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Oyaya, CO; Rifkin, SB (2003) Health sector reforms in Kenya: an examination of district level planning. *Health policy* (Amsterdam, Netherlands), 64 (1). pp. 113-127. ISSN 0168-8510 DOI: [https://doi.org/10.1016/S0168-8510\(02\)00164-1](https://doi.org/10.1016/S0168-8510(02)00164-1)

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Health sector reforms in Kenya: an examination of district level planning

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Received 13 September 2001; accepted 30 June 2002

Abstract

The paper examines health sector reforms in Kenya at the district level based on the Government of Kenya's Health Policy Framework of 1994. The authors present the context of and historical perspective to health sector reforms in Kenya and discuss the major reform policies including decentralization to the district level. The authors then review intended policy outcomes, investigating assumptions on which the implementation and effectiveness of the reform agenda at the local level are based. The authors argue that emphasis on outcomes rather than process have not supported sustainable reforms or achieved the government's goal of improving health and ensuring equity for the citizens of the country.

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Keywords: Kenya; Health sector reforms; Decentralization

1. Introduction

1.1. Background

Since independence in 1963, the Kenyan government has seen good health for all citizens as a fundamental right. The government's main objectives for the development of health services have been to strengthen and carry out measures for the prevention, eradication and control of diseases,

and to provide adequate and effective diagnostic, therapeutic and rehabilitative services for the whole population [1,2]. These objectives, however, have been pursued against a backdrop of a rapidly rising population currently estimated at 28 million people and increasing poverty levels with over 50% of Kenyans living in absolute poverty. To add to this gloomy environment, state support for health and education has been radically reduced. Government became the major provider of health care in the postcolonial government in 1963. As a harbinger of the more drastic reforms of the last decade, reforms were instituted in the health sector in 1982. In 1989, cost sharing between government and individual service users was introduced. More

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measures were crystallized and published in the Health Policy Framework of 1994 [3]. Despite these attempted remedies, the health sector has continued to experience a steady decline in resources, an increase in the burden of diseases, and inadequate institutional and organizational capacity to effectively respond to the existing and emerging health challenges.

The Health Policy Framework paper states that the goal of health sector reforms is: “To promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable” [3].

To achieve this goal, the government focused on devolving government support to the district level and strengthening the district as the point of delivery and development of health care. Key points included: cost sharing to recover fees for service, management of health services under a district health management team, and mechanisms to transfer funds from Ministry of Health (MOH) headquarters to the District including establishing local bank accounts.

The purpose of this paper is to review the policies of health care reforms in Kenya focusing on decentralization of power and authority to the district level. We will argue that the concentration on outcomes (based on questionable assumptions and poor governance) rather than on the process has undermined achievement of the Government’s laudable policy aims.

1.2. The context of health sector reforms in Kenya

The health sector reforms in Kenya are set against a backdrop of complex epidemiological, social, economic, and political factors that pose equally complex problems in terms of health needs and services. The economic growth (GDP) is estimated at 1.5% per annum. Kenya is one of the countries in Africa with the fastest declining economy. The growth in per capita income has been less than the average growth of the population (2.8% per annum). The growth of government services and official safety nets have been minimal, i.e. 0.8% in 1997 and 1.2% in 1998 [4–6]. Poverty has increased to over 50% of the population living

below the poverty line and in certain remote districts in the arid and semiarid areas, the poor account for as much as 80% of the population. In absolute terms, the number of the poor increased from 3.7 million people in 1972–1973 to about 15 million in the year 2000 [5,6].

The overall deteriorating economic situation linked with poor governance and increasing poverty has had devastating consequences for the health status of the population. The infant mortality rate increased from 62 per 1000 live births in 1993 to 74 per 1000 live births in 1998. The under 5 years child mortality rate increased from 96 per 1000 to 112 per 1000 live births in 1998. The prevalence of chronic under nutrition increased from 32.1% in 1987 to 34% in 1998. Malaria and respiratory diseases combined account for almost 50% of all reported diagnosis in public health facilities with diarrhea increasing this to 60% [7]. Perinatal and maternal health complication account for 27% of the total burden of diseases when measured in terms of life years lost [8].

An estimated 2.2 million Kenyans are living with HIV/AIDS while close to 500 people die everyday due to the pandemic. Currently, HIV prevalence is about 7% among adults but in urban areas it is estimated to be between 12 and 13%. Life expectancy has dropped from 60 years in 1993 to 47 years today. The National AIDS/STD Control Program confirms these figures [9]. In recognition of the growing HIV/AIDS problem, the Kenyan government declared HIV/AIDS a national disaster towards the end of 1999 [5,6].

