National Study to Review existing Policy Documents and Identification of upcoming Priority National Health Policy issues in East African Community Partner States: Kenya Country Report

Report submitted to:

The World Health Organization- Alliance for Health Policy and Systems Research (WHO-AHPSR)
The East African Community (EAC) Health Secretariat Arusha Tanzania
Ministry of Public Health and Sanitation
Ministry of Medical Services
Ministry of East African Community-Kenya

EVIDENCE-INFORMED POLICY MAKING: HEALTH POLICY AND SYSTEMS ISSUES

Setting REACH-Policy Initiative Kenya Priorities for 2008-2010

Authors

Lubano Kizito[1], J Kariuki[1], L Muthami[1], J Mutai[1], D Ojakaa[2], O Agina[3], J Okoth[3], S Muleshe[4], J Bwonya[4,] Wasunna M K [1]

1 – Kenya Medical Research Institute – KEMRI
2 – AMREF Kenya
3 – Kenyatta University
4 – Ministry of Medical Services

Correspondences to:-

REACH PI Kenya Office
P.O. Box 54840, 00200
Nairobi
Kenya
Email: lkizito@kemri.org; reachpi-kenya@kemri.org ; director@kemri.org

August 2008

FUNDING & TECHNICAL SUPPORT

The main Concept Note for Country Assessment Methodology and funding was from The World Health Organization- Alliance for Health Policy and Systems Research (WHO-AHPSR), through the East African Community Health Secretariat via the Regional East African Community Health –Policy Initiative (REACH-PI) hub supported by IDRC in Arusha Tanzania. This was **Grant Agreement between REACH, EAC and the Alliance HPSR.** This current grant agreement reflects the preparatory work necessary in order for the Alliance HPSR to put a grant agreement into place with REACH. This grant agreement provides for preparatory activities leading to the development of a full grant proposal

Limitations

The Authors do not warrant that the information contained in this document meets your requirements or that the information is free of errors. The information may include technical inaccuracies or typographical errors.

Acknowledgements

Thank you.

Executive summary

Introduction

The Regional East African Community Health-Policy Initiative (REACH-PI) recognizes increasing momentum towards reforms of national health systems East African countries. The REACH-PI aims at carrying out a range of concrete tasks aimed at fostering better links between researchers, policy and decision makers, and users with a view to promote "knowledge translation" between them overcome the know-do gap regarding large burdens of preventable diseases among populations in East Africa and under financed sub-optimally functioning health systems

The WHO-Alliance for Health Policy and Systems Research (WHO-AHPSR) is committed to support national processes for evidence-informed policy making through facilitating the use of research evidence in the policy making process. The main focus is on prospective evaluation of the impact of various interventions aimed at promoting evidence-informed policy making. Preferential engagement is accorded to countries that are building up to or currently implementing policy reform in its priority thematic areas namely health care financing, human resources for health and non-state sector.

Thus WHO-AHPSR and REACH-PI will play complementary roles in strengthening evidence based policy and decision making in the health sector. The focus of this collaboration between the organizations is on priority policy concerns in health systems issues of health care financing, human resources for health and non-state sector in the medium term. The intervention proposal covering this phase of collaboration will focus on solving challenges in policy and health systems, mainly in the three areas. Other areas that are relevant to this collaboration include organization and delivery of health services, governance and management of health services, health care provider network, pressing health problems of the population and stewardship/governance among others.

The **explicit and rational setting of priorities for investment in researc**h is now accepted as an integral part of any research management process. Setting priorities in research can serve to act as a catalyst for public debate, for bringing together different stakeholders, and for creating networks.

When making health policy and strategy decisions and allocating resources, it is crucial to use the most reliable scientific evidence. Currently there is use of **insufficient** evidence-based knowledge. First – there is a lack of health information based on performance within health settings. Second- evidence based work is not freely available (to policy-makers. Third- there is lack of an effective demand (pull) for evidence by policy makers from researchers.

In view of the foregoing, the WHO-AHPSR supported REACH-PI to conduct research whose objectives were:
Objective 1
Identify priority policy questions in health systems and policy that are likely to come onto the policy agenda in 2008-2010 period that can be informed through the application of research evidence.

Activities

a) Review of documents to identify policy gaps and confirm main actors in the sector. Relevant documents include – the current Health sector policy framework, specific sector policies and laws, current sector strategic plans, current, last one year and projected annual operations plans; policy agendas of main sector development partners

b) Develop a stakeholder map and identify potential respondents in government, development partners, civil society and faith based organizations, research and academia

- Conduct key informant interviews from key stake holders (At national and Regional/provincial levels) using an appropriately revised in-depth interview guide
- In-depth interviews by in-country team with key policy and decision makers, and development partners to identify specific policy issues.
- Further in-depth interviews to refine policy foci and extend discussions to a broader set of stakeholders through workshops.
- Revision of the Stakeholder map based on the evidence emerging from in-depth interviews.

This objective is the preparatory step to be followed by interventional phase whose objectives are elaborated in the report.

Study Period: The activities were carried out from April 2008 to July 2008.

Findings

(a) Desktop review of documents

A total of 41 documents and publications were reviewed and 25 references used. The main issues identified are:

1. Development of policy documents is isolated and not linked to Strategy, administrative and operational documents. There is clearly a disconnect between development of policy document and elaboration of the operational documents such as annual operational plans.
2. There is no clearly defined framework that links research agenda, research funding, research findings, policy formulation, policy translation into operational plans and monitoring and evaluation mechanism for the selected approach to health issues
3. There is lack of clearly referenced verifiable evidence for selected approaches to health issues. Thus most policy documents are developed by a consultative process, however the evidence base for the process of selection is lacking
4. Change in political leadership seems to have a very significant influence on policy even in the absence of evidence for the need to change
5. The priority areas requiring research evidence in the next 2 years are
   a. Health care financing and access and equity for the poor
   b. Human resource for Health especially approaches that ensure equitable distribution of health workers to rural and urban areas based on needs
   c. The government delinking from direct provision of healthcare and concentrating on policy formulation, stewardship and regulatory functions
   d. Shift from focus on curative services to preventive services

(b) In-depth interviews

A total of seven (10) respondents (7 Organizations/Institutions and 3 key individuals) were interviewed. The respondents included Ministry of Medical Services, Christian Health Association of Kenya (CHAK), Glaxo SmithKline Beachem, Health NGO Network (HENET), the Nairobi Hospital, AMREF-Kenya, and the International Livestock Research Institute (ILRI).The Director Of Medical Services, The Director of KEMRI and the Permanent Secretary Ministry of Public Health and Sanitation. Institutions to be covered during the second phase of review will include University of Nairobi, Kenyatta University, National Hospital Insurance Fund (NHIF), Kenya Medical Research Institute (KEMRI), National Social Security Fund (NSSF) and the Parliamentary Committee on Health.

The main findings are summarized in the four sub-themes namely; health care financing, human resource management, non-state sector participation and regulatory framework (especially pharmaceutical and Public Health Act).

Conclusion

The findings from the desktop review of documents and in-depth interviews with institutions and organizations as well as key individuals identify the priority research questions requiring research evidence as:-
1. What is/are the optimal mechanisms for health care financing that achieve access and equity for the population especially the poor and disadvantaged?
2. What is the optimal strategy to achieving appropriate Human Resource for Health especially to ensure equitable distribution of health workers to rural and urban areas based on needs?
3. What is the optimal model for delinking the government (Ministry of Health) from direct provision of healthcare and concentrating on policy formulation, stewardship and regulatory functions without compromising equity and access to healthcare?
4. What is the optimal approach for achieving a Shift from focus on curative services to preventive services?

Recommendations
1. There is need to establish a multi-disciplinary permanent dedicated effective framework linking research agenda, research funding, translation of research findings into policy while ensuring development of policy documents is carried out simultaneously with development of the strategy and operational documents including a well defined monitoring and evaluation framework. Without such a mechanism answering the research questions may not necessarily achieve the overall desired effects at population level
2. There is need to mainstream operational research such as targeted evaluations into routine medical and public health activities to continuously provide information on what works and what does not work
3. There is need to train and raise awareness among all stakeholders on linking policy, planning and budget as elaborated in the Medium-Term Expenditure Framework (MTEF) and other mechanisms for ensuring results based management.

CHAPTER 1
1.0 Introduction

Definitions

Priority setting: A priority issue is one that is regarded as highest or higher in importance, rank or privilege. Priority setting is important in Health sector especially in resource constrained settings (Baltussen 2006).

Policy: Webster (1975) defines policy as "a definite course or method of action selected from among alternatives in light of given conditions to guide and determine present and future decisions." Ryan (2001) raises questions on whether policy is "what is articulated, whether in writing or by word of mouth? Or is it what is done, whether it has been stated before or not or is it whether only such actions that are sustained." The point being raised here by Professor Ryan is important because many times policies are pronounced even when they have not been articulated in writing or when are enacted without being written. Policies are purposeful statements written or spoken aimed at solving a particular problem or problems. Policies are general plans of action that are outlined with an intention to influence the decision making process and course of action. They also set the direction and parameters for the formulation of laws and programmes

Research: Although no one specific interpretation of research is widely accepted, there is a similar thread weaving through most. The point of agreement is that research involves a detailed and systematic attempt, often prolonged, to discover or confirm through objective investigation the facts pertaining to a special field problem or problems and laws and principles in control. Hence research can be defined as a systematic investigation carried out to discover new information and relationships as well as expand and verify existing knowledge. The primary product of research is evidence.

Evidence: Most researchers would agree that depending on your viewpoint, there is either uncertainty or wildly varying standards decisions about what "evidence" is and where the best resource for evidence for decision making can be found. In defining what evidence is, one is tempted to recall the words of former Supreme Court Justice Byron White, who in describing his definition of pornography is famously remembered as noting, "I can't define it, but I know it when I see it." (Woodward 1979).   In making decisions regarding public health, many decision-makers seem to ascribe to the same theory.   Evidence can therefore be generically defined as the available body of facts or information indicating whether a belief or proposition is true or valid. In public health practice, it is a collection of data or scientific evidence (guidelines), with input from community members, input from other stakeholders and professional experience.

Evidence-based Policy: Evidence based policy takes place when decisions that affect health policy are taken with due weight accorded to all valid, relevant information. (*Source: Based on the definition of Evidence Based Medicine- Summerskill 2005, Claridge 2005, and Niessen 2000)*

- Due weight - acknowledges that there are many factors that contribute to decisions about health, valid, relevant evidence should be considered alongside other relevant factors in the decision making process. It does not assume that any one sort of evidence should necessarily be the determining factor in a decision.
- All - implies that there should be an active search for valid, relevant information
- 'Valid, relevant' - implies that before information is used in a decision, an assessment should be made of the accuracy of the information and the applicability of the evidence to the decision in question; that is, information should be appraised.
- 'Information'- there are many types of information that may be valid and relevant in particular circumstances. Include any particular type of information as long as an appraisal is made of its validity and relevance and the information is given 'due weight' - neither more nor less.

Evidence-based Policy: "putting the best available evidence from research at the heart of policy development and implementation (Phil Davis 2004).

1.1 Current state of knowledge in priority setting

There is a growing interest in promoting evidence-based policy-making. Different approaches described in the modern literature include classic/knowledge-driven, problem-solving/engineering, social interaction, actors/stakeholder-oriented, enlightening/percolation, political and tactical models [Hanney S *et al* (2003); Trostle J *et al* (1999), Sauerborn R *et al* (1999)]. The main distinctive characteristic of most of these models is how the research findings are communicated to policy-makers and hence influence health system development. In particular, this includes recognition of the main players/stakeholders and ensuring their ownership, interaction at all stages, highlighting the relevant parts and "sedimentation" of insights, theories, concepts and perspectives. [Martin DK *et al* (2003); Ham Coulter (2000); Daniels N (1994)].

Public policymakers must contend with a particular set of institutional arrangements that govern what can be done to address any given issue, pressure from a variety of interest groups about what they would like to see done to address any given issue, and a range of ideas (including research evidence) about how best to address any given issue. Rarely do processes exist that can get optimally packaged high-quality and high-relevance research evidence into the hands of public policymakers when they most need it, which is often in hours and days, not months and years (Lavis JN 2006-1).

1.2 Linking Research, Evidence, Policy and Priority setting in the Health Sector

The interface between evidence and policymaking is complex, particularly in low and middle income countries and has received increasing attention in the literature (Nuyens 2006). Recent calls have been made for continued researcher engagement in exploring the interface (Hanney 2006, Pang 2007and Syed 2007). The non-linear nature of translation of evidence into policy has been acknowledged and the multiple inputs into policy making processes in these settings have been subject to increasing review (Lavis JN 2006). Decision makers and researchers often come from different cultures and have disparate motivations; thus priorities emanating from these two groups are often distinct (Choi2005 and Brownson 2006). Increasing the global knowledge base

on the operation of the interface, especially in low and middle income countries, is required in order to facilitate evidence based health systems development.

Health policy is a highly contested arena where there has been increasing calls for policy to be more "evidence-based". A central question still remains "Is evidence-based health policy possible? A relationship between evidence generation (research) and policy formulation has to be determined. (Health organizations the world over are required to set priorities and allocate resources within the constraint of limited funding).

In making health policy and strategy decisions and allocating resources, it is crucial to use the most reliable scientific evidence. Currently there is use of **insufficient** evidence-based knowledge. First – there is a lack of health information based on performance within health settings. Second- evidence based work is not freely available to policy-makers.

1.2.1. Why evidence is based policy important?

Use of evidence to formulate policy enhances effectiveness; efficiency; service orientation; accountability; democracy; and trust. Other advantages of using evidence to formulate policy include: High likelihood of success; Identification of common indicators; Defend/expand an existing program; Advocate for new programs; New knowledge is generated to help others.

