Ministry of Health
Government of Kenya

KENYA
NATIONAL HEALTH ACCOUNTS
2005/06

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HEALTH SYSTEMS 20/20

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Mission

The Health Systems 20/20 **cooperative agreement,** funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

Date

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KENYA
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CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
BCC	Behaviour Change Communication
CBS	Central Bureau of Statistics
CSPro	Census and Survey Processing System
EA	Enumeration Area
FA	Financing Agent
FBOs	Faith-Based Organisations
FY	Financial Year
GDP	Gross Domestic Product
HDI	Human Development Index
HENNET	Health NGOs Network
HHEUS	Household Expenditure and Utilisation Survey
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IUD	Intrauterine Device
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Health Demographic Survey
KEPSA	Kenya Private Sector Alliance
KNBS	Kenya National Bureau of Statistics
Kshs	Kenya Shillings
MoH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS/STD Control Programme
NASSEP	National Sample Survey Evaluation Programme
NGO	Nongovernmental Organisation
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NHSSP	National Helath Sector Strategy Plan
NSE	Nairobi Stock Exchange
Nsk	Not Specified by Any Kind

OOP	Out-of-Pocket
OP	Outpatient
PEPFAR	President's Emergency Program for AIDS Relief
PLHIV	People Living with HIV
RH	Reproductive Health
RoW	Rest of the World
RTI	Reproductive Tract Infection
SPSS	Statistical Package for Social Scientists
STI	Sexually Transmitted Infections
SWAp	Sector-wide Approach
TB	Tuberculosis
THE	Total Health Expenditure
THE_{HIV}	Total Health Expenditure for HIV/AIDS
THE_{RH}	Total Health Expenditure for Reproductive Health
USAID	United States Agency for International Development
US$	U.S. Dollar
WHO	World Health Organisation

FOREWORD

Some of the most complex policy issues facing developing countries relate to health care financing, including: how much is invested in the overall health sector and is this adequate to meet equity and efficiency goals? If not, are there possible additional sources of financing that could be mobilised? What health services should be prioritised for a basic package and what is the appropriate mix of mechanisms to finance this package? National Health Accounts (NHA) is a useful tool for understanding many of these key policy issues that relate to health care financing.

NHA tracks all expenditure flows across a health system, and describes the sources, flow, and uses of financial resources within the health system, a basic requirement for optimal resource mobilisation and allocation. NHA is therefore an essential component of successful implementation of health reforms aimed at improving the provision of an optimal package of health care. The Government of Kenya has used the NHA framework to produce estimations for financial years 1994/95, 2001/02, and now for 2005/06. Taken together, such data provide valuable trend information to monitor whether funds are being spent as intended and if progress is being made towards national goals, particularly related to equity and efficiency.

Sources of health care funding in Kenya include: the Government of Kenya, donors, private firms, and households. Resources mobilised from these sources are channeled through intermediaries (called financing agents) to the providers of health care services and ultimately to the goods and services produced or paid for with those funds. For the 2005/06 estimation, a wide range of data and information were collected from various government documents. In addition, several surveys targeted to donors, nongovernmental organisations, insurance and other private companies, and households were conducted to complete the NHA process.

The data provided by this report are intended for all stakeholders involved in Kenya's health care system – public, private, and donors. It is hoped that the NHA estimates presented in this report will directly inform policy and go a long way to inform the development of the health care financing strategy for Kenya that shall feed into Vision 2030, Kenya's development blueprint, and other related policies. The NHA estimates should also encourage further research into Kenya's health care financing, leading to a better understanding of the problems facing the health sector while identifying areas in need of reform.

This NHA exercise was a collaborative effort between the Ministry of Health and Kenya National Bureau of Statistics. Financial support was provided by the United States Agency for International Development (USAID). USAID's Health Systems 20/20 project provided technical support.

Hon (Prof.) Anyang' Nyong'o EGH, MP
Minister for Medical Services

ACKNOWLEDGMENTS

The production of the NHA report for FY 2005/06, together with the subaccounts for HIV/AIDS and reproductive health, is a result of efforts from many people and institutions. The estimates to inform the NHA report are based on data collected by the Ministry of Health's Department of Policy and Planning, Kenya National Bureau of Statistics (KNBS), Kenya Private Sector Alliance (KEPSA), Health NGOs Network (HENNET), with contributions from the Ministry of Local Government and Inspectorate of State Cooperation.

The Ministry of Health would like to acknowledge the financial support provided by the United States Agency for International Development (USAID). USAID's Health System 20/20 project provided technical assistance through the efforts of Susna De, Lisa Fleisher, Ellie Brown, Darwin Young, Steve Musau, and Ken Carlson. The constant support provided by Melahi Pons and Bedan Gichanga, both of USAID/Kenya, is greatly appreciated.

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The Ministry of Health also appreciates the support, cooperation, and information supplied by the government departments and private organisations, nongovernmental organisations, insurance companies, development partners, and private firms, without which the NHA study would not have been complete. Special thanks go to all the departments/ sections of the Ministry of Health that participated and provided data for the NHA estimations. Special acknowledgements are extended to the Health Management Information System staff for their magnificent work in data entry.

Mr Stephen Muchiri, former head of the Department of Policy and Planning, oversaw the whole process while Mr Thomas Maina coordinated the data collection and analyses, and the compilation of the NHA report. Other central NHA team members include: Mr Dhimn Nzoya, and Mr Geoffrey Kimani. All are thanked for their contributions. The head of the Department of Policy and Planning, Mr Elkana Ong'uti, supported this effort as well.

Finally, estimates of NHAs are a process that must constantly be improved. Users of the data and the analyses in this report are, therefore, invited to freely comment on its contents, presentation, and format, as this will reveal areas where improvements could be made.

EXECUTIVE SUMMARY

BACKGROUND

National Health Accounts (NHA) is an internationally recognised method used to track expenditures in a health system for a specified period of time. Specifically, NHA details the flow of funding from financial sources (e.g., donors, Ministry of Finance), to financing agents (i.e., those who manage the funds, such as the Ministry of Health [MoH] or nongovernmental organisations [NGOs]), to providers (e.g., public and private facilities) and finally to end uses (e.g., inpatient and outpatient care, pharmaceuticals). Actual expenditures, rather than budget inputs, are used to fill a series of tables that show the flow of funding through the health sector. NHA also provides detailed breakdowns of disease-specific expenditures such as those for HIV/AIDS and reproductive health (RH). NHA is designed to be used as a policy tool to facilitate the implementation of health system goals.

This report describes findings from the third round of NHA in Kenya. The first two estimations covered financial years (FYs) 1994/95 and 2001/02, respectively. This third round, undertaken in 2007 and covering 2005/06 was implemented by the MoH and Kenya National Bureau of Statistics (KNBS) with financial support from the United States Agency for International Development (USAID). USAID's Health Systems 20/20 Project, led by Abt Associates Inc., provided technical support. The findings will be used as a platform for informing policy decisions concerning resource allocation and will also be used by stakeholders in the sector.

METHODOLOGY

The Kenya NHA estimation was conducted in accordance with the methodology described in the *Guide to Producing National Health Accounts; with special application for low-income and middle-income countries* (World Health Organisation, World Bank, and USAID 2003) and was informed by both primary and secondary data. A wide range of data and information were compiled from government reports such as the Appropriation Accounts, 2005/06 National AIDS Control Council Annual Report and Accounts, KNBS data, the Public Expenditure Review 2007, and others as referenced throughout this report. In addition, surveys were conducted to further triangulate secondary and primary data sources. Data collected included information from the household health expenditure and utilisation survey and institutional surveys for employers, government agencies, donors, NGOs, and insurance companies.

FINDINGS

The availability of estimations for overall health spending and HIV/AIDS health expenditures for 2001/02 provides a valuable opportunity to compare financing patterns from 2001/02 with the current round of 2005/06. The time periods are significant in that the 2001/02 estimate illustrates spending patterns prior to the roll out of a number of "pro-poor" government policies and the influx of donor funds for priority areas, such as HIV/AIDS, malaria, and tuberculosis. Conversely, the 2005/06 estimates represent the financial situation following the roll-out of these initiatives. Thus, by comparing expenditures between the two years, one can gain some understanding of the financial effect of policies and investments made

between the two time points. Note, all references to Kshs or dollar amounts for the year 2001/02 have been adjusted for inflation to facilitate comparison with 2005/06 estimates.

GENERAL HEALTH EXPENDITURES

Table ES.1 offers summary statistics from the 2001/02 and 2005/06 NHA estimates.

TABLE ES.1: GENERAL NHA SUMMARY STATISTICS, 2001/02 AND 2005/06

Indicators	2001/02	2005/06
Total population	31,190,843	35,638,694
Exchange rate	78.6	73.4
Total real GDP Ksh	1,118,781,868,506	1,519,400,000,000
Total real GDP US$	$ 14,233,866,012	$ 20,693,224,379
Total Gov't expenditure Ksh	211,517,580,466	401,518,324,607
Total Gov't expenditure US$	$ 2,691,063,365	$ 5,468,414,363
Total Health Expenditure (THE) Ksh	57,097,636,970	70,807,957,722
Total Health Expenditure (THE) US$	$ 726,433,040	$ 964,357,613
THE per capita	1,831	1,987
THE per capita (US$)	23	27
THE as a % of nominal GDP	5.1%	4.8%
Gov't health expenditure as a % of Gov't total expenditure	8.0%	5.2%
Financing sources as a % of THE		
Public	29.6%	29.3%
Private	54.0%	39.3%
Donor	16.4%	31.0%
Other	0.1%	0.4%
Household (HH) spending		
Total HH spending as % of THE	51.1%	35.9%
OOP spending as % of THE	44.8%	29.1%
HH spending per capita	770	713
OOP spending per capita	819	578
Financing agent distribution as a % of THE		
Public	42.8%	42.7%
Private	49.8%	36.5%
Donor	7.4%	20.8%
Provider distribution as a % of THE		
Public facilities	49.4%	44.3%
Private facilities	35.7%	29.2%
Other	14.9%	26.5%
Function distribution as a % of THE		
Inpatient care	32.1%	29.8%
Outpatient care	45.2%	39.6%
Pharmaceuticals	7.4%	2.6%
Prevention and public health programs	9.1%	11.8%
Health administration	5.0%	14.5%
Other	1.3%	1.7%

In 2005/06, Kenya spent approximately Kshs 71 billion (US$ 964.4 million) compared with Kshs 57 billion (US$ 726.4 million) in 2001/02, an increase of 24 percent. Per capita total health expenditure (THE) increased from Kshs 1,831 (US$ 23) in 2001/02 to Kshs 1,987 (US$ 27) in 2005/06.

In 2005/06, households accounted for 36 percent of THE, a decrease of 13 percent from 2001/02. In absolute values, the household expenditure decreased from Kshs 29 billion in 2001/02 to Kshs 24 billion

in 2005/06. Households remained the largest contributors of health funds, followed by the government and donors. However, the gap between the relative contributions of the three major financiers narrowed with increased investments largely from donors coupled with a decline in household health spending.

Donor contributions to THE have increased by 135 percent since 2001/02. The donor share of THE increased from 16 percent in 2001/02 to 31 percent in 2005/06. Government spending in absolute values increased from Kshs 17 billion in 2001/02 to Kshs 21 billion in 2005/06, or 23 percent. However, in 2005/06, government spending on health as a percentage of total government expenditure was 5 percent, down from 8 percent in 2001/02.

In 2005/08, the public sector managed 43 percent of the resources mobilised by financing sources, with the MoH accounting for 35 percent. The private sector managed 37 percent; this sector includes households' management of health funds through their out-of-pocket (OOP) spending on health, which accounted for 29 percent of THE. Donors and NGOs managed the balance of THE, 21 percent.

Private for-profit hospitals consumed the largest proportion of OOP funds, 38 percent; in 2001/02, they consumed only 15 percent. This share was followed by government hospitals' consumption of 30 percent of OOP funds, a decrease from 50 percent in 2001/02.

Although in relative terms, spending on outpatient care declined between 2001/02 and 2005/06, it still consumed the largest proportion of THE, 40 percent, followed by inpatient care at 30 percent. Prevention and public health programmes and health administration recorded substantial increases of 66 percent and 22 percent, respectively.

HIV/AIDS EXPENDITURES ON HEALTH

Table ES.2 offers summary statistics for the 2001/02 and 2005/06 HIV/AIDS subaccount estimations.

Total HIV/AIDS health expenditures (THE_{HIV}) increased from approximately Kshs 10 billion (US$ 126 million) in 2001/02 to approximately Kshs 19 billion (US$ 256 million) in 2005/06. In 2005/06, THE_{HIV} accounted for 27 percent of THE or 1.2 percent of the gross domestic product (GDP). Also in 2005/06, donors accounted for the vast share (70 percent) of THE_{HIV}, followed by households (22 percent) and government (7 percent). The government contribution to THE_{HIV} declined by about 30 percent, from Kshs 2.1 billion (US$ 26.9 million) in 2001/02 to Kshs 1.4 billion (US$ 18.7 million) in 2005/06 and may signal that donor funding is displacing government funding for HIV/AIDS.

The level of OOP spending on HIV/AIDS remained the same (about 22 percent) between the two estimates, although total HIV household expenditures as a percentage of THE increased from 5 percent in 2001/02 to 6 percent in 2005/06.

Donors and NGOs managed 56 percent of THE_{HIV} in 2005/06, an increase from 15 percent in 2001/02. This is in contrast to public financing agents, who managed the majority (60 percent) of HIV/AIDS funds in 2001/02, but less than one quarter in 2005/06.

OOP spending at public facilities accounted for over half of THE_{HIV} in 2001/02. In 2005/06, OOP spending at public facilities dropped to 18 percent of THE_{HIV}. Household OOP spending on pharmaceuticals decreased, from 16 percent of OOP expenditures in 2001/02 to 2 percent in 2005/06.

The share of THE_{HIV} going to providers of public health programmes decreased from 43 percent in 2001/02 to 29 percent in 2005/06. Nevertheless, this still represented the largest share of THE_{HIV}. In 2005/06 curative care accounted for 56 percent of THE_{HIV} followed by prevention and public health programmes at 27 percent.

TABLE ES.2: HIV/AIDS SUBACCOUNT SUMMARY STATISTICS, 2001/02 AND 2005/06

Indicators	2001/02	2005/06
Prevalence rate (adults)	6.7%	5.1%
Number of PLHIV	982,685	1,091,000
Total HIV/AIDS health expenditure (THE_{HIV}) Ksh	9,927,769,404	18,807,268,861
Total HIV/AIDS health expenditure (THE_{HIV}) US$	$ 126,307,499	$ 256,142,579
Total HIV/AIDS expenditure (THAE) Ksh	12,162,246,078	20,501,452,153
Total HIV/AIDS expenditure (THAE) US$	$ 154,735,955	$ 279,216,236
HIV/AIDS health spending per PLHIV Ksh	10,103	19,016
HIV/AIDS health spending per PLHIV US$	$ 129	$ 259
HIV/AIDS spending as a % of general THE	17.4%	26.6%
HIV/AIDS spending as a % of GDP	0.9%	1.2%
THE_{HIV} as a % of total HIV/AIDS spending (health and non-health)	-	91.7%
THE_{HIV} % targeted for HIV/AIDS	-	85.1%
Financing sources as a % of THE_{HIV}		
Public	21.3%	7.3%
Private	27.8%	22.7%
Donor	50.8%	70.0%
Other	0.1%	0.03%
Household (HH) spending		
Total HIV HH spending as % of general THE	4.6%	6.0%
OOP spending as % of THE_{HIV}	21.3%	22.0%
Financing agent distribution as a % of THE_{HIV}		
Public	60.0%	22.0%
Private	24.8%	22.4%
Donor and NGO	15.2%	55.5%
Provider distribution as a% of THE_{HIV}		
Public facilities	41.4%	35.0%
Private facilities	14.4%	21.4%
Other	44.2%	43.6%
Function distribution as a % of THE		
Curative Care	44.2%	56.0%
Prevention and public health programs	47.1%	26.6%
Pharmaceuticals	4.9%	1.7%
Other	3.7%	15.7%

REPRODUCTIVE HEALTH EXPENDITURES

There was no RH subaccount done in 2001/02, so no comparisons could be made and hence this section will provide only expenditure estimates for 2005/06. Table ES.3 offers summary statistics for the 2005/06 RH subaccount estimation.

TABLE ES.3: REPRODUCTIVE HEALTH SUBACCOUNT SUMMARY STATISTICS, 2005/06

Indicators	2005/06
Total RH (THE_{RH}) health expenditure Ksh	8,968,692,131
Total RH (THE_{RH}) health expenditure US$	$ 122,147,663
Total RH expenditure (TRE) Ksh	9,045,417,231
Total RH non-health expenditure (TRE) US$	$ 123,192,608
RH expenditure per woman of reproductive age Ksh	1,009
RH expenditure per woman of reproductive age US$	$ 14
RH expenditure as a % of GDP	0.6%
RH expenditure as a % of general THE	12.7%
THE_{RH} % targeted for RH	54.0%
THE_{RH} as a % of total RH spending (health and non-health)	99.4%
Financing sources as a % of THE_{RH}	
Public	34.2%
Private	41.0%
Donor	24.1%
Other	0.7%
Household (HH) spending	
Total RH HH spending as % of THE_{RH}	38.4%
OOP spending as % of total RH HH spending	68.5%
OOP spending as % of THE_{RH}	26.3%
OOP spending per woman of reproductive age	266
Financing agent distribution as a % of THE_{RH}	
Public	54.0%
Private	44.3%
Donor	1.6%
Provider distribution as a% of THE_{RH}	
Public providers	61.0%
Private providers	29.8%
Provision of public health programs	3.9%
Other	5.3%
Function distribution as a % of THE_{RH}	
Inpatient care	62.1%
Outpatient care	25.4%
Pharmaceuticals	0.1%
Prevention and public health programs	3.4%
Health administration	5.8%
Other	3.3%

Total RH spending (THE_{RH}) in 2005/06 was Kshs 9 billion (US$ 122 million). It accounted for 13 percent of THE or 0.6 percent of the GDP. The private sector contributed 41 percent of THE_{RH} (households provided 38 percent of THE_{RH}), followed by public sector at 34 percent.

Public sector entities managed 54 percent of THE_{RH}, with the MoH managing 46 percent. The private sector managed 44 percent.

Households spent approximately 57 percent of their OOP resources on RH at private providers. The money was used to purchase outpatient and inpatient curative care in nearly equal proportions. Maternal and antenatal health care consumed more than 67 percent of all spending on RH.

As a share of all expenditures on RH, public providers were the most significant, consuming 61 percent, while private providers accounted for 30 percent.

POLICY IMPLICATIONS

Although government spending on health increased by 23 percent between 2001/02 and 2005/06, the health sector appears to have slipped somewhat in the government's priorities. In 2001/02, total government spending on health was 8 percent of GDP compared with 5 percent in 2005/06. In view of the continuing health challenges facing the country, it is important that the government continues to invest in health and that health be recognised as an important component of economic development.

Policies favoring the poor, such as the "10/20 Policy," have produced a favorable and significant impact in reducing both per capita OOP spending by households as well as the share of total health funding contributed by households. Such efforts should continue with further investments to harness OOP spending into more efficient uses such as health insurance. While the government is promoting social health insurance, there should also be investigation into the role that micro health insurance initiatives can play.

The private sector continues to be a major force in the provision of health services. In 2005/06, 49 percent of household OOP health spending was at private hospitals (faith-based and for-profit). There is need for quality assurance in the private sector and the introduction of accreditation may be one way of encouraging private hospitals to higher levels of health care.