The worsening health status of the population is also reflected by the fact that the per capita expenditures in real terms on health have declined over time from US\$ 9.50 (1980/1981) to US\$ 3.40 (1997). It is expected to decline even further considering the current poor economic environment and escalating poverty situation [2]. Recurrent health expenditures now represent 7.61% of total government expenditure reduced from 9.26% in 1986/1987. Income from cost sharing at government hospitals and health centers account for only 3% of the total budget. As the Health Policy Framework paper aptly states:

The Ministry of Health today is faced with a crisis where available resources cannot match the demand for service [3].

This situation is aggravated by the fact that only about 70% of the funds voted are actually allocated to the recurrent budget thereby leaving in absolute terms, insufficient resources for operational expenses and in particular, the provision of quality and accessible health care services [3].

1.3. Evolution of health services policy in Kenya

Mwabu [10] has reviewed the history and the development of reforms in the health sector from independence to 1995. Very briefly, the history of modern health services and policies in Kenya dates back to the establishment of the religious missions and the arrival of the Imperial British East African Company in the later part of the 19th century. In 1963, an independent Kenyan government took responsibility for the health of its citizens. One prominent change was the expansion of rural health facilities to meet the needs of Kenya's predominantly rural population. Kenya's adoption of the 1977 World Health Assembly (WHA) "Health for All by the year 2000", the 1978 Alma-Ata Declaration on PHC, and the 1981 WHA "Global Strategy for Health for All by the year 2000" ushered in a new health policy direction. Subsequently, the Kenya government published in 1986, the "National Guidelines for the Implementation of Primary Health Care in Kenya" [1]. The new health policy resulted in major reorganization and reorientation of the existing health systems and structures based on the principles of decentralization, community participation, and inter-sectoral collaboration. While stressing the government's commitment in providing health care to the entire population, the policy shifted from purely government provision of services to sharing of costs with those receiving such services. In the Policy Guidelines, the government pledged to "increase alternative financing mechanisms for health care" [1]. A cost-sharing policy in the health sector was introduced in 1989 with a brief suspension of the policy in 1990, only to be reintroduced a year later in August 1991 [10,11]. The cost

sharing was aimed at supporting primary health care in the district and strengthening the clinical performance of the facilities and other service delivery aspects [3].

The 1990s saw a further shift in health policy towards institutional and structural reforms and market orientation of the health services following the publication of the World Development Reports: "Investing in Health" in 1993 [12], the "Kenya Health Policy Framework" in 1994 [3], and the "National Health Sector Strategic Plan 1999–2004" [2]. The 1994 Health Policy Framework presented, for the first time, Kenya's vision and mission for the health sector. In this policy document, the Government of Kenya restated its commitment in providing health services to all its citizens and to equity [3] to ensure that health care reaches the most vulnerable groups and the underserved areas. The new health policy modeled on the World Bank's Report 1993 [12] emphasized the role of the non-governmental sector and sought to transfer the provision of curative care to this sector. In this regard, the government pledged to provide an enabling environment for private sector and community involvement in health service provision and financing [13].

1.4. Health sector reforms, decentralization, and the district focus

The World Health Organization [14] views health sector reform as:

A sustained process of fundamental change in policy and institutional arrangements guided by the government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population.

In this context, health sector reform is concerned with defining priorities, refining policies, and reforming the institutions through which those policies are implemented to improve the health status of the population [15]. Green [16] identifies the following reasons for health sector reforms:

- The lack of government resources to support health care.
- The necessity of including private and non-governmental organization (NGO) actors in the health sector.
- The desirability of pursuing market approaches to the management and organizational relationships in the health sector.
- The value of decentralizing power and authority from the center (national level) to the periphery (district level).

The reforms thus entail evolving a national strategy that seeks to provide an enabling environment for the participation of a wide spectrum of stakeholders and to rationalize the management and delivery of health care.

A decentralized health service is the focus of health sector reforms and structural change in the public health management and delivery system in Kenya. The inception of decentralization policies dates back to the early 1980s following the government's publication of the District Focus for Rural Development (DFRD) strategy in 1983. The DFRD policy identified the district as the most basic and effective unit for planning, development, and delivery of public services in Kenya. In line with the DFRD policy and within the framework of health sector reform, the emerging functional organization of the health system is hierarchical in nature with the strategic and operational focal points at the national, provincial, and district levels. This hierarchy establishes the district as the basic level responsible for operational tasks with relatively limited strategic functions. The goal of decentralization is therefore to ensure the rationalization of the management and delivery of health care and the gradual transfer of the process of decision making and management of health resources from the central administration at the national level to the local levels.

These plans extend to decentralize decisions about finances for health care. They include the establishment of pilot districts that would establish local bank accounts, through World Bank credit, for a wide range of activities. All the districts are expected to have these accounts in the next 3 years. The District Health Management Teams will

operate the accounts. This implies that each district can receive and allocate funds at their own level without going through the highly bureaucratic central government system [17].