But policy makers may be practically incapable of using research-based evidence because of the 5 Ss: Speed; Superficiality; Spin; Secrecy and Scientific Ignorance

1.2.2. Some Challenges to Evidence-Based Policy

- ✪ Public misunderstanding of health issues and proposed solutions such as fluoridation
- ✪ Lack of engagement on the part of the media in communicating known effective strategies
- ✪ Reluctance on the part of policymakers to champion approaches that concern but may not be advocated by their constituencies.
- ✪ The increasing burden of chronic diseases put policymakers into non-traditional roles, such as advocating behaviour change as a preventive measure.
- ✪ Difficulty in disseminating, locating or finding the right evidence is also a challenge
- ✪ Mainstreaming prevention and care programs into normal bureaucratic activities such as planning, budgeting and evaluation.
- ✪ Ensuring and enhancing informal alliances
- ✪ Scaling-up of essential strategies to the entire public
- ✪ Lack of transparency and accessibility to needed information
- ✪ Lack of proper monitoring and evaluation
- ✪ Ineffective or failed program

1.2.3. Actors for the Policy Domains

Table1: Actors for the policy domains

DOMAINS	CLINICAL SETTING	PUBLIC HEALTH SETTING
Individuals, Families, Communities	Patients, Care-givers, patient associations and advocacy groups	Community groups, NGOs
Health Practitioners	Clinicians and Support Staff	Public Health and Preventive services workers
Health Organizations	Clinics, Hospitals	Public Health and Community Health Facilities
Health Systems	Governments, regulators, Insurers	Governments, MOH

1. Individuals, families and communities – better informed and more empowered individuals, families, and communities
2. Health practitioners – more responsive and competent health practitioners
3. Health service organizations – more effective and supportive health services and facilities
4. Health systems – better system design, rules, and incentives to support people-centred quality care

1.2.4. Dynamics of Health Policy choices

Health policy choices are influenced by for distinct aspects as described below.

a. Technical aspects
   i. Epidemiological information (real or perceived burden of disease/health issue)
   ii. Evidence-based medicine (first school of thought) (Evidence-Informed decisions)
   iii. Cost-effective analysis (second school of thought)
b. Political aspects (taking into account pressure groups and the population) and
c. Resources (availability and allocation)
d. Vision (value systems)

Aim to optimize rather than to maximize. Furthermore, it is desirable when considering health policy options or systems of health care delivery that apply to large numbers of people, the mandate may be to carry out a well designed scientific studies and resolve the questions of benefit and harm and not to continue to subject people to unnecessary effects and raise false hopes often at tremendous expense. Policy formulation regards a matter of fact that has to be determined by research and not by authority and is suitable for investigation

1.2.5. Systematic approach to Policy formulation

Some common known learnt lessons in policy formulation include:-

1. The first lesson is that policy processes are complicated:

- They are often presented as a cycle with distinct stages, though in reality these are often very indistinct
- There are many actors involved in many of the stages
- Most of the actors are also busy trying to influence each other

Policy processes have sometimes been described "chaotic", however a fair description would be that policy processes are complex, multi-factorial and non-linear.

2. The second lesson is that **scientific research-based evidence only forms a part, often a surprisingly small part of the evidence and other factors that policy makers have to take into account when they make policy**. They also need to take into account political factors, social factors, and financial factors. They are often also influenced by the media and public opinion. It is important to recognise this. The UK Government for example now recognises this and having promoted **"evidence-based" policy** for the last 10 years now tend to talk about **evidence-informed policy** because it is more realistic.

3. The third lesson is that scientific research can make a big difference. Household-level studies in the Tanzania Essential health Improvement Project were used to design more locally appropriate health progrmames than the "standard" programmes being promoted by the Ministry of Health which resulted in a dramatic reduction in infant mortality in the two districts involved in just 3 years!

4. The fourth lesson is that to improve the use of scientific evidence in policy processes needs a systematic approach. You need to systematically analyse the political context, gather and use the right sort of evidence to answer the policy problem, and work closely with all other stakeholders. We have developed a simple framework to help with this. The framework identifies 4 sets of factors you need to take into account. We call these:

   a. The **political context** – this includes political and economic structures and processes, culture, institutional pressures, incremental vs radical change etc.
   b. The **evidence** – which includes credibility, the degree it challenges received wisdom, research approaches and methodology, simplicity of the message, how it is packaged etc
   c. The **links** between policy and research communities – which can include networks, relationships, power, competing discourses, trust, knowledge etc, and
   d. **External Influences -** for example socio-economic and cultural influences, donor policies etc

1.2.6. Why do Programs/Policies Fail to Achieve Maximum Potential?

1. Choosing ineffective intervention approach
2. Selecting a potentially effective approach, but weak or incomplete implementation or "reach"
3. Conducting an inadequate evaluation that limits generalizability

1.2.7. Some Key Characteristics of Evidence-Based Policy Formulation

1. Intervention approaches developed based on the best possible scientific information
2. Problem solving is multi-disciplinary
3. Theory and systematic planning approaches are followed

2. Sound evaluation principles are followed (no evaluation = no program)
3. Results are disseminated to others who need to know and take action

Evidence-based Policy is a <u>process</u> of: Engaging stakeholders; Assessing what influences health, health behaviors and community health (literature, local needs, academic theory); Developing programs based on assessment (science); Evaluating process, impact, and outcome ;Learning from our work and sharing it in ways that are accessible to ALL stakeholders

1.2.8. How decisions are generally made in public health settings?

Decision making in public health settings is influenced some of the following factors:-
- Anecdote or "Gut Feeling"
- Media Driven
- Pressure from Policy Makers or Administrators
- History/inertia
- Expert opinions (e.g., academics)
- Peer reviewed literature/systematic reviews
- Resources/Funding availability (Cost- effectiveness-), *OR*
- Combined methods, based in sound science.. (How to make the best use of multiple sources of information and imperfect scientific evidence?)

Figure 1: Opinion-based policy Vs Evidence-based policy
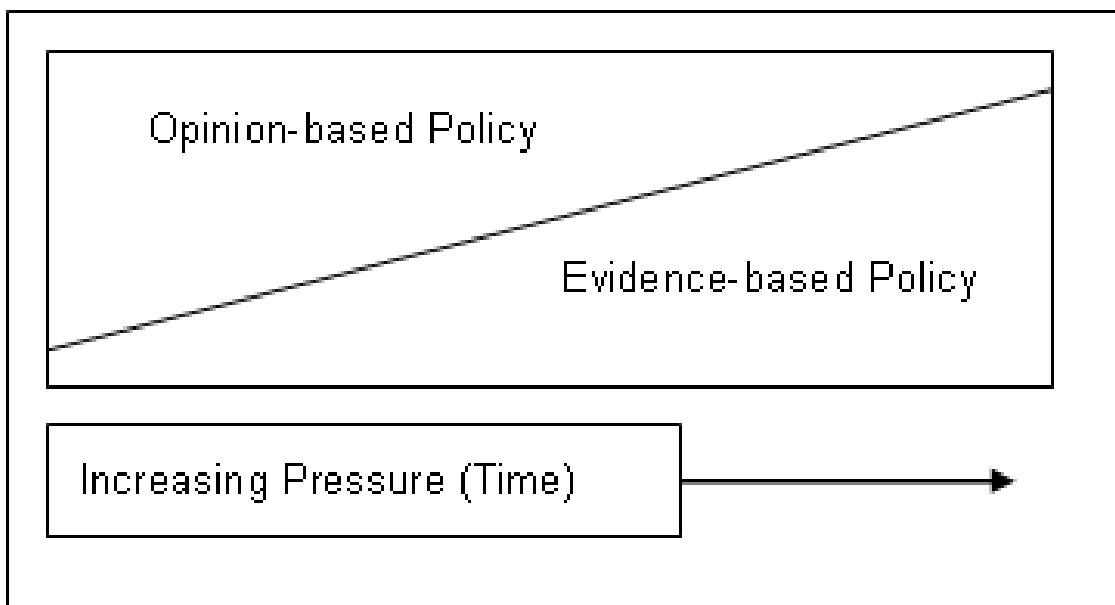
Evidence-based policy requires more time and patience yet many policy makers are under pressure of time or seem to be always.

"…..If we did not respect the evidence, we would have very little leverage in our quest for the truth."Carl Sagan

1.2. 10. How does the research process lead to evidence-based programs?

For research to influence policy, it has to be relevant, valid, timely and presented in a way that it can be easily understood by policy makers. On the other hand the policy makers need to develop an effective demand for research evidence to facilitate a two-way translation of research in Policy and practice. Some characteristics of research include:- Discovery of new knowledge; Mostly conducted in academic settings; Largely driven by the grant process; and, May or may not involve the community in meaningful ways. These realities of research both present an opportunity and threat to evidence-based/informed policies and programs

History of research in Human Health in Kenya

Kenya has a population of 35 million people, with a majority of below the age of fifteen. It has high morbidity and mortality rates affecting the population of all ages, especially children under 5 years. Although a significant proportion of this morbidity and mortality is due to infectious conditions, many other non-infectious factors play a role. These include chronic diseases and economic deprivation resulting in poverty, malnutrition and inadequate health care.

The culture of health research in the country dates back many years. During the colonial period research was catered mainly for the needs of the colonial authorities. The Medical Research Council (MRC) of Britain was responsible for research in the country. Research stations were opened all over East Africa in areas of interest to the colonial government, such as malaria, trypanosomiasis and tuberculosis. The data obtained had no direct links with the health authorities in East Africa. However, at the time of independence these research activities and stations were placed under the Ministry of East African Cooperation. Meanwhile the Medical School in Makerere University, and subsequently medical schools in Nairobi and Dar-es-Salaam, carried out health research, especially in clinical areas, in the national and teaching hospitals. However, such research was not guided by any national interest, policy or prioritization. After independence, the East African Research Council replaced the MRC as the coordinating mechanism for the various research stations, which had no direct linkages with the ministries of health in the respective countries.

In Kenya, after the collapse of the East African Community in 1977, the National Council for Science and Technology (NCST) was set up to advice the government on matters relating to science and technology and research for development, and to coordinate research. The areas covered by the NCST included priority areas like food, health, employment, environment and housing. In 1979 the Science and Technology Act was amended to create semi-autonomous, sector-related research institutes and the existing institutes were thereby absorbed. However, the NCST did not have the executive authority required to coordinate the activities and guide policies. It was not until 1987 that a full ministry was created, the Ministry for Research and Technical Training (MRTT), which gave the required authority to the Council and to the research institutes to coordinate research, science and technology. In the meantime the Government felt it was necessary to build its own new research institutions and seven such institutes were created in various sector ministries. These ministries, however, came under pressure to use the research funds for more pressing national needs. Once the MRTT was set up, all research institutes were then placed under it.

Nonetheless, health research has continued to be carried out by various institutions, which provide data on mortality, morbidity, risk factors, utility of diagnostic techniques, treatment outcomes, preventive strategies, disease surveillance, health policy and health economics. The research has often failed to focus on critical national needs, since these institutions are concentrated in urban, non-slum areas and do not adequately address health problems of the rural and urban slum areas.

Major issues in research methodology and utility, such as selection of research fields and topics, evaluation of outcomes and cost-effectiveness, have not been adequately tackled. This may be attributed to the lack of coordination and prioritzation of research. Placing emphasis on the highest priority needs will help to optimize available human, material and economic resources. There is growing recognition of the need for communities to be more actively involved in research in order to facilitate the implementation of research findings.

Kenya was among the first countries to adopt the Essential national Health Research (ENHR) strategy in June 1991, following a national convention, which recognized that capacity building, prioritization and co-ordination in the area of national health research offered the greatest challenge to the nation. The most appealing aspect of ENHR was seen to be its stated goal of addressing equity and its all-inclusiveness that makes it appropriate for a country like Kenya. At the end of the conference, it was recommended, as the way forward for ENHR in Kenya, that a body be created to coordinate all activities of ENHR, and with that in view, that a task force be set up to ensure the following :

- the coordination and networking of all institutions involved in health research;
- the amplification of action plans ;
- the review of the role of the Medical Science Advisory Research Committee ;
- the identification and prioritization of Essential Health Research.;
- the creation of a national health research information and documentation centre ;

Accordingly, the National Health Research and Development Centre (NHRDC) was established as the national mechanism to coordinate ENHR in the country. The conference also recommended that a formal system of networking among research institutions be built. At the close of the meeting of the National Consultative Group a number of major points emerged. They related to national priority setting, the level of resources for research, research capacity, African bargaining power and the creation of an effective African network.

The following were general conclusions from the national consultative process. It is acknowledged that Kenya has a critical mass of trained manpower, and an adequate infrastructure - albeit not equitably distributed – as well as workable health systems. However, there are significant inadequacies, including a weak policy framework, and the lack of expertise in certain critical areas. These include public health and policy research, as well as capacity for critical analysis of issues. Other serious problems include the country's generally poor economic performance and the severe donor squeeze aimed at forcing the country to effect major changes in its policies and systems. The public health sector is currently weak and the majority of the poor do not have access to adequate health services. The non-governmental sector, however, which accounts for 50% of the services is robust and growing. The Manpower training it provides is good, as too are its health research system and facilities. Researchers however would

welcome an improvement in policy framework, better health research coordination, and effective networking and communications with the rest of Africa, so that they may share experiences. Joint collaborative research in the region should be encouraged and African governments should jointly seek better apportionment of global resources.

CHAPTER 2
Objectives of Current Research

2.1. Background

The WHO-Alliance for Health Policy and Systems Research (WHO-AHPSR) is committed to support national processes for evidence-informed policy making through facilitating the use of research evidence in the policy making process. The main focus is on prospective evaluation of the impact of various interventions aimed at promoting evidence-informed policy making.