Donors continue to be the major source of HIV/AIDS funding, accounting for 70 percent of all HIV/AIDS health expenditures in 2005/06. This raises the question of how such levels of investment can be sustained in order to ensure that there is no break in funding the roll-out of HIV/AIDS interventions.

The government financed 34 percent of THE_{RH} in 2005/06. In view of Kenya's poor maternal and child health indicators, there is scope for more public investment, in particular, considering that households were funding 38 percent of THE_{RH}.

1. INTRODUCTION AND BACKGROUND

1.1 CONCEPT AND PURPOSE OF NHA

National Health Accounts (NHA) constitutes a systematic, comprehensive, and consistent method for monitoring resource flows in a country's health system. It is a tool for health sector management and policy development that measures total public and private (including households) health expenditures. It tracks all expenditure flows within a health system, and links the sources of funds to service providers and to ultimate uses of the funds. Thus, NHA answers questions like: Who pays? How much? For what?

NHA is designed to facilitate the successful implementation of health system goals by policymakers who are entrusted to provide an optimal package of goods and services to maintain and enhance the health of individuals and populations, to be responsive to their legitimate expectations, and to protect them from an unfair financial burden. For any given year, NHA traces all the resources that flow through the health system over time. Due to its internationally standardised framework, it also facilitates comparison across countries.

NHA therefore provides important pre-requisite data for optimizing health resource allocation and mobilisation, identifying and tracking shifts in resource allocations (e.g., from curative to preventive, or from public to private sector), comparing findings with other countries, and finally, assessing equity and efficiency in a dynamic health sector environment. Given the flexibility of the NHA, it is also possible to assess whether targeted efforts are having the desired impact.

1.2 HISTORY OF NHA IN KENYA

The demand for a comprehensive description of the flow of resources in the health sector to guide policy development was the motivation behind conducting the first round of NHA in Kenya in 1998, for financial year (FY) 1994/95. [1] The first round of NHA partly utilised household health expenditures data that were obtained from the *Welfare Monitoring Survey* of 1994 (Central Bureau of Statistics [CBS] 1994).

Results from the 1998 NHA were received with mixed reactions by policymakers, who felt that the results underestimated the government's contribution to total health expenditure (THE) in Kenya. Against this background, the Ministry of Health (MoH) [2] established a NHA team comprising the MoH Department of Policy and Planning and the CBS to carry out a more comprehensive NHA study in 2003 (for 2001/02 expenditures). The study was funded by the United States Agency for International Development (USAID)/Kenya mission, Swedish International Development Cooperation Agency (SIDA), government of Kenya, and National Hospital Insurance Fund (NHIF). This second round was well

[1] NB: Most years in this report, particularly years used in the NHA estimations, are financial years, and are written with a slash: 1994/95 (FY 1995), 2001/02 (FY 2002), and 2005/06 (FY 2006).
[2] The term "Ministry of Health" (MoH) is used throughout this report, although the ministry has been split into the Ministry of Medical Services and Ministry of Public Health and Sanitation.

received by all stakeholders and the findings were used to mobilise additional funds for the health sector, especially from the Ministry of Finance.

This third round of NHA, undertaken in 2007, used 2005/06 expenditures and was funded by the USAID/Kenya mission and government of Kenya. A number of stakeholders in the health sector, especially those who constitute the Health Care Financing Task Force and those engaged in the Sector-wide Approach (SWAp) process, were also involved. It is expected that the findings will be used to shape the financing framework of the health sector in Kenya.

1.3 POLICY OBJECTIVES OF THE THIRD ROUND OF NHA

The overall objective of the NHA study was to estimate THE in 2005/06 with a view to obtain data that will inform health policy formulation and development. The specific objectives included:

- Estimate THE in Kenya;
- Document the distribution of THE by financing sources and financing agents;
- Determine the contribution of each stakeholder in financing health care in Kenya;
- Articulate the distribution of health care expenditures by use;
- Analyze efficiency, equity, and sustainability issues associated with the current health care financing and expenditure patterns in Kenya; and
- Provide estimates that will inform the development of the health care financing strategy.

1.4 SOCIOECONOMIC AND POLITICAL BACKGROUND

During the past two decades, Kenya's economic performance has been far below its potential. The economy made initial gains soon after independence in 1963, but in the early 1980s it started a downward trend and deteriorated further by the late 1990s. During the period 1990 to 2002, the country went through a period of economic recession; real GDP growth fell from 4.6 percent in 1996 to –0.3 percent in 2000. The economy grew slightly (1.2 percent) in 2001 but then fell to 1.1 percent in 2002, mainly due to low demand for imports, low demand for credit, and failure by donors to disburse aid. The economy has shown signs of recovery with real GDP growing from 2.9 percent in 2003 to 7.0 percent in 2007 before slowing due to the effects of post-election violence.

The above scenario, coupled with the insurgency of diseases like malaria, tuberculosis (TB), and HIV/AIDS and increased poverty incidence at 56 percent in 2001 (*Welfare Monitoring Survey*, CBS 2001), led to the deterioration of Kenyans' welfare. The decline in their living standards is demonstrated by the rise in child mortality rates, maternal mortality rates, increasing rates of illiteracy, and rising unemployment rates. The Kenya Human Development Index (HDI), which measures the socioeconomic progress of the country, dropped from 0.556 in 1990 to 0.529 in 2000 and was reported to have slipped further to 0.521 in 2005 according to the *Human Development Report* 2007/2008 (United Nations Development Programme [UNDP] 2007). Life expectancy, which also explains the country's HDI, declined from 62 years in 1991 to 46 years in 2005, while adult literacy stood at 83.3 percent. In addition, the number of people openly unemployed was over 2 million or 9.2 percent of the labour force, with the youth accounting for 45 percent of the unemployed (*Economic Survey* 2005, Republic of Kenya, National Bureau of Statistics [KNBS]).

The provision of quality education has been a major priority for the government of Kenya as stated in the Vision 2030. Due to the free primary education introduced in 2003, the gross enrollment rate at the primary school level rose from 88.7 percent to 104.8 percent in 2007. Increases in enrollment have also been reported at both public and private universities.

1.4.1 DEMOGRAPHIC TRENDS

Kenya's population was estimated to be approximately 28.7 million by the Kenya Population and Housing Census of 1999 (CBS 2002). The estimated population for 2003 was 32.2 million, 34.7 million in 2007. With a projected annual growth rate of 2.2 percent, the population is projected to increase to 36.5 million by 2010. The population under 20 years of age accounts for about 60 percent of the population. Life expectancy, which was on the decline, is estimated to be about 52.1 years (UNDP 2007) and is expected to fall further due to the rising incidence of HIV. The fertility rate declined from 8.1 in 1978 to 5.4 in 1992, 4.7 in 1998 and 4.9 in 2003. This reflects a rise in the contraceptive prevalence rate of 18, 27, 31, and 39 percent in 1989, 1993, 1998, and 2003, respectively.

Child mortality has remained relatively high. In 1985, the infant mortality rate was reported to be 62/1,000; in the few years until 1998, the rate increased to 71/1,000, when the reverse should have taken place. By 2003, it had increased further, to 77/1,000. Under-five mortality also rose, by 25 percent, from 105/1,000 in 1998 to 115/1,000 in 2003. The maternal mortality ratio was 590/100,000 in 1998, 414/100,000 in 2003. Complications from abortion account for up to 40 percent of maternal deaths. Of major concern are the wide disparities of the health indicators across regions as shown in Table 1.1.

TABLE 1.1: SAMPLED HEALTH INDICATORS BY PROVINCE, 1998 AND 2003

Province	Infant Mortality Rate		Under-five Mortality Rate		Fertility Rate	
	1998	2003	1998	2003	1998	2003
Nairobi	41	67	66	95	2.6	2.7
Central	27	44	35	54	3.7	3.4
Coast	70	78	96	116	5.1	4.9
Eastern	53	56	78	84	4.7	4.8
Nyanza	135	133	199	206	5.0	5.6
Rift Valley	50	61	68	77	5.3	5.8
Western	64	80	123	144	5.6	5.8
North Eastern		91		163		7.0
National	71	77	105	115	4.7	4.9

Sources: National Council for Population and CBS (1998, 2003), henceforth referred to as the Kenya Demographic and Health Survey (KDHS)

Regional variations have been reported, with certain districts in North Eastern, Nyanza, and Coastal provinces having the highest burden of disease. Fevers and upper respiratory tract diseases are the two commonest causes of ill health, accounting for about 50 percent of all outpatient morbidity and 20-25 percent of all reported deaths. This pattern has persisted during the past decade. The top six causes of morbidity are malaria, upper respiratory diseases, skin diseases, diarrhoea, intestinal diseases, and malnutrition/anemia.

Access to safe water is currently estimated at 91 percent in urban areas and 51 percent in rural areas, or a national average of 60 percent. In addition, close to 86 percent of the population has access to safe sanitation, with 98 percent in urban areas and 82 percent in the rural areas. However, access to clean water and sanitation varies from region to region and with considerable disparities within regions (MoH

2007, henceforth referred to as the Household Health Expenditure and Utilisation Survey [HHEUS], 2007).

1.4.2 INTERNATIONAL COMPARATIVE ANALYSIS OF HEALTH AND ECONOMIC INDICATORS

Table 1.2 shows a comparison of selected indicators across the region. Relative to other countries in eastern Africa, Kenya is faring better on several economic and health indicators. The size of Kenya's economy and per capita income are amongst the highest in the subregion. However, its wealth does not necessarily translate into good health outcomes. For example, the infant mortality rate in Kenya remains high, especially in comparison with other countries with much smaller economies and per capita incomes, such as Eritrea and Tanzania. The under-five mortality rate in Kenya is one of the lowest in the subregion, as is maternal mortality. However, these issues remain high priorities for the country. The adult literacy rate is the highest in the subregion, perhaps resulting from government efforts to prioritise this issue relative to Millennium Development Goal 2. HIV prevalence, currently at 7.4 percent (MoH National AIDS/STD Control Programme [NASCOP] 2007, Kenya AIDS Indicator Survey, Preliminary report, henceforth referred to as KAIS 2007), is similar to prevalence in Uganda and Tanzania.

TABLE 1.2: INTERNATIONAL COMPARISON OF SELECTED HEALTH AND ECONOMIC INDICATORS

Indicators	Kenya	Uganda	Rwanda	Tanzania	Malawi	Zambia	Ethiopia	Eritrea
Population (millions), 2005	35.6	28.9	9.2	38.5	13.2	11.5	79	4.5
GDP (US$ billions), 2005	18.7	8.7	2.2	12.1	2.1	7.3	11.2	1
GDP per capita (US$), 2005	547	303	238	316	161	623	157	220
Infant mortality rate per 1,000, 2005	79	79	118	76	79	102	160	50
Under-five mortality per 1,000, 2005	120	136	203	122	125	182	164	78
Maternal mortality per 100,000 births, 2004	410	510	1,100	580	980	730	870	1,000
Total fertility (births per woman), 2005	5	6.7	6	5.7	6	5.6	5.8	5.5
Adult literacy rate (% age 15 and older), 2005	73.6	66.8	64.9	69.4	64.1	68	35.9	
Life expectancy, 2005	52.1	49.7	45.2	51	46.3	40.5	51.8	56.6
Contraceptive prevalence rate, 2005	39	20	17	26	33	34	15	8
HIV/AIDS prevalence (% age 15-49), 2005	6.1	6.7	3.1	6.5	14.1	17	0.9-3.5	2.4

Sources: UNDP 2007; KDHS 2003; CBS 2002

1.4.3 NATIONAL GOALS AND VISION

The MoH is currently implementing the second National Health Sector Strategic Plan (NHSSP II) for 2005-2010; its theme is "Reversing the Trends." The NHSSP is expected to build on the existing investment by the government and development partners. Its vision is to have an efficient and high-quality health care system that is accessible, equitable, and affordable to every Kenyan. The base of the NHSSP is a single comprehensive package known as the Kenya Essential Package for Health. Its focuses

on primary health care through community interventions and preventive care at the rural health facility level.

The goal of health sector as defined in the NHSSP is to reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators. The health sector strategic objectives are to: 1) increase equitable access to health services; 2) improve the quality and responsiveness of services in the sector; 3) improve the efficiency and effectiveness of service delivery; 4) enhance the regulatory capacity of MOH; 5) foster partnerships in improving health and delivering services; and 6) improve the financing of the health sector.

1.4.4 HEALTH SECTOR: OVERVIEW AND ORGANISATIONAL STRUCTURE

Key challenges to achieving better health status in Kenya include inequitable access to health services (removal of geographic, cost, and gender barriers); shortages of qualified health workers with appropriate skills; shortages of drugs, supplies, and equipment; inadequate resources for facility and outreach services; weak management and support capacity at the district level; cumbersome and inefficient support systems at the central level (financial management, procurement, human resources); an outdated centralised ministry structure poorly equipped to respond to new priorities; and governance and stewardship.

Health services in Kenya are provided primarily by three agents: 1) the MoH; 2) nongovernmental organisations (NGOs) (mostly faith-based organisations [FBOs]); and 3) the private for-profit sector. The MoH controls 53 percent of all health facilities while FBOs and the private for-profit sector control 16 percent and 31 percent, respectively. In addition, the MoH is mandated to create an enabling environment, and regulate and set standards for health care service provision in the country.

The health sector has been implementing a SWAp, which was initiated in 2005 to coordinate and harmonise the efforts of the government, development partners, and all other stakeholders in the health sector using one common sector strategy (NHSSP II) and expenditure framework, with common management arrangements (including fiduciary, and monitoring and evaluation) and MoH leadership.

1.4.4.1 PUBLIC SECTOR

The public sector is predominantly a tax-funded health system, but there has been a gradual introduction of a series of health financing policy changes. User charges for health services were introduced formally in 1989. Today, these user fees still exist and their impact on health care access has been the subject of several empirical studies. The NHIF was introduced in 1965, but this was compulsory only for formal sector workers and has been associated with an inadequate insurance benefit package. In November 2004, a new health financing reform was submitted to Parliament, involving the establishment of National Social Health Insurance Fund with the intent to cover all of the Kenyan population. This initiative has not yet been implemented. A health financing strategy is being prepared to inform debate on the development of the financing framework for the health sector.

1.4.4.2 PRIVATE NOT-FOR-PROFIT ORGANISATIONS (INCLUDING FBOS)

FBOs and other not-for-profit organisations are financed primarily by user fees, which account for more than 95 percent of their revenue (Assessment of FBO Sector, 2006). However, the increased utilisation of services in public health facilities has had a negative impact on services offered by FBOs. With more patients seeking care at public facilities, most FBOs are seeing a decline in their patient volumes and user fee revenues. As a result, many of them are struggling to stay afloat. Because FBOs are a major provider

of health care services, especially in the rural areas, the government continues to extend support to these providers to prevent their facilities from collapsing, in the form of secondment of staff and drug kits to all dispensaries.

1.4.4.3 PRIVATE FOR-PROFIT SECTOR

This sector, which typically serves the wealthier segments of the Kenyan population, is financed from user fees and reimbursements by health insurance companies. Small private clinics also abound and are frequented by even the poor, especially in rural areas.

1.5 ORGANISATION OF THE REPORT

This report presents the findings of the third round of Kenya's NHA for 2005/06. The report is organised into six chapters. This chapter has provided background information on socioeconomic conditions, demographic trends, and the organisation structure of the health care system. Chapter 2 describes the methodology used for data collection for household and institutional surveys, data entry and cleaning, and assumptions made to populate the data analysis Excel worksheets. Chapter 3 presents findings on the general NHA, Chapters 4 and 5 on the HIV/AIDS and reproductive health (RH) subaccounts, respectively. Chapter 6 gives concluding remarks and recommendations for next steps.

2. METHODOLOGY

2.1 OVERVIEW OF APPROACH

The Kenya NHA study was conducted in accordance with the *Guide to producing national health accounts; with special application for low-income and middle-income countries* (World Health Organisation, World Bank, and USAID 2003) and used both primary and secondary data. A wide range of data and information were collated from various government documents. In addition, the following surveys were conducted to complete the NHA process:

1. HHEUS; and

2. Institutional surveys covering:

- Employers/ firms;
- Public sector organisations/institutions providing health services/incurring expenditures on employees health including the MoH, local authorities, and parastatals;
- Donors (both bilateral and multilateral donors) ;
- Insurance (public and private); and
- NGOs involved in health

2.2 SAMPLING APPROACHES

This section describes the sampling strategy, data collection, and the sources of data collected for household and institutional surveys.

2.2.1 HOUSEHOLD HEALTH EXPENDITURE AND UTILISATION SURVEY

The NHA HHEUS was designed to generate national and provincial estimates. Data collection was carried out in September and October 2007. The target population for the survey was all the households in the country. For comparison with 2003 estimates, an attempt was made to visit the same households surveyed in 2003.

2.2.1.1 SAMPLE COVERAGE AND RESPONSE RATES

Table 2.1 shows the sample coverage and household response rates. A total of 8,844 households were selected for the survey. Of these, 8,453 were successfully interviewed, giving a response rate of 95.6 percent, and the survey reported observations on 38,235 individuals living in these households.

TABLE 2.1: SAMPLE COVERAGE AND HOUSEHOLD RESPONSE RATES, BY PROVINCE

Province	Urban		Rural		Total		Percent Response		Percent Response
	Selected	Responded	Selected	Responded	Selected	Responded	Urban	Rural	Total
Nairobi	1,080	1,012	-	-	1,080	1,012	93.7	NA	93.7
Central	216	213	984	953	1,200	1,166	98.6	96.8	97.2
Coast	444	419	636	624	1,080	1,043	94.4	98.1	96.6
Eastern	180	173	1,020	975	1,200	1,148	96.1	95.6	95.7
North Eastern	132	128	408	383	540	511	97.0	93.9	94.6
Nyanza	216	207	984	966	1,200	1,173	95.8	98.2	97.8
Rift Valley	252	251	1,176	1,156	1,428	1,407	99.6	98.3	98.5
Western	252	251	864	753	1,116	993	99.6	87.2	89.0
TOTAL	2,772	2,654	6,072	5,810	8,844	8,453	95.7	95.7	95.6

2.2.1.2 SAMPLING FRAME

Kenya is divided into eight administrative provinces. The provinces are in turn subdivided into 70 districts. Each district is subdivided into divisions while the divisions are split into locations and finally each location into sublocations. During the 1999 population census, each sublocation was subdivided into smaller units called enumeration areas (EAs). Kenya has about 62,000 EAs. The EAs provided census information on households and population. This information was used in the design of the National Sample Survey Evaluation Programme (NASSEP) IV master sample with 1,800 selected EAs. The cartographic records for each EA in the master sample were updated in the field, one year preceding the NHA survey. The 1,800 clusters were distributed into 540 urban and 1,260 rural clusters.

2.2.1.3 STRATIFICATION: SAMPLE SIZE AND ALLOCATION TO PROVINCES

The province provided a natural stratification of the population. The six major urban centres˜ Nairobi, Mombasa, Kisumu, Nakuru, Eldoret, and Thika˜ were further substratified into five socioeconomic classes based on incomes to circumvent the extensive socioeconomic diversity inherent in them as follows: *upper, lower upper, middle, lower middle and lower*; this improved the precision of estimates due to reduced sampling variation.

It was estimated that 8,844 households would be sufficient to provide estimates both at provincial and national levels as well as disaggregation to urban and rural components of the country. This sample was to yield 6,060 interviews in the rural and 2,784 in the urban clusters (Table 2.2). This was to be achieved through coverage of 737 clusters (505 rural and 232 urban clusters). Twelve households were to be covered in each cluster. The method of proportional allocation was used in assigning the sample households to the provinces and districts. The count of the households was transformed to the square root of the census households to avoid under-representing the smaller districts.