1.5. The health system and decision-making structures

The health system comprises all the groups and institutions that provide health care and services, regulate and finance health actions right from the household to the national levels [18]. It also includes all the activities whose primary purpose is to promote, maintain, and restore health, responsiveness, and fairness in health resources distribution. As can be seen from Fig. 1, Kenya's health system and decision-making structure is organized into four broad tiers. Fig. 2 shows the hierarchical relationship of authority and decision making of each of the tiers. At each level of the system, decision making, management, and service delivery functions require close interactions among the key health sector and health-related stakeholders. The aim is to facilitate better understanding of the planned activities for effective utilization of resources for maximum health outcomes.

2. Methods

This paper is a result of a 4-week Health Policy and Planning Elective Course run for students taking Masters degree in Community Health and Development at the Tropical Institute of Community Health and Development (TICH) in Africa based in Kisumu, Kenya. The course is based on an approach to academic training that seeks to integrate classroom learning with practical experiential learning in the community and institutional settings. The objective of this elective course was to enable the students to read about, analyze, and discuss with health policy actors (specifically implementers) policy making, implementation and analysis in the context of health systems reforms and globalization of health policy.

The students went through three basic steps. Firstly, each student presented a seminar on one of

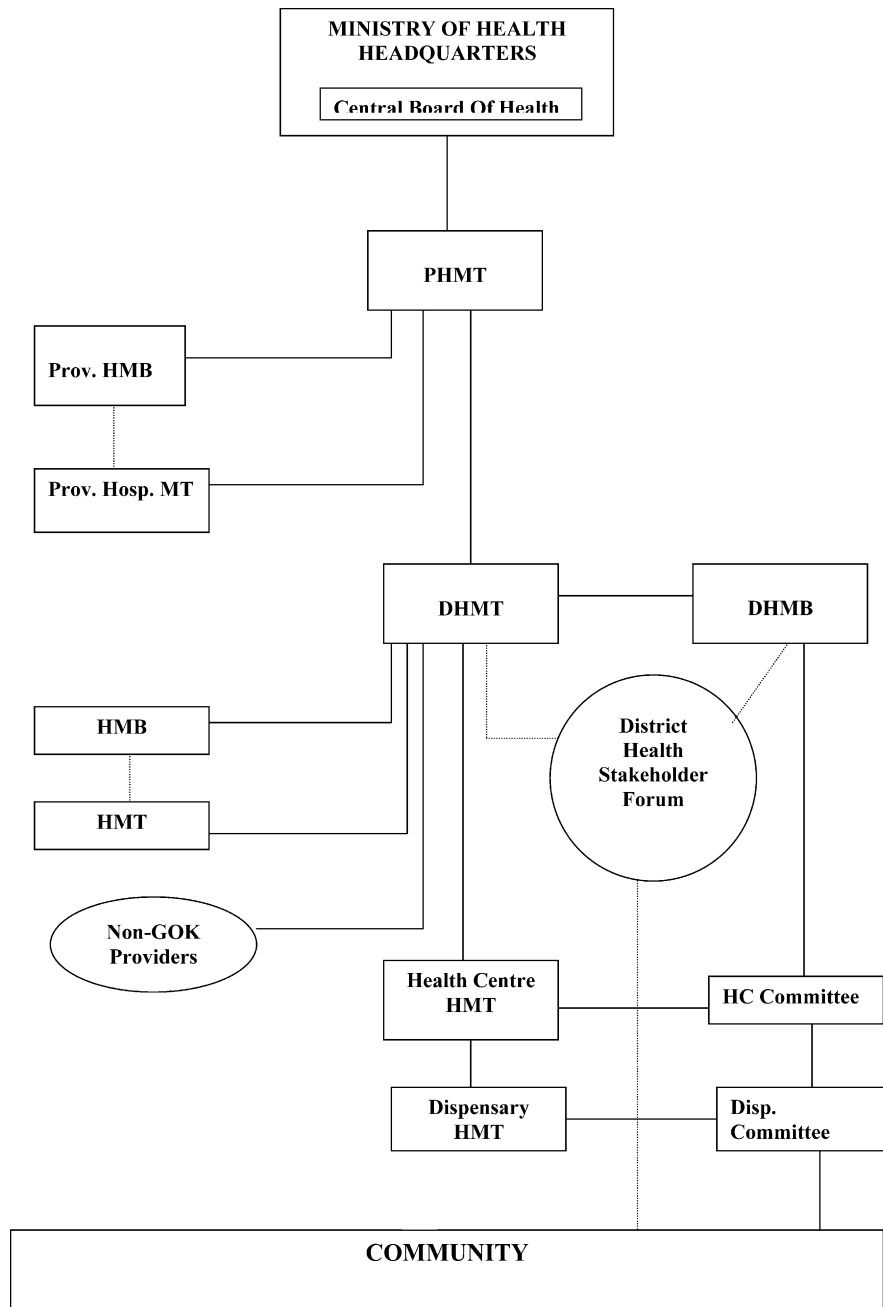


Fig. 1. MOH levels of responsibility.

