

**WHO COUNTRY COOPERATION STRATEGY:  
REPUBLIC OF KENYA**

2002–2005



**WORLD HEALTH ORGANIZATION**  
Regional Office for Africa  
Brazzaville



## Contents

	Pages
Abbreviations.....	iv
<b>1. Introduction.....</b>	<b>1</b>
<b>2. Government and People: Health and Development Challenges.....</b>	<b>1-14</b>
2.1 Demographic trends.....	1
2.2 Socioeconomic situation.....	2
2.3 Governance.....	3
2.4 Health profile.....	3
2.5 Health system development.....	7
2.6 Issues of particular concern.....	11
<b>3. Development Assistance: Aid Flow, Instruments and Coordination.....</b>	<b>15-17</b>
3.1 Overall trend in aid.....	15
3.2 Moving towards the sectorwide approach.....	15
3.3 Mechanisms of support.....	15
3.4 Moving development agencies in health.....	15
3.5 Coordination and partnerships: doing it together.....	16
<b>4 WHO Current Country Programme.....</b>	<b>17-21</b>
4.1 WHO technical cooperation programmes.....	17
4.2 WHO budget distribution and trends.....	18
4.3 Human resources aspect.....	19
4.4 Coherence of activities with WHO core functions.....	20
4.5 Intercountry coordination and support.....	20
4.6 WHO regional and headquarters support.....	20
4.7 Opportunities and assumptions.....	21
4.8 Constraints and threats.....	21
<b>5. WHO Corporate Policy Framework: Global and Regional Directions.....</b>	<b>22-24</b>
5.1 Goal and mission.....	22
5.2 New emphases.....	22
5.3 Strategic directions.....	22
5.4 Core functions.....	23
5.5 Global and regional priorities.....	23

5.6	Making WHO more effective at country level .....	23
<b>6.</b>	<b>Strategic Agenda for Kenya 2002–2005.....</b>	<b>24-29</b>
6.1	Shifts in general directions .....	24
6.2	Health system development .....	25
6.3	Disease prevention and control.....	26
6.4	Reproductive health, child health and adolescent health.....	28
6.5	Health promotion .....	29
6.6	Environmental health and sustainable development.....	29
<b>7.</b>	<b>Implementations of the Strategic Agenda for WHO .....</b>	<b>30-32</b>
7.1	Implications for WHO country office.....	30
7.2	Support from the regional office and headquarters .....	31
<b>8.</b>	<b>Conclusion .....</b>	<b>32</b>
	Selected References .....	33

## Abbreviations

ADB	African Development Bank
AMREF	African Medical and Research Foundation
ARV	Antiretroviral
BPOA	Biennial Plan of Action
CBO	Community-based Organization
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CIDA	Canadian International Development Agency
CSR	Civil Service Reform Programme
DANIDA	Danish International Development Agency
DFID	Department for International Development
DOTS	Directly Observed Treatment Short course
EB	Extra Budgetary
EHA	Emergency and Humanitarian Action
EPI	Expanded Programme for Immunization
FGM	Female Genital Mutilation
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GNP	Gross National Product
GTZ	German Technical Cooperation
HIP	Health Information and Promotion
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICC	Interagency Coordination Committee
IDSR	Integrated Disease Surveillance and Response
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
JICA	Japan International Cooperation Agency
JICC	Joint Interagency Coordination Committee
KDHS	Kenya Demographic Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Agency
KHDR	Kenya Human Development Report
MDG	Millennium Development Goal
MOH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NCD	Noncommunicable Diseases
NDP	National Development Plan
NGO	Nongovernmental Organization
NHSSP	National Health Sector Strategic Plan
NLTP	National Leprosy and Tuberculosis Programme
NPO	National Professional Officer
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission

PRSP	Poverty Reduction Strategy Paper
RB	Regular Budget
SIDA	Swedish International Development Agency
UNAIDS	United Nations Programme on AIDS
UNDAF	United Nations Development Assistance Framework
UNDCP	United Nations Drugs Control Programme
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UON	University of Nairobi
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization



## 1. Introduction

The Kenya Country Cooperation Strategy (CCS) aims at focusing, in the medium term, the support of the entire Organization on the people of Kenya through the government, to attain urgent national health goals and aspirations. The CCS will run for four years (2002–2005).

Through the CCS, WHO will respond strategically to Kenya's health priority to address the needs of the population based on the comparative advantage of WHO, without losing sight of the complementary mandates of other agencies and partners in health. The CCS, by influencing the programme budget and plans of action, will focus on WHO efforts to contribute to the implementation of national health policies and strategies.

Within the framework of CCS, WHO will catalyse and harmonize the vast opportunities presented by various actors in the health sector. The CCS, therefore, provides a guiding framework for the action of the entire WHO Secretariat.

The preparation of CCS takes cognizance of the WHO reform agenda (Global Corporate Strategy, the African Region Strategic Framework 2002–2005), the United Nations Development Assistance Framework (UNDAF), the Common Country Assessment (CCA), Kenya National Health Sector Strategic Plan (NHSSP, 1999–2004), National Development Plan (NDP, 2002–2008) and the Poverty Reduction Strategy Paper (PRSP, 2001–2004). Most of these documents have been developed bearing in mind the millennium development goals. The CCS document captures views and sentiments expressed by major stakeholders and partners during the consultative process.

This document is a product of extensive discussions between the WHO team and partners, including the Ministry of Health, World Bank, World Food Programme (WFP), United Nations Children's Fund (UNICEF), Kenya Medical Research Institute (KEMRI), United Nations Development Programme (UNDP), Swedish International Development Agency (SIDA), Canadian International Development Agency (CIDA), United Nations Population Fund (UNFPA), Japanese International Development Agency (JICA), British Department for International Development (DFID), United States Agency for International Development (USAID) and the University of Nairobi (UON).

## 2. Government and People: Health and Development Challenges

### 2.1 Demographic trends

Kenya covers a land area of 582,646 sq km and is administratively divided into eight provinces and 70 districts. According to the 1999 population census,<sup>1</sup> the total population of Kenya is 28,687,607 with the following age group proportions: under five years, 15.8%; under 15 years, 44%; 15–64 years, 52%; and over 65 years, 4%. The proportion of women in the total population is 50.6%. Although the 1999 population figures showed an increase of 34% over the 1989<sup>2</sup> population census, there was a significant decline in the intercensal growth rate, as compared to the previous decade (from 3.4 in the period 1979–89, to 2.9 in the period 1989–99). Disparities in population growth rate per annum among provinces range from 1.7% in Central Province to 9.5% in North Eastern Province. The decline in population growth rate is associated with declining total fertility rate among women 15–49 years of age: 8.1 in 1977/78 and 4.7 in 1998.<sup>3</sup> Of the total population, 34% live in urban areas. The urban population has increased from 3.8 million in 1989 to 9.9 million in 1999 and is projected to grow to 16 million in 2005.<sup>4</sup> There are approximately 200,000 refugees in Kenya from Somalia, Ethiopia, Sudan and other

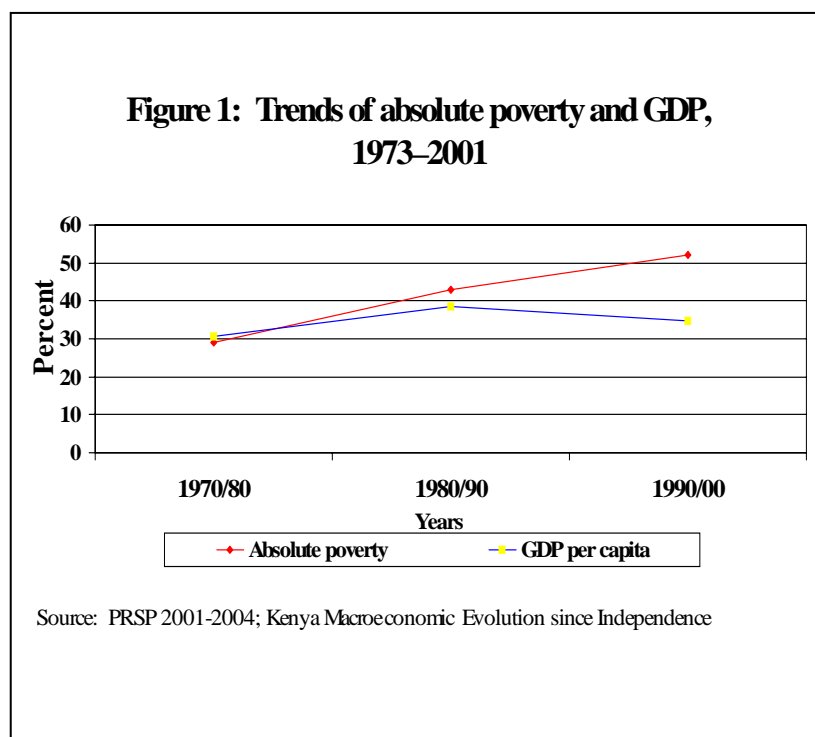
neighbouring countries.

## 2.2 Socioeconomic situation

The major economic generators are agriculture, industry, trade, communication and tourism. The per capita income in the year 2000 was US\$ 345, its growth rate having dropped from 4.6% in 1996 to the negative side (-0.3%) in 2001.<sup>5</sup>

The external debt as percentage of the gross national product (GNP) in 2000 was 42.1% while the domestic debt was 23.3%.<sup>5</sup> The inflation rate was 8.9% in 2000. Falling per capita income and its uneven distribution have led to a rise in poverty. The country's slow socioeconomic performance is attributed to poor implementation of macroeconomic policies, over-reliance on external funding, slow rate of structural reforms and deteriorating infrastructures, among others.<sup>5</sup>

The Human Development Index for 2001 was 0.539, ranging from 0.413 in North Eastern Province to 0.783 in Nairobi.<sup>6</sup> According to the UN Common Country Assessment,<sup>7</sup> the gross enrolment rate in 1999 for primary schools was as high as 81.9%. The adult literacy rate was 70.9%. As shown in Figure 1, there has been a rising incidence of absolute poverty in Kenya over the years. This progressed as per capita income declined. In 1997, the overall national incidence of poverty was estimated at 52%.<sup>8</sup> Qualitative surveys have shown that poverty manifests as hunger, malnutrition, illiteracy, lack of shelter and failure to access essential social services such as basic education, health, water and sanitation. Poverty has also been seen to signify lack or deficiency of social, economic, cultural and human rights.<sup>8</sup>



## 2.3 Governance

In 1992, the most important event that took place was the restoration of multiparty democracy. Kenya has a parliamentary form of government with over forty registered political parties. It holds regular parliamentary and civil elections. A related transformation that is gradually taking root is the increased awareness of human rights. The government has licensed a number of private television, radio and print media.