TABLE 2.2: DISTRIBUTION OF CLUSTERS AND HOUSEHOLDS IN THE SAMPLE BY PROVINCE, URBAN/RURAL, 2007

Province	Cluster			Household		
	Rural	Urban	Total	Rural	Urban	Total
Nairobi	0	90	90	-	1,080	1,080
Central	82	18	100	984	216	1,200
Coast	53	37	90	636	444	1,080
Eastern	85	15	100	1,020	180	1,200
North Eastern	34	11	45	408	132	540
Nyanza	82	18	100	984	216	1,200
Rift Valley	98	21	119	1,176	252	1,428
Western	72	21	93	864	252	1,116
TOTAL	506	231	737	6,072	2,772	8,844

2.2.1.4 DATA COLLECTION

Data collection was undertaken in September and October 2007 in all provinces. The country was divided into 10 regions for ease of supervision. Data were collected from the selected households using the face-to-face interview method. In each household included in the sample, information was collected with regard to household membership (alongside demographic variables), health status, health care seeking pattern, health expenditure if any, and other common household expenditures such as rent, education costs, expenditure on certain large items (for example, purchase of vehicle, construction of building over the previous 12 months), and income. The information was obtained mainly from the head of the household, husband/wife, or other household members who were familiar with the particulars asked.

To maximise response, interviewers made up to three call backs at different times of the day on households that were difficult to contact. In each cluster, a total of 12 households were covered. Completed questionnaires were reviewed for completeness as well as data quality.

2.2.1.5 DATA PROCESSING AND ANALYSIS

To expedite data entry and monitor data quality, all completed questionnaires were sent to a data management unit at the MoH Planning Department, which was the designated secretariat for the activity. This approach helped in standardizing and speeding up data entry and reducing errors. Questionnaires were also checked for completeness before entry. Data were entered in a Census and Survey Processing System (CSPro) by a team of data entry clerks under the supervision of data entry supervisors. The data were reentered for validation. The data files were then converted into SPSS, the software used for data analysis. Much of the analysis was replicated using Stata, to confirm that weighted estimates were correct. Stata was also used to perform analysis that could not be undertaken using SPSS.

2.2.1.6 WEIGHTING THE SAMPLE

The sample based on NASSEP IV is not self-weighted. It was, therefore, necessary to weight the data to enable expansion of the sample results to the population. Weighting was done using the cluster design weights from the NASSEP IV sampling frame. Necessary adjustments for population change and nonresponse were done. The selection probabilities were based on the measure of size and the sampling

interval of the clusters within the district. Adjustment of the weights was done upon completion of the data entry.

2.2.2 INSTITUTIONAL SURVEYS

The institutional surveys were conducted between December 2007 and May 2008. The aim of the institutional surveys was to generate expenditures on health from institutions selected for the period under review. The institutional surveys covered both private and public sector. Institutional surveys conducted covered the following:

- Donors;
- Employers (both private and public);
- Health insurance companies;
- NGOs; and
- Public sector organisations

2.2.2.1 HEALTH INSURANCE SURVEY

The private insurance sector is fairly well developed in Kenya. In 2007, about 65 insurance firms were providing both life and general business. Of these, 23 were providing health insurance policies and were therefore covered by the survey. Fifteen firms responded to the survey. Data on the total reimbursements made by insurance firms to health providers were obtained as well as identifying the nature of services rendered (e.g., inpatient, outpatient, pharmaceuticals). Weighting based on the number of members covered by the 15 insurance firms sampled to the total members covered by private health insurance was done to obtain total expenditures.

2.2.2.2 EMPLOYER SURVEY

The KNBS maintains a list of firms. However, this list has not been updated for quite a while and, moreover, the majority of the firms listed are unlikely to provide medical support to their employees.

A census of employers that would be likely to provide health benefits for their employees was created as a composite of two lists, from the Nairobi Stock Exchange (NSE) and the Kenya Private Sector Alliance (KEPSA), an alliance of private sector firms. The NSE list contained large, publicly traded employers who were likely to provide health benefits to their employees. The KEPSA list contains companies that are not traded on the NSE but contribute a significant amount of resources to health benefits. A total of 79 firms were identified; 46 of these were sampled and 23 responded to the survey questionnaire.

To extrapolate the expenditures of the 23 respondents, the firms were divided into terciles based on their respective number of employees. A weighting factor was generated by determining the portion of employees that were surveyed in each tercile. The health expenditures for each firm were divided by their respective weighting factor in order to estimate THE.

2.2.2.3 DONOR SURVEY

Foreign assistance is a significant source of financing in Kenya's health sector. A listing of all donors involved in health sector was compiled from the Ministry of Finance compendium. A total of 16 were identified. All donors in the health sector were contacted and all returned the survey questionnaires.

2.2.2.4 NGO SURVEY

Through the assistance of the Health NGOs' Network (HENNET), an umbrella organisation of NGOs in the health sector, a list of NGOs was compiled to form the sampling frame. A total of 76 NGOs were identified for the survey. Out of this, 28 NGOs responded to the survey. Data from the NGOs that responded were triangulated and used to estimate the total expenditure for NGOs.

2.2.2.5 GOVERNMENT MINISTRIES/DEPARTMENTS/PARASTATALS SURVEY MINISTRY OF HEALTH

The main sources of the MoH expenditure data were obtained from 2005/2006 Annual Appropriation Accounts for the period ended 30 June 2006 (Recurrent and Development). These data were corroborated with the *Public Expenditure Review 2007* report for the MoH.

2.2.2.6 LOCAL GOVERNMENTS

All local authorities delivering health care services were surveyed in order to generate information on health expenditures by local authorities. Local authorities surveyed were the cities of Nairobi, Mombasa, and Kisumu and the major towns of Nakuru and Eldoret.

2.2.2.7 STATE CORPORATIONS (PARASTATALS)

State corporations (parastatals) incur health expenditures. Some of them operate their own health care facilities, primarily offering outpatient care to their employees and their families. A listing of parastatal organisations was obtained from the State Statutory Board. Forty-four major parastatals distributed throughout the country were selected. Audited annual accounts for these state corporations were reviewed and the necessary information on health expenditures obtained. Twenty-eight of them (78 percent) returned completed questionnaires.

2.2.3 PEOPLE LIVING WITH HIV/AIDS SURVEY

Household OOP contributions to the AIDS subaccount are estimated from the KAIS 2007, which was designed to provide national and provincial estimates on HIV prevalence and expenditures. The KAIS collected data on 40,000 individuals in 9,700 households in late 2007. Nearly half of these (19,840) were between the ages of 15 and 64, and were voluntarily requested to provide blood samples for a test of HIV antibodies. A total of 15,893 persons provided blood for testing, a response rate of 80 percent. [3] Of these, 1,106 returned positive results. The spending estimates are based on an analysis comparing the respondents returning these positive tests with demographically and behaviourally similar survey respondents who were not HIV positive.

[3] The KAIS analysts computed a weighting adjustment to correct for the small bias introduced because some demographic groups were more likely to provide samples than others. Our statistical estimates take this adjustment into account. They also account for the effects of the survey's stratified and cluttered design.

We used logistic regression to compute a propensity score for the probability that a respondent was HIV positive, given his or her age, gender, place of residence, marital status, and self-reported sexual activity. We then divided the respondents into six groups based on these propensity scores. Within each group positive and negative respondents had similar propensity scores, and, consequently, similar average scores on each of the variables used to compute the scores. [4] We estimated the incremental effect of having HIV as the difference between spending that people living with HIV (PLHIV) actually reported and the average spending of HIV-negative respondents within the same propensity score group. Our estimates of national out-of-pocket (OOP) spending are formed by taking the weighted sum of these individual differences for all PLHIV in the sample.

The survey asked whether each person in the household was sick in the last four weeks. Those who answered yes were then asked whether they obtained outpatient care, and, if so, who provided it, and how much they spent out of pocket. The survey also asked the same questions about any inpatient admissions occurring in the six months period prior to the survey. These outpatient and inpatients expenditure estimates were then extrapolated to obtain an annual estimate, and then added to obtain total OOP expenditures. The total OOP expenditures were adjusted to obtain 2005/06 estimates. In addition, the survey collected data on respondent and household characteristics, including an inventory of possessions and spending that is used to construct indices of wealth and income.

2.3 LIMITATIONS AND CONSIDERATIONS

The team faced a number of challenges while in the process of implementing data collection, collation, and analysis. The post-election violence necessitated the suspension of data collection activities. Though data collection resumed shortly, the sampling frame was adversely affected.

Lack of disaggregated data meant that classification by functions was a challenge. For example, the NHA data analysis team had to rely on assumptions and ratios to break down expenditure by provider type, provider expenditure by inpatient vs outpatient. Ratios were also used to disaggregate RH expenditure by function.

The heavy rains experienced in some regions of the country hampered movement of the enumerators and the frequent vehicle breakdowns caused delays in data collection from these regions.

Originally one round of data entry was planned for. A second round of data entry was required after serious data entry errors were discovered.

A significant limitation experienced during this round of NHA is the difference in methodology for computing household HIV/AIDS-related OOP spending between the 2001/02 estimation and the 2005/06 estimation. In the 2001/02 subaccounts for HIV/AIDS, household OOP spending was estimated by analyzing a sample of 1,900 PLHIV, mostly recruited from HIV support groups and voluntary counseling and testing sites, but also including 412 people recruited in hospitals and 360 recruited from TB clinics. This distribution was assumed to represent the 1.05 million people estimated to then be living with the virus in Kenya. As the preliminary findings from KAIS later showed, at least 80 percent of the PLHIV had never been tested, and thus should not have been selected in a sample of this kind. Although this sample was not representative of PLHIV in Kenya, it offered the best data available at the time, and formed the basis for the HIV subaccount of the 2001/02 NHA.

[4] We checked each variable with a level .05 t-test.

The present report offers significant methodological improvements for two reasons. First, KAIS includes biomarkers, so that PLHIV are objectively identified, and it was possible to be reasonably confident that the sample is representative of the nation. For the first time, the estimates include actual data on the spending experiences of undiagnosed PLHIV. Secondly, because the survey is rich in socioeconomic and behavioural data, it was possible to find HIV-negative respondents who were otherwise similar to PLHIV, and use them to estimate the incremental effect of HIV status on OOP spending. This difference between PLHIV and others was used in our HIV/AIDS subaccount. These limitations should be considered in the analysis of numbers presented in this report concerning OOP spending.

3. GENERAL NHA FINDINGS

3.1 PRESENTATION OF FINDINGS

The availability of estimates for overall health spending and HIV/AIDS health expenditures for 2001/02 provides a valuable opportunity to compare financing patterns from 2001/02 with the current round of 2005/06. The time periods are significant in that the 2001/02 estimate illustrates spending patterns prior to the roll-out of a number of "pro-poor" government policies and the influx of donor funds for priority areas, such as HIV/AIDS, malaria, and TB. Conversely, the 2005/06 estimates represent the financial situation following the roll-out of these initiatives. Thus, by comparing expenditures of the two years, one can gain some understanding of the financial effect of policies and investments made between the two time points. Note, all references to Kshs or dollar amounts for 2001/02 have been adjusted for inflation to facilitate comparison with 2005/06 estimates.

3.2 SUMMARY STATISTICS FOR THE GENERAL NHA FINDINGS

In 2005/06, Kenya spent approximately Kshs 71 billion (US$ 964.4 million). This represents an increase of 24 percent over 2001/02, when THE was Kshs 57 billion (US$ 726.4 million). Table 3.1 provides a comparison of the key health-related indicators between 2001/02 and 2005/06.

In 2005/06, THE in Kenya was equivalent to about 4.8 percent of GDP at current market prices; this translates to a per capita health spending of approximately Kshs 1,987 (US$ 27). The percentage of health spending to GDP was a slight drop from what was reported by NHA 2001/02 (5.1 percent). However, there was an increase in the per capita health spending of about 17 percent from US$ 23 reported in 2001/02.

The World Health Organisation (WHO) Commission on Macro Economics and Health (WHO 2001) recommended a per capita health spending of US$ 34 to finance an essential package of health services. Kenya's spending on health care, like other countries in the sub-Saharan Africa region, falls short of the WHO recommendation. This is a clear indication of scarcity of resources to finance health care. The challenge is therefore to address the resource gaps, continue to improve efficiency in resource allocation and use, and maintain the relatively high level of domestic resources invested in health.

TABLE 3.1: GENERAL NHA STATISTICS FOR 2001/02 AND 2005/06

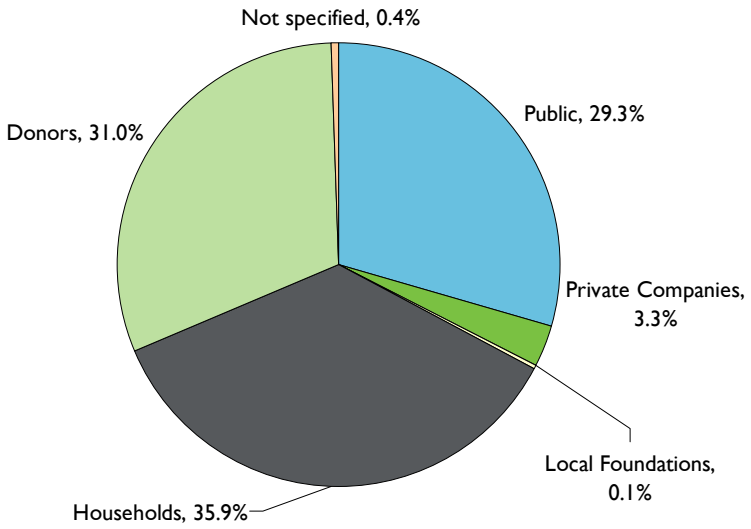
Indicators	2001/02	2005/06
Total population	31,190,843	35,638,694
Exchange rate	78.6	73.4
Total real GDP Ksh	1,118,781,868,506	1,519,400,000,000
Total real GDP US$	$ 14,233,866,012	$ 20,693,224,379
Total Govt expenditure Ksh	211,517,580,466	401,518,324,607
Total Govt expenditure US$	$ 2,691,063,365	$ 5,468,414,363
Total Health Expenditure (THE) Ksh	57,097,636,970	70,807,957,722
Total Health Expenditure (THE) US$	$ 726,433,040	$ 964,357,613
THE per capita	1,831	1,987
THE per capita (US$)	23	27
THE as a % of nominal GDP	5.1%	4.8%
Govt health expenditure as a % of Govt total expenditure	8.0%	5.2%
Financing sources as a % of THE		
Public	29.6%	29.3%
Private	54.0%	39.3%
Donor	16.4%	31.0%
Other	0.1%	0.4%
Household (HH) spending		
Total HH spending as % of THE	51.1%	35.9%
OOP spending as % of THE	44.8%	29.1%
HH spending per capita	770	713
OOP spending per capita	819	578
Financing agent distribution as a % of THE		
Public	42.8%	42.7%
Private	49.8%	36.5%
Donor	7.4%	20.8%
Provider distribution as a % of THE		
Public facilities	49.4%	44.3%
Private facilities	35.7%	29.2%
Other	14.9%	26.5%
Function distribution as a % of THE		
Inpatient care	32.1%	29.8%
Outpatient care	45.2%	39.6%
Pharmaceuticals	7.4%	2.6%
Prevention and public health programs	9.1%	11.8%
Health administration	5.0%	14.5%
Other	1.3%	1.7%

3.3 FINANCING SOURCES: WHO PAYS FOR HEALTH CARE?

In the NHA framework, financing sources are those institutions or entities that ultimately contribute funds used in the health care system. The health sector in Kenya obtains varying levels of funding from the traditional sources: public (government), private firms, households and donors. The information to follow outlines the trends in contributions from each of these sources.

In 2005/06, contributions to health spending by all the major sources – public, private, and donors – were greater than in 2001/02 (after adjusting for inflation). Figure 3.1 shows the relative contributions of financial sources to THE in 2005/06. Households remained the largest contributors of health funds, followed by the government and donors. In 2001/02, households financed over half of all health expenditures; in 2005/06, their share accounted for just over one third. However, the gap between the relative contributions of the three major financiers narrowed with increased investments, largely from donors.

FIGURE 3.1: THE BREAKDOWN BY FINANCING SOURCE, 2005/06



The private sector [5] contributed 39 percent of THE in 2005/06, with 36 percent coming from households, mainly through OOP spending. This represents a 13 percent decrease from 2001/02, when household contributed 51 percent. The decrease may have resulted in part from the implementation of the 10/20 Policy [6] and free HIV/AIDS care at public health facilities. The public sector [7] contribution to THE was 29 percent (2005/06), a slight decrease (from 29.6 percent to 29.3 percent) from the estimate reported in FY 2001/02 (see Table 3.1 in the preceding section).

Donor contributions to THE increased by 135 percent, from Kshs 9.3 billion (US $118.9 million) in 2001/02 to Kshs 21.9 (US$ 298.6 million) in 2005/06 (Table 3.2). The influx of funding from donors such as Global Fund for AIDS, TB and Malaria and the President's Emergency Plan for AIDS Relief (PEPFAR) may explain the large increase.

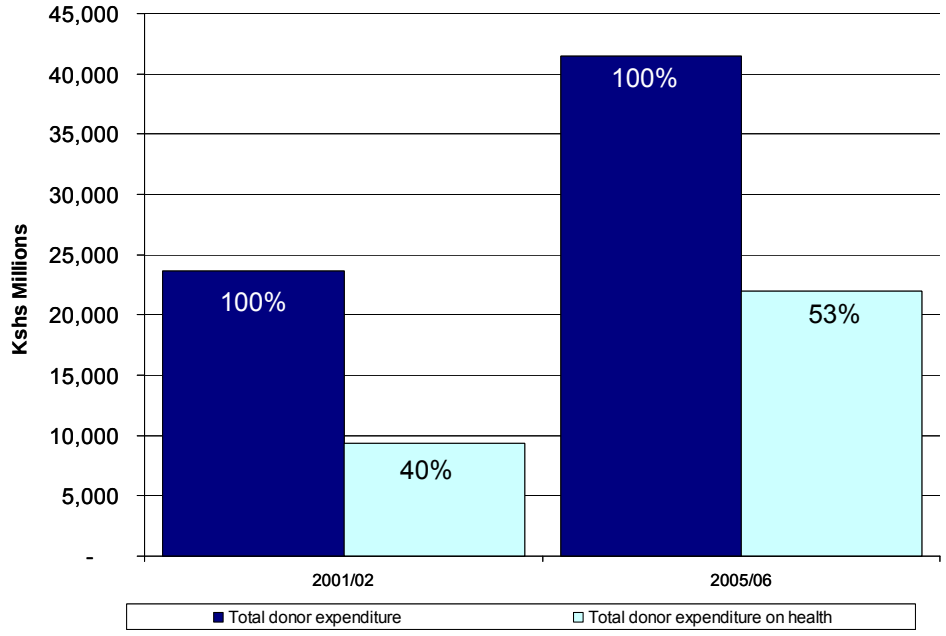
[5] The private sector comprises households, private companies, and local foundations.
[6] 10/20 Policy implemented standardized charges at the lower level: Kshs 10 at the dispensary level and Kshs 20 at the health centre level
[7] The public sector comprises the MoH, NHIF, local authorities, National AIDS Control Council (NACC), and parastatals.