The REACH-Policy Initiative (REACH-PI) on the other hand recognizes increasing momentum towards reforms of national health systems East African countries. The REACH-PI aims at carrying out a range of concrete tasks aimed at fostering better links between researchers, policy and decision makers, and users with a view to promote "knowledge translation" between them overcome the know-do gap regarding large burdens of preventable diseases among populations in East Africa and under financed sub-optimally functioning health systems. REACH-PI is a permanent, dedicated, professional mechanism operating as an entity within the East African Health Research Commission (EAHRC) and enjoys the highest political commitment by the partner states of the East African Community.

Thus WHO-AHPSR and REACH-PI will play complementary roles in strengthening evidence based policy and decision making in the health sector. **The focus of this collaboration between the organizations is on priority policy concerns in health systems issues of health care financing, human resources for health and non-state sector in the medium term**. The intervention proposal covering this phase of collaboration will focus on solving challenges in policy and health systems, mainly in the three areas.   Other areas that are relevant to this collaboration include organization and delivery of health services, governance and management of health services, health care provider network, pressing health problems of the population and stewardship/governance among others.

2.2. Objectives and interpretations

Objective 1

Identify priority policy questions in health systems and policy that are likely to come onto the policy agenda in 2008-2010 period that can be informed through the application of research evidence.

Activities

c) Review of documents to identify policy gaps and confirm main actors in the sector. Relevant documents include – the current Health sector policy framework, specific sector policies and laws, current sector strategic plans, current, last one year and projected annual operations plans; policy agendas of main sector development partners

d) Develop a stakeholder map and identify potential respondents in government, development partners, civil society and faith based organizations, research and academia

e) Conduct key informant interviews from key stake holders (At national and Regional/ provincial levels) using an appropriately revised in-depth interview guide.

- In-depth interviews by in-country team with key policy and decision makers, and development partners to identify specific policy issues.
- Further in-depth interviews to refine policy foci and extend discussions to a broader set of stakeholders through workshops.
- Revision of the Stakeholder map based on the evidence emerging from in-depth interviews.

Objective 2

Identify and plan activities that can facilitate linking evidence to policy and develop work plans.

Activities

a) Application of self-assessment tool, and discussion with those participating organizations identified under (a) and (c) under objective 1 above to identify the gaps in evidence to policy link and preliminary list of interventions

b) Revision of the stakeholder map based on results of self assessment by institutions.

c) Identify the process likely to be used in the policy formulation process. Suitability of the four models proposed by Lavis et al (2006)* included in the concept note should be considered.

Outputs:
  i) Description of the process used highlighting usefulness and challenges encountered, and how they were addressed.
 ii) Policy background and short listed priority issues for the plan period;
iii) Draw a final map of stakeholders who are likely to participate in follow-up interventions.
 iv) Identify activities to be supported by funding agencies.
  v) Short list 3-4 potential country/regional priority policy issues to be addressed by REACH-PI in the short and medium term (2-3 years). Country team develops a proposal for the period and detailed interventions for year one - identifies key policy issues to focus on, stakeholders to engage, and appropriate detailed interventions to address the weaknesses identified in the system.
 vi) Update the Country Node work plan for the year.

CHAPTER 3

3.0. Methods and Processes

Organizing the national priority setting

The exercise began in early April 2008. It was unanimously agreed that the process be conducted by an in-country team led by the coordinator of the National focal point and guided by the Kenya country team that had received a 5-day training/orientation on priority setting process in Tanzania in June 2007. The team has brought on board individuals with key skills in the area of focus where such skills are lacking. These individuals have been drawn from Institutional (Auxiliary) nodes in the MoH, Health Research Institutes or Centres and Universities. We have a multidisciplinary team of experienced professionals with appropriate skill mix to gather, analyse and synthesize qualitative and quantitative data. We shall identify a broader country human resource base composed of experienced individuals in public health policy and planning, economics, financing, management, public health disciplines, and research skills in qualitative and quantitative methods and National stakeholders by the end of the exercise. The team shall be instrumental in all future country Node activities.

3.1. Processes & Procedures

The process has involved a series of meetings to develop implementation plans and carry out the exercise simultaneously. A 4-pronged approach was adapted
1. Listing of policy documents for review, gathering the documents from relevant offices and carrying out desktop review using a standardized pre-determined criteria
2. Identifying institutions and individuals targeted for key informant interviews
3. Liaising with the parent Ministry to write to the identified individuals requesting for appointment to conduct in-depth interviews
4. Conducting in-depth interviews and distributing self-assessment tools (Annex1 and Annex 2 respectively)

3.2. Administration and Finance

The Country Node coordinator in consultation with the Director/ CEO of KEMRI has provided administrative coordination of the review process and or technical direction as envisaged in the REACH-PI plans. This activity was supported by EAC/AHPSR grant of USD 4,500 that covered , local travel, communication, subsistence and accommodation, photocopying, stationery and report production. An additional USD 2,500 is expected to cater for cost of the national stakeholders meeting once the current activity is completed.

CHAPTER 4

4.0.   RESULTS

4.1.   DESKTOP REVIEW OF DOCUMETS

MAIN DOCUMENTS REVIEWED

1. Kenya Health Policy Framework (1994 – 2010)
2. Kenya Vision 2030: Government of the Republic of Kenya. ,July 2007
3. Economic Recovery Strategy for Wealth and Employment Generation (2003-2007)
4. The Kenya National HIV/AIDS Strategic Plan (KNASP) 2005-2010
5. National Health Sector Strategic Plan I (1999 – 2004)
6. National Health Sector Strategic Plan II (2005 – 2010)
7. Ministry of Health: Annual Operational Plan 1 (AOP1)- 2005/2006
8. Ministry of Health: Annual Operational Plan 2 AOP2)-2006/2007
9. Ministry of Health: Annual Operational Plan 3 (AOP3) 2007/2008
10. Ministry of Health: Health Sector Performance Report July2005-June 2006 (AOP1 Report)
11. Kenya Pharmaceutical Policy Framework
12. National Reproductive health Research guidelines June 2006
13. Kenya HIV and AIDS Research Coordinating mechanism (KARSCOM) : HIV and AIDS Research strategy, July 2007
14. Ministry of Health. The Report on Human Resource Mapping and Verification Exercise December, 2004
15. KEMRI Strategic Master Plan 2005-2010: Meeting the Health Challenges of the 21st Century
16. Kenya African National Union (KANU) Manifesto: the Sessional Paper No. 10 of I965 on African Socialism and Its Application to Planning in Kenya
17. Party of National Unity (PNU) manifesto
18. Orange Democratic Party (ODM) manifesto
19. Kenya Service Provision Assessment Survey 2004
20. Ministry of Health. Health Sector Reform Secretariat: Kenya Health Sector Wide Approach Code Of Conduct. 2nd August 2007
21. Ministry of Health. Norms and Standards for Health Service Delivery. June 2006
22. Ministry of Health. Joint Programme of Work and Funding for the Kenya Health Sector 2006/07–2009/10. June 2006
23. Guidelines for District Health Management Boards, Hospital Management Boards, and Health Centre Management Committees
24. Ministry of Health. Health Sector Reform Secretariat. Kenya Health Sector Wide Approach (SWAP): Concept Paper. October 2005

Other Publications and Documents reviewed

1. "Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases", April 27, 2001, Abuja. Available at United Nations Economic Commission for Africa webpage: www.uneca.org.

2. Anna H Glenngård and Thomas M Maina. Reversing the trend of weak policy implementation in the Kenyan health sector? – a study of budget allocation and spending of health resources versus set priorities. *Health Research Policy and Systems 2007, 5:3 doi: 10.1186/1478-4505-5-3*

3. Central Bureau of Statistics, Ministry of Health – Government of Kenya, Kenya Medical Research Institute, Centre for Disease Control and Measure DHS+ ORC Macro, 2003. "Kenya Demographic and Health Survey **(KDHS)** 2003", Nairobi and Calverton.

4. Glenngård A. H. and Hjalte, F., 2004. "Issue Paper on NHA – The Case of Kenya, Zambia and Mali", Health Division Document 2004:3,

5. Swedish International Development Cooperation Agency, Stockholm.

6. Health and Economics Development Consortium (Hedc) LTD, September 2004. "Ministry of Health: Evaluation of the National Health Sector Strategic Plan for 1999–2004", Nairobi.

7. Kenya Consultative Group, 2005. "Kenya: Consultative Group Meeting April 2005 – Joint Donor Statement on Health", available at www. worldbank.org.

8. Ministry of Health – Government of Kenya and Partnerships for Health Reform, 1999. "Kenya National Health Accounts 1994 – Draft Report", Nairobi.

9. Ministry of Health –Facts and Figures at a Glance: Health and Health Related Indicators 2006. Division of Policy and Planning ,January 2007

10. Ministry of Health – Government of Kenya – Health Sector Reform Secretariat, July 1999. "The National Health Sector Strategic Plan (NHSSP) 1999–2004", Nairobi.

11. Ministry of Health – Government of Kenya, 2004. "Public Expenditure Review 2004", Nairobi.

12. Ministry of Health – Government of Kenya, March 2005. "Public Expenditure Review 2005", Nairobi.

13. Ministry of Health – Government of Kenya, 2005. "Household Health Expenditure and Utilisation Report 2003"

14. Ministry of Health – Government of Kenya, 2005. "Kenya National Health Accounts 2001/2002", Nairobi.

15. PHRplus, 2005. "Kenya National Health Accounts 2002: Estimating Expenditures on General Health and HIV/AIDS care", Partnerships for Health Reform plus, Bethesda.

16. Stephen R Hanney, Miguel A Gonzalez-Block, Martin J Buxton1 and Maurice Kogan. The utilisation of health research in policy-making: concepts, examples and methods of assessment. Health Research Policy and Systems 2003, 1:2.
http://www.health-policy-systems.com/content/1/1/2

17. United Nations webpage, 2005-04-29, "UN Millennium Development Goals (MDG)", available at www.un.org/millenniumgoals/

18. World Health Organization 2008: WORLD HEALTH STATISTICS 2008

19. SIDA. Health Division Document 2005:3 SEPTEMBER 2005 • HEALTH DIVISION
20. Issue Paper on NHAPolicies in the Kenyan Health care sector: – Why are they so difficult to implement? At www.sida.se/publications (http://www.sida.se/sida/jsp/sida.jsp?d=118&a=3576&language=en_US&searchWords=Policies%20in%20the%20Kenyan%20health%20%20care%20sector) Accessed July 2008

21. WHO Statistical Information System (WHOSIS). KENYA - National Expenditure on Health (Mn. Kenyan Shillings). http://www.who.int/nha/country/ken.pdf . Accessed July 2008

4.2.   Health Policy Overview in Kenya

Since independence the government has given high priority to the improvement of the health status of Kenyans. It recognizes that good health is a prerequisite to socioeconomic development. In a number of government policy documents and in successive National Development Plans, it has set forth that the provision of health services should meet the basic needs of the population, be geared to providing health services within easy reach of Kenyans and place emphasis upon preventive, promotive and rehabilitative services without ignoring curative services.

The policies that the government has pursued over the years have had a direct impact in improving the health status of Kenyans. Despite a decline in economic performance, cumulative gains have been made in the health sector as evidenced by the improvements in the basic health indicators. The crude death rate has dropped over the years from 20 per 1000 at independence to 12 per 1000 in 1993. Likewise both infant mortality and life expectancy which are basic indicators of health status have improved dramatically. The national health indicators look impressive but there are significant   geographical disparities which need to be addressed in order to achieve equity.

4.3.   Policy Evolution

In 1965 fee collection in health facilities was abolished. In 1970 the Ministry of Health took over the health centers and dispensaries run by local authorities without a corresponding transfer of budget from local authorities to the Ministry of Health. The Ministry of Health has the responsibility of ensuring the provision, improvement and promotion of health for all Kenyans.

Different policy initiatives have had mixed success. One initiative was cost sharing amended in 1989. It introduced consultation fees in government health facilities and it was later modified in 1992 to convert user charges from consultation fee to treatment fee. This program has increased the level of resources available at the local level for improving the functions of the health system. Three quarters of the revenue are used at the collecting facility, and one quarter is set aside for district level expenditure on primary health care. However, with the poverty level in the country, many are the people unable to access the health facilities as they could not afford.

In 1992, District Health Management Boards were created by legal notice; these boards provide local insight of the cost sharing program. In 1993 the Ministry of health adopted the civil service health manpower reform which seeks to trim the size of the civil service on a voluntary basis for those in lower job groups. The decline in resource availability and to some extent the mismanagement of resources limited the implementation of policy and expected benefits were not fully realized. The government is no longer able to provide unlimited free care as budgetary allocations are insufficient to meet rising costs.

Civil Society Participation

The Kenya Health Policy Framework, 1994, recognizes the need for promoting a strong health sector where the private sector is given greater responsibility for healthcare delivery while the public sector concentrates its efforts on delivering 'public goods' in health. The successive National Health Sector Strategic Plans underpin future delivery of healthcare on this principle of promoting the non-Government (non-GoK) sub-sector by providing an enabling environment. The health Sector-Wide Approach is an emerging force driving the stakeholders together to forge a common vision in healthcare development in the country among key MOH stakeholders. [HENENT 2005]. The National Health Strategic Plan II (NHSSP II) provides the means to plan together, implement together, monitor and evaluate jointly through the following instruments for realizing SWAps in Kenya.

- The Joint Program of Work and Financing (JPWF)
- The Code of Conduct (COC)
- The Annual Operations Planning Process (AOP)
- Joint Monitoring and Review (JMR)

Sector Wide Approach (SWAp) strategy & Community involvement: district focus strategy for rural development (DFRD) & Constituency Development Fund (CDF)

In 1983, the health related component of the inter-sectoral encompassing the District Focus for Rural Development (DFRD) policy was introduced. [Moi Daniel, 1986]. Furthermore, the government recognized the weakness of the centralized management and planning approach, and thus resolved to change this by increasingly involving the districts in it. The rationale of the strategy lay on the principle of the complementary relationships between ministries, with their

sectors approaches to development, and the districts with their integrated approach to addressing local needs.