the following topics: poverty alleviation and health; health financing and sustainability of health services; health sector reforms and decentralization; and planning for the district health

system and the role of civil society. On the basis of the presentations, an interview guideline for the second step was developed. The second step involved students interviewing a range of actors

Tier	Structure	Functions
National	Central Board of Health	Policy formulation; strategic planning; regulatory control; co-ordination of human resource development; resource mobilization; donor relations
Provincial	Provincial Health Management Board; Provincial Health Management Team	Supervision and support of regional and district activities; implementation and enforcement of health standards and regulations;
	Provincial Medical Officer	Inspectorate for monitoring health system performance, management and financial audit; continuing education; on job training; action research
District	District Health Management Board;	Administer cost sharing schemes; oversee planning, governance, management and development of health services in the district; allocation and distribution of funds (including donor funds); make recommendations on expenditures and budgets of the District Development Committees
	District Health Management Team	Planning, implementing and monitoring all health Activities in the district; reporting, generating and controlling expenditures of voted financial resources and donor funds
	District Health Stakeholders forum	Functions not yet clarified
Community	Village health committees; dispensary and health center management committees	Development, governance, financing and sustaining community level health services

Fig. 2. Levels of authority and decision-making in the health system.

engaged in policy formulation and/or implementation at the provincial, district, and community levels. At the provincial level, the students interviewed the Provincial Medical Officer (PMO) of Nyanza Province. At the district level, two District Health Management Teams (DHMTs) were interviewed in Bondo (a rural district) and Kisumu (an urban district). In addition, members of the Non-governmental Organization (NGOs) represented by ACTIONAID Kenya were interviewed. The third step was to analyze the information collected from the field in juxtaposition with the information initially reviewed and presented before the

field visits. Although the two facilitators of the elective have written the paper, it is a result of contributions of everyone who participated in the course. The students are listed at the end of the paper.

3. Results

A critical finding from the data was that the Government of Kenya had laudable outcomes expected from policies. However, it would appear that these outcomes have not been achieved for

two reasons. One is that assumptions on which these sought outcomes are based are questionable. We shall discuss these assumptions and realities in this section. The second is that the government has focused mainly on the outcomes while neglecting the policy process. As a result, implementation has been difficult. This reason will be discussed in Section 4.

3.1. Assumptions and realities of the HSR policy implementation at the district level

The Kenya's Health Policy Framework Paper 1994 [3] clearly states the vision of health sector reforms based on reformation of the health system and decentralization of decision making, authority, and responsibility to the districts. The policy framework presents a logical and convincing argument that the deteriorating health care situation in Kenya can be halted and reversed by both sustained improvement of the institutional functioning and performance of the health sector. In discussions with various governments, NGO and community officials in Nyanza Province, Kenya, it became clear that the success of the health policy implementation based on a number of fundamental assumptions that are examined below.

3.1.1. Assumption 1: the health sector has resources; the fundamental problem is the mismanagement of these resources

Management of health sector resources in Kenya has been studied by a number of people [19–24]. Although these studies have tended to focus on difficulties in effecting user charges, they highlight the problems of poor infrastructure, lack of accountability, and coordination that plague the effective functioning of the health sector. In an effort to address some of these problems, the MOH produced two major policy papers: Kenya's Health Policy Framework Paper 1994 [3] and the Health Sector Strategic Plan 1999–2004 [2]. These papers set forth a logical and systematic approach aimed at improving management targeting the problems of overexpenditure, poor priority setting, waste of resources, lack of accountability, and lack

of coordination between governmental and non-governmental health stakeholders. They assume that resources will be available to solve these problems.

There are, however, several reasons for questioning this assumption. Firstly, there is the problem of financial funding from outside donor agencies. The MOH states that 80% of the Development Budget alone is represented by donor contributions. They also supply 40% of this budget to the recurrent budget that supports particularly medicines to the Essential Drug program (mainly through the Danish DANIDA program) and the Expanded Program on Immunizations and Family Planning [3]. However, funds available for health care provision from both the government and foreign donor agencies have decreased over the last decade. As Table 1 shows, DANIDA has halved its support for the health sector. In addition, many donors (mostly bilateral) froze their aid to Kenya when the World Bank and IMF suspended their funding in 1997. The World Bank, through its affiliate, the IDA (International Development Association) in 1995–1996 gave money to support 32.04% of the Development Budget. This was frozen in 1997. Donors are now not only reluctant to return but also some have decided to stop funding altogether, e.g. the Dutch government.