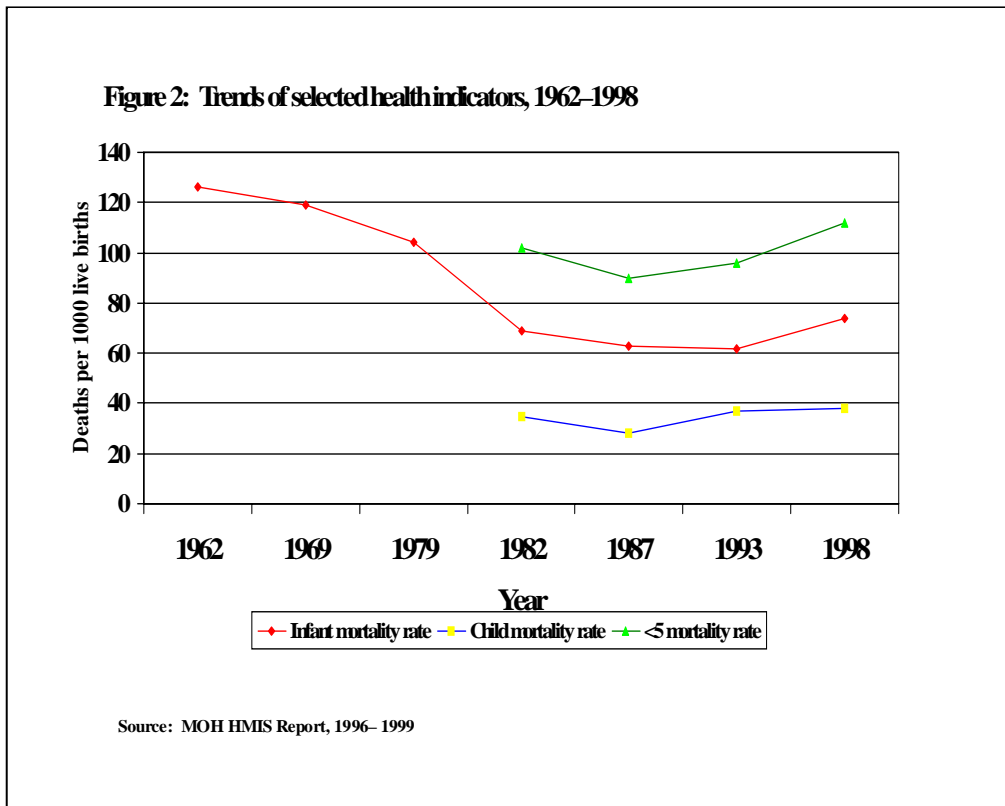
One of the most noteworthy aspects of governance has been slow but steady increase in the participation of women in the various national bodies. In 1999, women held 4.1% of parliamentary seats, 13.3% posts of permanent secretaries and 15.1% deputy secretary posts. Among ambassadors and provincial commissioners, women held 6% and 12.5% of the posts, respectively.<sup>9</sup> Despite these efforts, certain policies, cultural roles and traditional practices have continued to undermine women's progress. Although women account for 50.6% of the population of Kenya, disparities in access to income, resources and influence over decisions among poor women affect their access to basic social services.

Kenya has ratified most international conventions and passed the Children's Act. Recent reports indicate that out of over eight million children of school age, only five million currently attend school. The remaining children are at home or in the streets and are susceptible to problems such as sexual exploitation, early pregnancies, drug abuse or child labour.<sup>10</sup>

Kenya's challenge for economic and political governance revolves around allocation of resources, transparency and accountability, economic efficiency, creation of employment opportunities and the promotion of human rights. The government has established an Anti-Corruption Unit in the Ministry of Finance and Planning to address this issue.

## **2.4 Health profile**

Figure 2 shows that Kenya has recorded two phases in its health development. There was the phase of improvement (1960–1992) during which the goal of government was the provision of free health care for all, especially infants, children and mothers.



During the phase of improvement,<sup>4</sup>

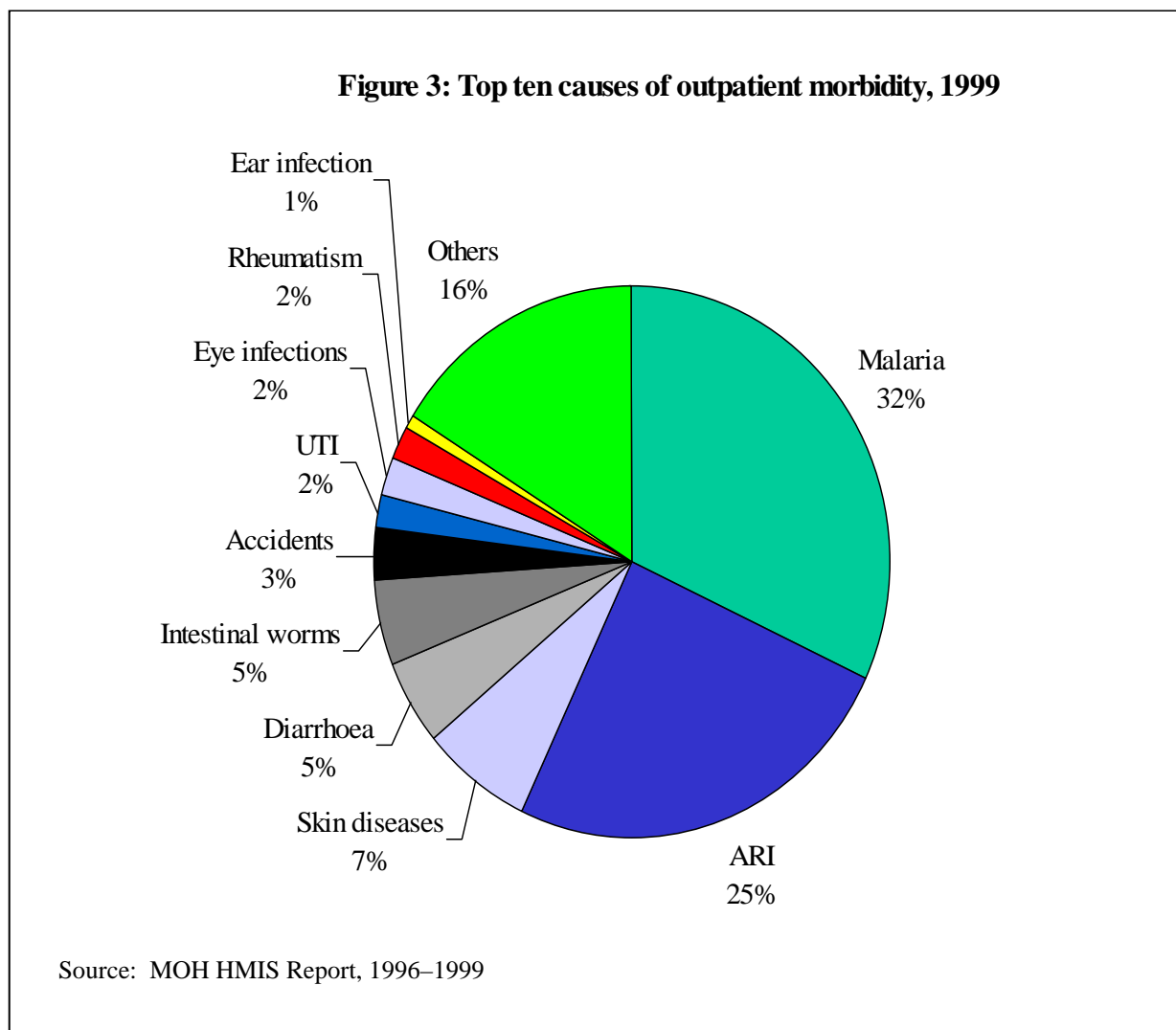
- (a) life expectancy at birth improved from 44 years in 1962 to 60 years in 1993;
- (b) fertility rate among childbearing age women (15–49 years) declined from 8.1 in 1975/77 to 4.7 in 1994/98;
- (c) infant mortality rate declined from 120 per 1,000 live birth in 1963 to 64 per 1,000 live births in 1993.

The phase of degeneration (1993–2000)<sup>4</sup> was characterized by:

- (a) declining life expectancy at birth from 60 years in 1993 to 47 years in the year 2000;
- (b) rising infant mortality rate from 64 per 1,000 live births in 1993, 72 in 1998 to 74 per 1,000 live births in 2000;
- (c) rising under five mortality rate from 90.9 per 1,000 live births in 1993 to 105.2 per 1,000 live births in 1998;
- (d) high maternal mortality rate of 590 per 100,000 in 1998;
- (e) rising population estimated at 30.4 million in 2001 and projected as 35 million in 2008 with an annual growth rate of 2.4%; this population is largely young and dependent (44% is aged 0–15 years and 1% is aged above 65%).

### 2.4.1 Top ten diseases

As shown in Figure 3, the leading causes of morbidity and mortality are related to communicable diseases like malaria, acute respiratory infections and diarrhoea.<sup>11</sup>



### 2.4.2 Reproductive and child health

Despite recent gains such as the decline in fertility and increase in contraceptive prevalence rate, reproductive health eludes many Kenyans. The high maternal mortality is essentially due to complications related to pregnancy and childbirth such as haemorrhage, sepsis, eclampsia, obstructed labour, unsafe abortion, anaemia.

The 1999 Kenya Service Provision Assessment<sup>12</sup> indicated that shortage of basic supplies, equipment and drugs limit the ability of health facilities to provide effective services, especially in handling obstetrics complications. The low attendance of delivery by skilled personnel aggravates the

situation. Only 42% of births were delivered in health facilities<sup>12</sup> as compared to 44% in 1993.<sup>13</sup> In addition, access to youth friendly services is limited. The reproductive rights of women and youth continue to be hindered by traditional harmful practices. Female genital mutilation (FGM) is a major hindrance to empowerment of women.