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 reforms (Table 2).

Although the system had noble intentions, the strategy did not deliver the expected results due to a myriad of problems and political patronage. Furthermore, the existence of many bureaucracies in the various government ministries and departments and lack of evidence based decision supporting mechanism resulted to stalling of many projects initiated by those committees. [Makundi E *et al*, 2000].

However, the change of political landscape in the first quarter of the twenty first century saw the re-introduction of a more responsive strategy in which the political constituencies become the centre of rural development replacing the district. The introduction of Constituency Development Committees (CDCs) by the new political regime saw the committees endowed with a revolving financial kitty called the Constituency Development Funds (CDF).

Decentralization of health services
A decentralized health service is the focus of health sector reforms and structural changes 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. [Moi Daniel, 1986].

To date, the MoH central level still retains the responsibilities of formulating policy (setting national health goals as well as cost sharing fees), monitoring, evaluating, and supervising health care; preparing and maintaining national accounts and financial information systems, and liaising with other stakeholders.

4.4. Organization of the Health Sector

The organization of the Kenya's health care delivery systems revolves around three levels, namely the Ministry of Health (MoH) headquarters, the provinces and districts. The headquarter sets policies, coordinates the activities of the NGOs and manages, monitors and formulates policy formulation and implementation. The provincial tier acts as an intermediary between the central ministry and the districts. It oversees the implementation of health policy at the district level, maintains quality standards and coordinates and controls all district health activities. In addition it monitors and supervises district health management boards (DHMBS) which supervises the operation of health activities at the district level.

The district level concentrates on the delivery of health care services and generates their own expenditure plans and budget requirements based on the guidelines from the headquarters through the provinces.

The health system in Kenya is organized and implemented through a network of facilities organized in a pyramidal pattern. The network starts from dispensaries and health clinics/posts at the bottom, up to the health centres, sub-district hospitals, district hospitals, provincial general hospitals and at the

apex there is the Kenyatta National Hospital. Facilities become more and more sophisticated in diagnostic, therapeutic and rehabilitative services at the upper levels.

The health system and decision-making structures in Kenya

The current health system comprises of all the groups and institutions that provide healthcare services, regulate and finance health actions right from the household to the national levels. It also includes all the activities whose primary purpose is to promote, maintain and restore health, responsiveness and fairness in health resources distribution. Table 1 summarizes the hierarchical relationship of authority and decision making in each level. The aim is to facilitate better understanding of planned activities for effective utilization of resources for maximum health outcomes.

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

Tier	Structure	Functions
National level	Central Board of Health*	Policy formulation; strategic planning; regulatory control; coordination of human resource development; resource mobilization; donor relations.
Provincial level	Provincial Health Management Board / Team	Supervision and support of provincial and district activities; implementation and enforcement of health standards and regulation.
	Provincial medical officer (PMO)	Inspectorate for monitoring health systems performance, management and financial audit; continuing education; action research.
District	District Health Management Boards	Administer cost sharing schemes; oversea planning, governance, management and development of health services at the district; allocation and distribution of funds (including donor funds); make recommendations on expenditures and budgets of the district development committees. Coordinate district health stakeholders' forums.
	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.
Community	Village health committees; dispensary and health centre management committees	Development, governance, financing and sustaining community level health services.

The Central Board of Health has never been operationalized

4.5. Health policy framework

Despite the expansion in health care delivery systems since independence, it is widely recognized that increasing population and demand for health care outstrip the government's ability to provide effective services. In 1994, the Ministry of Health produced Kenya's Health Policy Framework (KHPF) which is the Government blueprint for future development in the Health sector to today.

This policy document is based on a comprehensive situational analysis of the various factors affecting the health sector and addresses broadly the Agenda for reform for policy implementation. The aim of the policy framework is to ensure that the health status of the Kenyan population is improved. It sets out the policy Agenda for the health sector up to the year 2010. This includes

strengthening of the central public policy of the Ministry of Health, adoption of an explicit strategy to reduce the burden of disease and definition of an essential cost effective care package.

To operationalize this Health policy Framework Paper, the National Health Sector Strategic Plan (NHSSP, 1991-2004). The strategic plan emphasized the decentralization of the health care delivery through redistribution of health services to rural areas. The revised National Health Sector Strategic Plan II (NHSSP II-2005-2010) has been developed to reflect poverty reduction strategy paper (2001-2004) agenda. The new plan focuses on the essential key priority packages based on the burden of disease and the service required support systems to deliver these services to the Kenyans. Major players in the health sector include government represented by the ministry of health (MoH) and the local government, private sector and NGOs.

4.6.   Health services: access and quality

The MoH is the major financier and provider of healthcare services in Kenya. Out of over 4500 health facilities in the country, the MoH controls and runs about 52% while the private sector, the mission organizations and the ministry of local government run the remaining 48%. The public sector controls about 79% of the health centres, 92% of the sub-health centres and 60% of the dispensaries. The NGO sector is dominant in health clinics, maternity and nursing homes (94%) and medical centres (86%). Both the public and the NGO sector have an almost equal representation of hospitals.

The health sector is faced with inequalities. Only 30% of the rural population has access to health facilities within 4km, while such access is available to 70% of urban dwellers. The arid and semi arid north and north eastern areas of Kenya are underserved due to limited number of health facilities. The quality of health services is reputedly low due to inadequate supplies and equipment as well as lack of personnel. Moreover, regulatory systems and standards are not well developed.

4.7.   Kenya's Health Policy Framework (1994)

In 1994, the Government of Kenya (GOK) approved the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. It spells out the long-term strategic imperatives and the agenda for Kenya's health sector. To operationalise the document, the Ministry of Health (MOH) developed the Kenya Health Policy Framework Implementation Action Plan and established the Health Sector Reform Secretariat (HSRS) in 1996 under a Ministerial Reform Committee (MRC) in 1997 to spearhead and oversee the implementation process. A rationalization programme within the MOH was also initiated. The above policy initiatives aimed at responding to the following constraints: decline in health sector expenditure, inefficient utilisation of resources, centralized decision making, inequitable management information systems, outdated health laws, inadequate management skills at the district level, worsening poverty levels, increasing burden of disease, and rapid population growth.

Kenya's Health Policy Framework (1994) whose theme is **Investing in Health** provides an analysis of the current health sector, identifies specific
strategic imperatives, and provides an agenda for reform. The overall goal of the health sector 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.

The paper recognizes a number of critical problems facing the health sector, including growing financial pressures, over-stretched capacity of the public health care system, imbalances in MOH staffing, and health sector laws which are inadequately enforced or outdated.

To overcome these constraints and to achieve the stated goal of the health sector, the following six *strategic imperatives* have been identified:

1. **Ensure equitable allocation of Government resources to reduce disparities in health status.** This involves the development and use of carefully formulated criteria for geographic distribution of facilities and allocation of resources to individual facilities.
2. **Increase the cost-effectiveness and cost-efficiency of resource allocation and use.** This requires placing budgeting priorities on the most essential, cost-effective curative and preventive health services. Greater efficiency will be achieved through more careful allocation of personnel; sound management practices, contracting of selected services to the private and mission sectors, and improved use of information for planning.
3. **Continue to manage population growth.** Managing population growth requires expanding the number of service delivery points, diversifying family planning services, focussing on areas of unmet need, and increasing maternal literacy rates.
4. **Enhance the regulatory role of Government** in all aspects of health care provision. This will be achieved by strengthening the Ministry's policy-making role, strengthening the provincial tier of the health system, extending the role of DHMBs, empowering local facilities through Health Management Boards (HMBs) and Health Centre Management Committees (HCMCs) to develop and manage health services, and building the capacity of districts in modern management and planning methods.
5. Create an enabling environment for increased private sector and community involvement in health service provision and finance. This includes creating incentives to encourage greater use of nongovernmental health services, streamlining registration and licensing of private, Non Governmental Organisation (NGO) and mission health providers as well as promoting the formation of health centre and dispensary committees.
6. Increase and diversify per capita financial flows to the health sector. Health sector financing will be increased through the expansion and diversification of National Health Insurance Fund (NHIF) and other social health financing mechanisms, increasing cost sharing revenue, and expanding Bamako Initiative mechanisms for community financing.

Realization of these six strategic imperatives will depend to a very large measure on the extent to which they can be put into practice at the district level. Legislative, central budgetary decisions and certain other actions must be taken at headquarters. But the districts should be the focus for efforts to ensure equitable allocation of resources, increased cost-effectiveness and efficiency, greater control of population growth, greater private and community involvement in health, and increased cost sharing revenue.

4.8.   National Health Sector Strategic Plan (NHSSP-I) 1999-2004

The development of the first National Health Sector Strategic Plan (NHSSP-I) for the period 1999-2004 was a follow-up to the Ministry of Health's efforts to translate the policy objectives into an implementable programme . In addition to taking into account past constraints, the document involved key stakeholders in the planning process from the start through consultative workshops within the Ministry itself and with other stakeholders, such as development partners,

public sector, districts, and provinces, the private sectors, NGOs, religious groups, professional organisations, communities, and users of health services, as well as teaching and research institutions. The end product thus incorporated the views and priorities of all these groups.

In responding to the daunting challenge of operationalizing the 1994 Health Policy Framework Paper, the Ministry of Health with her development partners developed the National Health Sector Strategic Plan NHSSP-I (1999-2004) and set up the Health Sector Reform Secretariat to spearhead the reform process. The NHSSP sought to implement appropriate structural, financial and organizational reforms within a sector wide approach to resolve the inherent constraints in the health sector. It specifically provided a well-articulated vision for health care financing as well as the requisite support systems, and governance structures. Through the NHSSP-I, the Ministry committed itself to decentralization by providing increased authority for decision-making, resource allocation and management of health care to the District and facility levels. This is in part to allow greater participation of the community in the management of health funds and implementation of the essential clinical and public health package at the lower levels.

Findings of the External Evaluation of NHSSP-I
The NHSSP-I was evaluated in September 2004 by an external team of independent consultants. The evaluation found that
"...despite having well focused national health policies and reform agenda whose overriding strategies were focused on improving health care delivery services and systems through efficient and effective health management systems and reform, the overall implementation of NHSSP-I (1999-2004) did not manage to make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators of health and socio economic development as expected by the plan". This may be attributed to a set of factors, most of which are inter-related, such as
• *Absence of a legislative framework to support decentralisation;*
• *Lack of well articulated, prioritized and costed strategic plan;*
• *Inadequate consultations amongst MOH staff themselves and other key stakeholders involved in the provision of health care services;*
• *Lack of institutional coordination and ownership of the strategic plan leading to inadequate monitoring of activities;*
• *Weak management systems;*
• *Low personnel morale at all levels; and*
• *Inadequate funding and low level of resource accountability.*
As a result, the efforts made under NHSSP-I did not contribute toward improving Kenyans' health status. Rather, health indicators showed a downward trend. Infant and child mortality rates increased. The use of health services in public facilities declined; in 1990 there were 0.6 new consultations per person, while in 1996, there were only 0.4 new consultations per person. The doctor-to-population ratio declined from the 1980s to the 1990s. The public sector's contributions to healthcare stagnated, going from US$12 per person in 1990 to US$6 per person in 2002. In more general development terms, poverty levels also increased, going from 47 percent in 1999 to 56 percent in 2002.

In summary the following factors contributed to failure to realize goals in NHSSP-I:
– Lack of consensus and therefore commitment among policy makers.
– Lack of practical operational management of the NHSSP.
– Lack of means to monitor and evaluate the implementation of the NHSSP.
– Lack of confidence in available data among government officials.

– Catch 22 scenario regarding the re-allocation of resources from general hospitals to primary and preventive services.

4.9. The report on Human Resource Mapping and Verification exercise December, 2004

A total of 2,158 MOH facilities were mapped. They comprised: 1527 dispensaries; 440 health centres; 126 hospitals; 65 not classified. Facility to population rates varied from 1: 11,376 (Rift Valley) to 1:23,964 (Western Province). Nairobi province appears the worst served (1:91,620), but the figures do not include local government facilities and Kenyatta National Hospital. Nationally, there are 7 MOH facilities for every 100,000 persons. 34,986 health employees were mapped in their respective health facilities. 48% worked in District hospitals, 16% in Health Centres, and 14.2% in Dispensaries (table 4.1). The health worker to population ratio varied from 1:705 (Central Province) to 1:1,646 (North Eastern Province).

Nurses comprise 47.3% of the workforce; doctors represent 3.1%, clinical officers 6.1%, public health technicians 14.4%, and public health officers 11.9% (table 4.3). 77.6% enrolled nurses, and 58.9% registered nurses were aged over 35 years (table 4.7).

Staffing levels do not meet MoH staffing norms. 47.3% (722) dispensaries are staffed by just one community nurse and support staff (who can administer drugs), and 2.8% (42) have support staff only (table 4.6). North Eastern Province has just one doctor per 100,000 population. 60% of staff had been in their workplace for more than 3 years, and 48.3 had been there for more than 5 years. Utilisation rates of facilities showed a wide variation, both in bed occupancy rates (high in some district hospitals) and outpatient attendance. 46.4% of permanent employees have not received a confirmation of employment letter.

There is no data on sickness absence or deaths due to HIV/AIDS related illness as employees were reluctant to provide the information.

Data on academic qualifications of MOH staff show that 75.5% are of certificate or diploma level while only 5.9% are graduates or post graduates. Very few key health personnel have attended training to enhance their skills.

The findings suggest that MoH is making overpayments in excess of Kshs 500 million each year to MoH staff. 1,447 (4.1%) employees on the national payroll database (September 2004) were not identified by the mapping exercise, an overpayment of nearly Kshs 364 million. 10,810 (31% workforce) were not eligible for the higher housing allowance they are receiving, at a cost of Kshs 140 million. Furthermore, 571 of 5,917 (9.7%) employees receiving the hardship allowance did not qualify for the entitlement; this represents an overpayment of Kshs 11.7 million.

