Examples include: giving up the reimbursement procedure in favor of advancing project funds to Treasury to be maintained in special accounts, and/or to a limited extent, fund the NGOs directly.

14. NCPD should arrange urgent consultations with donors and implementing NGOs for purposes of agreeing on efficient procedures of disbursement and accountability for project funds.

15. The Cabinet Paper should be developed requesting authority to prepare a new Sessional Paper on population and development as well as legislation to: define Kenya's population goals and strategies and; to establish a National Commission for Population and Development.

There is a consensus among those within and outside NCPD that the implementation of the Nakuru Workshop recommendations would result in a restructuring and reorganization that would greatly enhance its capacity to fulfill its core functions.

D.1.1 The GOK Task Force: Restructuring the NCPD (1994)

In March 1994, the GOK appointed a Task Force to "study the constraints being experienced by the NCPD and make appropriate recommendations with a view to restructuring the NCPD in order to enhance its functioning and improve the population program (GOK 1994d)." The Task Force reviewed the recommendations of the Nakuru Workshop and the World Bank Mid-Term Review Report. The Task Force's conclusions and recommendations are summarized below.

Points of Agreement: The Task Force:

1. Endorsed most recommendations to modify the original NCPD mandate.

2. Agreed that NCPD should not act an implementor of programs.

3. Agreed that NCPD should not control NGO's or other implementing agencies.

4. Agreed to allow the NCPD more financial flexibility (not autonomy) by advancing project funds into a special account.

Points of Disagreement: The Task Force:

1. Did not agree with the Nakuru recommendations for an NCPD as an autonomous commission to be sanctioned by an Act of Parliament, or its transformation into a parastatal.

2. Did not agree with the World Bank's recommendation that the Director of NCPD be made an accounting officer. It agreed with most recommendations for financial restructuring but said that standard GOK accounting systems and procedures must be followed. Under this arrangement, the Permanent Secretary in the MPND will be the Chief Accounting Officer as in all ministries.

3. Stated that recruitment and remuneration of personnel should not be given special consideration and that they "will be subject to the Civil Service Code of Regulations."

Other Task Force Recommendations

1. The consolidation of the executive level positions and reduction of the number of departments. The Task Force recommends a reduction in standing committees and clarifies the linkages between the field positions and headquarters. It recommends the establishment of three major functional Divisions: (1) Research Planning and Policy Analysis; (2) IEC and Program Coordination; and (3) Finance and Administration.

2. The restructuring of the DPO positions and their reorganization on a zonal basis (ZPO's).

3. An Act of Parliament to give the NCPD legal status and Special Account facilities. This should alleviate some of obstacles to efficient financial management.

4. The other proposed reforms include: a minimum three year period for the Director, the redesignation of all NCPD officers as Population Officers and the implementation of the 1989 Scheme of Service for Population Officers.

D.1.2 Conclusion

The Nakuru Workshop brought together a wide range of participants from within and outside government. Their diagnosis of NCPD's problems was comprehensive and the workshop report suggests a consensus on the direction and content of structural reform and organizational change.

The Task Force creatively addressed many organizational and administrative issues, but rejected the Nakuru recommendation to transform the NCPD into an autonomous Commission with full legal status. The NCPD will, therefore, remain as a Department within the MPND and be subject to the same constraints that hampered its effectiveness in the past.

While those within and outside the NCPD may have other opportunities to restructure the agency within the GOK, the immediate concern should be to move rapidly to implement the reforms called for in the Task Force report. Donors can help influence the reform process by targeting aid to support activities such as policy formulation, strategic planning and capacity building of the NCPD staff. They should also carefully monitor the changes within the organization and tie funding to organizational change and the achievement of critical objectives and outputs. Most important will be to avoid the use of NCPD as a funding agency and either provide support directly to NGOs and other local institutions for service delivery and other activities. Other institutional options to carrying out these functions should also be explored.

Appendix E

E.1. KEMRI Organization and Staffing

In 1979, KEMRI had one Director and a small number of research and technical staff inherited from the East African Community. By 1994, there were 121 research staff and 256 technical staff. This increase in staff has not been paralleled with an increase in funding, and staff salaries are requiring a greater and greater percentage of operating funds:

Year	Personal Emoluments (%)	Operations (%)
1989/90	65	35
1990/91	70	30
1991/92	76	24
1992/93	81	19
1993/94	92	8

Table 7.5.1 KEMRI Recurrent Spending. Source: NHRCD, 1994

Because most of the funds are used to pay salaries, there is little left for equipment and supplies. This means that without external research funds, staff cannot work, and they feel frustrated.

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