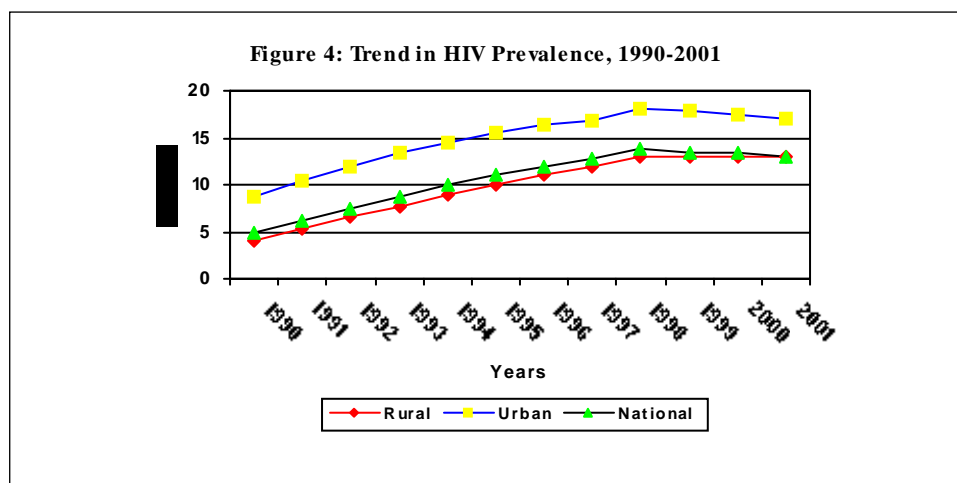
Although significant gains in child health were recorded earlier, these have not been sustained. Poor access to health services especially essential drugs and referral systems, are some of the contributing factors to the decline.

### 2.4.3 Communicable diseases

Significant progress has been made in the eradication of poliomyelitis, elimination of neonatal tetanus and control of measles. The targets for eradication of guinea worm disease and elimination of lymphatic filariasis and leprosy have been attained. Other parasitic diseases of epidemiological concern, such as schistosomiasis, helminthiasis, leishmaniasis, will need to be addressed. However, new emerging and re-emerging diseases continue to be threats.

Figure 3 shows the communicable diseases of major concern in Kenya.<sup>11</sup> Malaria has remained the leading cause of morbidity and mortality. It accounts for 30% of outpatient visits. About 19% of all cases require inpatient services. The disease causes 5% of the total deaths, with an estimated 26,000 children dying annually.<sup>14</sup> Acute respiratory infections are the second leading cause of morbidity, accounting for up to one quarter of outpatient attendance in health facilities. Diarrhoeal diseases are the third leading cause of morbidity as well as mortality, especially among children.

By the year 2000, over 2.2 million people in Kenya had been infected with HIV with a seroprevalence rate of 14%.<sup>15</sup> It is estimated that since the epidemic commenced in 1984, 1.5 million deaths have occurred, resulting in approximately one million orphans.<sup>16</sup> Recent data indicate possible stabilization and decline in national sero-prevalence (Figure 4).<sup>11</sup>



Tuberculosis is one of the diseases of poverty that has assumed epidemic proportions; 73,000 new cases were registered in 2001 as compared with 12,000 cases in the early 1990s. The directly observed treatment short-course (DOTS) has been adopted as a national strategy in Kenya, and the cure rate has been 68%. The coverage of resistance to multidrug therapy was insignificant.<sup>17</sup>

#### **2.4.4 *Noncommunicable diseases***

Malnutrition is common among the under-fives, with mild stunting being 37%, severe stunting 18%, mild wasting 6% and severe wasting 1.3%. It was estimated that 23,000 deaths among under-fives were associated with malnutrition in 2000.<sup>12</sup> Micronutrient deficiency is also a major problem. Up to 76% of children under five are anaemic or are deficient in vitamin A and zinc; 50% of women of childbearing age are also anaemic, and 40% are deficient in both vitamin A and zinc.<sup>18</sup> Other conditions contributing to the growing burden of these diseases include cardiovascular disorders, hypertension, diabetes, chronic respiratory infection, mental illness and health conditions related to tobacco use, drug abuse and injuries.

#### **2.4.5 *Environmental health***

The poor environmental sanitation conditions prevailing in most of Kenya's urban centres emanate from inadequate provision of safe disposal of excreta, solid and liquid wastes. This is reflected by a low sanitation coverage (46% in 1992 and 42% in 1996).<sup>19</sup> To counter unsatisfactory performance, the government has adopted a number of strategies (including PHAST) to improve environmental sanitation by changing behaviour and practices at the community level. However, despite their implementation, mortality and morbidity from sanitation related diseases continue to impact negatively on the general population. Access to safe drinking water has been on the decline, from 48% in 1992 to 45% in 1996. However, unpublished data indicate that by 2001 this had increased to 65%. The major drawbacks are poor water quality, rapid population growth and increasing pollution.<sup>20</sup> Food safety is also one of the major developmental concerns in Kenya.

### **2.5 *Health system development***

#### **2.5.1 *Health policies and systems***

The Kenya Health Policy Framework (1994)<sup>21</sup> sets out the agenda for health sector reforms. These include strengthening of the central public policy role of the Ministry of Health, adoption of an explicit strategy to reduce the burden of disease and defining cost effective curative and preventive services. To move from policy to action, the 1999–2004 National Health Sector Strategic Plan (NHSSP)<sup>22</sup> was launched; this emphasized decentralization of health authority through redistribution of services to rural areas. It is being revised to reflect the PRSP agenda.<sup>8</sup>

The players in the health system are government, NGOs and private sector. The public health sector is organized at three levels: national for policy formulation and dissemination, coordination, resource mobilization and allocation, monitoring and evaluation; provincial for supervision and monitoring; and district for policy implementation, data collection, analysis and reporting.

Communities are being mainstreamed into health stewardship by being incorporated into District Health Management Boards, health centre or dispensary committees and village management committees.

There are additional attempts by the government to forge partnerships with donors, private sector, professional associations dealing in health and NGOs in the development or refinement of health policy

and strategic direction. Effective coordination of donor and private provider networks is a current concern of the MOH.

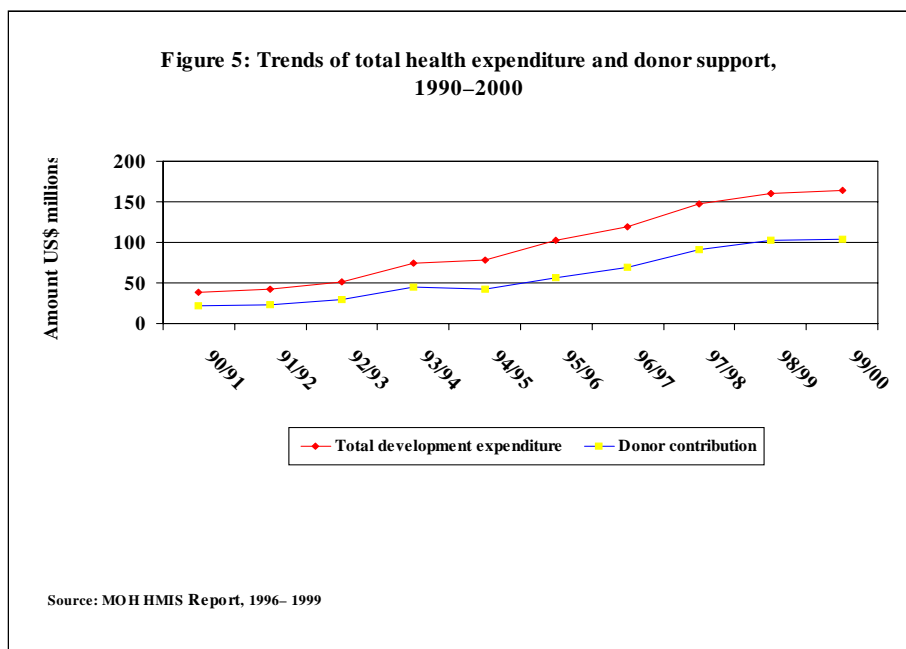
### 2.5.2 Health financing

The empirical total health expenditure, as shown in Figure 5, has been on an upward trend in the last 10 years. However, the per capita public expenditure on health has been on a downward trend. For instance, in 1988 per capita health expenditure stood at US\$ 8, and dropped in 1999 to US\$ 3.4. Kenyan health expenditures for 1998 are estimated at around 7.6% of budget.<sup>22</sup>

Equity in health expenditure is still a major issue, with only 30% going to the rural areas where 80% of the population live. Government allocation of resources is skewed towards the curative sector rather than to preventive and promotive interventions.<sup>5</sup> The contribution of public expenditure to the total health expenditure was 28% in 1998 of which the social security contribution represents around 13.6%, tax funded expenditure 59.9% and external sources 26.5%.<sup>8</sup>

Within the private funds that account for 72% of total health expenditure, the private insurance component represents 4.5% and out of pocket disbursement is around 74.3%,<sup>23</sup> representing approximately 50% of total health expenditure. Furthermore, there is no effective mechanism to assist the poor. About 40% of the recurrent and 90% of the development budget was dependent on donor financing.<sup>22</sup>

Cost sharing mechanisms were introduced in the mid-1990s and constitute around 5% of the non-wage recurrent budget of the Ministry. However, waiver and exemption schemes are not functioning satisfactorily, posing serious challenges to accessibility in an environment of growing poverty.



### 2.5.3 Health services: access and quality

Health service provision is delivered by 4,214 health facilities, with the public health system accounting for 51% through the MOH and Ministry of Local Government. Other providers are NGOs who have 20% of the facilities, and private services (including missions) accounting for 29%.<sup>22</sup>

The referral system is at three levels: national (two hospitals), provincial (eight hospitals) and district (70 hospitals). The health sector is faced with inequalities. Only 30% of the rural population has access to health facilities within 4 km, while such access is available to 70% of urban dwellers.<sup>6</sup> The arid and semi-arid north and north eastern areas of Kenya are underserved due to limited number of health facilities.

The essential public health and clinical packages include malaria, EPI, IMCI, HIV/AIDS/TB, reproductive health and control of communicable diseases. The quality of health services is reputedly low due to inadequate supplies and equipment and lack of personnel. Moreover, regulatory systems and standards are not well developed.