TABLE 3.2: ABSOLUTE VALUE OF FINANCING SOURCE CONTRIBUTIONS, 2001/02 AND 2005/06

	2001/02	2005/06	Percent Change
Public	Ksh 16,887,646,242	20,767,151,342	23.0%
Private	Ksh 1,287,202,570	2,343,624,368	82.1%
Local Foundations	Ksh 359,878,761	64,990,232	-89.9%
Households	Ksh 29,180,463,954	25,402,361,132	-12.9%
Donor	Ksh 9,343,893,921	21,929,224,106	134.7%
Not Specified	Ksh 38,553,522	300,606,541**	679.7%

Donor funding for health represented 53 percent of total donor spending (on all sectors) in Kenya in 2005/06, an increase from the 40 percent reported in 2001/02 (Figure 3.2).

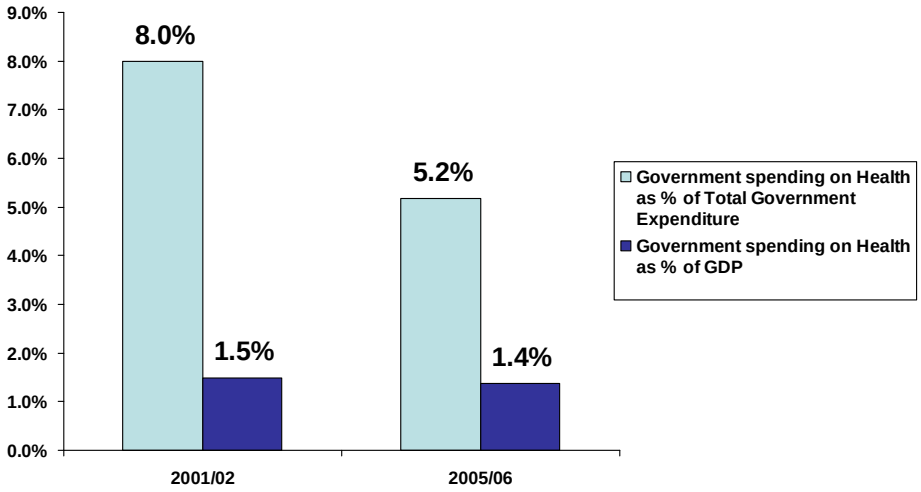
FIGURE 3.2: DONOR CONTRIBUTION TO HEALTH AS A PERCENTAGE OF TOTAL DONOR SPENDING, 2001/02 AND 2005/06



Government spending on health increased by 23 percent in absolute terms between 2001/02 and 2005/06. Despite this modest increase, government spending on health as a percentage of total government expenditure (on all sectors) declined during the period, from 8 percent to 5 percent (Figure 3.3). This is because total government spending doubled. The 5 percent government contribution to health is considerably less than the Abuja target of 15 percent. [8]

[8] The Abuja target, committed to by African heads of state and government in 2001, calls for African countries to spend 15 percent of their government budget on health (typically measured as funds allocated to the MoH).

FIGURE 3.3: GOVERNMENT SPENDING ON HEALTH, 2001/02 AND 2005/06

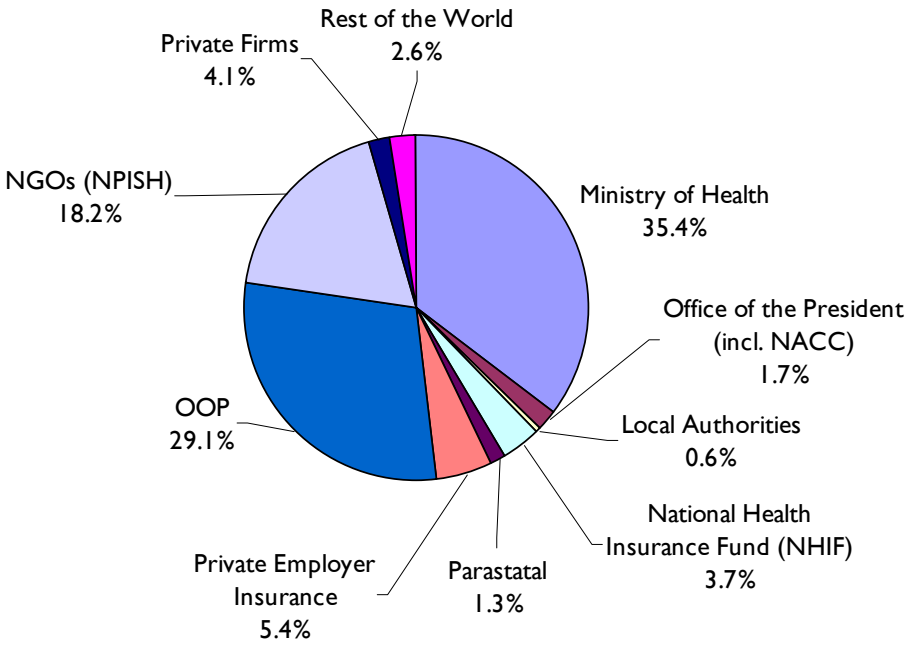


3.4 FINANCING AGENTS: WHO MANAGES HEALTH FUNDS?

Financing agents are institutions that receive and manage funds from financing sources to pay for or purchase health goods and services. Resources mobilised by financing sources pass through financing agents, but the agents are not simply intermediaries; rather they maintain programmatic control over how resources are allocated across providers, i.e., they determine by what proportions and which functions will consume the resources mobilised. Financing agents include such entities as the MoH and other ministries, parastatals, public and private insurance entities, households (through OOP spending), NGOs, private firms, and rest of the world, including donors.

As Figure 3.4 shows, in 2005/06, about 57 percent of the resources mobilised by financing sources passed through the private sector (including spending by household, private employer insurance, private firms, and NGOs) with household OOP spending accounting for 29 percent. This is comparable to the amount that passed through the private sector in 2001/02 (50 percent), when households also controlled the largest share.

FIGURE 3.4: THE BREAKDOWN BY FINANCING AGENT, 2005/06



The public sector controlled 43 percent of the total funds mobilised. The MoH controlled 35 percent of publicly programmed resources.

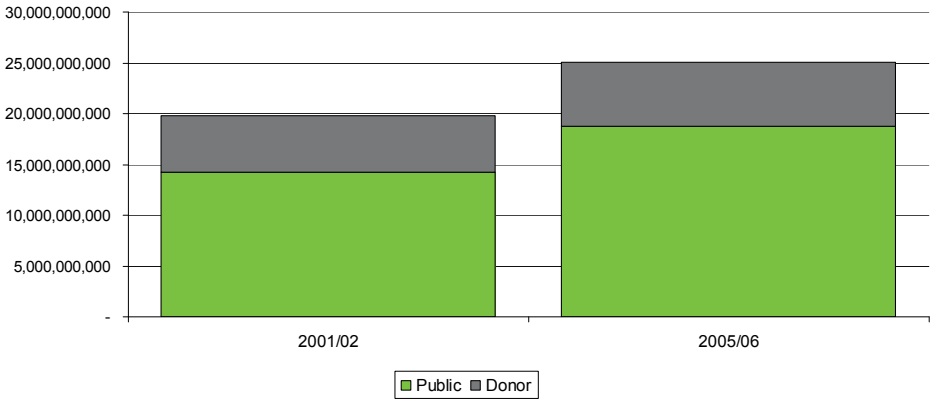
In absolute terms, resources controlled by the public sector in 2005/06 (Kshs 30 billion) were slightly higher than in 2001/02 (Kshs 24 billion) (Table 3.3). Between 2001/02 and 2005/06, the resources managed by the MoH increased by 26 percent and the amount of funds managed by international partners (NGOs and donors) almost tripled.

TABLE 3.3: ABSOLUTE VALUE OF FUNDS MANAGED, 2001/02 AND 2005/06

Financing Agent (Managers)	2001/02	2005/06	Percent Change
Ministry of Health	19,836,253,511	25,050,931,100	26.3%
Office of the President (incl. NACC)	n/a	1,216,785,073	n/a
Other Ministries	30,475,011	n/a	n/a
Local Authorities	607,355,910	408,634,082	-32.7%
National Health Insurance Fund (NHIF)	2,315,231,606	2,632,570,016	13.7%
Parastatal	1,659,141,436	936,484,747	-43.6%
Private Employer Insurance	2,218,216,909	3,849,460,713	73.5%
OOP	25,556,778,897	20,611,667,607	-19.3%
NGOs (NPISH)	3,519,794,285	12,908,526,174	266.7%
Private Firms	617,388,100	1,378,221,517	123.2%
Rest of the World	698,447,779	1,814,676,693	159.8%
Not Specified	1,814,676,693	n/a	n/a

As indicated in Figure 3.5, the government continued to be the main financier of the MoH, accounting for approximately 75 percent of its funding in 2005/06; donors accounted for the rest.

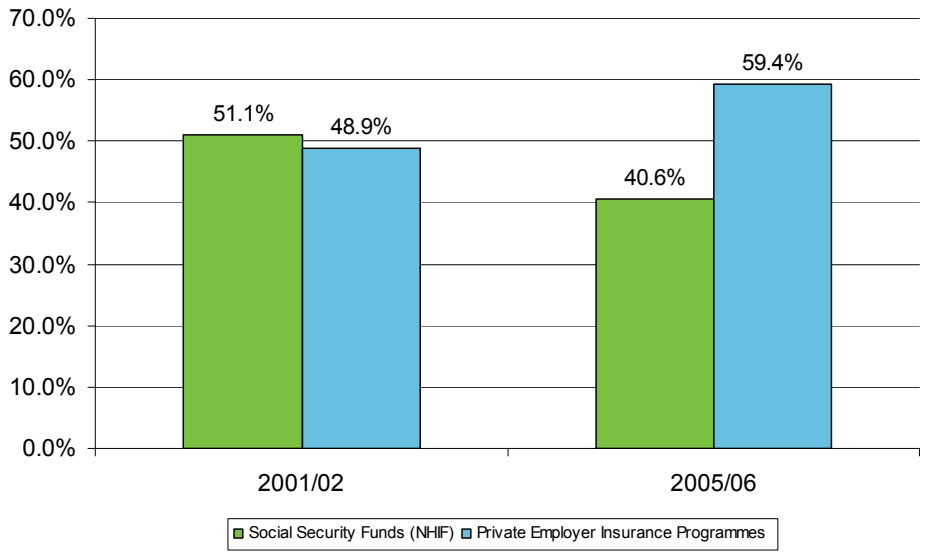
FIGURE 3.5: TRENDS IN MOH FUNDING, 2001/02 AND 2005/06



Notes: Reported in constant 2006 US$ to facilitate comparison across years.

Absolute NHIF spending increased 14 percent, going from Kshs 2.3 billion in 2001/02 to Kshs 2.6 billion in 2005/06. However, as shown in Figure 3.6, the NHIF share of the total health insurance spending decreased from 51 percent in 2001/02 to 41 percent in 2005/06, while the private health insurance sector share increased from 49 percent in 2001/02 to 59 percent in 2005/06.

FIGURE 3.6: BREAKDOWN OF INSURANCE BY FINANCING SOURCE AS PERCENTAGE OF TOTAL INSURANCE EXPENDITURE, 2001/2 AND 2005/6



3.5 PROVIDERS OF HEALTH CARE: WHO USES HEALTH FUNDS TO DELIVER CARE?

For purposes of NHA, "providers of health care" refers to entities that receive money in exchange for or in anticipation of producing the activities inside the health accounts boundary: these include public and private facilities, pharmacies and shops, traditional healers and community health workers as well as public health programmes and general health administration and others as described in this section. Public health programmes refer to the provision and implementation of programmes such as health promotion and protection. General health administration refers to costs associated with the overall regulation of activities of agencies that provide health care.

As indicated in Figure 3.7, in 2005/06, public health facilities accounted for the largest share of THE (44 percent), private health facilities for 29 percent.

FIGURE 3.7: THE BREAKDOWN BY PROVIDER, 2005/06

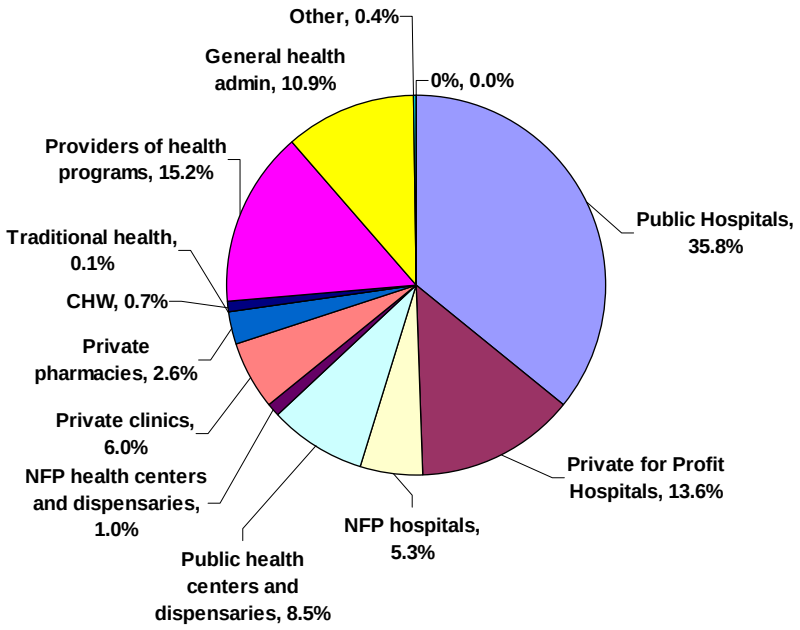
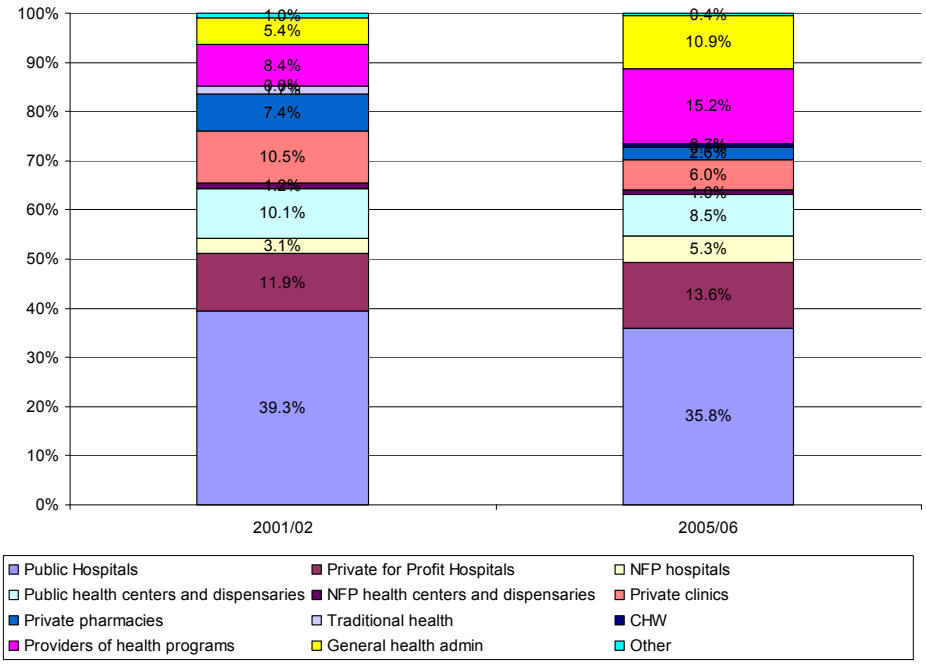


Figure 3.8 shows trends in provider consumption of health care funds in 2001/02 and 2005/06. Providers of public health programmes experienced the most significant increase in proportion of THE consumed, from Kshs 4.8 billion (8 percent) in 2001/02 to Kshs 10.8 billion (15 percent) in 2005/06. Similarly, health administration increased from Kshs 3.0 billion (5 percent of THE) in 2001/02 to Kshs 7.8 billion (11 percent of THE) in 2005/06.

FIGURE 3.8: DISTRIBUTION OF PROVIDERS OF HEALTH SERVICES AND COMMODITIES, 2001/02 AND 2005/06



Additionally, consumption of health funds at private pharmacies decreased, from 7.4 percent in 2001/02 to 2.6 percent in 2005/06, perhaps due to an increased availability of drugs at public facilities. This agrees with the findings of Patients/Clients Satisfaction Survey (MoH 2007), carried out in May and June 2007, which showed that although there was an over-50 percent increase in utilisation of public health facilities, especially lower-level facilities, and 72 percent of the patients reported an improved supply of highly subsidised medication.

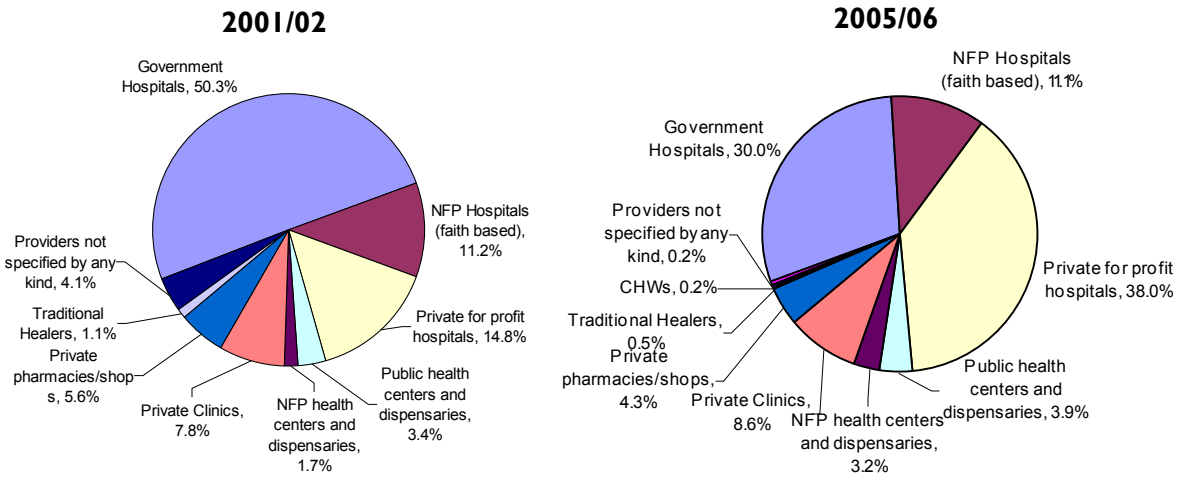
Table 3.4 shows that in absolute terms, consumption of financial resources at public and private hospitals increased while consumption at private clinics and private pharmacies decreased. Spending on public health programmes and health administration increased 124 percent and 150 percent, respectively.

TABLE 3.4: ABSOLUTE VALUE OF PROVIDER CONTRIBUTIONS, 2001/02 AND 2005/06

	2001/02	2005/06	Percent change
Public hospitals	Ksh 22,451,381,471	25,349,918,227	12.9%
Private for profit hospitals	Ksh 6,817,117,587	9,594,537,033	40.7%
NFP hospitals	Ksh 1,744,596,859	3,750,661,195	115.0%
Public health centers	Ksh 5,767,756,504	6,018,829,327	4.4%
NFP health centers	Ksh 662,169,074	704,932,373	6.5%
Private clinics	Ksh 6,005,157,369	4,223,592,456	-29.7%
Private pharm.	Ksh 4,202,176,808	1,824,149,922	-56.6%
Traditional healer	Ksh 956,209,236	93,476,597	-90.2%
CHW		497,191,771	n/a
Providers of health programs	Ksh 4,822,738,707	10,777,346,844	123.5%
Health admin	Ksh 3,095,161,065	7,719,302,797	149.4%
Other	Ksh 573,172,290	254,019,180	-55.7%
Total	57,097,636,970	70,807,957,722	24.01%

Private for-profit hospitals and government hospitals consumed the largest proportion of household OOP funds in 2005/06, 38 percent and 30 percent, respectively (Figure 3.9). This represents a decrease in the government hospitals' share of OOP spending (from 50 percent in 2001/02) and an increase in the private hospitals' share (from 15 percent in 2001/02). The decrease in the government share can be attributed to free treatment for opportunistic infections and HIV at public hospitals. The share of OOP spending at pharmacies and shops also declined, most likely due to the availability of medicines from the public sector. This is supported by the findings of the *Patients/Clients Satisfaction Survey* (MoH 2007).