Summary of recommendations from the human resource mapping:-
 I. *The MOH to take appropriate action following the HR mapping exercise and the short term recommendations made in this report.*

 II. *The MOH to introduce workforce planning into the Health Sector to facilitate the maximum utilization of the current workforce and to adequately plan for the future workforce*

 III. *The MOH to introduce planned education commissioning for the Health Sector based on future staffing needs formulated through workforce planning*

IV. *The MOH to introduce a planned approach to training needs and a training programme through a needs assessment form workforce planning*

V. *The MOH to establish and implement annual human resource and service performance indicators to ensure the maximum efficiency and outcomes from the workforce*

VI. *The MOH to establish a sickness absence management scheme to control and limit sickness absence, to ensure all sickness is reported and collated and that targets are set and achieved by the workforce*

VII. *The MOH to write a human resources strategy to map-out the route to effective workforce management for the next ten years in Kenya*

VIII. *The MOH to foster ownership of the data in all provinces to gain understanding, and ideas for the HR management through this report and the recommendations therein.*

IX. *The MOH to consider a study tour to the UK civil service.*

X. *The MOH to establish and maintain an electronic database which should be updated on a monthly basis via inputs from returns from the provinces. The database now exists through the HR mapping exercise but a system of reporting and updating is required.*

XI. *The MOH to consider the next steps approach as suggested in this report and establish a workforce management implementation board to manage progress of all the action required.*

To date it is not clear whether any of the above recommendations have been implemented

4.10. The Second National Health Sector Strategic Plan 2005-2010

The goal of National Health Sector Strategic Plan 2005-2010 (NHSSP II) is to reverse the negative trends in health outcomes. The plan realises that this goal can only be achieved if there is a synergy in action and a regular and open coordination of all activities by all partners, and it calls for a health Sector Wide Approach (SWAp) under the leadership of MOH

The second National Health Sector Strategic Plan 2005–2010 (NHSSP II) intends to reverse the decline in the health status of Kenyans. The vision of the sector is of an efficient, high quality health care system that is accessible, equitable and affordable for every Kenyan household. The mission is to promote and participate in the provision of integrated and high quality curative, preventive, promotive and rehabilitative health care services for all Kenyans. The plan is further designed to contribute to the accomplishment of Kenya's Economic Recovery Strategy and the achievement of the Millennium Development Goals.
Besides a whole new approach to service delivery, NHSSP II lays out a series of supporting measures ranging from community involvement, human resources and financial management, to monitoring and evaluation, infrastructure, and institutional reforms. The indicators, targets and outputs of NHSSP II will be used as the basis for the development of annual operational plans (AOPs) and internal and external annual performance reviews.

Reducing inequalities in health care and reversing the downward trend in health related impact and outcome indicators are the twin goals of NHSSP II. Six separate but interlinked policy objectives aim towards the realization of this goal:
• *Increase equitable access to health services.*
• *Improve the quality and responsiveness of services in the sector.*
• *Improve the efficiency and effectiveness of service delivery.*
• *Enhance the regulatory capacity of the Ministry of Health.*
• *Foster partnerships in improving health and delivering services.*
• *Improve the financing of the health sector.*

A thorough review of the experiences with Kenya's Health Policy Framework 1994–2010 and the efforts to implement NHSSP I (the first National Health Sector Strategic Plan) yielded the basic design principles that guided the development of this second strategic plan. First, service delivery will place human capital development and the human rights approach squarely at the core of its interventions. Moreover, NHSSP II shifts the emphasis from the burden of disease to the promotion of individual and community health. It does this by introducing the Kenya Essential Package for Health (KEPH), which focuses on the health needs of individuals through the six stages of the human life cycle. Finally, the strategy emphasizes strong community involvement in health care.

4.11. Vision 2030

Kenya Vision 2030 is the country's new development blueprint covering the period 2008 to 2030. It aims to transform Kenya into a newly industrialising, "middle-income country providing a high quality life to all its citizens by the year 2030". The Vision has been developed through an all-inclusive and participatory stakeholder consultative process, involving Kenyans from all parts of the country. It has also benefited from suggestions by some of the leading local and international experts on how the newly industrialising countries around the world have made the leap from poverty to widely-shared prosperity and equity.

The Vision is based on three "pillars": the economic, the social and the political. The adoption of the Vision by Kenya comes after the successful implementation of the Economic Recovery Strategy for Wealth and Employment Creation (ERS) which has seen the country's economy back on the path to rapid growth since 2002, when GDP grew from a low of 0.6% and rising gradually to 6.1% in 2006. The relationships between the pillars can be seen in Table 1, which was recommended to the Government by Kenya's National Economic Council in January, 2006, and subsequently adopted by the Cabinet.
The economic pillar aims to improve the prosperity of all Kenyans through an economic development programme, covering all the regions of Kenya, and aiming to achieve an average Gross Domestic Product (GDP) growth rate of 10% per annum beginning
in 2012. The social pillar seeks to build a just and cohesive society with social equity in a clean and secure environment. The political pillar aims to realise a democratic political system founded on issue-based politics that respects the rule of law, and protects the rights and freedoms of every individual in Kenyan society.
The Kenya Vision 2030 is to be implemented in successive five-year Medium-Term Plans, with the first such plan covering the period 2008 – 2012. For that reason, the reader will find frequent references to projects and programmes scheduled for implementation between 2008 and 2012. While the "flagship" projects are expected to take the lead in generating rapid and widely-shared growth, they are by no means the only projects the country will be implementing.

The Health Sector in Vision 2030

The Health sector falls in the Social Pillar. To improve the overall livelihoods of Kenyans, the country aims to provide an efficient and high quality health care system with the best standards. This will be done through a two-pronged approach: (i) devolution of funds and management of health care to the communities and district medical officers; leaving the Ministry to deal with policy and research issues; and (ii) shifting the bias of the national health bill from curative to preventive care. Special attention will be paid to lowering the incidence of HIV/AIDS, malaria and TB, and lowering infant and mortality ratios. All this will reduce equalities in access to health care and improve key areas where Kenya is lagging, especially in lowering infant and maternal mortality. Specific strategies will involve: provision of a robust health infrastructure network; and improving the quality of health service delivery to the highest standards and promotion of partnerships with the private sector. In addition, the Government will provide access to those excluded from health care due to financial reasons. Through encouragement to the private sector, Kenya intends to become the regional provider of choice for highly-specialised health care, thus opening Kenya to "health tourism" as an income-generating activity.

The health sector's flagship projects for 2012 are to:

- Revitalise Community Health Centres to promote preventive health care (as opposed to curative intervention) and by promoting healthy of individual lifestyles;
- De-link the Ministry of Health from service delivery in order to improve management of the country's health institutions primarily by devolution of health management to communities and healthcare experts at district, provincial and national hospitals;
- Create a National Health Insurance Scheme in order to promote equity in Kenya's health care financing;
- Scale up the output-based approach system to enable disadvantaged groups (e.g. the poor, orphans) to access health care from preferred institutions.

4.12. Kenya Medical Research Institute (KEMRI)

PROFILE

The Kenya Medical Research Institute (KEMRI) is a state corporation. It was established through the Science and Technology (Amendment) Act of 1979. The Institute is one of the leading health research institutions in Africa.

III.   MANDATE/FUNCTIONS

KEMRI's mandates as outlined in the Science and Technology (Amendment) Act of 1979 have been further translated to be in harmony with the Institute's current health research development realities and the envisaged future direction.

KEMRI's mandates are as follows:-

1.   To conduct research in human health

2.   To cooperate with other organizations and institutions of higher learning in training programmes and on matters of relevant research.

3.   To liaise with other relevant bodies within and outside Kenya carrying out research and related activities.

4.   To disseminate and translate research findings for evidence-based policy formulation and implementation.

5. To cooperate with the Ministry of Health, the Ministry for the time being responsible for research, the National Council for Science and Technology and the Medical Science Advisory Research Committee on matters pertaining to research policies and priorities.

6. To do all such things as appear necessary, desirable or expedient to carry out its functions.

The following is a profile of the Institute:-

Human Resource

At its inception in 1979, the Institute had only 5 members of staff – 2 research scientists and 3 non-research staff. As at 1st January 2005, the Institute had 1535 full-time members of staff, of whom 200 were research scientists, 500 technical staff and the rest specialized and general supportive staff.

Financial Resources

The Institute's annual budget in 1979 was KSh. 10,000,000 (USD 125,000). As at 1st January 2005, its total annual budget was KSh. 3.0 billion (USD 37,500,000). The Government of Kenya provides 50% of the budget while collaborating research partners and organizations provide 45%. Approximately 5% of the budget is raised from the Institute's own internal sources. The latest projections show that the KEMRI annual budget is approximately Ksh4 billion with nearly 75% coming from external sources. It is noteworthy that the Kenya Government support only caters for employee's salaries. Thus, there is no direct Kenya Government funding for research. External donor funding for research often may not necessarily fully agree with and support Kenya National Health priorities. Kenyan researchers are therefore often unable to carry out research relevant to the needs of Kenyans.

KEMRI Strategic Master Plan 2005-2010: Meeting the Health Challenges of the 21st Century

The purpose of this Strategic Master plan is to prepare KEMRI to meet the health challenges of the 21st Century in an increasingly competitive world.

The Master Plan will, therefore, guide KEMRI to meet Kenya's health priorities which from the National Health Sector Strategic Plan II (2005 – 2010) may be summarized as follows:-

1. Reverse the downward trends in Kenya's national health scene.

2. Pursue aggressively diseases related to poverty, exclusion and ignorance.

3. Improve efficiency and effectiveness of health interventions to address basic health needs of Kenyans.

4. Emphasis on health promotion and disease prevention, using a community based approach.

5. Allocate more resources to health promotion and diseases prevention at lower levels of health care system.

6. Promote holistic health, and not just mere treatment or absence of disease infirmity.

7. Adopt an integrated "basket" health system. (KEMRI will contribute knowledge, skills, ideas and technologies to the basket).

8.   Reduce the risk of infection with STD/HIV and TB and mitigate the social economic consequences of HIV/AIDS and TB.

9.   Reduce malaria morbidity and mortality

10. Reduce under 5 morbidity and mortality attributed to measles, pneumonia, diarrhoea, malaria and malnutrition.

11. Improve sanitation, food safety, hygiene and safe water supply by developing links between the health sector, other sectors and local authorities in water and sanitation.

12. Increase public knowledge and understanding of the mode of spread and prevention of disease at the community level.

Special note is taken that the new Kenya Essential Package for Health (KEPH) under the Plan puts emphasis on health (rather than disease), on rights (rather than needs) and on revitalization of health particularly at community level. This ties up well with the KEMRI Strategic Master Plan whose holistic view is to improve not just health but quality of human life.

The KEMRI Strategic Master Plan seeks to also contribute to the realization of the following Millennium Development Goals as defined by the UN in 2000.

Despite the long list of strategic objectives that seem to reflect what is identified in the NHSSP-II, there is lack of coordination of formulation, implementation and monitoring of annual operation plans that are meant to translate the strategic plans into   Specific, Measurable, Achievable, Realistic and Time bound (SMART) goals.

4.13. Kenya Institute for Public Policy Research and Analysis (KIPPRA)

This is an autonomous public institute whose primary mission is to provide quality public policy advice to the government of Kenya and to the private sector in order to contribute to achievement of national development goals. The Institute contributes to improved public policy making and implementation by: Conducting objective public policy research and analysis; Informing and providing advice during policy-making process; Building capacity of the Government of Kenya to absorb, undertake and analyze public policy; Strengthening working modalities with the Government of Kenya and other stakeholders; and Enhancing KIPPRA's institutional capacity in order to effectively support the policy process.

KIPPRA is therefore a central source of information and advice on a wide range of policy issues.

The following documents from KIPPRA were reviewed:

KIPPRA Documents http://www.kippra.org/resources/publications.asp#Occasional%20Papers
Discussion Papers:
   1. Health and Growth in Africa

2. User Charges and utilization of Health Services in Kenya
3. A review of the regulatory framework for private healthcare services in Kenya

Occasional Papers
1. Effective Private sector representation in policy formulation and implementation
2. Strengthening the link between policy research and implementation

Working Papers
1. A situational analysis of poverty in Kenya
2. A review of the Health sector in Kenya

Overall there is no clearly defined mechanism linking the Ministry of Health, KEMRI, KIPPRA, local Universities, and other research institutions in order to coordinate research and evince-informed policy formulation. The apparent dependence on donor funding for research may not necessarily focus on solving the Kenyan Health Research priority issues.

4.14. Summary: Identified Key priority areas from desktop review of documents and publications requiring research evidence in 2008-2010

1. Health care financing (Creation of National Health Insurance Scheme)
2. Delinking Ministry of Health from health care provision (encouraging independent operations in service provision)
3. Human resource for health (availability and deployment, competence and motivation)
4. Focus on preventive and promotive as opposed to curative health care services
5. Access for health care to the disadvantaged populations (scale-up output- based system to enable disadvantaged groups to access health care from preferred institutions)

Stewardship and Regulatory System issues requiring attention
1. Regulatory framework for private healthcare provision and pharmaceuticals products
2. Operationalization of the Central Board of Health under Cap 242 of the Public Health Act.
3. Elaboration of Policy formulation framework clearly linking research-evidence-policy formulation

CHAPTER 5
In-depth interviews

5.0.   Methodology and interpretation

Study design: This was a cross-sectional study with triangulation of qualitative methodology and data. The unit of interview was individuals while the units of analysis were the organizations/Institutions they represented

Study site: Majority of the decision/policy makers were either stationed in Nairobi or have their operation headquarters within the capital. Others that were targeted were some of the National Universities and Provincial Health administration based outside Nairobi.