Secondly, the majority of funding (70%) from the MOH is allocated to staff salaries leaving very little resources for operational and strategic service delivery functions of the government. To effec-

Table 1
Donor aid to the Development Budget as percentage of Total Development Budget [3]

Source	1993–1994	1995–1996
Belgium	0.06	0.00
Denmark	4.58	2.80
Finland	6.26	1.93
Japan	22.54	0.00
Germany	1.48	1.93
Netherlands	4.30	0.49
Sweden	9.99	10.83
USA	15.62	24.43

tively implement policies for decentralization, there is a need for resources to establish the necessary institutional frameworks and train staff to function within these frameworks. For example, the Provincial office has not yet completed an infrastructure to provide the required supervision the District units. All this suggests that more resources will be needed to actually implement reforms.

Thirdly, the MOH is no longer the only provider of health care in Kenya. It, therefore, is not in a position to fully control all available health care resources. Of the total health sector expenditure, the government accounts for only 43.26% with the remaining 56.74% being spent by the non-governmental sector which includes the religious health institutions, NGOs, and private (for profit) providers [3]. The non-government sector accounts for 50% of all hospitals and 36% of the available hospital beds. In addition, it accounts for 21% of all health centers and 51% of all outpatient facilities. Private providers of health care have grown from very few at the time of independence in 1963 to nearly 1500 in 1993 [25]. Because of lack of clearly defined and functioning mechanisms for coordinating the non-governmental providers, they are not in practice, accountable to the government. The large number of non-governmental providers are hence not regulated and not required to focus on national health sector vision and goals [25]. Thus while there exists a great potential to mobilize additional resources from the non-governmental sector, it is difficult, at present, to regulate and gain continuity of their contributions towards the achievement of the national health goals.

In reality, therefore, poor management and lack of good stewardship of resources is just one of the factors responsible for the health crisis. In fact diminishing resources against rising health needs and demands in the public domain both for the government and non-profit sectors is the greatest challenge facing the health sector today. It is not merely a question of better management but more importantly, availing adequate resources to ensure quality and continuity of service provision under the new management structures.

3.1.2. Assumption 2: both governmental and non-governmental health stakeholders will have the capacity to successfully implement the HSR policy

The health sector reform policy recognizes that the vision and mission of the health sector can only be achieved if both the government and non-governmental providers play their respective roles effectively. To do so, they must make more efficient and coordinated use of their strengths and resources to enhance greater access health care. One basic assumption is that the non-governmental providers have the capacity and willingness to support government goals. Based on the presumed strength in each of the two sectors (governmental and non-governmental), the most cost-effective strategy is thought to be the gradual divestiture of the government from direct provision of particularly curative services with the non-governmental providers assuming the responsibility for these services [13]. To implement this policy, it is assumed that the government only needs to create an enabling environment for increased private sector (both for profit and non-profit) and community involvement in health services provision and financing.

However, members of the DMHT clearly identified lack of capacity to implement the new policies at the district level as a major barrier to success [17]. The public sector has no adequate infrastructure to regulate the system, enforce standards and to provide an enabling environment for effective participation of the non-governmental stakeholders. The leveling of user charges provides a striking example to support this statement. Because the Health Care Financing Division whose task it is to regulate fees for service has not performed adequately, DHMTs decide upon their own charges. Table 2 shows the range of prices charged by different DHMTs for a specific service.

At present, most members of the DHMT do not have the knowledge and skills in health sector reforms management to effectively implement the new policies and to use the new accountability mechanisms. This view is supported by research undertaken by the Institute of Policy Analysis and

Table 2
Range of user charges for specific health service [26]

Services	Government prices in Kenya Schillings (Kshs)	Current fees		
		Average in Kshs	Minimum in Kshs	Maximum in Kshs
General ward	30	76	30	100
Maternity ward	30	179	50	500
Normal delivery	80	433	300	500
Major surgery	100	1833	1000	3000
Injection	20	30	20	50
Dressing	20	46	20	100
Laboratory test intermediate	70	77	40	100
X-ray	25	92	50	150
Pharmacy drugs	20	31	20	50
Physiotherapy	20	43	20	50
Medical certificate	100	133	100	150
Circumcision	50	175	100	300
Mortuary	100	260	200	500

Research in Nairobi [27]. For example, the provincial office is just beginning to evolve an infrastructure to provide the required supervision of the district health system. Members of the DHMT therefore felt that further allocation of staff, financial and material resources, and capacity building would be needed to strengthen their respective roles in the implementation of the health sector reforms at the local level [17].