FIGURE 3.9: PROVIDERS CONSUMING HOUSEHOLD OOP FUNDS, 2001/02 AND 2005/06

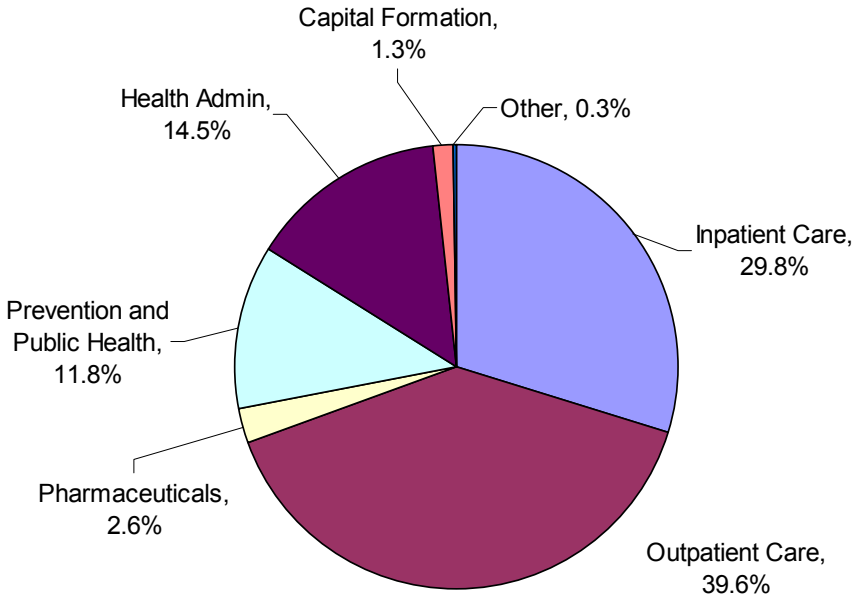


3.6 HEALTH CARE FUNCTIONS: WHAT SERVICES AND/OR PRODUCTS ARE PURCHASED WITH HEALTH FUNDS?

Health care functions refer to the types of goods and services provided and activities performed within the health accounts boundary. General health functions include curative care (inpatient and outpatient), provision of pharmaceuticals from independent pharmacies (i.e., pharmaceuticals not procured from a health facility as part of inpatient or outpatient treatment), prevention and public health programmes, health care administration, and capital formation. Inpatient care refers to a patient who is formally admitted to an institution for treatment for a minimum of one night (and includes all associated costs for labs, medicines, operations, etc.), while outpatient care is medical services administered to patients who are not admitted to the facility (do not stay over night).

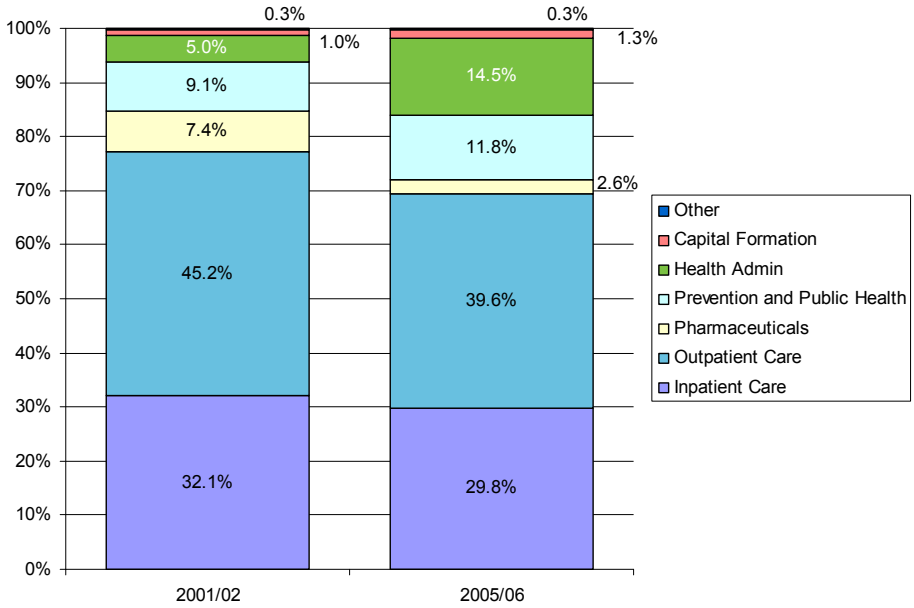
Curative care consumed the largest share of THE, 69 percent in 2005/06, with 40 percent going to outpatient care and 30 percent to inpatient care (Figure 3.10). Prevention and public health programmes combined with health administration accounted for most of the remaining THE by function.

FIGURE 3.10: BREAKDOWN OF THE BY FUNCTION, 2005/06



THE going to inpatient and outpatient care decreased from 45 percent and 32 percent, respectively, in 2001/02, to 40 and 30 percent, respectively, in 2005/06 (Figure 3.11). Prevention and public health programmes and health administration increased, from 9 percent and 5 percent in 2001/02 to 12 percent and 15 percent respectively in 2005/06.

FIGURE 3.11: TRENDS IN USES OF HEALTH FUNDS, 2001/02 AND 2005/06



In absolute terms spending on inpatient and outpatient care increased by a total of 24 percent in 2005/06 from 2001/02 (Table 3.5). Prevention and public health programmes, health administration, and capital formation also experienced increases in funding in absolute terms. Expenditure on health administration experienced a dramatic increase of 262 percent in the period. This reflects the influx of donor funding and the passage of this funding through NGOs as financing agents at the function level. Expenditure on capital formation increased by 68 percent, due to significant investment by the public sector on upgrading of equipment and infrastructure.

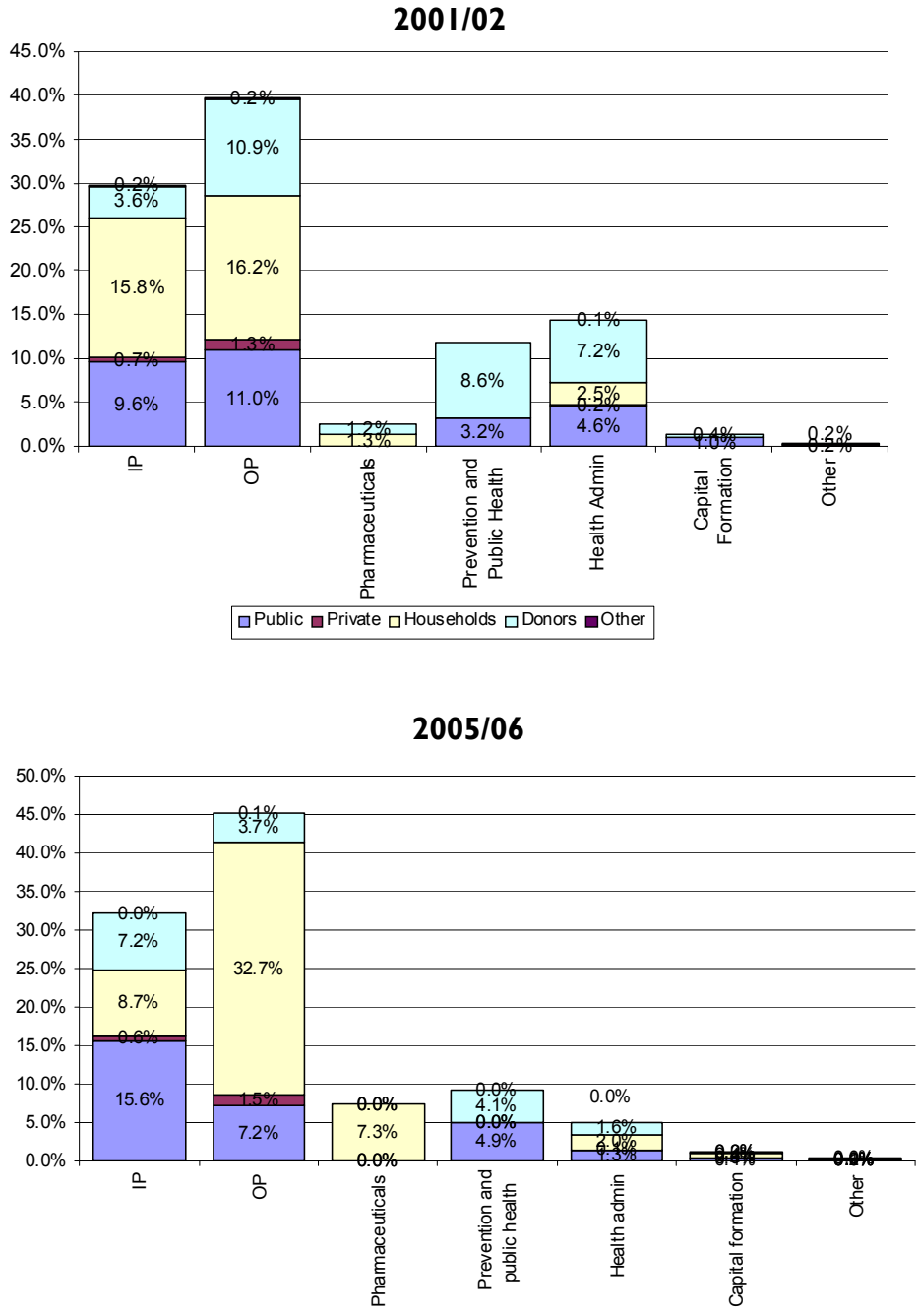
TABLE 3.5: ABSOLUTE VALUE OF BREAKDOWN OF THE BY FUNCTION

	2001/02	2005/06	Percent Change
Inpatient Care	18,351,408,847	21,107,818,603	15.0%
Outpatient Care	25,784,303,377	28,047,926,816	8.8%
Pharmaceuticals	4,203,305,320	1,824,149,922	-56.6%
Prevention and Public Health	5,196,484,053	8,266,474,489	59.1%
Health Admin	2,839,657,753	10,266,502,524	261.5%
Capital Formation	569,341,388	953,957,340	67.6%
Other	153,136,231	243,370,617	58.9%

3.6.1 WHO FINANCES WHICH HEALTH FUNCTIONS?

Figure 3.12 shows the functional uses of health funds as financed by public, private and donor sources.

FIGURE 3.12: ALLOCATION OF HEALTH FUNDS FROM FINANCING SOURCES TO FUNCTIONS, 2001/02 AND 2005/06



In 2001/02, the burden of financing outpatient care and pharmaceuticals, as well as a significant percentage of inpatient care, fell mainly on households. Public sources spent a majority of funds on inpatient care and prevention and public health programmes. By 2005/06, households were spending proportionally less on outpatient care and pharmaceuticals because of the increase in funding by public and donor sources in these areas.

Donor funding to prevention and public health programmes and health administration increased from 4 percent and 2 percent in 2001/02 to 9 percent and 7 percent in 2005/06, respectively.

3.7 PRIORITY AREAS OF HEALTH

HIV/AIDS and RH are considered priority areas of health for the government of Kenya. These two areas consume 38 percent of total health resources (Figure 3.13).

FIGURE 3.13: SPENDING ON HIV/AIDS AND RH IN CONTEXT OF GENERAL HEALTH

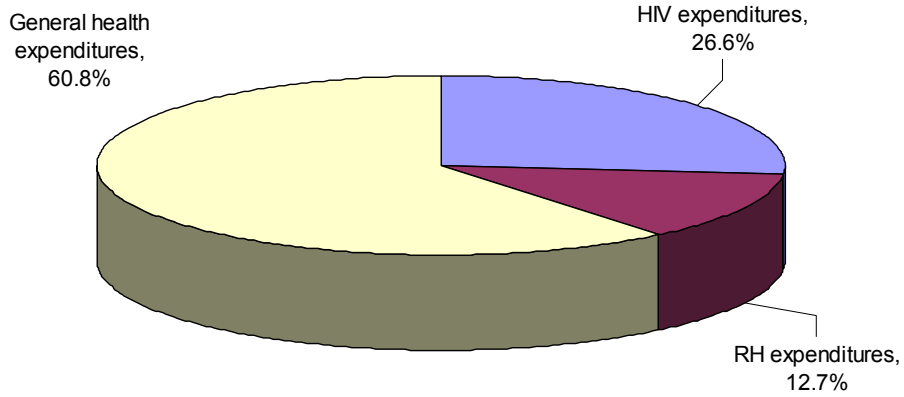
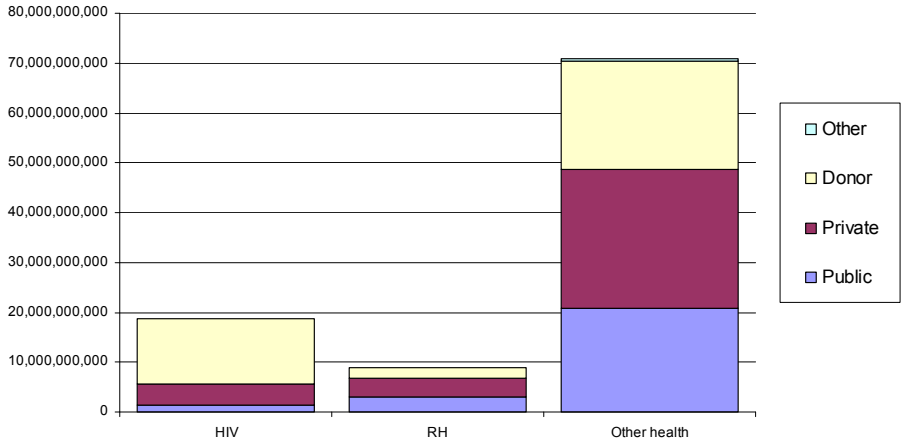


Figure 3.14 illustrates the level of funding for priority areas by public, private, and donor sources in absolute terms

FIGURE 3.14: WHO IS FINANCING WHICH PRIORITY AREA?



In 2005/06, public and private sources spent almost equal amounts of funding on RH and HIV/AIDS, while donors accounted for the largest share of funding for HIV/AIDS health care. Of donors' total contribution to health, 60 percent was spent on HIV/AIDS.

3.8 SUMMARY FINDINGS OF THE GENERAL NHA, 2005/06

- **THE increased by 24 percent.** Between 2001/02 and 2005/06, THE increased from Kshs 57 billion (US$ 726 million) to Kshs 71 billion (US$ 964 million), largely due to the increase in donor spending.
- **Households' expenditure on total health decreased by 13 percent.** In 2005/06, households accounted for 36 percent of THE, a decrease of 13 percent from 2001/02. In absolute terms, household expenditure decreased from Kshs 25.4 billion in 2001/02 to Kshs 20.7 billion in 2005/06. The reduction may be attributable to the 10/20 Policy and free HIV/AIDS care provided in public health facilities.
- **Expenditures by donors and the public sector have increased.** Government expenditure on health increased by 23 percent, from Kshs 17 billion to Kshs 21 billion, between 2001/02 and 2005/06. However, in relation to THE, the public sector contribution remained at 29 percent. Donor contribution to THE increased by 135 percent, representing 16 percent of THE reported in 2001/02 and 31 percent in 2005/06. The influx of funding from the Global Fund and PEPFAR explain the increase.
- **Government spending on health relative to other sectors decreased.** In 2005/06, government spending on health as a percentage of total government expenditure was estimated at 5 percent, down from 8 percent reported in 2001/02. The estimate is far less than the Abuja target of 15 percent.
- **Government remains the major financier of the public health sector.** Government contributions accounted for close to 75 percent of the total resources that went to the public health system in 2005/06.
- **The private sector manages the majority of health.** Fifty-seven percent of the resources mobilised by financing sources passed through the private sector, with households accounting for 29 percent. The public sector controlled 43 percent of the total resources, with MoH accounting for 35 percent of that total.
- **Private for-profit hospitals and government hospitals consumes the largest proportion of OOP funds**. In 2005/06, private for-profit hospitals consumed 38 percent and government hospitals consumed 30 percent of total OOP spending. However, when compared with 2001/02 estimates, the government hospitals' share of OOP spending decreased from 50 percent in 2001/02, while the private hospital' share increased from 15 percent in 2001/02.
- **Public insurance has decreased as a percentage of total insurance spending.** The NHIF share of the total health insurance spending increased in absolute terms, from Kshs 2.3 billion in 2001/02 to Kshs 2.6 billion in 2005/06. However, it decreased from 51 percent to 41 percent in terms of its share of total insurance. Meanwhile, the share of private insurance increased from 49 percent in 2001/2002 to 59 percent in 2005/06.
- **Public health facilities consumes the largest share of THE.** Public facilities, including hospitals, health centres, and dispensaries, accounted for 45 percent of THE in 2005/06. This is a decrease from 2001/02, when public facilities received close to 60 percent of THE.

- **Total expenditure on outpatient care as a percentage of THE has decreased.** In 2005/06, expenditures on outpatient care were 40 percent of THE, down from 45 percent in 2001/02. However, in absolute terms, expenditures for outpatient care increased from Kshs 25.8 billion (US$ 3.3 million) to Kshs 28.0 billion (US$ 381.0 million).

4. HIV/AIDS SUBACCOUNT

4.1 BACKGROUND

HIV/AIDS continues to be a major challenge to the health sector and to the economy in Kenya. It is estimated that over 50 percent of hospital beds are occupied by HIV/AIDS patients (MoH NASCOP 2006). Women and urban poor carry the biggest burden of HIV/AIDS (MoH NASCOP 2006). Notable amongst the challenges in the implementation of HIV/AIDS services are: changing priorities of HIV/AIDS interventions, which require regular updates and formulation of policies; inadequate and high turnover of staff to handle the demand of HIV/AIDS-related services; and inadequate funding to roll out antiretroviral treatment (ART) to eligible patients.

4.2 HIV PREVALENCE IN KENYA

HIV prevalence increased from 5.1 percent in 2006 to 7.4 percent in 2007. The number of PLHIV who received ART increased to 230,000. However, another 250,000 people were eligible but were currently not receiving it (KAIS 2007).

4.3 SUMMARY STATISTICS FOR HIV/AIDS FINDINGS

In 2005/06, Kshs 19 billion (US$ 256 million) was spent on HIV/AIDS services in Kenya, nearly double what was spent in 2002/02 (Kshs 10 billion/US$ 126 million), reflecting the influx of external funds for HIV/AIDS from programmes such as the Global Fund and PEPFAR. Table 4.1 summarises HIV/AIDS health expenditures in 2001/02 and 2005/06.