There are deliberate efforts by the government to shift towards decentralization of health care provision. The MOH has embarked on developing the legal and regulatory framework and capacity building to devolve the entire authority for planning and financial management to districts.

#### ***2.5.4 Human resource development***

Currently the MOH has a surplus of staff in lower cadres and a deficit in the number of professional staff. This is compounded by a rise in the number of those leaving for the private sector or to other countries. This has resulted in district health facilities being staffed with fewer and less qualified health personnel.

According to the latest available data,<sup>5</sup> the personnel per 100,000 population are as follows: 15.4 doctors, 2.5 dentists, 15.3 clinical officers, 31.4 registered nurses, 95.2 enrolled nurses, 3.0 public health officers and 17.2 public health technicians. The distribution of the staff has not been done in accordance with population needs, and this has resulted in overstaffing in some stations at the expense of others, especially in the rural areas.

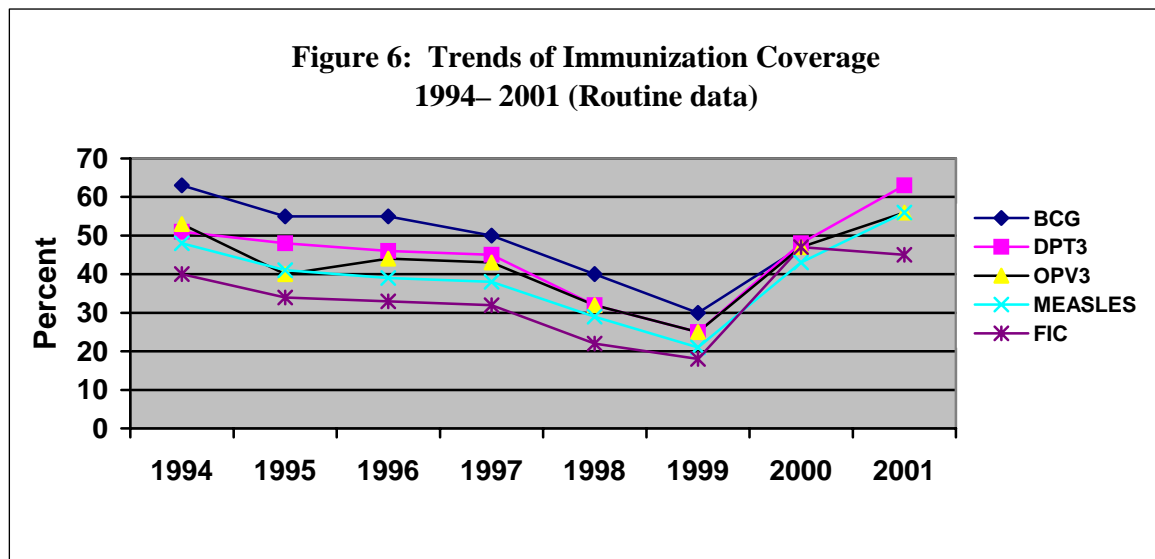
The MOH has identified weaknesses related to staff projections, norms, human resource analysis and systems performance. The intended rationalization through the Civil Service Reform Programme (CSRP) has been evolving at a slow pace.

Kenya has well-developed institutions, some of which are recognized internationally and offer pre-service, in-service and post-basic training programmes. However, there is a perceived need to shift the focus from specialist training to primary health care (PHC), including essential public health and clinical packages, and management as a priority in training and operations research to improve service delivery. This calls for review of the curricula.

#### ***2.5.5 Health support systems***

Due to inadequate and irregular supply of drugs and non-pharmaceuticals, there is a trend to rely

on private pharmacies, local shops and even unlicensed drug-vendors, resulting in the utilization of sometimes expired and dangerous drugs. The budgetary provision for the procurement of essential drugs covers only 40% of the requirements.<sup>22</sup> The over-reliance on donor support for drugs and vaccines supply raises serious issues of sustainability. For instance, in October 2000, Kenya was awarded a five-year grant from GAVI to strengthen immunization systems and introduce of new and underutilized vaccines. Based on this support, Kenya has introduced pentavalent vaccines nationwide. Since April 2001, the funds for strengthening immunization systems were disbursed annually to all 70 districts based on a district micro-plan. As shown in Figure 6, this has resulted in a reversal of the hitherto downward trend of routine immunization coverage in Kenya. GAVI suggested the possibility of opening district accounts. This has become a model for decentralization of funds to districts. The challenge of the positive impact of GAVI is to sustain and consolidate the gains at the end of the grant period.



In the management information system, there is scarcity of reliable information for policy development, planning, budgeting, monitoring and evaluation. Epidemiological data have been developed their historically but their completeness and timeliness are on average at 50% to 60% level. Lack of follow-up and inadequate capacity for data analysis are some of the reasons.

Kenya is endowed with a good number of renowned health researchers and a network of research institutions (Kenya Medical Research Institute, African Medical and Research Foundation, universities, National Health Research and Development Centre), some of which are WHO collaborating centres. The National Health Research and Development Centre coordinates the health research agenda in Kenya. Linkage between health research and policy implementation requires strengthening.

## 2.6 Issues of particular concern

### 2.6.1 Health system development

Since 1999, the main thrust has been systematic planning and capacity building to prepare the districts to assume decentralized tasks. In 2001, the government developed the Poverty Reduction Strategy Paper which recognized health as central to development.<sup>8</sup>

The following challenges have been identified:

- (a) full-scale evaluation of the current Health Sector Strategic Plan, and based on the results, development of a new vision for the health sector with a focus on poverty reduction;
- (b) inequity in health care provision, financing and quality;
- (c) shifting resources from curative to preventive services in the context characterized by increasing demands, especially on curative services;
- (d) capacity of the MOH to coordinate partners;
- (e) inadequate capacity to manage and retain human resources in the public sector.

### **2.6.2 Disease prevention and control**

Kenya is part of global initiatives to eradicate poliomyelitis, eliminate maternal and neonatal tetanus and accelerated control of measles by the year 2005. In the last 6 years, national or sub-national immunization campaigns have been conducted to vaccinate eligible children or adults; surveillance systems for acute flaccid paralysis, measles and neonatal tetanus have been developed and are functioning effectively. Polio and measles laboratories have been equipped to support the surveillance effort. A major strategy for all these disease eradication, elimination and control initiatives is high routine immunization coverage. Unfortunately, routine immunization coverage in Kenya has been on a downward trend since 1994 (see Figure 6). In order to address the situation, an indepth review was conducted in March 2000 and a five-year strategic plan (2001–2005) developed. Subsequent improved funding of routine immunization services using grants from GAVI, DFID and government has reversed the declining trends.

In order to achieve the targets of the disease eradication, elimination and control initiatives, the following challenges need attention:

- (a) declining political and financial commitment to mass vaccination campaigns;
- (b) lack of progress in the development of wild polio laboratory containment activities;
- (c) inadequate planning, monitoring, supervision and evaluation of immunization services at lower levels;
- (d) dependence of routine immunization on time limited grants and loans.

The government continues to pursue the global target for eradication and elimination of dracunculiasis, leprosy and lymphatic filariasis.<sup>24</sup> The MOH has mapped out the dracunculiasis endemic areas, has instituted mass chemotherapy for lymphatic filariasis as a pilot project in one of the highly affected districts and has an effective leprosy elimination programme.

The major challenges are inadequate case findings and sustaining the supply of drugs for leprosy and lymphatic filariasis.

A National Malaria Strategy (2001–2010)<sup>25</sup> has been developed based on the WHO Roll Back

Malaria Initiative.<sup>26</sup> The MOH has established a Division of Malaria Control, initiated expanded in-service training for health workers and established close partnerships with stakeholders. The following issues need to be considered:

- (a) inadequate programme management capacity and expertise in malaria;
- (b) increasing resistance to first line antimalarial drugs;
- (c) low ITN coverage and retreatment rates;
- (d) late presentation of cases of fever at the health facility;
- (e) inadequate capacity for early detection of malaria epidemics;
- (f) high resource gap in the long term for malaria strategic plan;
- (g) uncoordinated malaria control activities by stakeholders;
- (h) inadequate local data on new malaria control technologies.

HIV/AIDS was declared a national disaster in 1999.<sup>27</sup> A National AIDS Control Council (NACC) was set up at the Office of the President. A sessional paper and other policy documents were formulated which currently provide direction to government departments and partners. In spite of all these measures, the prevalence of HIV/AIDS remains high. To meet the funding gaps, the government, in collaboration with all stakeholders including NGOs, submitted a grant application to the Global Health Fund in September 2002.

The following issues need to be addressed:

- (a) increasing trends of HIV/AIDS in workplaces;
- (b) lack of guidelines on prevention of mother to child transmission of HIV (PMTCT) and management of opportunistic infections at service delivery points;
- (c) availability of affordable drugs for the treatment of AIDS and related illnesses and PMTCT;
- (d) inadequate coverage of community-based care initiatives;
- (e) inadequate laboratory capacity for monitoring treatment with ARVs.

The government has adopted the DOTS strategy countrywide for treatment of TB cases. The TB control activities have been integrated into HIV/AIDS programmes to improve cost-effectiveness.

The following issues will need to be addressed to improve TB control:

- (a) inadequate funds to ensure sustainability of TB drug supply, including reserve stock;
- (b) late TB case detection and low detection rate;
- (c) limited implementation of community-based DOTS;
- (d) lack of data on trends of TB co-infection with HIV.

With the perception of the growing magnitude of NCDs, the government has included this

programme in its agenda and has established a Division of NCD. A situation analysis is planned. However, the situation of nutrition is well documented. The following issues need consideration:

- (a) lack of data to assess the proportion of the problem and facilitate policy decisions regarding control/prevention;
- (b) development of a national policy and a strategic plan on NCDs;
- (c) development of a national policy on food and nutrition.

Kenya is committed to implementing Integrated Disease Surveillance and Response (IDSR) and has adapted the WHO Africa regional strategy and technical guidelines.<sup>24</sup> Training materials have also been adapted. The case-based component of Kenya's IDSR has been implemented using measles case-based surveillance as an entry point. The five-year IDSR strategic plan is being revised. Kenya is on the verge of scaling up IDSR implementation nationwide. Despite this progress towards integration, disease control programmes in the Ministry of Health, such as malaria, HIV/AIDS, and EPI, still run parallel disease surveillance systems. The following challenges require attention:

- (a) lack of a central epidemiology unit;
- (b) inadequate capacity for early detection of emerging and re-emerging infections;
- (c) limited resource base for scaling up IDSR to all districts.