On the side of the non-governmental providers, their presumed strength and capacity to take over greater responsibility from the government is compromised in a number of ways. Firstly, while the non-governmental providers offer a wide spectrum of services comparable to the government, their services are, however, too unevenly distributed and uncoordinated to act as a viable alternative to government services. Table 3 illustrates uneven distribution of hospitals and doctors suggesting that private care is available where people with money and willingness to pay are located.

The extent to which the community accesses their services although significant is not quantified or precisely known. Secondly, there are no procedures to manage efficiently the referral system between the non-governmental and governmental

Table 3
Distribution of private services in percent of total private provision available [25]

Province	Hospital	Doctors
Nairobi	20.70	50.80
Central	–	–
Coast (Mombasa)	13.80	18.00
Eastern	3.50	–
Northeastern	–	–
Nyanza	6.90	–
Rift Valley (Nakuru)	51.60	4.80
Western	3.50	–
Total	100.00	72.80

health care providers. Nor do many NGOs have a holistic health delivery program. The scope of their preventive health services is limited to mainly immunization, family planning, and community-based health care that is not included in the formal health services portfolio [13]. In reality, neither the government nor the non-governmental stakeholders appear to have necessary organizational or institutional capacity to effectively implement health sector reform policy particularly at the district and local levels.

3.1.3. Assumption 3: moving from “needs-based” to a “resource-based” (demand-driven) planning will make the provision of health care more cost-effective and accessible

The World Health Organization Report 2000 argues that the weakness of Primary Health Care approach was that it paid too little attention to people’s demands for health and thus, undervalued the contribution of the private sector and influence of the market economy [28]. It is argued that market forces produce a better quality of care by giving individuals the opportunity to choose providers and types of care [29]. In advocating for a “resource-based” planning approach, it is assumed that the economic environment is such as to generate enough demand for health care services. At present, economic deterioration has reduced the actual cash available for purchasing care and thus, the ability to demand care. In addition, preventive services that could potentially reduce the use of expensive curative care are almost never demanded. Without effective demand, there are no adequate resources to improve facilities and as a result the government continues to depend on external support to meet its health sector obligations.

Equally critical is the question of whether equity, a principle to which the government is committed [3], can be preserved under a market environment where majority of the population is poor. Today, with about 80% of Kenyans living in rural areas and over 50% living below the poverty line, it is difficult to fathom how their health can improve if they depend on market forces. At present, the majority of the population is faced with not only a deteriorating quality and range of services but also lack of purchasing power to “demand” health services even though their health care needs are overwhelming. There are no studies that show how much people do pay “out of pocket” for health care. However, data does show Kenyans, on the average, spend about 2.2% of their non-food expenditures on health care. Although the “non-poor” provide a lesser percentage of their income (2.1%), they spend more money in absolute terms. The poor give a larger percentage (3.3%) of their money to health care [25]. In the current situation, there are no

proven and viable mechanisms to shift resources towards providing health care for those living in absolute poverty in order to equalize their needs, demands, and access to health care. As a result, life expectancy has decreased and there is an increasing reliance on the informal health services, no matter who is providing them.

3.1.4. Assumption 4: decentralization will provide an enabling environment for the provision of responsive health care

Both the Health Policy Framework Paper 1994 [3] and the Health Sector Strategic Plan 1999–2004 [2] have presented decentralization as the panacea to most of the systemic problems bedeviling the health sector. The reasons for decentralization include provision of enabling environment for improved health sector performance, increased responsiveness to local health needs, improved multi-stakeholder collaboration, and increased potential to develop new funding mechanisms towards a well functioning and equitable health system [16].

The DHMTs interviewed in Bondo and Kisumu Districts confirmed that the decentralized approach to the provision of health care is desirable. They, however, expressed a number of concerns particularly with regard to the governance and accountability in the health system at both the provincial and district levels. Although the District Health Management Boards are envisioned to provide the accountability and governance mechanisms for checks and balances, the teams expressed concern over the way in which members of the Boards are constituted. The Minister for Health appoints the Boards based on the recommendations of primarily the District Commissioner, the District Medical Officer of Health (on behalf of the DHMT) and prominent members of the political elite. Even though, Board members selected are supposed to be people of high respect, integrity, and professional/technical know-how in their respective fields, very often they are selected on the basis of political allegiance and patronage. Consequently, they are not accountable to any defined constituency except the appointing authority.

In addition, while on paper the arguments for greater community involvement are indisputable, in reality poverty, illiteracy, and ignorance have made majority of Kenyans apathetic. To prepare such people to assume greater responsibility in the health system without resources is a major undertaking.