TABLE 4.1: HIV/AIDS SUBACCOUNT SUMMARY STATISTICS, 2001/02 AND 2005/06

Indicators	2001/02	2005/06
Prevalence rate (adults)	6.7%	5.1%
Number of PLHIV	982,685	1,091,000
Total HIV/AIDS health expenditure (THE_{HIV}) Ksh	9,927,769,404	18,807,268,861
Total HIV/AIDS health expenditure (THE_{HIV}) US$	$ 126,307,499	$ 256,142,579
Total HIV/AIDS expenditure (THAE) Ksh	12,162,246,078	20,501,452,153
Total HIV/AIDS expenditure (THAE) US$	$ 154,735,955	$ 279,216,236
HIV/AIDS health spending per PLHIV Ksh	10,103	19,016
HIV/AIDS health spending per PLHIV US$	$ 129	$ 259
HIV/AIDS spending as a % of general THE	17.4%	26.6%
HIV/AIDS spending as a % of GDP	0.9%	1.2%
THE_{HIV} as a % of total HIV/AIDS spending (health and non-health)	-	91.7%
THE_{HIV} % targeted for HIV/AIDS	-	85.1%
Financing sources as a % of THE_{HIV}		
Public	21.3%	7.3%
Private	27.8%	22.7%
Donor	50.8%	70.0%
Other	0.1%	0.03%
Household (HH) spending		
Total HIV HH spending as % of general THE	4.6%	6.0%
OOP spending as % of THE_{HIV}	21.3%	22.0%
Financing agent distribution as a % of THE_{HIV}		
Public	60.0%	22.0%
Private	24.8%	22.4%
Donor and NGO	15.2%	55.5%
Provider distribution as a% of THE_{HIV}		
Public facilities	41.4%	35.0%
Private facilities	14.4%	21.4%
Other	44.2%	43.6%
Function distribution as a % of THE		
Curative Care	44.2%	56.0%
Prevention and public health programs	47.1%	26.6%
Pharmaceuticals	4.9%	1.7%
Other	3.7%	15.7%

In 2005/06, HIV/AIDS health expenditures accounted for 27 percent of THE (see Figure 3.13 in Chapter 3). This translates to US$ 259 per PLHIV in 2005/06; in 2001/02 this figure was US$ 129. It is important to note that much of the funding goes to prevention programmes, benefiting the general population, not just those who are HIV positive.

4.4 FINANCING SOURCES OF HIV/AIDS HEALTH CARE: WHO PAYS FOR HIV/AIDS SERVICES?

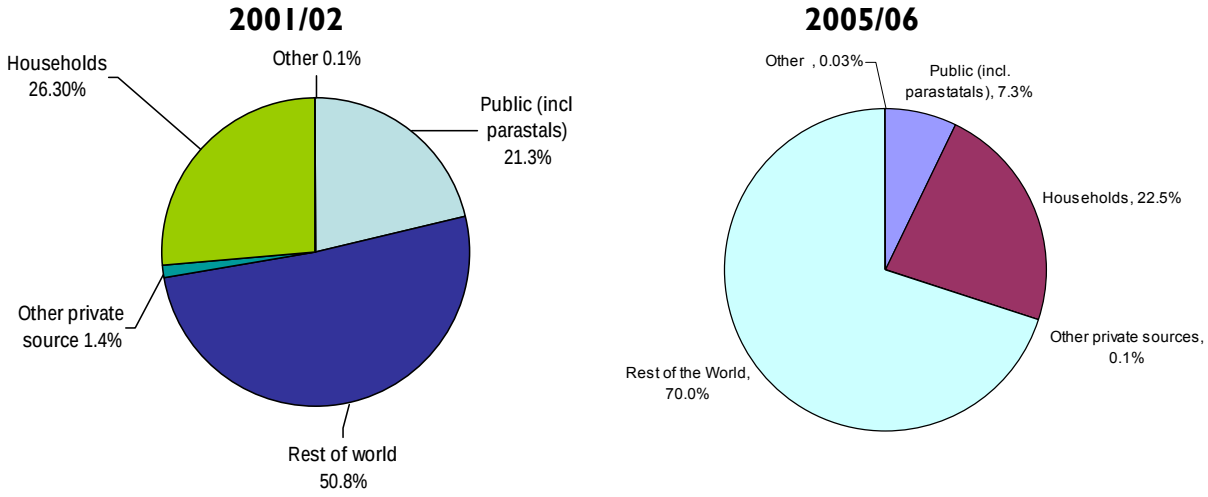
In absolute terms, the THE on HIV/AIDS health care (THE_{HIV}) increased by 89 percent between 2001/02 and 2005/06. Donor funding more than doubled (increase of 161 percent), while household funding increased by 62 percent. [9] Public financing decreased in absolute terms, by 35 percent (Table 4.2).

TABLE 4.2: ABSOLUTE VALUE OF FINANCING SOURCE CONTRIBUTIONS TO HIV/AIDS SERVICES

	2001/02	2005/06	Percent Change
Public	2,113,125,587	1,379,227,735	-34.7%
Private	143,055,958	24,249,342	-83.0%
Households	2,614,379,223	4,238,662,340	62.1%
Donor and NGO	5,047,095,328	13,159,571,857	160.7%
Other	10,113,308	5,557,587	-45.0%

As Figure 4.1 shows, donors continued to be the major source of HIV/AIDS financing, accounting for 70 percent in 2005/06, up from 51 percent in 2001/02. The HIV/AIDS programme expansion was due mainly to Global Fund and PEPFAR funding. Financing by households decreased slightly as a percentage of THE_{HIV}, but remains a major source of funding (23 percent).

FIGURE 4.1: WHERE DOES HIV/AIDS FUNDING COME FROM, 2001/02 AND 2005/06?



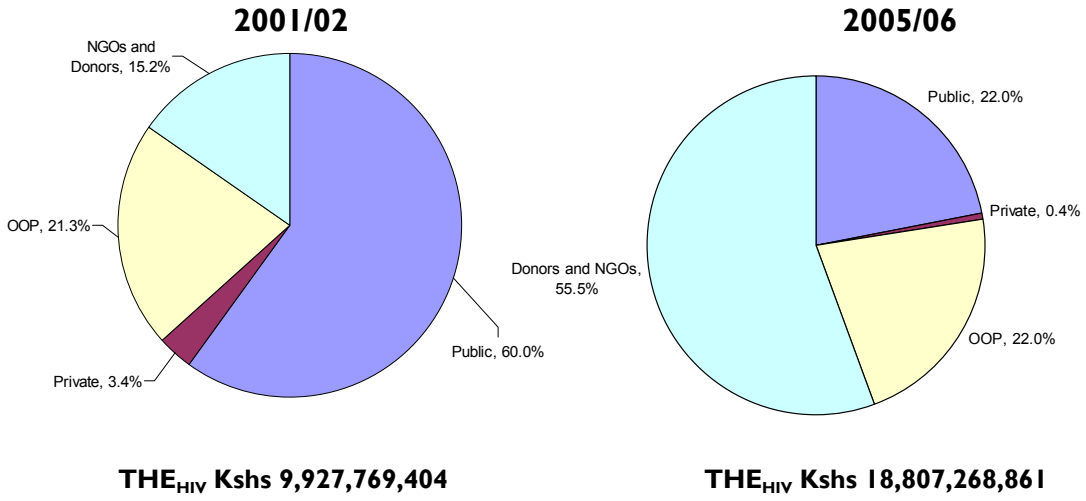
THE_{HIV}:KShs 9,927,769,401 **THE_{HIV}: KShs 18,807,268,861**

[9] The 2005/06 estimates of household spending on HIV/AIDS health services were obtained from KAIS 2007, which provided better estimates relative to 2001/02 when estimates were from targeted surveys of PLHIV.

4.5 FINANCING AGENTS OF HIV/AIDS HEALTH CARE: WHO MANAGES HIV/AIDS FUNDS?

The financing agent level signifies those entities with programmatic control over how funds are spent (Figure 4.2). In this regard, NGOs and donors manage the greatest proportion (56 percent) of THE_{HIV} in 2005/06. Public sector financing agents, which managed 60 percent of the funds in 2001/02, managed 22 percent in 2005/06. Given the significance of funding that donors and NGOs manage, there is clearly a great need to integrate their interventions into the annual operating plans implemented by the MoH and ensure that the activities are in line with the Kenya National AIDS Strategic Plan.

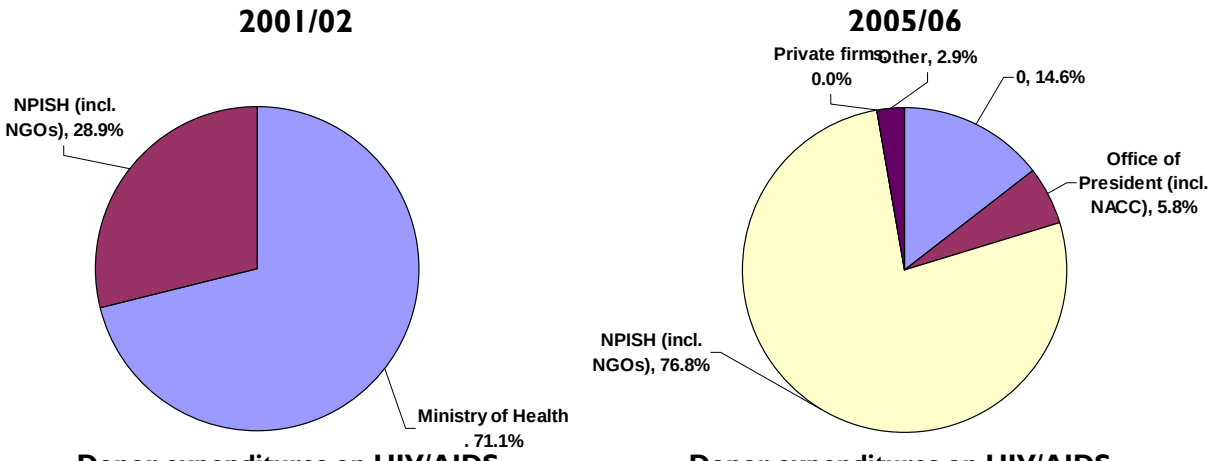
FIGURE 4.2: MANAGERS OF HIV EXPENDITURES, 2001/02 AND 2005/06



THE_{HIV} Kshs 9,927,769,404 **THE_{HIV} Kshs 18,807,268,861**

Many more entities managed donor funds for HIV in 2005/06 than in 2001/02 (Figure 4.3). NGOs managed 77 percent, compared with 29 percent in 2001/02. One NGO in particular become a major financing agent in the period: the Mission for Essential Drugs and Supplies (MEDS) was contracted to procure ART drugs with USAID funding. NACC, which managed almost no funding in 2001/02, increased its share to 6 percent in 2005/06.

FIGURE 4.3: MANAGERS OF DONOR HIV/AIDS FUNDS, 2001/02 AND 2005/06

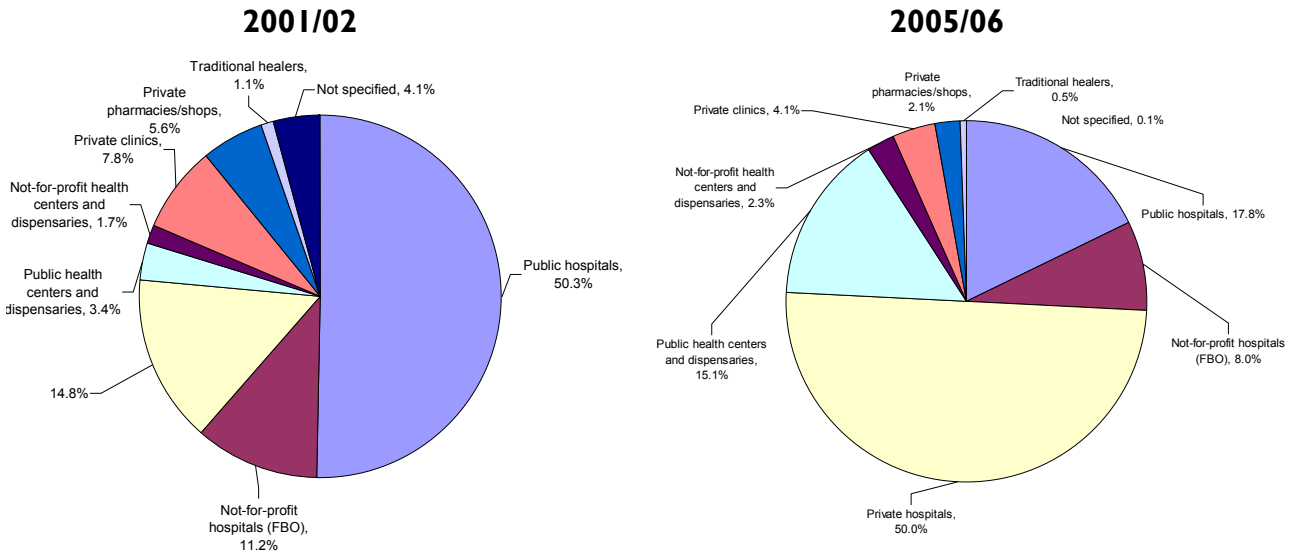


Donor expenditures on HIV/AIDS Kshs 5,047,095,328 **Donor expenditures on HIV/AIDS Kshs 13,110,934,401**

4.6 OOP SPENDING ON HIV/AIDS

In 2001/02, half of household OOP spending went to public hospitals, but this changed dramatically; in 2005/06, half of OOP spending was in private hospitals, up from 15 percent in 2001/02 (Figure 4.4), and OOP spending at public hospitals was only 18 percent. KAIS data show that this was due to a decreased volume of patients receiving care at public hospitals and an increased volume – specifically, a ninefold increase in the number of PLHIV visits – at rural public health facilities (health centres and dispensaries), i.e., utilisation of public health centres by PLHIV increased from 6 percent in 2001/02 to 35 percent in 2005/06 (KAIS 2007). This shift is attributable to availability of free ART services.[10] As a result of this increase in visits, the percentage of household OOP spending at public health centres increased from 3 percent to 15 percent of THE_{HIV}.

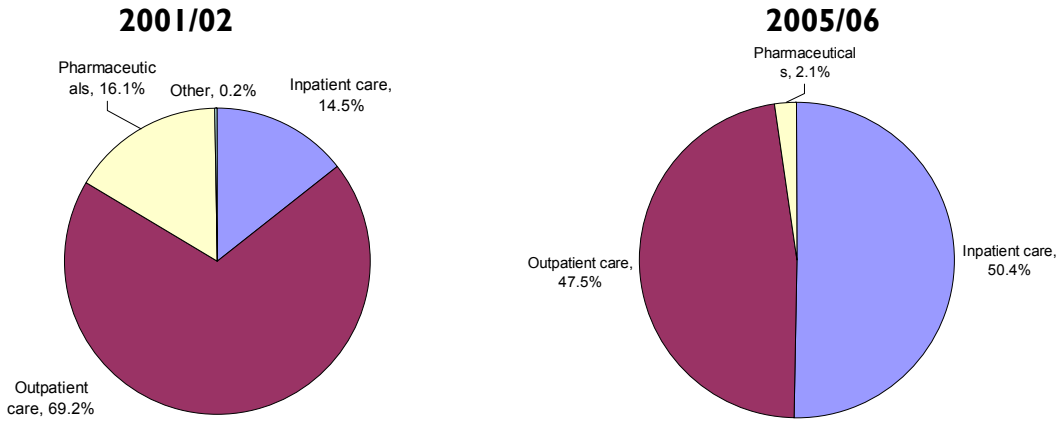
FIGURE 4.4: CONSUMPTION OF HOUSEHOLD OOP FUNDS, BY PROVIDER, 2001/02 AND 2005/06



[10] Although the ART services are free, patients pay registration and consultation fees as determined by the provider.

Outpatient care was the primary service purchased out of pocket in 2001/02 – 70 percent of HIV/AIDS OOP spending went to outpatient care (Figure 4.5). In contrast, in 2005/6, OOP spending on HIV/AIDS services as a share of total OOP spending was nearly equally divided between outpatient and inpatient care. Inpatient HIV/AIDS care increased from 15 percent to 50 percent of OOP spending. OOP spending on pharmaceuticals decreased from 16 percent in 2001/02 to 2 percent in 2005/06. Of course, it is important to note that some OOP expenditure on pharmaceuticals might have been subsumed under expenditures on inpatient and outpatient care.

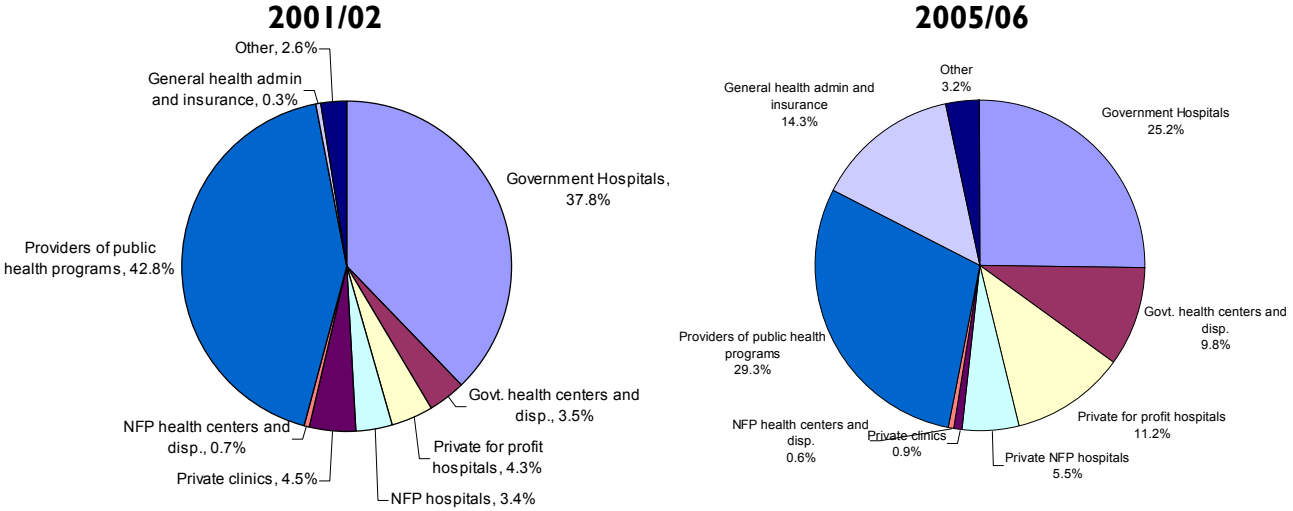
FIGURE 4.5: HIV SERVICES BOUGHT OUT OF POCKET, 2005/06



4.7 PROVIDERS OF HIV/AIDS HEALTH CARE: WHO USES HIV/AIDS HEALTH FUNDS TO DELIVER CARE?

In absolute values, providers of public health programmes utilized Kshs 5.5 billion (US$ 75.7 million) in 2005/06, up from Kshs 4.2 billion (US$ 53.8 million) in 2001/02, an increase of 30 percent (Figure 4.6). Providers of public health programmes, although utilizing a decreased percentage of THE_{HIV}, retained the largest share, 29 percent. Government hospitals utilised a decreased share of THE in 2005/06, while utilisation at government health centres and dispensaries increased from 4 percent in 2001/02 to 9 percent in 2005/06.