Sampling of respondents

A purposive sample was drawn after grouping organizations on the bases of their health care mandates/ function both in the public and private sector. These constituted the development partners and private health care service providers. Snowballing sampling approach was also adopted in situations where the interviewees gave information that required to be gathered from others. [Yin RK (1994)]. Table 2 shows the various groupings of the source of study respondents who were selected to represent the larger groups.

Table 2: List of targeted and sampled institutions

Groups & Target institutions	Target institutions	Selected institution
Group 1: Civil societies, UN agencies, HMOs & development agencies	AMREF, HHNET, Christian Health Association of Kenya (CHAK) & UN agencies	AMREF, HENET, CHAK
Group 2: Ministry of Public Health & Sanitation / Ministry of Medical Services /	Heads of Department, Programmes & Divisions / Provincial Medical Officers of Health	Permanent Secretary DMS
Group 3: Line ministries & parastatals	Kenya Medical Research Institute (KEMRI), National Hospital Insurance Fund (NHIF), Moi Teaching & Referral Hospital (MTRH) and Kenyatta National Hospital (KNH)	KEMRI & NHIF
Group 4: Universities (public & private). Specifically targeting	University of Nairobi, Moi University / Baraton / Strathmore / Aga Khan / Kenya Methodist University (KEMU) / Jomo Kenyatta University of Agriculture & Technology (especially ITROMID)	University of Nairobi, Moi University & Aga Khan University

Methods for Data Collection

The following approaches were used to conduct the review and developed a joint action plan

- Review of existing policy documents and guidelines including survey and routine Health Management Information Systems (HMIS) reports
- Interviews with stakeholders and selected focus group discussions
- In-depth interviews with selected stakeholders
- Interviews and discussions were conducted using an interview guide (annex 1) over a period of five weeks. Key informant interviews and FGD's were all audiotaped and transcribed

Data Analysis Methodology

o The priorities were identified through in-depth interviews and personal communication. Every issue was assessed in accordance to the following guideline.
o Problem description – the severity of the problem, associated health effects, social consequences and economic costs.
o Measures the health effects of the population – The team also reflected on the number of people the problem was likely to be associated with in the country, those most at risk and their characteristics and identify trends and patterns over the years.
o Assess health risks- The discussants highlighted causes/factors that contribute to the problem and the individual and/or population at greater risk.
o For each identified problem the team identified the policy alternatives for the issue, the potential policy interventions. Existing knowledge regarding their effectiveness were also discussed and the relevant research was sighted.

Limitation

In an such much as this exercise served as a preparatory activity for laying the foundation of future activities in priority setting adequate time for   conducting interviews for this preparatory phase was a constrain. The time allotted to this exercise was very short. In this regard, not all the identified stakeholders were interviewed despite schedules having been made for the interview meetings.

5.1.   Findings

A total of seven (7) respondents were interviewed. The respondents included Ministry of Medical Services, Christian Health Association of Kenya (CHAK), Glaxo SmithKline Beachem, Health NGO Network (HENET), the Nairobi Hospital, AMREF-Kenya, and the International Livestock Research Institute (ILRI). Institutions to be covered during the second phase of review will include University of Nairobi, Kenyatta University, National Hospital Insurance Fund (NHIF), Kenya Medical Research Institute (KEMRI), National Social Security Fund (NSSF) and the Parliamentary Committee on Health.

The main findings are summarized in the four sub-themes namely; health care financing, human resource management, non-state sector participation and regulatory framework (especially pharmaceutical and Public Health Act).

5.1.1. Health care financing

There is need to revisit the issue of patient fees which has witnessed revenues declines patterns. In addition, there is need to develop models of health care financing to the under-served / marginalized / poor population so to allow them access to quality health care.

In addition, there is need to establish a health sector service fund where funds are transferred directly to lower levels health facilities. Increase the authority for dispensaries and health centres to incur expenditure. Currently, policy regarding possible public funding to faith-based organizations (FBOs) is under review.

Although NHIF although performing well, there is need to strengthen the pre-paid medical schemes through outsourcing of providers using the output-based approach. This should be tied with strengthening of the district treasury:

Possible priority issue
Policy issue 1: Equity in health care financing to ensure access to quality health care by all.
Significance – many people have no access to quality health care because of rising poverty levels.

5.1.2. Human Resource for Health

There is skewed distribution of health care providers with majority concentrated in urban centres while majority of the population and need is in the rural areas. There is need to undertake reforms in order to make the public service more attractive. Areas of focus should include upgrading of certificates, post qualification training and transfers, linking recruitment to facility needs and public advertising vacant posts especially those of Provincial Medical Officer of Health (PMO) and Medical Officer of Health (MOH).

Furthermore, involvement of employees in performance appraisal is lacking in public sector domain. Thus, there is need to decentralize manpower to all districts. Ministry of Health should appreciate the role of coordinating human resource development.

Possible priority issue
Policy issue 2: Policy: Incentives to attract and retain appropriate healthcare workers in rural areas coupled with– training guidelines for upgrading various cadres in the health sector in order to keep abreast with the new technological changes taking place in the world.

Policy issue 3: Decentralization of provision of health care delivery and recruitment of selected staff to the district level.

5.1.3. Non-state sector participation
The current public- private partnership framework based on comparative advantage (resources, geographical, etc.). Thus there is need to improve public-private sector collaborations.

Possible priority issue

Policy issue 4: Develop best strategy/guideline for delivery of Health services to the community which should cover:-
i. Delivery of health services in partnership with the community
ii. The roles of the DMOH, the community and the financing modalities of the new structure created. This will necessitate the repeal of the public health Act.
iii. Design and test models for private sector delivery of health services while the government plays a regulatory role

5.1.4. Pharmaceutical Regulatory framework

Observed that although initial pharmaceutical reforms started over 7 years ago, not much has been implemented. In this regard, the issues that will attention over the coming years include:
iv. Strengthening of the regulatory body (pharmacy & poison board) so that it could impose stiffer penalties, and employ more inspectors.
v. Training required in accountability
vi. Make an all inclusive pubic inspectorate team with participation drawn from public and private sectors.
vii. Also inclusion of drug manufactures in policy making process at the Ministry
viii. Reforms are required to re-structure the government owned Kenya Medical Supplies Agency (KEMSA) so they are to keep up with latest use of management disease areas e.g. asthma, managed by steroids.

Possible priority issue
Policy issue 5: Pharmacy & Poison Board:- Revise the functions of the board to be in line with other policy documents and current realities.
Significance – minimize wastage of drugs, acquisition of unnecessary substandard drugs

5.1.5. Public Health Act Review

The current Public Health Act is outdated and requires revision. There is urgent need to at the entire legal framework sure it supports the NHSSP and Vision 2030 strategies. The revision of the Public Health Act should among other things define collaborations and partnership and the extent or nature of potential partnership (contractual arrangements).

Possible priority issue
Policy issue 6: Revision of the Public Health Act to conform to the dynamic changes that have taken place in the health system and the country at large. It should also define collaboration and partnership with the stakeholders in both public and private sector. The Central Board of Health should be constituted and operationalized as stated in the Public Health Act.
Significance – This is very important in order for it to be more inclusive.

5.1.6. Other management issues including domestication of technology
Decentralization is required especially in procurement and supplies management as well salaries preparation for non-care staff which currently is the domain of headquarters.

Need to set up a more responsive public data exchange where vital data could easily be exchanged especially with the private sector which requires more data to inform decision making processes in service delivery / community participation.

Guidelines on disaster preparedness are limited. Consequently, stakeholder participation and responses is limited and not clearly defined.

Possible priority issue
Policy issue 7: Resource procurement and supplies, sourcing and allocation and the need for a sound regulatory framework.

Significance - Just like schools and other institutions of higher learning, the Ministry of Health should let go the running of district hospitals and below. However, they should not comprise on the standards.

CHAPTER 6

Discussion

The process has taken longer than planned because

   a. Formation of country team (required meetings and discussions)
   b. Broadening of the mandate
   c. Delay in release of funds (received in May)
   d. Government restructuring in Kenya (more time for officers to settle into new positions before ready for interviews)
   e. Slow response from the organizations contacted
   f. Interview appointments set at the convenience of the person/ institution to be interviewed
   g. Lack of clear pre-existing catalogue of existing policy documents (longer time to search for document)
   h. Group dynamics, logistics and coordination of country team operations

Despite the challenges encountered, the decision to use country team as opposed to a consultant has had very clear advantages especially:
   a. The social capital generated from the various institutions that for the first time have felt useful for being contacted to participate in priority identification for policy setting
   b. The ownership of the process by the Country Node and the team that received training in June 2007
   c. The necessary momentum generated for the upcoming events
   d. The funding available is unlikely to have been acceptable to a consultant of the magnitude required for the task

Challenges

   1. The teething problems of a REACH-PI country Node still under development
   2. Apparently new concept to many policy makers
   3. The self-assessment tool is too heavy (many felt intimidated by the tool)

Lessons learnt

   1. Many non-governmental and some governmental institutions had never had a chance to discuss matters of policy despite being key players in the health sector
   2. The Country Node requires core staff and resources to carry out such preparatory activities as the priority setting exercise

Conclusion

The findings from the desktop review of documents and in-depth interviews with institutions and organizations as well as key individuals identify the priority research questions requiring research evidence as:-

5. What is/are the optimal mechanisms for health care financing that achieve access and equity for the population especially the poor and disadvantaged?
6. What is the optimal strategy to achieving appropriate Human Resource for Health especially to ensure equitable distribution of health workers to rural and urban areas based on needs?
7. What is the optimal model for delinking the government (Ministry of Health) from direct provision of healthcare and concentrating on policy formulation, stewardship and regulatory functions without compromising equity and access to healthcare?
8. What is the optimal approach for achieving a Shift from focus on curative services to preventive services?

Recommendations
1. There is need to establish a multi-disciplinary permanent dedicated effective framework linking research agenda, research funding, translation of research findings into policy while ensuring development of policy documents is carried out simultaneously with development of the strategy and operational documents including a well defined monitoring and evaluation framework. Without such a mechanism answering the research questions may not necessarily achieve the overall desired effects at population level
2. There is need to mainstream operational research such as targeted evaluations into routine medical and public health activities to continuously provide information on what works and what does not work
3. There is need to train and raise awareness among all stakeholders on linking policy, planning and budget as elaborated in the Medium-Term Expenditure Framework (MTEF) and other mechanisms for ensuring results based management.

4. References

Baltussen R and Louis Niessen. Priority setting of health interventions: the need for multi-criteria decision analysis. *Cost Effectiveness and Resource Allocation 2006, 4:14 doi:10.1186/1478-7547-4-14*

Brownson RC, Royer C, Ewing R, McBride TD: Researchers and policymakers travelers in parallel universes. *Am J Prev Med 2006, 30:164-172.*

Choi BC, Pang T, Lin V, Puska P, Sherman G, Goddard M, Ackland MJ, Sainsbury P, Stachenko S, Morrison H, Clottey C: Can scientists and policy makers work together? *J Epidemiol Community Health 2005, 59:632-637.*

Claridge JA, Fabian TC: History and development of evidence based medicine. *World J Surg 2005, 29(5):547-53*

Daniels N. Accountability for reasonableness. *British Medical Journal 2000; 321:1300-1301*

 Daniels N. Four Unsolved Rationing Problems: A Challenge. *Hastings Center Report 1994; 24:27-9*

Ham, Coulter. Global Challenges of Health Care Rationing. (*London, UK: Open University Press) 2000.*

Hanney SR, Gonzalez Block MA: Building health research systems to achieve better health. *Health Res Policy Syst 2006, 4:10.*

Hanney S, Gonzalez-Block M, Buxton M., Kogan M. (2003) The utilization of health research in policy-making: concepts, examples and methods of assessment. *Health Research Policy and Systems.* 1:1. Available electronically at http://www.health-policy-systems.com/content/1/1/2

Lavis JN, Lomas J, Hamid M, Sewankambo NK: Assessing country level efforts to link research to action. *Bull World Health Organ 2006, 84:620-628.*

Lavis, JN. Research, Public Policymaking, and Knowledge-Translation Processes: Canadian Efforts to Build Bridges.*The Journal of Continuing Education in the Health Professions*, Volume 26, pp. 37–45. 2006

Makundi E, Mubyazi G, Hiza P, Mcharo, Senkoro K. Mwisongo A, Kisinza W, Malebo H, Magesa S, Mushi A and Kitua A: Participatory approach in evaluating   the performance of thirty seven district councils of phase-1 in implementing health sector reforms in mainland Tanzania. Page 79.

Moi Daniel. Kenya African Nationalism; nyayo philosophy and principles. 1986. *MacMillian Publishers. 2nd Edition. Pages 60 – 69.*

Niessen LW, Gijssels EW, Rutten FF: The evidence-based approach in health policy and health interventions delivery. *Soc Sci Med 2000, 51(6):859-69.*

Nuyens Y, Lansang MA: Knowledge translation: linking the past to the future. *Bull World Health Organ 2006, 84:590.*

Phil Davies Is evidence-based government possible? Jerry Lee Lecture, *4th Annual Campbell Colloquium, Washington DC 2004)*

Ryan T. C. I. 2001. Research and Policy and Problems in Kenya. A paper presented at the annual *SAIS John Hopkins University, Conference on Africa, Washington D. C.*

Sauerborn R, Nitayarumphong S, Gerhardus A (1999). Strategies to enhance the use of health systems research for health sector reform. *Tropical Medicine and International Health. 4(12) 827-35*

Summerskill W: Cochrane Collaboration and the evolution of evidence. *Lancet 366(9499):1760. 2005 Nov 19*

Trostle J, Bronfman M., Langer A. (1999). How do researchers influence decision-makers? Case studies of Mexican policies. *Health policy and Planning. 14(2), 103-114*

Webster's New Collegiate Dictionary. 1975. G&C. Meriam Co., Springfield, MA. U.S.A.