Another major factor is that the decentralization process continues to be largely driven and supported by external donor agencies. Ensuring sustainability of the decentralized system under such circumstance remains questionable. As several officials, including those of the bilateral donor community, pointed out the health system reforms are externally led and spearheaded by the World Bank. In the existing economic environment, the Kenyan government has little leeway in negotiating support for an improved health care system. It can be argued therefore that the donor led approaches to health sector reforms lack responsiveness to the needs of the local communities particularly the poor. In addition, the vision of resource allocative efficiency is restricted to the institutional agenda rather than the direct health needs of the population. Against this background, the assumption that with a decentralized health system, there would be improved health care and hence improved health status of the population can be seen as mere rhetoric given the extent of poverty among the population and donor dependency.

4. Discussion

The previous section highlights the difficulties between policy objectives and reaching these objectives. We can ask the question “Why is implementation so difficult?”. There are several people who have addressed this issue [30–32]. Perhaps most useful for examining this question in the context of health sector reforms in Kenya is the framework developed by Gilson [33]. In a paper, assessing the implementation and evaluating the health reform process based on a literature review, Gilson argues that implementation failure is a result of stressing policy outcomes but virtually ignoring the policy process. “A lack of

concern for process has led to a situation where policy is often implemented ineffectively and so expected policy outcomes are not achieved” [33]. In the case of Kenya, it can be argued that policy makers relied upon a number of assumptions that greatly contributed to this result. In addition, we have noted many factors that complicate the policy process including economic constraints and poor governance.

The analysis of the health policy framework and the assumptions upon which its implementation at the district is based highlight the major challenge facing the Kenyan government today. This challenge is translating health policy intentions into health care benefits. The health policy papers have defined the vision, mission, goal and objectives, and have put forward workable strategic steps for their achievement. But the fact remains that health care provision and the health status of the population continue to deteriorate. After 10 years of systematic health sector reforms, there are few tangible health benefits. The health policy goal to promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable remains a dream for the majority of people and a nightmare for the policy implementers. In this section, we identify and discuss the most critical processes to which the government must pay attention in order that its stated health outcomes can be achieved.

4.1. Closing the gap between policy makers and policy implementers

A major process that demands concern is that of closing the gap between those who formulate policy and those who are expected to implement it. At present, the MOH headquarters is developing and directing the health sector reform policy. Although policy is supposed to be “bottom-up” with the districts being identified as the source of policy direction and implementation, in reality, it is “top-down”. Those who must carry the load of the health sector reforms at the district level, for example, complained that they have not been involved in the process. While the officers interviewed agreed that the gap is not serious at the

provincial level, at the district level they felt that people in key positions of decision making are not clear on many issues regarding the reform process. As one member of the Kisumu DHMT put it “Health Sector Reform is in the Headquarters, not in the District” [17]. An example is lack of a clear definition of the role of various district level health officials, non-governmental health care providers and communities within the newly defined district health system, particularly with regard to lines of responsibility and accountability. Another example is that lack of clarity concerning the tasks of the DHMTs in relation to the requirement that they work closely with the communities in planning and provision of health care. While the DHMTs are expected to “initiate the development of local policies and plans” [34], they have been given neither specific instructions nor resources to undertake this task. A consequence of this gap between the policy makers and policy implementers is that the reform policy implementation at the district level is not systematic. Rather it tends to be led by individuals rather than institutions. Where, for example, the District Medical Officer of Health is both a leader and a manager, the implementation of the policy seems to be working and where there is no leadership capacity, little progress is made.

4.2. Maintaining the government’s role as a protector of the citizens health rights

A second process that must be given attention is how the Government can continue to play a credible role as the protector of its citizens’ health rights while at the same time responding to the demand of a market economy. The Kenyan health policy is driven by the neoliberal economic thinking that advocates and insists on the need and use of economic performance indicators [28]. This approach has been criticized as an ideological instrument that excludes those in greatest need of the health system [35]. In Kenya, one result of this market orientation is that the main health policy actors—the State, the private sector, and the organized civil society—have not included the poor majority in their schemes as the poor can neither make effective demand nor act as viable

players in the health markets. Thus the “people” (the communities, households, and individuals) although identified as main policy actors in the health sector reform process are functionally excluded and have increasingly little or no voices in policy development and implementation processes. A second consequence relates to the issue of the State/government’s ability to promote, preserve, and ensure equity. It is evidently clear that moving from the state-centered health service policies and planning towards market orientation has tended to create a contradiction. This contradiction is between the state primary’s responsibility for the health for all of its citizens’, the majority of whom cannot afford health care, and demand, necessary to keep the for profit private sector in the provision of health care.