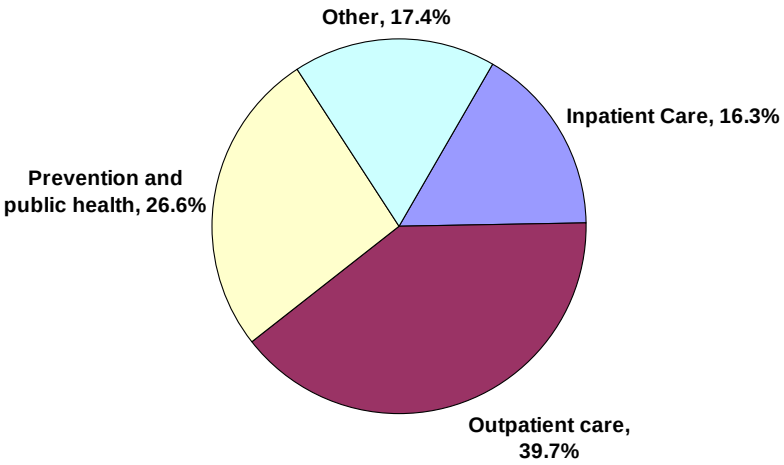
FIGURE 4.6: PROVIDERS OF HIV/AIDS HEALTH SERVICES, 2005/06



4.8 FUNCTIONS OF HIV/AIDS HEALTH CARE: WHAT SERVICES AND PRODUCTS ARE PURCHASED WITH HIV/AIDS HEALTH FUNDS?

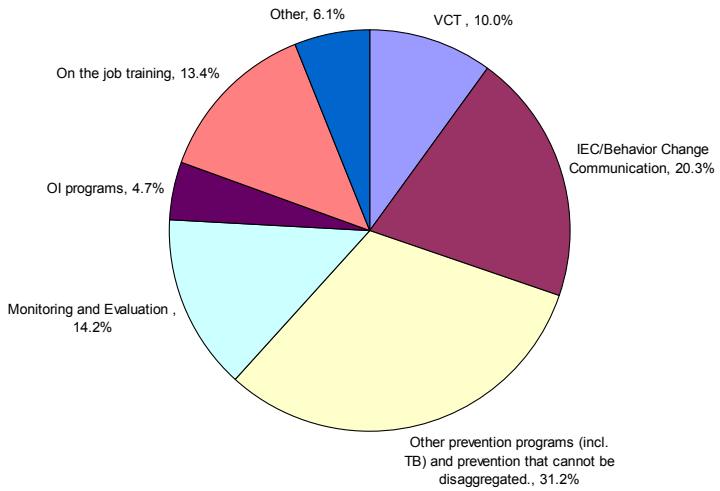
In 2005/06 outpatient care consumed the greatest share of THE_{HIV} (40 percent), followed by prevention and public health programmes (27 percent) (Figure 4.7). In 2001/02, prevention and public health accounted for the largest share (47 percent) followed by inpatient care (24 percent).

FIGURE 4.7: BREAKDOWN OF THE ON HIV/AIDS BY FUNCTION, 2005/06



A breakdown of prevention and public health shows that general prevention programmes comprised the largest share (31 percent) of expenditures on total prevention and public health programmes, followed by information, education, and communication (IEC) and behaviour change communication (BCC) programming at 20 percent (Figure 4.8).

FIGURE 4.8: BREAKDOWN OF EXPENDITURES ON HIV PREVENTION AND PUBLIC HEALTH PROGRAMS, 2005/06



Figures 4.9a and 4.9b illustrate a breakdown of programmatic spending. It should be noted that this breakdown is dependent upon the level of disaggregation provided by survey respondents. Donor contribution to prevention and public health programmes continued to be the largest source of funding for this category, although the allocation decreased from 33 percent in 2001/02 to 25 percent in 2005/06. Donor allocation increased significantly in the area of outpatient care, rising from 4 percent of outpatient care expenditure in 2001/02 to 26 percent in 2005/06.

The household contribution to inpatient care has increased, although the overall increase in inpatient care was primarily financed by donors.

FIGURE 4.9A: FINANCING SOURCES OF HIV/AIDS FUNCTIONS, 2001/02

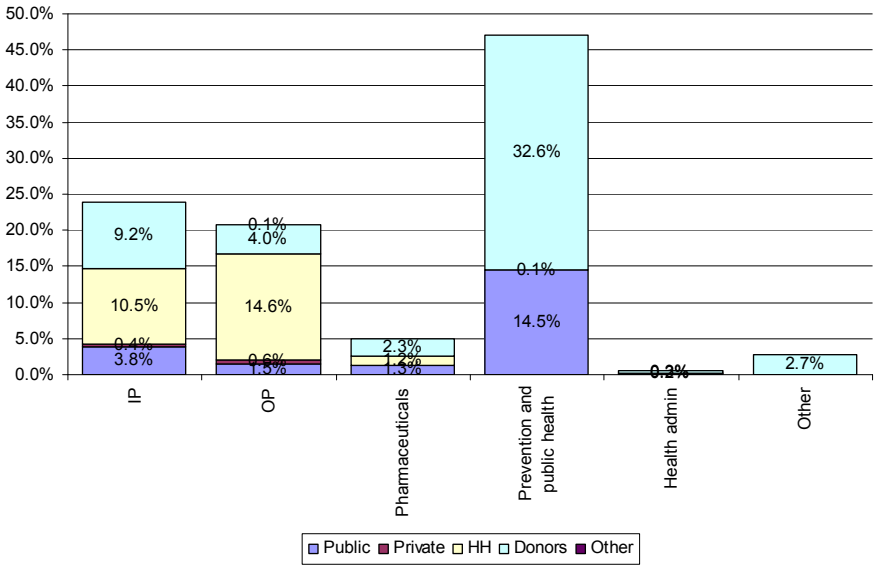
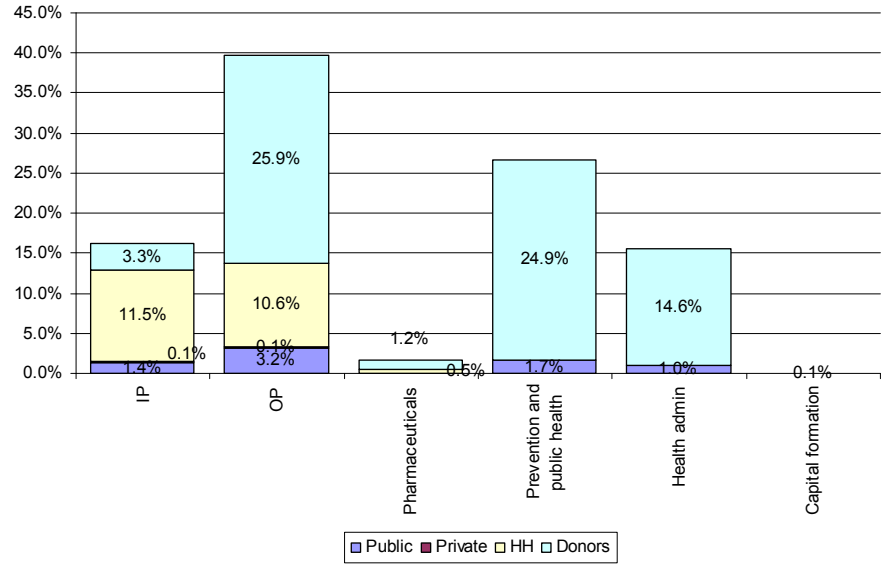


FIGURE 4.9B: FINANCING SOURCES OF HIV/AIDS FUNCTIONS, 2005/06



4.9 SUMMARY OF HIV/AIDS FINDINGS

- **The HIV/AIDS share of THE has increased.** HIV/AIDS absolute health expenditures increased by 89 percent between 2001/02 and 2005/06 (from Kshs 10 billion to Kshs 19 billion). In 2005/06, health expenditures for HIV/AIDS accounted for 27 percent of THE, while in 2001/02 they accounted for only 17 percent.
- **Donors have fueled the increase in HIV/AIDS health expenditures.** In 2005/06, donors accounted for the vast share of HIV/AIDS health expenditures. Donors financed 70 percent of total HIV expenditures followed by private sources (23 percent) and government (7 percent).
- **Donors and NGOs are the primary managers of HIV/AIDS funding.** Donors and NGOs managed 56 percent of all HIV/AIDS health funding in 2005/06 compared with 15 percent in 2001/02. Public financing agents, which managed the majority of total HIV/AIDS funding in 2001/02, managed less than one quarter of it in 2005/06.
- **Spending at public hospitals has decreased significantly as a percentage of total HIV/AIDS OOP spending by households.** OOP spending at public facilities accounted for over half (54 percent) of all HIV/AIDS health expenditures in 2001/02. In 2005/06, OOP spending at public facilities was 33 percent of THE_{HIV}.
- **OOP spending on pharmaceuticals decreased from 16 percent to 2 percent between 2001/02 and 2005/06.** This was in line with the observed trend in general OOP health expenditures as a result of the 10/20 Policy and the availability of free ART drugs and other medical supplies in public facilities.
- **Providers of public health programmes are the largest consumer of THEHIV.** Donors continued to fund the largest share of these programmes; however, the relative share of THE_{HIV} decreased from 2001/02 to 2005/06.
- **Donors supported an increased percentage of outpatient care.** In 2001/02, households were the primary source of funding for outpatient care, while in 2005/06 donors were the primary source.

5. REPRODUCTIVE HEALTH SUBACCOUNT FINDINGS

5.1 INTRODUCTION

RH has become an increasingly important policy issue in the health sector in Kenya in recent years. The delivery of effective RH interventions has been complicated by the HIV/AIDS epidemic and lack of specific interventions to target hard-to-reach areas. To scale up RH interventions, the government developed the National Reproductive Health Policy in 2007, the focus of which is to enhance the RH status for all Kenyans. Hence, RH is a major component of the Kenya Essential Package for Health. The MoH has prioritised the following four components of RH based on the magnitude and significance of the problem:

1. Safe motherhood, and maternal and neonatal health;

2. Family planning;

3. Adolescent/youth sexual and reproductive health; and

4. Gender issues.

Various RH indicators are shown in Annex A comparing Kenya with other countries in sub-Saharan Africa.

The 2001/02 NHA estimation did not include a RH subaccount. Hence, data presented in the following sections address only 2005/06.

5.2 CONCEPT AND SCOPE OF THE RH SUBACCOUNT

The Guidelines for producing the reproductive health subaccounts within the National Health Accounts framework define RH as: A state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[11]

[11] Guidelines for producing the reproductive health subaccounts within the National Health Accounts framework.

The RH subaccount follows the same framework as the general NHA and hence uses the same format for analysis of expenditures and the same general rules for setting expenditure boundaries. The specific items included in the subaccounts follow the guidance given in the Guidelines.

Although there may be more specific goals depending on the country context, generally speaking the RH subaccount aims to:

1. Provide key expenditure information for national policymakers, donors, and other stakeholders to guide their strategic planning in the area of RH care;

2. Identify all sources and uses of financial flows for RH in the context of overall health spending; and

3. Provide internationally comparable data.

Given the criteria described above, listed below are the major RH activities that were included in the subaccount. The activities are grouped according to five core aspects of reproductive (and sexual) health care as defined in the RH Strategy adopted by the WHO in 2004. The non-programmatic elements of the core aspects have been mapped to specific ICD (International Classification of Disease) categories in Annex A.

Maternal health care: Improving antenatal and postpartum care [12], [13]

- Prenatal and postnatal care:
- Including the provision of micronutrients (such as iron sulfate, folic acid, vitamin A) and food supplements [14] to mothers before, during, and after pregnancy;
- Postnatal care refers to services rendered up to six weeks post-delivery for the mother and 28 days post-birth for routine care for the infant.
- Deliveries:
- Including emergency obstetric care to deal with complications;
- Including transportation for emergency obstetric care.

[12] As they pertain to the mother (due to functional boundary demarcations between RH and child health subaccounts) and routine care for the newborn (defined as up to 28 days post-birth).
[13] Note: For comparative purposes, it is recommended that prevention of mother-to-child transmission (PMTCT) of HIV/AIDS be excluded from the RH subaccount and included in the HIV/AIDS subaccount, because the service is generally offered in medium-high prevalence country settings where the implementation of a distinct HIV/AIDS subaccount is recommended. Irrespective of the subaccount chosen, care should be taken to clearly distinguish expenditures associated with services that may be perceived to overlap with other subaccounts.
[14] Included as health related.

Providing high-quality services for family planning, including infertility services

- All programmes, goods, and services intended to assist people to control their fertility, and all counseling, health education, and information:
    - Outpatient counseling and issuance of contraceptive commodities such insertion of intrauterine devices (IUDs) and injectables;
    - Retail sale of family planning commodities such as oral contraceptives, condoms, spermicidals;
    - Female and male surgical sterilisation;
    - Abortion where legal; and
    - Programmes that support or promote family planning such as IEC, public awareness, health education campaigns, training, and research.
- Infertility counseling, fertility drugs, or procedures, etc.

Eliminating unsafe abortion [15]

Combating sexually transmitted infections (STIs) including HIV, reproductive tract infections (RTIs), RH cancers, and other gynecological morbidities

- Including general gynecological care:
    - Routine examinations (e.g., Pap smears);
    - Diagnosis, management, and treatment of STIs (may be included in either the RH subaccount or the HIV/AIDS subaccount depending on country context);
    - Health education;
    - Treatment of RTIs;
    - Screening and treatment of uterine/cervical/ovarian/breast/prostate cancers, etc.; and
    - Treatment of fistulas.
- STI prevention and awareness programmes;
- Prevention campaigns aimed at stopping female genital mutilation.

Promoting sexual health [16]

- Programmes addressing gender-based violence, elimination of harmful sexual practices, sexual trafficking, and exploitation of minors;
- Programmes addressing adolescent sexual and reproductive health;

---

[15] According to WHO, an "unsafe abortion is the termination of a pregnancy carried out by someone without the skills or training to perform the procedure safely, or in an environment that does not meet minimal medical standards, or both."

[16] Considered as addendum activities.

- Programmes addressing the issue of sexual trafficking (social protection, family and children);
- Programmes addressing the issue of exploitation of minors.

The estimation includes expenditures on services and products whose primary purpose was to meet the above objectives. The analysis was focused on the following areas of expenditure: outpatient care, inpatient care, pharmaceuticals and medical nondurables including contraceptives, support services, capital formation, and research and development. These are more fully explained below:

Outpatient care: Family planning consultations and commodities; prenatal and postnatal care for the mother on an outpatient basis

Inpatient care: Deliveries; abortions; other diseases of the genito-urinary system

Pharmaceutical and medical nondurables: Includes oral contraceptives, condoms, IUDs, etc.

Services that support or promote family planning and maternal health: Programme expenditures on IEC, BCC, public awareness campaigns; administration and coordination

5.3 TOTAL RESOURCE ENVELOPE FOR RH HEALTH CARE

In 2005/06, total RH expenditure was Kshs 9 billion (US$ 122 million), 0.6 percent of GDP (Table 5.1). Per woman of reproductive age, RH expenditure was approximately Kshs 1,009 (US$ 14). The private and public sectors were the primary sources of financing for RH, contributing 41 percent and 34 percent, respectively, while donor's contributed 24 percent. RH accounted for 13 percent of THE (see Figure 3.13 in Chapter 3). This 13 percent, added to 25 percent of THE going to HIV/AIDS health services, means that RH and HIV/AIDS account for nearly 40 percent of Kenya's THE.

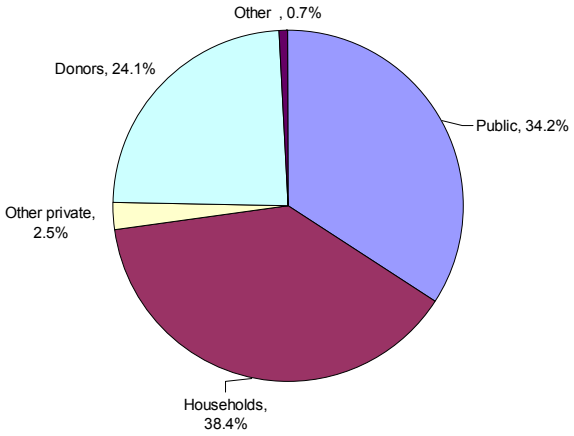
TABLE 5.1: SUMMARY OF RH SUBACCOUNT FINDINGS, 2005/06

Indicators	2005/06
Total RH (THE_{RH}) health expenditure Ksh	8,968,692,131
Total RH (THE_{RH}) health expenditure US$	$ 122,147,663
Total RH expenditure (TRE) Ksh	9,045,417,231
Total RH non-health expenditure (TRE) US$	$ 123,192,608
RH expenditure per woman of reproductive age Ksh	1,009
RH expenditure per woman of reproductive age US$	$ 14
RH expenditure as a % of GDP	0.6%
RH expenditure as a % of general THE	12.7%
THE_{RH} % targeted for RH	54.0%
THE_{RH} as a % of total RH spending (health and non-health)	99.4%
Financing sources as a % of THE_{RH}	
Public	34.2%
Private	41.0%
Donor	24.1%
Other	0.7%
Household (HH) spending	
Total RH HH spending as % of THE_{RH}	38.4%
OOP spending as % of total RH HH spending	68.5%
OOP spending as % of THE_{RH}	26.3%
OOP spending per woman of reproductive age	266
Financing agent distribution as a % of THE_{RH}	
Public	54.0%
Private	44.3%
Donor	1.6%
Provider distribution as a% of THE_{RH}	
Public providers	61.0%
Private providers	29.8%
Provision of public health programs	3.9%
Other	5.3%
Function distribution as a % of THE_{RH}	
Inpatient care	62.1%
Outpatient care	25.4%
Pharmaceuticals	0.1%
Prevention and public health programs	3.4%
Health administration	5.8%
Other	3.3%

5.4 FINANCING SOURCES OF RH: WHO PAYS FOR RH SERVICES?

In 2005/06, private sector and government sources were the primary sources of expenditures for RH, accounting for 41 percent and 34 percent of total RH expenditures, respectively (Figure 5.1). The private sector here is mostly households, which accounted for 38 percent of total RH expenditures. Donors accounted for approximately 24 percent of total health expenditures on RH care.

FIGURE 5.1: FINANCING SOURCES OF RH SERVICES

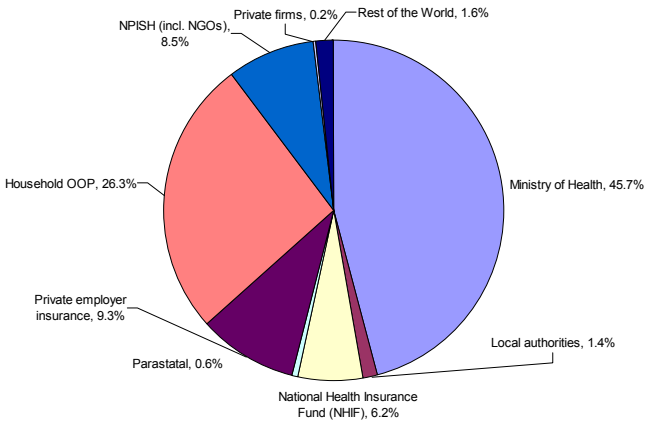


THE_{RH}: KShs 8,968,692,131

5.5 FINANCING AGENTS: WHO MANAGED RH FUNDS?

Figure 5.2 shows the financing agents, or managers, of RH funds. Overall, nearly 54 percent of total expenditures on RH care flowed through public entities (MoH, local authorities, parastatals, and NHIF). Within public entities, however, the MoH was the primary financing agent, managing about 46 percent of RH funds. Amongst private entities, households were the most significant manager of RH expenditure, at about 26 percent. Just over 10 percent of funds for RH care were channeled through NGOs and donors.

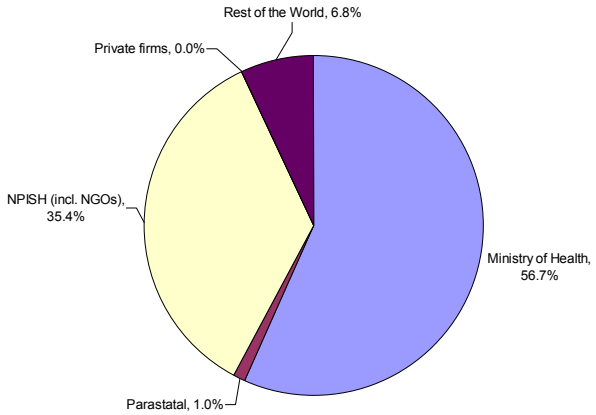
FIGURE 5.2: MANAGERS OF RH FUNDS, 2005/06



THERH: KShs 8,968,692,131

As is common, most donor funding for RH care (57 percent) in 2005/06 was channeled through the MoH (Figure 5.3). NGOs managed the next largest share of donor RH funds, 35 percent.