Woodward B, Armstrong S. The Brethren: Inside the Supreme Court. Simon and Shuster. *New York, NY. 1979.)*

Jill Eden, Ben Wheatley, Barbara McNeil, and Harold Sox, Editors, Committee on Reviewing Evidence to Identify Highly Effective Clinical Services. ISBN: 0-309-11357-1, 280 pages, 6 x 9, (2008). Knowing What Works in Health Care: A Roadmap for the Nation

World Health organization, 2007. Draft global strategy and plan of action on public health, innovation and intellectual property: Priority-setting models for research and development

Investing in health research and development: report of the Ad Hoc Committee on Health Research Relating to Future Intervention Options (document TDR/Gen/96.1).

ANNEX 1: In-Depth Interview Guide

EVIDENCE-INFORMED POLICY MAKING: HEALTH POLICY AND SYSTEMS ISSUES

Setting REACH-Policy Initiative Priorities for 2008-2010

Background

*The WHO-Alliance for Health Policy and Systems Research (WHO-AHPSR) and Regional East African Community Health-Policy Initiative (REACH-PI) are committed to support national processes for evidence-informed policy making through facilitating the use of research evidence in the policy making process. Thus WHO-AHPSR and REACH-PI will play complementary roles in strengthening evidence based policy and decision making in the health sector. **The focus of this collaboration between the organizations is on priority policy concerns in health systems issues of health care financing, human resources for health and non-state** sector in the medium term**. As part of its strategy to support evidence-informed policy making at the country level, the Alliance HPSR has provided support to the REACH-Policy Initiative country node as part of the preparatory work necessary for further technical and financial assistance towards promoting evidence-informed health policy making. Kenya country node is based at KEMRI. KEMRI and her counterparts in partner states have been mandated to conduct this exercise.*

In-Depth Interview Guide

1. Personal Identifier:_____   Date_____
   Place_____

   a. National level policy maker
   b. Sub-national level policy maker
   c. Development partner
   d. Implementing partner
   e. Other (*specify*)_____

Introduction
The purpose of this interview is to obtain information about the ongoing and/or planned reforms/changes in the health sector of your country. Learn more about the policy-making process for the current/upcoming reforms and if and when the research evidence is helpful and/or contributing to this process. We intend to limit ourselves to certain general questions.

2. Could you please briefly describe challenges that health sector in Kenya faces?

(*Probe questions about: pressing health problems of the population, lack and/or problems in health care financing, in organization and delivery of personal or public health services, problems about health care provider network including human resources, governance and management issues in the health sector*, etc.)

3. Could you describe current or planned reform efforts in the health sector in Kenya? (*Probe for reforms in the area of health care financing, provider network, human resources for health, management capacity, the role of private sector in financing or service provision, stewardship/governance*, etc.)

4. Currently what are the three most important policy issues your organization / institution is dealing with in the health sector?
(*Probe for what/who informs, evidence informed / based etc*)

   a. _____

   b. _____

   c. _____

5. Can you please describe the process through which the policy development takes place in Kenya? (It will be easier to pick the very last policy making process and use it as an example and *probe for: who raises the need for policy change/need and where and how the policy options are formulated/discussed, who contributes to this process, what is the role of the state and non-state players, research community, advocacy groups, where and by whom the final decisions are made*).

6. In your opinion do you think that policies developed in your organization / institutions are largely evidence informed/based? If Yes, could you describe the process through which evidence is acquired, assessed, adopted/adapted and applied? (*Probe when policy issue is identified who decides to seek for evidence, who acquires the research and prepares policy brief or other relevant document, how systematic or non-systematic is this practice, how do other institutions access them etc.*)

7. In general who are the critical players/contributors to the health policy making in Kenya? (*Probe for government agencies, research organizations and private sector and civil society organizations active in policy making, what/who informs, evidence informed / based etc*)

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

   f. _____

g. _____
h. _____
i. _____
j. _____
k. _____
l. _____

8. Could you provide information about the development partners/donors that are significant contributors to the health sector reforms in Kenya? (*Probe for their names, what they contribute, how they contribute, who/what informs them, evidence informed/based, who decides for their contributions, what are the procedures for their contributions, etc?*)
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____

9. Presently, how many policy statements/documents exist and are in use in the health sector or indirectly affect health sector in Kenya? *(probe for each document type)*
   a. Policy documents_____
   b. Strategy documents_____
   c. Operational plan documents_____
   d. Clinical guidelines_____
   e. Administrative guidelines_____
   f. Circulars_____
   g. Others *(specify)*_____

10. What is the specific role you play (have played) in the Health sector policy formulation in Kenya? (*probe for an example of a specific policy where yourself, your organization/office or Ministry participated or contributed, past, present roles*)
    a. Responsibilities_____
    b. Authority_____
    c. Other (specify)_____

Thank you. Feel free to get in touch with REACH-PI office at KEMRI Headquarters, Nairobi. with further information or clarification. Email: director@kemri.org; reachpi-kenya@kemri.org

ANNEX2. A SELF-ASSESSMENT TOOL - 1

EVIDENCE-INFORMED POLICY MAKING: HEALTH POLICY AND SYSTEMS ISSUES

Setting REACH-Policy Initiative Priorities for 2008-2010

Background

*The WHO-Alliance for Health Policy and Systems Research (WHO-AHPSR) and Regional East African Community Health-Policy Initiative (REACH-PI) are committed to support national processes for evidence-informed policy making through facilitating the use of research evidence in the policy making process. Thus WHO-AHPSR and REACH-PI will play complementary roles in strengthening evidence based policy and decision making in the health sector. **The focus of this collaboration between the organizations is on priority policy concerns in health systems issues of health care financing, human resources for health and non-state** sector in the **medium term**. As part of its strategy to support evidence-informed policy making at the country level, the Alliance HPSR has provided support to the REACH-Policy Initiative country node as part of the preparatory work necessary for further technical and financial assistance towards promoting evidence-informed health policy making. Kenya country node is based at KEMRI. KEMRI and her counterparts in partner states have been mandated to conduct this exercise.*

You are kindly requested to fill in this self-assessment questionnaire and hand deliver or mail back to Director KEMRI, P.O Box 54840-00200 Nairobi, Attention REACH-PI, or email director@kemri.org

A SELF-ASSESSMENT TOOL - 1

FOR HEALTH SERVICES AND HEALTH POLICY ORGANIZATIONS

The Questions and Ratings
Use the following rating system to record your answers to the following questions. There are five ratings from which to choose for the current situation in your organization.

Rating

1	2	3	4	5
Don't do	**Do poorly**	**Do inconsistently**	**Do with some consistency**	**Do well**
Don't do it at all.	*Do it - but poorly.*	*Do it - but not very well and not consistently*	*Do it quite well but with room for improvement.*	*Confident in your ability to do it well.*

PART ONE: ACQUIRE Are we able to acquire research?

	Rating
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well	

		Rating				
1. We have **skilled staff** to undertake research	1	2	3	4	5
2. Our staff has **enough time** for research	1	2	3	4	5
3. Our staff has **the incentive** to do research (it is used in our decision-making)	1	2	3	4	5
4. Our staff has **the resources** to do research	1	2	3	4	5
5. We have **arrangements with external (to organization) experts** who search for research, monitor research, or do research for us	1	2	3	4	5

Are we doing research in the right places?

	Rating
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well	

	Rating				

6. We look for research in **journals** (for example, by subscription, Internet, or library access). Examples are *Please list the sources:*
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____
    f. _____
    g. _____
	1	2	3	4	5

7. We look for research in **non-journal reports (grey literature)** by library or Internet access, direct mailing from organizations such as ministries of health, the *Please list the sources:*
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____
    f. _____
    g. _____
	1	2	3	4	5

8. We look for research in **databases** by subscription or Internet access such as the *Please list the sources:*
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____
    f. _____
    g. _____
	1	2	3	4	5

9. We look for information on **web site**s (those that collate and/or evaluate sources) such as *Please list the sources:*
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____
    f. _____
    g. _____
	1	2	3	4	5

10. We work with **researchers** through formal and informal networking meetings with our staff.	1	2	3	4	5
11. We **get involved with researchers** as a host, decision-maker partner, or sponsor.	1	2	3	4	5

	Rating
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well	

12. We **learn from peers** through informal and formal networks to exchange ideas, experiences, and best practices	1	2	3	4	5

PART TWO: ASSESS Can we tell if the research is reliable and of high quality?

	Rating
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well	

13. Staff in our organization has **critical appraisal skills and tools** for evaluating the **quality** of methodology used in research.	1	2	3	4	5
14. Staff in our organization has the **critical appraisal skills** to evaluate the **reliability** of specific research by identifying related evidence and comparing methods and results.	1	2	3	4	5
15. Our organization has **arrangements with external experts** who use **critical appraisal skills and tools** to assess methodology and evidence reliability, and to compare methods and results.	1	2	3	4	5

Can we tell if the research is relevant and applicable?

	Rating
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well	

16. Our staff can **relate our research to our organization** and point out similarities and differences.	1	2	3	4	5
17. Our organization has **arrangements with external experts** to **identify the relevant similarities and differences between** what we do and what the research says.	1	2	3	4	5

PART THREE: ADAPT Can we summarize results in a user-friendly way?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
18. Our organization has enough skilled staff with time, incentives, and resources **that use research communications skills to present research results concisely and in accessible language.**	1	2	3	4	5
19. Our organization has enough skilled staff with time, incentive, and resources **that use research communications skills to synthesize in one document all relevant research, along with information** and analyses from other sources.	1	2	3	4	5
20. Our organization has enough skilled staff with time, incentive, and resources **who use research communications skills to link research results to key issues facing our decision makers.**	1	2	3	4	5
21. Our organization has enough skilled staff with time, incentive, and resources **who use research communications skills to provide recommended actions to our decision makers.**	1	2	3	4	5
22. Our organization has arrangements with **external experts** who use research communications skills to **present research results concisely and in accessible language.**	1	2	3	4	5
23. Our organization has arrangements with **external experts** who use research communications skills to **synthesize in one document all relevant research, along with information and analyses from other sources.**	1	2	3	4	5
24. Our organization has arrangements with **external experts** who use research communications skills to **link research results to key issues facing our decision makers.**	1	2	3	4	5
25. Our organization has arrangements with **external experts** who use research communications skills to **provide recommended actions to our decision makers.**	1	2	3	4	5

PART FOUR: APPLY

4.1 Do we lead by example and show how we value research use?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
26. Using **research is a priority in our organization.**	1	2	3	4	5
27. Our organization has committed **resources** to ensure **research is accessed, adapted, and applied in making decisions.**	1	2	3	4	5
28. Our organization ensures **staff** is **involved in discussions on how research evidence relates** to our main goals.	1	2	3	4	5

29. The **management** of our organization has clearly **communicated our strategy and priorities** so those creating or monitoring research know what is needed to support our goals.	1	2	3	4	5
30. |We **communicate internally** in a way that ensures there is information exchanged across the entire organization.	1	2	3	4	5
31. Our corporate culture **values and rewards flexibility, change, and continuous quality improvement with resources to support these values.**	1	2	3	4	5

Do our decision-making processes have a place for research?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
32. When we make major decisions, we usually allow **enough time** to identify researchable questions and create/obtain, analyze, and consider research results and other evidence.	1	2	3	4	5
33. Our management team has **enough expertise** to evaluate the feasibility of each option, including potential impact across the organization and on clients, partners, and other stakeholders.	1	2	3	4	5
34. Decision makers in our organization usually give **formal consideration to any recommendations** from staff who have developed or identified high-quality and relevant research.	1	2	3	4	5
35. Staff and appropriate stakeholders know **when and how major decisions will be made.**	1	2	3	4	5
36. Staff and appropriate stakeholders **know how and when they can contribute evidence and how that information will be used.**	1	2	3	4	5
37. Staff who has provided evidence and analysis usually **participate in decision-making discussions.**	1	2	3	4	5
38. Relevant **on-staff researchers are part of decision-making discussions.**	1	2	3	4	5
39. Staff and appropriate stakeholders receive **feedback** on decisions with a rationale for the decision.	1	2	3	4	5
40. Staff and appropriate stakeholders are **informed of how available evidence influenced the choices** that were made in our organization.	1	2	3	4	5

Our Results: A Discussion Guide

Based on the self-assessment, our organization should discuss the following aspects of using research to make informed decisions that help meet our goals and objectives:

41. Establish research as a priority in our organization
We feel research in our organization should have (circle one):

a. Higher priority
b. Same priority
c. Lower priority

42. Integrate the use of research into the work of people in our organization
We feel we need to (circle one):

a. Integrate research (we do not do this right now)
b. Integrate research more often
c. Improve the quality of our integration of research

43. Encourage the use of research by our decision makers

*We feel our decision makers (**circle one**):*

a. Do not use research
b. Use research sometimes
c. Use research enough

44. Increase our capacity for research

We need (if you have more than one answer, please rate your needs from 1 to 5, with 1 being the highest priority):

	Highest priority				Lowest Priority
Skilled staff	1	2	3	4	5
Resources	1	2	3	4	5
Time	1	2	3	4	5
Incentives	1	2	3	4	5
Arrangements with external experts	1	2	3	4	5

45. Acquisition of research

*We need more access to (if you have more than one answer, please rate your needs from 1 to 6, with 1 being the highest priority)***:**

	Highest priority				Lowest Priority
Journals	1	2	3	4	5
Non-journal reports (grey literature)	1	2	3	4	5
Databases	1	2	3	4	5
Web sites	1	2	3	4	5
Working with researchers	1	2	3	4	5
Learning from peers	1	2	3	4	5

46. Assessment of research

We need to (circle the one which is most appropriate or best describes your situation):
   a.   Assess and adapt research
   b.   More frequently assess and adapt research
   c.   Improve the quality of our assessment

47. Development of research summaries

We need to (circle the one which is most appropriate or best describes your situation):
   a.   Develop expertise in research summaries
   b.   Increase expertise in research summaries
   c.   Improve expertise

48. Linking research results to key issues facing our decision makers

Our decision makers need to (circle the one most appropriate or which best describes your situation):
   a.   Consider research in making decisions
   b.   Consider research somewhat more often in making decisions
   c.   Improve the quality of linking research results to key issues facing our decision makers

A SELF-ASSESSMENT TOOL - 2

FOR RESEARCH AND ADVOCACY ORGANIZATIONS

The purpose of this self-assessment tool is to help <u>research and advocacy</u> organizations evaluate their capacity to identify policy challenges/issues in the country and timely use research evidence to inform policies. There are no right or wrong answers in the self-assessment. Ideally, such organizations need to be able to:

1. **Identify policy issues:** can your organization find out what are most pressing policy issues that concern the policy makers?
2. **Acquire research:** can your organization find and obtain the research findings that are relevant to policy concerns?
3. **Assess research:** can your organization assess research findings to ensure they are reliable, relevant, and applicable to the policy issues identified?
4. **Adapt its format:** can your organization present the research to decision makers in a useful way?
5. **Communicate research evidence to policy/decision maker:** are there skills, structures, processes, and the culture in your organization to promote and facilitate use of research findings in a policy making process?