### **2.6.3 Reproductive, child and adolescent health**

Given that the UN millennium development goals (MDGs) call for reduction of maternal mortality by two-thirds and under-five mortality by two-thirds between 1990 and 2015,<sup>28</sup> it is imperative that Kenya address the unacceptably high maternal and infant mortality rates which currently stand at 590–650 per 100,000 live births and 74 per 1,000 live births, respectively. To this end, the government of Kenya has developed a Reproductive Health Policy (1996)<sup>29</sup> and has adopted the IMCI strategy (1998).<sup>30</sup>

The following challenges need to be addressed:

- (a) inadequate management capacity within the MOH;
- (b) inadequate emergency obstetric equipment, essential drugs and supplies, transport and communication systems;
- (c) inadequate skills in the management of obstetric emergencies and case management of childhood illnesses, including youth friendly services;
- (d) weak community participation in maternal and child health;
- (e) lack of evidence on factors associated with maternal and infant deaths at community and health care delivery point;
- (f) lack of youth friendly services;
- (g) absence of a network for information sharing among stakeholders.

### **2.6.4 Health promotion**

Kenya recognizes health promotion as a core strategy for disease prevention and control. That is

why the MOH in 2000 created the Department of Promotive and Preventive Health. Divisions in this department are concerned with malaria control, EPI, HIV/AIDS control, child health, reproductive health, health education. Along with their technical mandates, each of these divisions implements its own vertical IEC programme. This has resulted in inefficient utilization of resources and insufficient information dissemination. The Division of Health Education has the mandate to coordinate and develop integrated health communication within the health sector as well as in other government ministries. However, its effectiveness has been hampered by inconsistent leadership. For instance, in the last 4 years, there have been four divisional heads, leading to lack of consistency in programme planning and implementation. This can be seen in the fact that the National Health Communication Strategy (1999–2010)<sup>31</sup> has not been disseminated to lower levels. Presently, school health programmes are not well developed in Kenya.

The following challenges need attention:

- (a) lack of health promotion policies and guidelines to support the implementation of the National Health Communication Strategy;
- (b) inadequate technical and management capacity within MOH;
- (c) inadequate IEC production capacity within the Division of Health Education;
- (d) lack of synergy between health promotion and delivery of health services;
- (e) inadequate coverage of school health programmes.

### **2.6.5 Health, environment and sustainable development**

The government has taken bold steps to improve the status of environmental sanitation. The effort should be widely supported by all stakeholders. In addition, food safety is a major concern.

The following issues need to be considered:

- (a) lack of environmental health policy and strategic plan;
- (b) outdated Public Health Act;
- (c) lack of baseline data on environmental sanitation coverage;
- (d) absence of water quality control systems;
- (e) lack of food safety implementation guidelines.

## **3. Development Assistance: Aid Flow, Instruments and Coordination**

### **3.1 Overall trend in aid**

Significant increase in external funding (Figure 5) to the health sector, through specific projects and programmes, has been observed in the last decade. However, the unsatisfactory performance of the Kenya economy caused by the stop-go macroeconomic policies, the slow pace of structural reform and governance problems, which were manifested in lack of transparency and accountability (PRSP), have

resulted in reduction of flow of funds through the government system.

### **3.2 Sectorwide approach**

The National Health Sector Strategic Plan (NHSSP) states the modalities and structures of cooperation among the development partners. The plan indicates that all the resources available for health will be applied within this framework in accordance with the set priorities. The NHSSP envisages a shift from project-based programming to sectorwide planning and implementation of health activities. Three years since the launch of the NHSSP, the policy and implementation framework for sectorwide approach has not been finalized. This has meant that most partners have continued to directly support specific districts or areas. This has created disparities in terms of the degree, availability and quality of services offered and has impacted negatively on the sustainability component in district-based projects.

### **3.3 Mechanisms of support**

Various partners have adopted different types of disbursement mechanisms for aid flow. In most cases, it has tended to be project type operation where funds are directed to specific projects, or through contracting procedures where the services are provided by a contractor/sub-contractor or through Memoranda of Understanding (USAID, UNICEF, AMREF, DFID, JICA, etc). The other types of support offered were credit or soft grants, as well as supply of commodities (World Bank, WFP). Some bilateral and multilateral partners provide technical assistance for capacity building through their own national experts, volunteers, fellowships and other training (e.g. JICA, DFID, CIDA).

### **3.4 Major development agencies in health**

Kenya is a country having a large concentration of multilateral and bilateral donors and NGOs. For example, support in the prevention and control of HIV/AIDS, blood safety and transfusion, supply of equipment, HIV test kits, IEC/advocacy, ARV guidelines and surveillance is provided by USAID, JICA, UNFPA, WFP, UNDP, UNICEF, UNAIDS, WHO, CIDA, SIDA, AMREF, DFID, UNDCP, UNHCR, ILO, UNIFEM and numerous NGOs.

The Roll Back Malaria Initiative has increased the interest of partners in the disease. Social marketing, use of ITN, ANC aides, IEC, antimalaria drug sensitivity testing and capacity building are areas of support provided by JICA, USAID, DFID, UNDP, UNICEF, WB, WHO and others. Control of other parasitic diseases such as schistosomiasis is supported by JICA and WHO.

Health system development continues to attract substantial support in the areas of rehabilitation and improvement of hospitals (JICA, ADB), policy development, decentralization, human resource development, logistics and supplies (UNDP, UNICEF, WB, DFID, WHO, SIDA, GTZ, DANIDA and AMREF).

School health promotion and oral health rehabilitation are supported by UNFPA, UNICEF, CDC, WFP and WHO in the sectors of IEC, de-worming, physical education, nutrition and health education.

Integrated disease surveillance and research, and health management information systems are supported by WHO and The Rockefeller Foundation. Areas of interest are capacity building, training, technical guidelines, communication, equipment, planning and the strengthening of laboratories.

Reproductive health is attracting many partners such as UNFPA, USAID, UNICEF and WHO

with focus on child and adolescent health policies, FGM, Making Pregnancy Safer Initiative and empowerment of women.

Environmental health is another area supported by UNICEF, WHO, GTZ, SIDA and other NGOs which contribute to water and sanitation, health education, community participation, development of water facilities, capacity building and water quality surveillance.

### **3.5 Coordination and partnerships**

The government vision for stakeholder and partner coordination is broad based and well formulated in the National Development Plan<sup>4</sup> and Poverty Reduction Strategy Paper.<sup>8</sup> This vision will be implemented through the National Monitoring and Evaluation Commission and Central Planning Coordination Unit at the Ministry of Finance and Planning. They have respective committees at province and district level; the Technical Task Forces are multisectoral bodies also located in the Ministry of Planning. The PRSP Task Force has six thematic groups: gender, HIV/AIDS, youth, monitoring and evaluation, media, pastoralism. Each of these coordinates and monitors implementation of PRSP health objectives. At the Ministry of Health level there are various coordination mechanisms and structures. The major one is the Health and Population Committee chaired by the Permanent Secretary, Ministry of Health. It holds bi-monthly meetings for the implementation of NHSSP. It has a sub-committee on health sector reform chaired by the Health Sector Secretariat to coordinate donor support directed to health reform initiatives.

In the pipeline, there is the Joint Interagency Coordination Committee (JICC) that will act as an overall coordinator for all existing technical Interagency Coordination Committees (ICC); PEI, RBM, reproductive health and others.

To maximize on available funds in the health sector, the government is encouraging the formation of other health programme-specific ICCs to coordinate the implementation of activities in the health sector.

In the attainment of common goals, the UN system in Kenya plays a facilitating and enabling coordination role in various sectors through the Kenya Coordination Committee (KCC). The Committee is chaired by the UN Resident Coordinator. This Committee has various theme groups, one of which is health and nutrition chaired by WHO and UNICEF, rotationally.

The United Nations Development Assistance Framework<sup>10</sup> (UNDAF) has adapted a programme approach to enable the government to develop clear indicators for monitoring the implementation of agencies' joint plans of action. Collaboration instruments agreed upon among UN agencies include joint planning, exchanging operational plans, joint reviews, project co-financing, thematic group meetings, retreats and other amalgamating forms of collaboration. The aim is geared towards harmonizing development efforts and mutual reinforcement for attainment of the MDGs relevant to Kenya.

In spite of all the coordinating mechanisms in place, they need to be revitalized and strengthened. The role of WHO as a catalyst has been underscored by all partners during the consultations.

## **4. WHO Current Country Programme**

The World Health Organization Kenya Country Office started as a liaison office in 1964<sup>32</sup> with three staff members; it is now among the largest offices in the WHO African Region with a total of 48 professional and support staff. The office has established a wide range of collaborative programmes with

the Government of Kenya and plays an important role in national health development.

## **4.1 WHO technical cooperation programmes**

The WHO country team has a biennial budget consisting of regular and extra-budgetary contributions, exceeding US\$ 6 million. These funds are directed to the national programmes through the Kenya Ministry of Health in accordance with the established joint procedures.

### ***4.1.1 Current operations***

The current WHO operations are based on the programme budget and the Biennial Plan of Action (BPOA) for the period 2002–2003.<sup>33</sup> In developing the plan, the lessons learned from the preceding biennial plan, the National Strategic Plan, PRSP, the United Nations CCA, UNDAF processes and other initiatives were taken into consideration. The aim of the plan is, in collaboration with other development partners, to support the government in addressing the health priorities: health system strengthening, communicable disease control, reproductive health and others.

In the current biennium, the cooperation programme includes WHO technical, financial and material support through 27 areas of work (AOW) which are described below.

### ***4.1.2 Health systems development***

Organization of health service consists of capacity building for health sector reform, local health financing and management initiatives, assistance in developing the Health Management Information System and review of the NHSSP. Essential drugs and medicines policy focuses on development of a business plan for the capitalization of Kenya Essential Medicines Supply Agency and development of guidelines on rational use of drugs. Blood safety and clinical technology includes quality assurance in laboratories, training, supply of critical laboratory equipment, provision of norms and standards.