These issues have been studied in detail in a cross-country analysis of Zambia, Benin, and Kenya [36]. This study examines the experience with community financing in the context of equity. It looks at the results of the Bamako Initiative as a means of making care available at the community level with an emphasis on the poorest members of the community. The authors concluded that the process undertaken in Benin where money generated at the local level was kept at the local level and not returned in any part to the central government resulted in improvements of the quality of care and immunization coverage. This mechanism assured that at least resources were available at the point of need rather than demand. On the other hand, in all three countries, ensuring equity was a big problem. Interviews showed that the very poor were never asked by officials about their concerns reflecting a continued top-down planning process where professionals decide what is best for those without access to power and resources. In addition, the poor had little chance to join bodies that were involved in decision making for collection and use of funds at the local level. As the study stated, “community decision-making bodies created to strengthen accountability by giving a ‘voice’ to the community often did not appear to serve the interests of the poorest” [36].

4.3. *Sustaining the health sector reform process*

A third process is the one that considers how to address the issue of sustainability of health sector reforms. It is complicated by the fact that a large proportion of resources is being provided by the external donors either as loans and grants. Reflecting on the prevalent ideology of neoliberalism, the donors through the allocation of their funds for health sector reforms are pushing the market agenda and creating policy mechanisms to support and maintain a demand-driven health system. Government officials and other stakeholders in the civil society, although often cry out foul against donor-driven policies, have done little to research or promote policies based on indigenous knowledge and experience. As the State, because of international, political, and economic pressures, continues to withdraw from an active role in ensuring better health for its citizens, the dominant donor-led policies are now beginning to lose their continuity, credibility, and capability to build sustainable and resilient infrastructure for the health sector. This situation calls for a concerted government effort to involve a whole range of stakeholders working together to address the issue of capacity building.

4.4. *Overcoming poor governance and management of the health sector*

The fourth, and perhaps the most critical process, is that which must address the growing anxiety created by the environment of poor governance and lack of credible, concerned and committed political leadership. The prevalence of high-level mismanagement of public resources and the inept political leadership response has sustained what the New York-based Human Rights Watch calls “an environment that promotes personal gain, lack of accountability and centralization of authority” [37]. As a result of the State ineptitude and lack of commitment to promote public interest, people by default rather than design, have been forced to invent informal ways of managing their own lives in every other aspect, from security, health, education, technology, and to food security. This has seen the steady decline of

the public services in the last few decades and the steady rise of the informal health and development sectors managed by community-based systems.

A recent study by Sobhan [38] examining the situation of poor governance in Bangladesh argues that poverty alleviation has not failed due to lack of resources but rather to the lack of good governance. It suggests that failure have resulted from the lack of vision, from commitment that goes beyond rhetoric and weak capacities at both the technical and political level. Further, it says that the government has surrendered ownership of national policies to the international donors and NGOs. Its conclusions that the situation could be overcome if alliances were built by those genuinely committed to alleviating poverty and bypassed state power elements that were obstructive. This description and analysis could also describe Kenya. There is a great need in both countries to pay attention to the processes that assure the outcomes of policy meet the published goals of the policy makers.

5. Conclusion

It appears that the public health system is at crossroads. While the Health Policy seeks to promote and improve the health status of all Kenyans, realities presented by the dominant neoliberal approach, market orientation of the health system, and poor governance of the political system have continued to make the state commitment to making good health for all a mirage. Policy formulation and implementation seem to be as wide apart as the increasing health disparities among the population. Essentially health sector reforms are meant to result into a sustained process of fundamental change in the functioning and performance of the health sector towards improving the health status of the whole population. But the poor and worsening health status of the population and the national health disparities have brought to the fore more major questions rather than answers concerning the health sector reform process.

We have argued that the need to manage the health policy process to gain the stated outcomes is

critical. To manage health reforms in this way highlights the need to identify the most critical processes, build and manage these processes in a systematic way and to monitor and evaluate the results. It also highlights the need to build organizational and institutional capacity to undertake this task. There is no question that the potential in both human and economic terms is available in Kenya. Within the next year, the Kenyan government is due to hold elections. The incumbent is not allowed by the existing constitution to run for re-election. How the new government deals with issues of governance and donor support will be a bell weather of its commitment to its highly laudable written commitments for health for all.

Acknowledgements

The TICH, in Africa, students who participated in the module were: Mabel Wendo, Paul Mbanga, Michael O'chieng and John Odera. The authors would also like to acknowledge the comments, assistance and information received from Dr. J. Odoyo, DMOH Bondo; Dr. A. Misore, the PMO Nyanza province; Dr. Rosemary Okeyo, DMOH, Kisumu; Kisumu District Development Officer, Isabel, Regional Coordinator ACTIONAID Kenya, Western Region and all the members of the DHMTs in Bondo and Kisumu Districts. We also would like to thank those who spent time and trouble to comment on this paper Dr. Jens Aagard-Hansen, Dr. Hugh Annett, Dr. June Odoyo, Ben Osuga and two anonymous referees.

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