<u>Since this is an assessment, there are no right or wrong answers.</u>

The Questions and Ratings
Use the following rating system to record your answers to the following questions. There are five ratings from which to choose for the current situation in your organization.

Rating

1	2	3	4	5
Don't do	**Do poorly**	**Do inconsistently**	**Do with some consistency**	**Do well**
Don't do it at all.	*Do it - but poorly.*	*Do it - but not very well and not consistently*	*Do it quite well but with room for improvement.*	*Confident in your ability to do it well.*

PART ONE: ACQUIRE Are we able to acquire research?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
1. We have **skilled staff** to undertake research	1	2	3	4	5
2. Our staff has **enough time** for research	1	2	3	4	5
3. Our staff has **the incentive** to do research (it is used in our decision-making)	1	2	3	4	5
4. Our staff has **the resources** to do research	1	2	3	4	5

Are we doing research in the right places?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
5. We work with **policy makers** through formal and informal networking meetings with our staff to **identify pressing policy issues**.	1	2	3	4	5
6. We **learn from peers** through informal and formal networks about pressing policy challenges	1	2	3	4	5
7. **We set research agenda of our organization around critical policy issues**/challenges faced by policy makers in our country	1	2	3	4	5
8. We look for policy relevant research evidence in **journals** (for example, by subscription, Internet, or library access). Examples are *Please list the sources*: a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ g. _____	1	2	3	4	5
9. We look for policy relevant research evidence in **non-journal reports (grey literature)** by library or Internet access, direct mailing from organizations such as ministries of health, the *Please list the sources*: h. _____ i. _____ j. _____ k. _____ l. _____ m. _____ n. _____	1	2	3	4	5

	Rating
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well	

	Rating				
10. We look for policy relevant research evidence in **databases** by subscription or Internet access such as the *Please list the sources:* o. _____ p. _____ q. _____ r. _____ s. _____ t. _____ u. _____	1	2	3	4	5
11. We look for information on **web site**s (those that collate and/or evaluate sources) such as *Please list the sources:* v. _____ w. _____ x. _____ y. _____ z. _____ aa. _____ bb. _____	1	2	3	4	5

PART TWO: ASSESS Can we tell if the research is reliable and of high quality?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
12. Staff in our organization has **critical appraisal skills and tools** for evaluating the **quality** of methodology used in research.	1	2	3	4	5
13. Staff in our organization has the **critical appraisal skills** to evaluate the **reliability** of specific research by identifying related evidence and comparing methods and results.	1	2	3	4	5

Can we tell if the research is relevant and applicable?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
14. Our staff can **relate our research to known policy challenges** and point out its relevance.	1	2	3	4	5
15. Our organization has **arrangements (formal and informal) with policy makers** to **identify the relevance of** what we do and what they need.	1	2	3	4	5
16. Our staff can plan and carry out research so that **research evidence is timely supplied and informs policy making process**	1	2	3	4	5

PART THREE: ADAPT Can we summarize results in a user-friendly way?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
17. Our organization has enough skilled staff with time, incentives, and resources **that use research communications skills to present research results concisely and in accessible language.**	1	2	3	4	5
18. Our organization has enough skilled staff with time, incentive, and resources **that use research communications skills to synthesize in one document all relevant research, along with information** and analyses from other sources.	1	2	3	4	5
19. Our organization has enough skilled staff with time, incentive, and resources **who use research communications skills to link research results to key issues facing our decision makers.**	1	2	3	4	5
20. Our organization has enough skilled staff with time, incentive, and resources **who use research communications skills to provide recommended actions to our decision makers.**	1	2	3	4	5
21. Our organization has arrangements with **external experts** who use research communications skills to **present research results concisely and in accessible language.**	1	2	3	4	5
22. Our organization has arrangements with **external experts** who use research communications skills to **link research results to key issues facing our decision makers.**	1	2	3	4	5
23. Our organization has arrangements with **external experts** who use research communications skills to **provide recommended actions to our decision makers.**	1	2	3	4	5

PART FOUR: APPLY

4.1 Do we lead by example and show how we value research use?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
24. Using **research evidence and linking with policy development is a priority in our organization.**	1	2	3	4	5
25. Our organization has committed **resources** to ensure **research is accessed, adapted, communicated and applied in decision making.**	1	2	3	4	5
26. Our organization ensures **staff** is **involved in discussions on how research evidence relates** to policy issues.	1	2	3	4	5
27. |We **communicate internally** in a way that ensures there is information exchanged across the entire organization.	1	2	3	4	5
28. The **management** of our organization has clearly **communicated our strategy and priorities** so those developing policies know what they can expect from our organization.	1	2	3	4	5

29. Our corporate culture **values and rewards flexibility, change, and continuous quality improvement with resources to support these values.**	1	2	3	4	5

Does decision-making process in our country have a place for research?

	Rating				
1=Don't do 2=Do poorly 3=Do inconsistently 4=Do with some consistency 5=Do well					
30. When policy makers make major decisions, they usually allow **enough time** to identify researchable questions and consider research results and other evidence.	1	2	3	4	5
31. Decision makers in our country usually give **formal consideration to any evidence** identified and recommended by our organization for policy making.	1	2	3	4	5
32. Our staff knows **when and how major decisions will be made.**	1	2	3	4	5
33. Our staff **knows how and when they can contribute evidence and how that information will be used.**	1	2	3	4	5
34. Staff, who has provided evidence and analysis usually **participated in decision-making discussions.**	1	2	3	4	5
35. Staff and appropriate stakeholders receive **feedback** on decisions with a rationale for the decision.	1	2	3	4	5
36. Staff and appropriate stakeholders are **informed of how available evidence influenced the choices** that were made by policy makers.	1	2	3	4	5

Our Results: A Discussion Guide

Based on the self-assessment, our organization should discuss the following aspects of using research to facilitate evidence-informed policy making in our country/region/district:

37. Establish closer linkages with policy making process
We feel establishing linkages with policy makers should have (circle one):

   a. Higher priority
   b. Same priority
   c. Lower priority

38. Enable our staff/organization to better communicate research evidence to policy makers
We feel we need to (circle one):

   a. Better communicate research-evidence to policy makers (we do not do this right now)
   d. Communicate research-evidence to policy makers more often
   e. Establish clear communication channels and processes to deliver research-evidence to policy makers

39. Encourage the use of research-evidence by our decision makers

*We feel our staff/organization (**circle one**):*

a. **Do not** encourage the use of research evidence by policy-makers
d. Encourage the use of research evidence by policy-makers **sometimes**
e. Encourage the use of research evidence by policy-makers **enough**

40. Increase our capacity for relevant research-evidence production
We need (if you have more than one answer, please rate your needs from 1 to 5, with 1 being the highest priority):

	Highest priority				Lowest Priority
Skilled staff	1	2	3	4	5
Resources	1	2	3	4	5
Time	1	2	3	4	5
Incentives	1	2	3	4	5
Arrangements with experts/networks	1	2	3	4	5
Arrangements/linkages with policy makers to be aware of current policy challenges/issues	1	2	3	4	5

41. Strengthen our links with policy makers and policy making process
We need (if you have more than one answer, please rate your needs from 1 to 5, with 1 being the highest priority):

	Highest priority				Lowest Priority
Closely monitor policy processes in the country	1	2	3	4	5
Establish close linkages with policy makers	1	2	3	4	5
Develop formal channels of communicating research evidence to policy makers/stakeholders	1	2	3	4	5
Improve the quality of linking research results to key issues facing our decision makers	1	2	3	4	5

42. Acquisition of research
*We need more access to (if you have more than one answer, please rate your needs from 1 to 6, with 1 being the highest priority)***:**

	Highest priority				Lowest Priority
Journals	1	2	3	4	5

Non-journal reports (grey literature)	1	2	3	4	5
Databases	1	2	3	4	5
Web sites	1	2	3	4	5
Working with researchers	1	2	3	4	5
Learning from peers	1	2	3	4	5

43. Assessment of research

We need to (circle the one which is most appropriate or best describes your situation):
   a. Assess and adapt research
   d. More frequently assess and adapt research
   e. Improve the quality of our assessment

44. Development of research summaries

We need to (circle the one which is most appropriate or best describes your situation):
   a. Develop expertise in research summaries
   d. Increase expertise in research summaries
   e. Improve expertise

45. Development skills/capacity to better communicate research evidence to policy makers/stakeholders

We need to (circle the one which is most appropriate or best describes your situation):
   b. **Develop expertise** communicating research evidence to policy makers/stakeholders
   f. **Increase expertise** communicating research evidence to policy makers/stakeholders
   g. **Improve expertise**

ANNEX 3: Country Implementing Team

The country implementation team is composed of the following

1.	Dr Monique K Wasunna	Director/CEO KEMRI
2.	Dr Peter Waiyaki	Deputy Director KEMRI (Research & Training)
3.	Dr David Mwaniki	Assistant Director KEMRI (M&E/REACH-PI Coordinator)
4.	Dr Judith Bwonya	Ministry of Health
5.	Dr Kizito Lubano	Ag. Assistant Director KEMRI (M&E/REACH-PI Coordinator)
6.	Dr Stephen Muleshe	Ministry of Health
7.	Dr Isabella Ayaga	Ministry of Health
8.	Dr Okello Agina	Kenyatta University
9.	Dr Okoth	Kenyatta University
10.	Dr David Ojakaa	AMREF
11.	Dr Christine Wasunna	Senior Research Officer KEMRI
12.	Mr Lawrence Muthami	Principal Research Officer KEMRI
13.	Mr James Kariuki	Research Officer KEMRI
14.	Mr Joseph Mutai	Senior Research officer KEMRI
15.	Dr Steve Gichuhi	Senior Lecturer UON

ANNEX 4: Proposed list of stakeholders

Level	Organization/Office	Functions	Office holders
Policy enactment	Ministers – the Cabinet		
	Parliamentary Health Working Committees		
Policy drivers/ decision makers	Permanent Secretaries MoH, Local Govt.		
	Directors/Director General of Medical Services		
	Directors of NHRIs		
	Director of Budget		
	Director of Planning		
	D/National HIV/AIDS Commission/Council		
	National Councils and Commissions: Research Sc &Tech; Environment and Health related agencies etc		
	Main bi- and multilateral Health Sector Agencies:		
	World Bank		
	JICA - ESARO		
	USAID - REDSO		
	DFID		
	DANIDA		
	SIDA		
	UN Agencies – WHO, UNAIDS, UNICEF – (ESARO, Country), WFP, UNDP		
Senior facilitators (formulation and analysis)/ decision makers	Deputy Directors/Commissioners		
	Principals or Deans of Medical Schools/ Directors of medical training institutions/		
	Director – Medical Supplies Agencies		
	Directors – Hospital Insurance Fund		
	Heads - Health Sector Reforms		
	Heads - Health Planning and Policy		
	Directors of other Govt and non-Govt research organizations		
	D/Veterinary services and Agricultural services		
	Faith based and non–Govt. .Service providers		
	Catholic Relief Services -		
	Christian Health Associations -		
	Muslim Health -		
	Private sector associations -		
Implementers - Policy guidelines drafters	Heads of Divisions		
	Provincial Heads		
	Lead NGO health service providers – AMREF,		
	CARE, World Vision		
	UN Agencies – WHO, UNAIDS, UNICEF , WFP, UNDP		
Receptors and implementers of guidelines (users)	Facility and service managers		
	NGOs, FBOs		
	HMOs (Acacia, AAR, CfC, Resolution Health)		
	General population (members of the Community)		

Annex 5: Kenya Health Sector Wide Approach Stakeholders

The first group in the public arena are:-
1. Ministry of Health
2. Ministry of Finance,
3. Ministry of Planning and National Development,
4. Office of the President (Public Sector Reform and Development Secretariat),
5. Ministry of Local Government (responsible for the City Council health services),
6. Ministry of Education and other relevant Ministries; (iii) the
7. Six Parastatal Organisations (State Corporations) under MOH that are governed by a Board of Management;
8. Regulatory Bodies (like Pharmacy and Poison Board, the Medical Practitioner and Dentist Board) and
9. Professional Associations.

The second group in the private arena stakeholders are:-
1. Private-for-profit organizations;
2. Private not-for-profit organizations (like Faith Based Organizations, Non Governmental Organizations and Civil Society Organizations)
3. Traditional Practitioners.

The third group of stakeholders is the:-
Development Partners (DP) that constitutes a heterogeneous group with a variety of technical and reporting requirements and funding modalities, and supporting a range of interventions.