The regular budget (RB) allocations supporting AOWs in this group are US\$ 464,000 representing 30% of the total biennial regular budget. These areas are supported by one technical staff who spends approximately 60% of his time and the WHO Representative (20%).

### ***4.1.3 Disease prevention, eradication and control***

Within the essential area of Disease Prevention, Eradication and Control, WHO Kenya develops activities related to leprosy control, guinea-worm disease eradication, filariasis elimination, communicable and noncommunicable diseases. It also addresses malaria, tuberculosis and HIV/AIDS. Immunization and vaccine development covers polio eradication, accelerated measles control and strengthening of routine immunization systems. These areas attract US\$ 342,000, 22% of the WHO RB, and over US\$ 6 million from the extra-budgetary (EB) resources in the 2002–2003 biennium. Eight full-time and four part-time technical officers, including the WR, support these areas of work.

### ***4.1.4 Reproductive health, child health, and adolescent health***

Support to child health, adolescent health and the Making Pregnancy Safe initiative is provided through training, development of guidelines and IEC materials, supervisory tools, procurement of essential obstetric and newborn care supply and equipment. This group is supported by a full-time

national officer and has a biennial regular budget of US\$ 377,000 (24%).

#### ***4.1.5 Health promotion and healthy life styles; health and sustainable development***

This component consists of three areas of work and is supported by a full-time national programme officer. The areas of work are health promotion, sustainable development, poverty alleviation and resource mobilization. Specific activities include training, guidelines and health promotion materials as well as policy and advocacy support. The budget to support this area is US\$ 213,000 (14%).

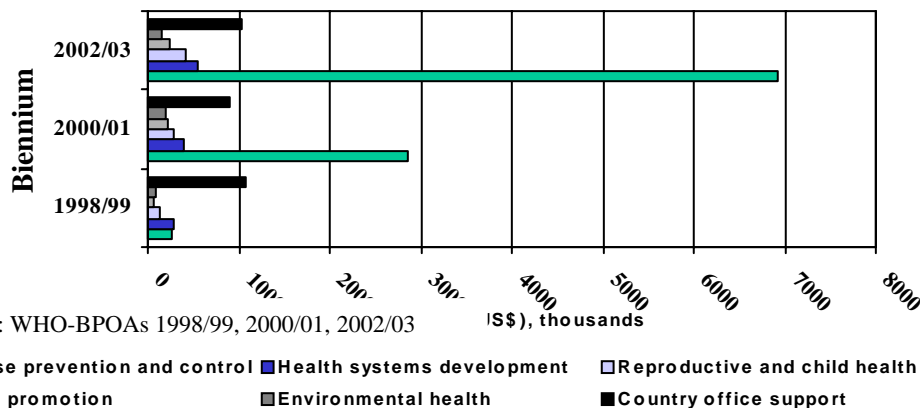
#### ***4.1.6 Health and environment***

Technical and financial support by a WHO national officer complements government's efforts in the implementation of environmental health policies and programmes. The aim is to collaborate with the main stakeholders and partners to develop an environmental health profile reflecting environment-related health risk factors. Other activities include training on Participatory Hygiene and Sanitation Transformation (PHAST) approaches and support to an assessment exercise for sanitation and water supply services. The budget is US\$ 155,000 (10%).

### **4.2 WHO budget distribution and trends**

WHO budgetary allocation (Figure 7) to the five programme areas has been relatively stable over the last three biennia. The very high allocations to communicable disease control in 2000/2001 and 2002/2003 were due to extra-budgetary funding for polio and measles mass vaccination campaigns in years 2000/2001 and 2002, respectively, and RBM in 2002/2003. The total regular budget allocation of the Country Office for the 2002–2003 biennium to the technical programmes is US\$ 1,551,000, a slight increase from the previous biennium (US\$ 1,491,000). Distribution according to the programme components shows that disease prevention and control, health systems and reproductive health received more than 70% of the funds.

**Figure 7: Trends of WHO financial support to Kenya, 1998–2003**



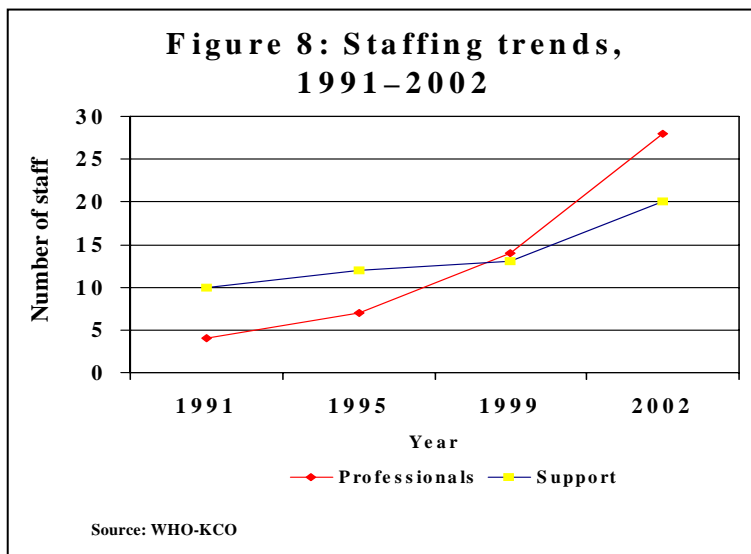
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**4.3 H  
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The staff strength of the WHO office has grown over the years (Figure 8). Currently, there are 28 professional staff and 20 support staff. Professional staff include 19 in the WR’s office (four international and 15 national) and nine in the intercountry programmes (seven international and two national).

The distribution of the human resource is in favour of disease prevention and control. There is no full-time technical staff in support of health system development. The intercountry team provides technical support to all countries of eastern Africa and the great lakes region in the areas of immunizations and emergency and humanitarian action.



**4.4 Coherence of activities with WHO core functions**

Examining the planned activities in conjunction with WHO core functions at country level during the last two biennia revealed interesting trends that can be seen in Table 1. Table 1 shows a significant decrease in support for routine activities in the 2002/2003 biennium, an indication of WHO commitment to more strategic functions (F2 and F3). There is evident stability in the level of investment in F5, mainly because most policy documents required for effective health sector management were developed in earlier biennia.

**Table 1: Relationship between WHO-Kenya programme and generic core functions**

WHO Functions (F) at country level	2000–2001 Biennial POA		2002–2003 Biennial POA	
	#	%	#	%
F1: Supporting routine long-term implementation	53	37	65	27
F2: Catalysing adaptation of technical strategies innovations; seeding large-scale implementation	21	15	50	21
F3: Supporting research and development, policy experimentation, development of guidelines, stimulating monitoring health system performance, trends assessment and anticipation	20	14	47	20
F4: Sharing information: generic policy options, guidelines and standards, case studies of good practice and advocacy	33	23	51	21
F5: Providing specific high level policy and technical advice; serving as broker and arbiter, exercising influence on policy, action and spending of government and development partners	17	11	25	11
<b>Total</b>	<b>144</b>	<b>100</b>	<b>238</b>	<b>100</b>

#### 4.5 Intercountry coordination and support

Two intercountry teams are based at the WHO Kenya Country Office. Through seven international technical staff, valuable support is provided to Kenya and neighbouring countries in the areas of disease eradication, routine immunization as well as emergency preparedness and humanitarian action. The WHO Representative as a team leader coordinates the activities of these two teams and provides administrative support for operations. The latter includes country visits for technical support, monitoring country specific activities, programme reviews and evaluation, and others. The WHO Kenya Country Office also offers diplomatic and administrative assistance to the Somalia and southern Sudan offices of the WHO. The office hosts a large number of WHO regional and global meetings.

#### 4.6 WHO regional and headquarters support

WHO Regional Office for Africa and Headquarters support to Kenya has been in the areas of policy and technical advice, research and development, information sharing and national capacity building. Financial and technical support is further provided towards the eradication or elimination of vaccine preventable diseases, in particular poliomyelitis and measles, as well as malaria. Support was further provided by AFRO towards HIV/AIDS, mental health and other noncommunicable disease programmes to supplement country office resources. WHO Regional Office and Headquarters undertook a number of technical support missions to the country to assist in establishing an integrated approach to disease surveillance, introducing new initiatives (e.g. RBM, IMCI), reviewing progress of on-going disease control and eradication, among many others.

#### 4.7 Opportunities and assumptions

There are a number of opportunities which optimize WHO support to the Kenya government:

- (a) political stability creating an enabling environment for cooperation;
- (b) presence of internationally recognized research institutions and WHO collaborative centres;
- (c) good relationship between MOH and WHO at decision making level and an “open door” policy allowing work on a daily basis;
- (d) availability of basic policy and strategic documents developed by the government in collaboration with other stakeholders and partners;
- (e) under the leadership of the UN Resident Coordinator, the UNDAF process facilitates partner coordination through the network of Thematic Groups and Interagency Coordination Committees; these are good fora for advocacy and resource mobilization for health;
- (f) strong technical team of WHO capable of managing priority programmes with the national partners and providing technical support based on the WHO comparative advantage in health issues;
- (g) confidence among donor community in WHO Country Office financial management and transparency resulting in provision of local donor funds to execute certain programmes (e.g. malaria control funds), or to enter into business relationship for joint action.

#### **4.8 Constraints and threats**

There are constraints and certain threats that may hamper or delay the implementation of the WHO programmes in Kenya. These include diminishing donor confidence in the health sector resulting in reduction of external funds, insufficient technical staff in some of the WHO technical programme areas, overlapping programmes or activities with various partners including UN agencies and others. The instability in neighbouring countries and the resultant waves of refugee influx Kenya pose the risk of importation of diseases already under control in Kenya, e.g. polio or guinea-worm disease. Other constraints include shortage of some essential support and technical staff members at the WHO Kenya Office to cope with increased demands by country and inter-country teams as well as to improve quality of support to Kenya.

## **5. WHO Corporate Policy Framework: Global and Regional Directions**

WHO has been - and is still - undergoing changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges. This organizational change process has, as its broad frame, the WHO Corporate Strategy.<sup>34</sup>

### **5.1 Goal and mission**

The mission of WHO remains “the attainment by all peoples of the highest possible level of health” (Article 1 of WHO Constitution). The Corporate Strategy and the Policy Framework for

Technical Cooperation with Member Countries of the African Region outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

## **5.2 New emphases<sup>34</sup>**

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

- (a) adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;
- (b) playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;
- (c) triggering more effective action to improve health and to reduce inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;
- (d) creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

## **5.3 Strategic directions<sup>34</sup>**

On the basis of these new emphases, WHO has set out four strategic directions for its contribution to building healthy populations and combating ill-health. These strategic directions, which are interrelated, provide a broad framework for the technical work of the Secretariat:

- (a) reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
- (b) promoting healthy lifestyles and reducing risk factors to populations;
- (c) developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;
- (d) developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

## **5.4 Core functions<sup>34</sup>**

The typology of WHO core functions, presented below, is based on the comparative advantage of the Organization at all its levels:

- (a) articulating consistent, ethical and evidence-based policy and advocacy positions;
- (b) managing information, assessing trends and comparing performance of health systems; setting the agenda for and stimulating research and development;

- (c) catalysing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;
- (d) negotiating and sustaining national and global partnerships;
- (e) setting, validating, monitoring and pursuing proper implementation of norms and standards;
- (f) stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health-care management and service delivery.

## 5.5 Global and regional priorities<sup>35</sup>

In order to be more effective and efficient in its interventions, the Organization has selected a limited number of global priorities on which to focus over the four-year period (2002-2005). The global priorities selected on the basis of those criteria are: malaria, HIV/AIDS and TB; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco; maternal health; food safety; mental health; safe blood; and health systems.

The WHO African Region<sup>36</sup> is facing enormous health challenges in relation to health. The WHO Regional Office for Africa has decided to focus its attention on 12 priorities closely related to the 11 global priorities, but adapted to the regional context. These 12 priorities are: HIV/AIDS; tuberculosis; malaria; maternal health; child and adolescent health; strengthening of health systems; blood safety; humanitarian and emergency action; health promotion; noncommunicable diseases control including mental health; and poverty and health.

## 5.6 Making WHO more effective at country level

The expression of WHO Corporate Strategy at country level will vary from country to country. Taking into consideration country-specific health and development challenges, the involvement of other external partners, WHO's current work in and with the country, and the global and regional policy frameworks, WHO will look at getting the balance right between its key functions at the country level. This means the Organization will act more as an adviser, a broker and a catalyst and will involve itself in routine implementation in case of specific, clearly identified initiatives, with a time-limited perspective. A working typology of WHO functions at country level has been developed based on the broader core functions presented above.

The specific functions at country level are:

- (a) supporting routine long-term implementation;
- (b) catalysing adoption of technical strategies and innovations; country-specific adaptation of guidelines; and seeding large-scale implementation;
- (c) supporting research and development; policy experimentation; development of guidelines; stimulating monitoring of health sector performance; and trends assessment and anticipation;
- (d) sharing information; generic policy options and positions; guidelines and standards; case studies of good practice; and advocacy;

- (e) providing specific high-level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and spendings of government and development partners.

## **6. WHO Strategic Agenda 2002–2005**

### **6.1 Shifts in general directions**

Health sector reform and pro-poor programming as envisaged by the PRSP constitute a prevailing business paradigm in Kenya. Within the health sector, some issues of particular concern are inefficient performance of the health system, maternal and child health, disease patterns including high rate of HIV/AIDS and environmental health determinants.

The WHO strategic directions derive from the National Development Plan for sustainable development. In addition, the agenda spelt out in the CCS takes cognizance of all existing policies and plans and links to WHO core functions.

This strategic agenda represents the determination of WHO to address the real health needs of the people of Kenya, having been derived from an exhaustive situation analysis. It entails a shift from routine activities to advocacy for policy development and its implementation.

WHO strategy orientation focuses on five priority components that address the major pro-poor health challenges in Kenya based on WHO functions and comparative advantages. These components are health system development, disease prevention and control, reproductive and child health, health promotion and environmental health.

### **6.2 Health system development**

The World Health Report of 2000,<sup>23</sup> which ranked countries according to their health system performance, placed Kenya in position 140 out of 191 countries. This indicates that the current health system does not adequately address the needs of the population, and there is a need for strengthening health systems.

#### **6.2.1 *Health systems strengthening***

The strategic directions identified under these domains are:

- (a) policy advocacy, technical assistance and financial support to review the NHSSP in line with the PRSP;
- (b) linkages between government and partners to achieve a sectorwide approach;
- (c) expertise and technical assistance to the MOH to strengthen the capacity of the districts in communication (internet), HMIS, health planning and management.

#### **6.2.2 *Health care equity***

The strategic directions identified under these domains are:

- (a) support to government to develop health financial systems;
- (b) advocacy and technical assistance for the monitoring of equity in health financing and access using the most appropriate benchmarks, indicators and tools;
- (c) policy advocacy to increase funds allocation to the health sector.

### **6.2.3 *Coordination of partners***

The government and partners requested WHO to act as a broker and to catalyse partner coordination to attain closer relationships between government and donors. To this end, WHO will provide:

- (a) technical support to the MOH to enhance capacity for partner coordination;
- (b) forum for partners to share experiences and information;
- (c) advocacy for joint evaluation of health programmes with stakeholders and partners.

### **6.2.4 *Human resource development and management***

In order to improve the performance of the health system, one of the critical issues to be addressed is human resource development. WHO will contribute through:

- (a) assisting to update human resource development policies and plans;
- (b) supporting operationalization of the human resource development plan;
- (c) sharing information on existing training institutions preferably within Africa, including exchange of visits and curricula;
- (d) continuing to support fellowships in human resource development and management.

## **6.3 *Disease prevention and control***

Based on WHO experience in disease prevention and control, the conditions to be focused on have been selected according to the following criteria: diseases of public health importance particularly among the poor; commitment of the Kenya government to existing regional and global disease eradication and elimination goals; availability of cost effective prevention or control strategies such as vaccines, ITNs and DOTS; availability of other stakeholders with specific advantages in disease control.

### **6.3.1 *Vaccine preventable diseases***

There are two components to vaccine preventable diseases. The first component includes diseases targeted for eradication and elimination. For poliomyelitis, maternal and neonatal tetanus and measles, WHO will continue to provide technical and financial support for mass vaccination campaigns and disease surveillance as well as support activities for laboratory diagnosis and containment with

respect to polio eradication and accelerated measles control. The second component is routine childhood immunizations. For this component, WHO will support regular programme reviews and strengthen immunization systems through planning, micro-grants, training, monitoring and evaluation. For this component, WHO will also advocate with the MOH and partners, including the private sector, to ensure sustainability of immunization programmes.

### **6.3.2 Other diseases targeted for eradication and elimination**

As part of its commitment to disease eradication and elimination, Kenya has designed plans to tackle the challenges of leprosy, guinea-worm disease and lymphatic filariasis. WHO will continue to support routine implementation towards surveillance of these diseases and provide drugs for leprosy and lymphatic filariasis.

### **6.3.3 Diseases of poverty**

The following diseases have been identified as contributing to poverty: malaria, HIV/AIDS and tuberculosis. For malaria, WHO will focus on:

- (a) strengthening technical and managerial capacity within the MOH;
- (b) technical and financial support for monitoring drug resistance;
- (c) catalysing adoption of ITN strategies and innovations;
- (d) strengthening community-based activities including home-based treatment of malaria;
- (e) supporting the development of epidemic monitoring systems;
- (f) advocacy for resource mobilization;
- (g) supporting the MOH to coordinate partnership in malaria control;
- (h) supporting operational research on new malaria control technologies.

For HIV/AIDS, WHO will focus on:

- (a) supporting MOH to improve HIV control in workplaces;
- (b) dissemination of guidelines on prevention of mother to child transmission of HIV and management of opportunistic infections;
- (c) advocacy for access to ARVs and OI drugs;
- (d) supporting dissemination of guidelines and advocate for implementation of community-based care initiatives;
- (e) supporting development of laboratory capacity for monitoring treatment outcomes.

For tuberculosis, WHO will:

- (a) advocate for resource mobilization in order to ensure sustainable drug supply;

- (b) advocate for resource mobilization for procurement of microscopes and laboratory consumables for expanding early case detection;
- (c) provide technical and financial support for expansion of community DOTS;
- (d) provide technical support for monitoring trends of TB/HIV.

#### **6.3.4 Noncommunicable diseases**

Perceived situation and trends of NCDs is a growing concern for both the government and partners. WHO inputs in this area will be to:

- (a) provide technical expertise to assess noncommunicable disease burden and trends;
- (b) support the government to adopt appropriate policies and develop noncommunicable disease policy and strategic plan;
- (c) provide technical and financial support to finalize and disseminate the national policy on food and nutrition.

#### **6.3.5 Integrated disease surveillance and response**

Kenya has adapted the regional strategy and technical guidelines for integration of disease surveillance and response. WHO will continue to support IDSR through:

- (a) advocacy and technical assistance for the creation of a central epidemiology unit within MOH;
- (b) capacity building for early detection of emerging and re-emerging diseases;
- (c) advocacy for resource mobilization in support of capacity building, management, monitoring and evaluation of the IDSR system.

### **6.4 Reproductive health, child health and adolescent health**

High maternal, infant and child mortality remain major challenges. The government and WHO will continue to work together towards implementation of the following strategies.

#### **6.4.1 Making pregnancy safer**

Making pregnancy safer is an initiative to reduce maternal mortality through improved quality of maternal care. Within this initiative WHO will focus on:

- (a) advocacy with partners for strengthening capacity of the MOH to manage reproductive health services;
- (b) advocacy with partners and communities for provision and maintenance of essential equipment and improved referral systems;
- (c) technical expertise and financial support to update skills in the management of obstetric

- emergencies;
- (d) technical and financial support to finalize and disseminate service guidelines;
  - (e) advocacy with stakeholders for community involvement and participation in improvement of maternal health care, including female genital mutilation and early marriages;
  - (f) financial support to develop guidelines on maternal death audit at facility and community levels;
  - (g) promote sharing of information on best practices on making pregnancy safer.

#### **6.4.2 Child and adolescent health**

The main areas include IMCI and youth friendly services, both supported by many partners. The IMCI strategy focuses on reducing infant and child mortality. Youth friendly services are aimed at removing access barriers to health for adolescents. To implement these strategies WHO will:

- (a) advocate with partners to expand the IMCI strategy implementation at district and community level and support the adaptation and dissemination of community IMCI guidelines;
- (b) support the development and dissemination of newborn child guidelines;
- (c) support the development and dissemination of the adolescent reproductive health policy and strategy in collaboration with other partners;
- (d) advocate for resource mobilization to expand youth friendly services;
- (e) promote sharing of best practices and operational research on adolescent health.

#### **6.5 Health promotion**

The major causes of morbidity and mortality in Kenya are preventable. Change in behaviour and practices may contribute to curb the burden of diseases. The government has developed a health promotion policy with the support of WHO and other partners. The WHO Regional Office for Africa has, at the request of member states, developed a health promotion strategy which has been adopted by the Regional Committee. WHO will:

- (a) provide technical and financial support to the MOH to adapt and disseminate the regional Health Promotion Strategy;
- (b) strengthen technical and management capacity of MOH;
- (c) advocate for the Integrated Health Communication Programme within the MOH and for resource mobilization to implement the health promotion policy;
- (d) advocate for resource mobilization for production of IEC materials;
- (e) strengthen the MOH to promote synergy between health promotion and delivery of health

services;

- (f) advocate for the strengthening of the National School Health steering committee;
- (g) provide technical and financial support to the MOH to adapt and implement a comprehensive School Health Promotion Initiative in collaboration with the Ministry of Education and other partners;
- (h) provide technical support to the School Health Unit of the Ministry of Education in collaboration with the MOH.

## 6.6 Health, Environment and Sustainable Development

The declining standards of environmental health together with rapid population growth in urban settings have resulted in increased diseases related to unhealthy environments. Such diseases include cholera, typhoid and other diarrhoeal diseases. In addressing these, WHO will focus on:

- (a) supporting the finalization of the ESH policy and development of the strategic plan;
- (b) providing technical support to the MOH for the revision of the Public Health Act (Cap. 242);
- (c) providing technical and financial assistance to the MOH to evaluate the implementation of PHAST and conduct environmental health assessments and share the results;
- (d) providing technical and financial support to the MOH for water quality monitoring and dissemination of results;
- (e) supporting the MOH to develop food safety guidelines.

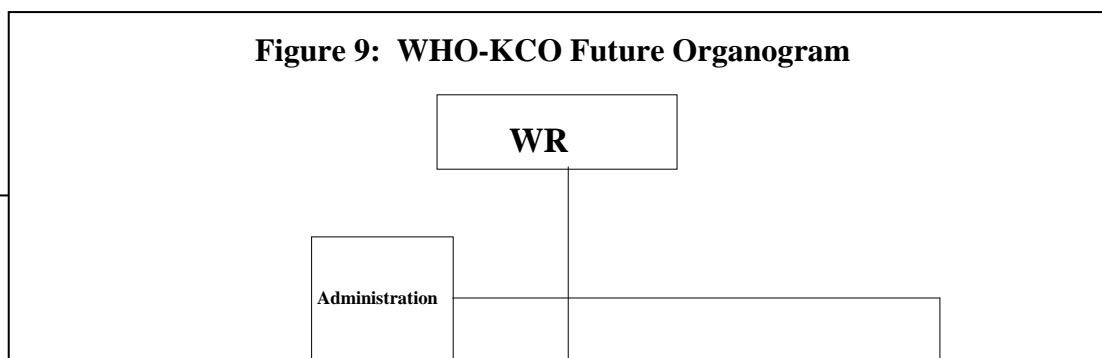
## 7. Implications of the Strategic Agenda for WHO

The CCS document entails strategic shifts in the vision and work of the WHO in Kenya. At the country office level, this shift in strategic focus affects staffing, management and operational implications; at the WHO/AFRO and headquarters levels, programming and budgeting implications should meet the Kenya needs for technical and financial support.

### 7.1 Implications for WHO Country Office

#### 7.1.1 Staffing support

The staffing issues concern both revisiting the work of the existing staff and recruiting new ones. The proposed new organogram is shown in Figure 9.



The following actions should be undertaken:

- (a) Updating the tasks of the position of Disease Prevention and Control (DPC) to include management process and health systems management functions in accordance with the challenges identified in the CCS. The profile of the DPC officer should focus on disease prevention and control, health policy, planning, health management, monitoring, evaluation and quality.
- (b) Recruiting NPOs for tuberculosis/HIV/AIDS, Essential Drugs Programme (EDP) and tobacco/NCD. The NPOs to be recruited will perform some of the functions previously handled by the DPC. The profile of the EDP should be focused on the management and quality assurance of drugs, equipment and drug quality control in laboratories.
- (c) Revising the TOR of the EPI officer to include the IDSR functions and those of the tobacco officer to include the NCD functions.
- (d) Streamlining the work of the HIP officer to focus on health promotion, documentation and information dissemination through use of short-term contracts to support health promotion.
- (e) Increasing the number of support staff to cater for the proposed technical staff activities.
- (f) Enhancing staff career development to meet the new challenges.

### **7.1.2 Managerial support**

The WHO Kenya Country Office will revisit biennial plans of action 2002–2003 and 2004–2005 in the light of the Kenya-CCS, hold semi-annual formal consultations with MOH programme managers organize an annual country office retreat on CCS implementation, advocate with partners to support

vehicle maintenance and replacement to sustain surveillance and subsequent eradication of polio and other diseases targeted for eradication and elimination and advocate for MOH and partners to strengthen transport management system (e.g. adapt the Riders for Health initiative).

## **7.2 Support from the Regional Office and Headquarters**

### **7.2.1 Capacity building**

The Regional Office will strengthen the technical and managerial capacity of the WHO Kenya staff by training NPOs and providing guidelines on new initiatives such as advocacy and resource mobilization and supporting exchange on best practices in the region.

### **7.2.2 Technical support**

Technical support from AFRO and HQ to the Kenya Country Office will be provided in the following areas: health system performance, including decentralization and development of SWAP; development of maternal death audit guidelines and skills for emergency obstetrics care; assessment of the burden of NCDs; health promotion skills; health financing, especially expertise to assist Kenya in accessing the Global Fund for HIV /AIDS, Tuberculosis and Malaria.

### **7.2.3 Financial support**

In most technical areas, Kenya has the expertise either in the WHO Country Office or in the country, but the office needs financial support for:

- (a) review of the Public Health Act and development of the strategic plan on environmental sanitation;
- (b) finalization of the draft national policy on nutrition and revision of the existing plan;
- (c) support to the Riders for Health Initiative and catalysing partners and MOH actions;
- (d) marketing the Kenya CCS to mobilize extra resources;
- (e) regular budget funds to address the needs expressed in the CCS.

## **8. Conclusion**

The 1994 Kenya Health Policy Framework sets out the agenda for health sector reform to promote and improve the health status of all Kenyans through deliberate restructuring of the health sector to make health services more effective, accessible and affordable. To translate this government policy into action, the National Health Sector Strategic Plan (1999–2004) was launched with a focus on decentralization of health authority through redistribution of services to the rural areas. Furthermore, the government adopted the Poverty Reduction Strategy Paper (2001–2004) in 2001. The PRSP recognizes that health is central to development and that poverty impacts negatively on health. The PRSP envisages pro-poor programming in the health sector.

The Ministry of Health has a plan to review the NHSSP with a vision to strengthening the health component of the PRSP. The WHO country cooperation strategy in Kenya in 2002 is seen as an opportunity, with other partners, to support the Ministry of Health in strengthening its capacity to better

respond to the reduction of the burden of disease among the Kenyan population. Based on a broad situation analysis and perceptions expressed by national and international partners, the CCS document identifies five components: health system development, disease prevention and control, reproductive and child health, health promotion and environmental health. These were selected in accordance with WHO comparative advantages.

The implementation of these components will contribute to reduction of morbidity and mortality from killer diseases, especially those targeting children and women; improvement of the performance of the health system; increased awareness of the population on health issues; development of sustainable environmental health.

In line with the CCS, the Organization will optimize its response to Kenya's needs by providing technical, material and financial support within the framework of its budget (regular and extra-budgetary). Furthermore, WHO will mobilize resources and advocate for increased resource allocation to health in Kenya with emphasis on programmes that reach the poor. To achieve these commitments, WHO Kenya will seek support from AFRO and HQ to strengthen its capacity in terms of staffing, development of managerial skills and programme funding.

## **Selected References**

1. Kenya National Population Census, 1999.
2. National Population Census, 1989.
3. Kenya Demographic Health Survey, 1998.
4. Kenya National Development Plan, 2002-2008.
5. The Kenya Economic Survey, 2001.
6. Kenya Human Development Report, 2001.
7. The United Nations Common Country Assessment for Kenya, 2001.
8. Kenya Poverty Reduction Strategy Paper (PRSP), 1997.
9. Kenya Manpower Development Report, 2001.

10. United Nations Development Assistance Framework, 1999–2003.
11. MOH HMIS Report, 1996–1999.
12. Kenya Health Service Provision Assessment, 1999.
13. Kenya Demographic and Health Survey, 1993.
14. Kenya National Malaria Situation Analysis, 1998.
15. Kenya National AIDS Programme Report, 2000.
16. Kenya National AIDS Control Council Report.
17. Kenya Leprosy and Tuberculosis National Programme Report, 2000.
18. Kenya Micronutrient survey, 2001 (unpublished).
19. Situation Analysis of Children and Women in Kenya. UNICEF, 1998.
20. Country Strategy on Water and Sanitation Services, 2001 (final draft).
21. Kenya Health Policy Framework, 1994.
22. Kenya National Health Sector Strategic Plan 1999–2004.
23. World Health Report, 2000.
24. Technical Guidelines for Integrated Disease Surveillance and Response in the African Region.
25. Kenya National Malaria Strategy (2001–2010).
26. Roll Back Malaria Initiative.
27. Sessional Paper No. 4 on AIDS in Kenya, 1999.
28. The United Nations and the MDGs, A Core Strategy, June 2002.
29. National Reproductive Health Strategy 1997-2010 (1996).
30. IMCI Strategy, 1998.
31. National Health Communication Strategy, 1999–2010.
32. Basic Agreement between WHO and GOK, 1964.
33. BPOA, 2002–2003.
34. WHO EB105/3. A Corporate Strategy for the WHO Secretariat.

35. WHO General Programme of Work 2002–2005.
36. The Work of WHO in the African Region, Strategic Framework 2002–2005.