FIGURE 5.3: MANAGERS OF DONOR RH FUNDS

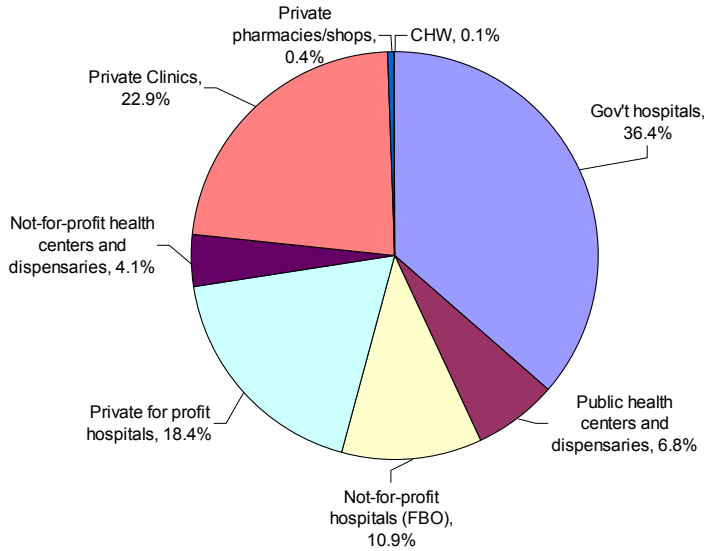


Absolute value of donor spending on RH: Kshs 2,157,109,625

5.6 HOUSEHOLD OOP SPENDING

Households made a majority of their OOP expenditure on RH care (57 percent) at private facilities (Figure 5.4). About 41 percent of OOP spending on RH services went to private for-profit hospitals and clinics, the remaining 15 percent to not-for-profit providers. Public facilities accounted for about 43 percent of household OOP spending on RH care.

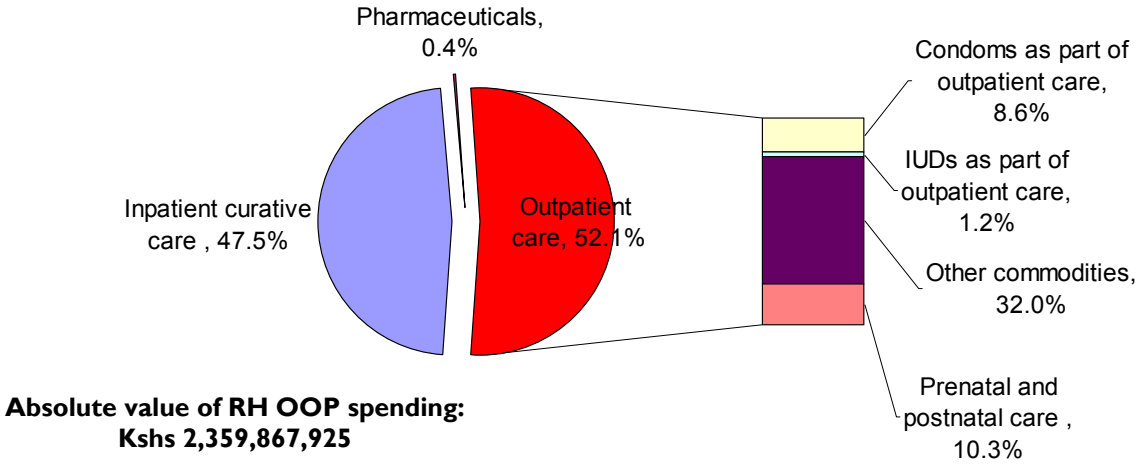
FIGURE 5.4: RH OOP SPENDING, BY PROVIDER, 2005/06



Absolute value of RH OOP spending: Kshs 2,359,867,925

With their OOP expenditures, households purchased about equal amounts of inpatient curative care (48 percent) and outpatient care (52 percent) (Figure 5.5). A breakdown of outpatient care shows that commodities consumed most resources (32 percent), followed by prenatal/postnatal care (10 percent) and condoms distributed as part of outpatient care (9 percent). Data to disaggregate the commodities by type were not available.

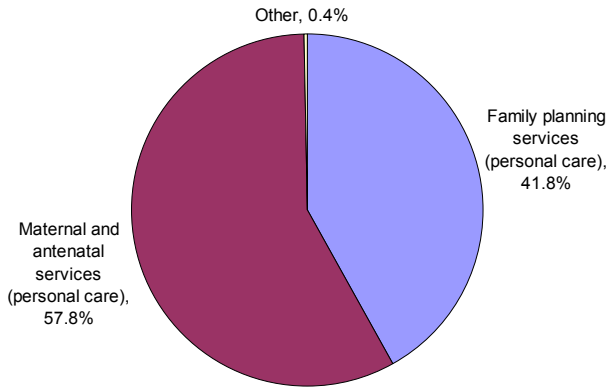
FIGURE 5.5: SERVICES BOUGHT WITH HOUSEHOLD OOP SPENDING, 2005/06



Absolute value of RH OOP spending: Kshs 2,359,867,925

By area of RH care, 58 percent of household OOP expenditures were for maternal and antenatal services, 42 percent for family planning services (Figure 5.6).

FIGURE 5.6: BREAKDOWN OF RH OOP SPENDING, BY AREA OF RH CARE, 2005/06

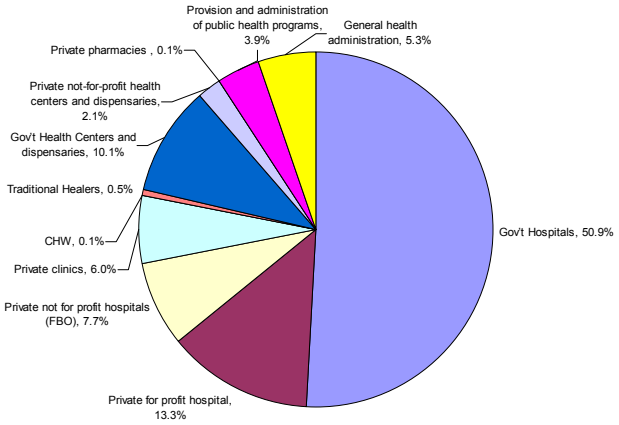


Absolute value of RH OOP spending: 2,359,867,925

5.7 PROVIDERS OF RH SERVICES: WHO USES FUNDS TO PROVIDE RH CARE?

Figure 5.7 shows the breakdown of spending on providers of RH care in 2005/06.

FIGURE 5.7: PROVIDERS OF RH SERVICES, 2005/06



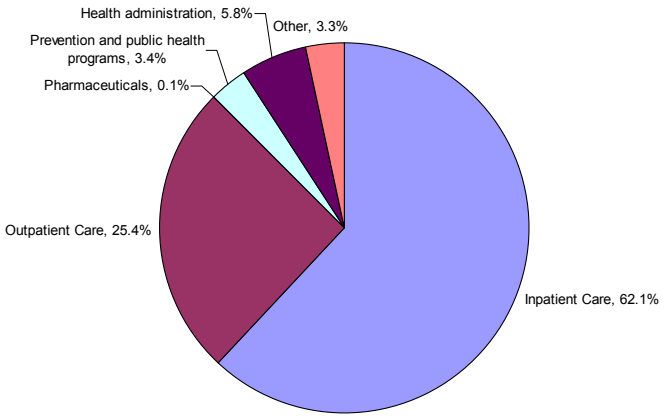
THE_{RH}: KShs 8,968,692,131

Public providers consumed the largest share (61 percent) of RH expenditures; 51 percent was spent on care in government hospitals, 10 percent in public health centres and dispensaries. Amongst private providers, for-profit hospitals consumed the largest share, 13 percent.

5.8 RH CARE FUNCTIONS: WHAT RH SERVICES ARE CONSUMED?

Curative care consumed the largest share of THE_{RH}, 87 percent, with 62 percent for inpatient care and 25 percent for outpatient care (Figure 5.8). Inpatient care includes deliveries and sterilisations, as well as other services that could not be disaggregated.

FIGURE 5.8: WHAT DO RH FUNDS BUY? 2005/06



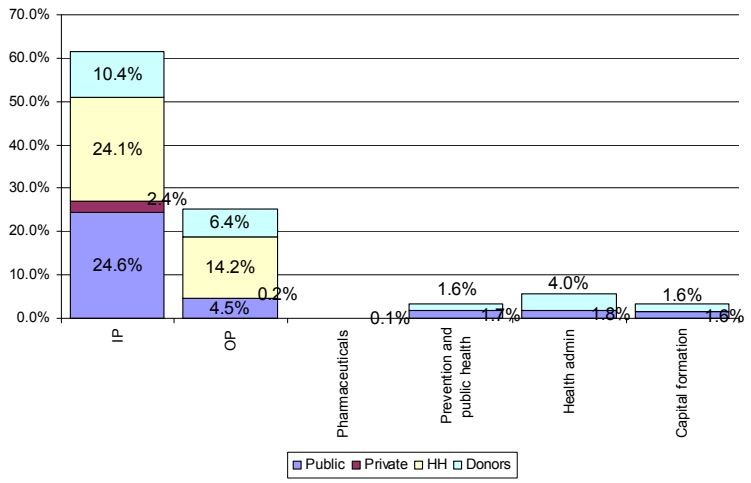
THE_{RH}: KShs 8,968,692,131

5.9 RH CARE FUNCTIONS: WHO FINANCES WHICH RH SERVICES AND/OR PRODUCTS?

RH Care Overall

Figure 5.9 shows the breakdown of RH functions by public, private, and donor sources.

FIGURE 5.9: FINANCING SOURCES FOR RH CARE FUNCTIONS, 2005/06

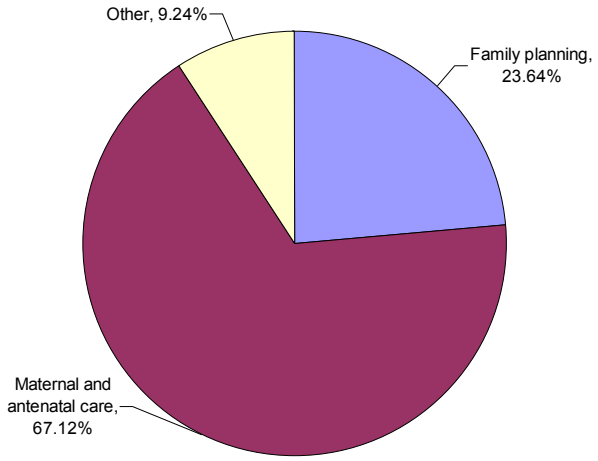


As seen in Section 5.6, RH expenditures in 2005/06 principally pay for the provision of inpatient and outpatient care. A combination of public and household sources finance most of these services. Although pharmaceuticals appeared to only comprise 0.1 percent of THE_{RH}, additional expenditures on pharmaceuticals are incorporated into outpatient curative care, within the RH commodities that could not be disaggregated.

Maternal Health Care

For the purposes of this NHA estimation, maternal health comprises prenatal and postnatal care, obstetric care, and programmes relating to maternal health. In 2005/06, maternal health care accounted for 67 percent of THE_{RH} (Figure 5.10).

FIGURE 5.10: BREAKDOWN OF RH SPENDING BY RH CATEGORY, 2005/06



THE_{RH}: 8,968,692,131

Inpatient care, including deliveries and other obstetric care services, accounted for the largest percentage of maternal health care, at 93 percent (Figure 5.11). As seen above in Figure 5.9, inpatient deliveries are largely financed by the government (25 percent of all delivery expenditures), followed by households, which finance 24 percent. Prenatal and postnatal care accounted for just over 7 percent of total maternal health care expenditures.

5.10 SUMMARY OF RH FINDINGS

- RH spending accounts for 13 percent of THE. Total RH spending in Kenya is Kshs 9 billion (US$ 122 million). This is smaller than the share of THE allocated to HIV/AIDS (26 percent).
- Households, followed closely by public sector entities, are the primary financing sources of RH care. However, public sector entities, particularly the MoH, are the primary agents managing the programmatic spending of RH funds.
- Households spend the majority of their RH OOP resources at private providers. Households make approximately 57 percent of their OOP expenditures on RH at private providers, and they purchase outpatient and inpatient curative care in nearly equal proportions. However, as a share of all expenditures on RH, public providers are the most significant.
- Curative care, including inpatient and outpatient care, consumes the largest share of THE_{RH}, at 87 percent, with 60 percent for inpatient care and 27 percent for outpatient care. Government and households are the major financing sources for inpatient and outpatient RH care.
- Maternal and antenatal health care consume the largest share of THE_{RH}. Maternal and antenatal health care account for over 60 percent of all spending on RH. Maternal health care includes deliveries, prenatal and postnatal care, and maternal health public health programmes. Family planning accounts for about 24 percent of health spending for RH.

6. CONCLUDING REMARKS AND NEXT STEPS

Since 2007, Kenya has been developing a health financing strategy to inform debate on the development of the financing framework for the health sector. Based on this framework, a holistic vision of the future health financing system in Kenya will be developed. To inform the health financing strategy with up-to-date, refined estimates of total health spending and uses of resources in the health sector, an update of the 2001/02 NHA estimation was needed. These 2005/06 NHA findings will not only inform the financing strategy but also will guide the decentralisation agenda under discussion and assist in better programming of HIV/AIDS and RH interventions.

6.1 OVERALL HEALTH SPENDING

In 2005/06, Kenya spent approximately Kshs. 71 billion (US$ 964.4 million), approximately 5 percent of GDP, on the health sector. This shows a 24 percent increase in spending, from 57 billion (US$ 726.4 million) in the 2001/02 NHA estimates. The per capita spending on health in 2005/2006 is Kshs 1,987 (US$ 27), up from Kshs 1,831 (US$ 23) in 2001/02.

Households now contribute less financially to health care than they did in 2001/02: 36 percent of THE in 2005/06 compared with over half in 2001/02. This lower percentage is closely associated with the implementation of pro-poor policies by the government, including the 10/20 Policy on user fees. Nevertheless, household continue to be the major source of health financing, followed by donors and government, which contribute 31 percent and 29 percent, respectively.

In absolute values, public and donor spending increased by 23 percent and 135 percent, respectively, between 2001/02 and 2005/06. These increases are a result of government prioritisation of the health sector in the Economic Recovery Strategy, and the large inflows from the Global Fund and PEPFAR. Household spending in absolute terms has decreased by 13 percent since 2001/02, primarily due to the 10/20 Policy and access to free HIV services.

While government spending in absolute values increased 23 percent, from Kshs 16.9 billion in 2001/02 to Kshs 20.8 billion in 2005/06, government expenditure for all sectors doubled during this same period. Because spending on health did not keep pace with this general increase, government spending on health as percentage of total government expenditure was 5 percent in 2005/06, down from 8 percent reported in 2001/02 and below the Abuja target of 15 percent. Government remains the major financer of public health sector, accounting for close to 75 percent of total resources that went to the public health system in 2005/06. However, donor contributions to the public sector increased, from US$ 76.7 million to US$85.6 million, between 2001/02 and 2005/06.

Donor contributions to health as a percentage of total donor spending increased from 40 percent in 2001/02 to 53 percent in 2005/06, indicating their commitment to the social sector.

Close to 57 percent of the resources mobilised by financing sources passed through the private sector, [17] with households accounting for 29 percent. The public sector[18] controlled 43 percent of the total resource mobilised by financing sources, with the MoH accounting for 35 percent.

Private for-profit hospitals and government hospitals consumed the largest proportion of household OOP funds, at 38 percent and 30 percent, respectively. This represents a decrease in the government hospitals' share of household spending, down from 50 percent in 2001/02, and an increase in the private hospitals' share from 15 percent in 2001/02.

6.2 HIV/AIDS HEALTH SPENDING

HIV/AIDS health expenditures, Kshs 19 billion (US$ 256 million), represent 26 percent of THE for 2005/06. This is an 89 percent increase in spending since the last HIV/AIDS subaccount, in 2001/02.

Donors continue to be a major source of HIV/AIDS funding, accounting for 70 percent of THE_{HIV} in 2005/06, up from 51 percent in 2001/02. Financing by private sector sources (including household OOP spending) decreased slightly but remained a major source (23 percent) of THE_{HIV}, while government contributed 7 percent of THE_{HIV}.

Donors and NGOs managed 56 percent of funding for HIV/AIDS in 2005/06, while public sector financing agents and households managed 22 percent each. Public sector financing agents managed the majority of funding (60 percent) in 2001/02, a much greater share than the current 22 percent.

Household OOP spending at public hospitals decreased from 50 percent to 18 percent of total OOP spending. In contrast, household OOP at private hospitals increased from 15 percent to 50 percent. The percentage of household OOP spending at public health centres increased from 3 to 15 percent.

General prevention programmes comprised the largest share of expenditures on prevention and public health programmes, followed by IEC and BCC programming.

OOP spending on pharmaceuticals decreased from 16 percent to 2 percent between 2001/02 and 2005/06.

6.3 RH SPENDING

For 2005/06, total expenditure on RH was estimated at Kshs 9 billion (US$ 119 million), 13 percent of THE and 0.6 percent of GDP. Households were the primary financing sources, accounting for 38 percent of total RH health expenditures. However, this household share was only slightly higher than the current government share, 35 percent. Donors' contribution to RH was smaller than to HIV/AIDS, and accounted for only 24 percent THE_{RH}.

Approximately half of total resources mobilised for RH are channeled through the MoH, and close to 46 percent of donor RH funds flowed through the MoH. NGOs managed approximately 36 percent of donor RH funds.

[17] Households, private employer insurance, private firms, and NGOs
[18] MoH, NHIF, local authorities, NACC, and parastatals

Households did approximately 57 percent of their OOP spending on RH care at private health facilities. Approximately 58 percent of the OOP expenditures were used for maternal and antenatal services, and 42 percent went to family planning services.

Curative care, primarily deliveries, and antenatal care consumed the largest share of THE_{RH}, with 60 percent of it going to inpatient care and 27 percent to outpatient care. Inpatient care, including deliveries, sterilisations, and other obstetric services that could not be disaggregated, accounted for the largest percentage of maternal health care, at 90 percent. Prenatal and postnatal care accounted for the remaining 10 percent.

6.4 NEXT STEPS

Based on the NHA findings and their implications on informing policy, the following recommendations are made:

- Although household expenditure on health decreased, it is important to continue to alleviate the burden of health financing on households, especially the poor.
- NHIF should be reengineered to play a larger role in financing health care given that its contribution to total insurance expenditure increased only marginally over the three years between the two rounds of NHA.
- OOP expenditure on pharmaceuticals at private pharmacies and shops has drastically decreased as a result of better supply of public health facilities, especially health centres and dispensaries. This needs to be sustained by improving the performance of the Kenya Medical Supplies Agency (KEMSA). It is important that the public does not lose faith again in the ability of the public sector to provide needed drugs and other medical supplies.
- Donor investments in RH are low in comparison to their contributions to HIV/AIDS care, and, although the government is spending more on RH, the overall low resource allocation may be contributing factor to poor RH indicators such as maternal mortality. As such, it will be important to address RH resource allocations in future.
- Donor expenditures on HIV/AIDS have increased significantly without corresponding increases from the public sector. This raises issues of sustainability and government commitment to address HIV/AIDS.
- Between 2001/02 and 2005/06, donor funding increased by 135 percent, with NGOs managing the majority of these funds. NGO activities should be monitored to ensure that they are aligned to health sector priorities. NGOs, as signatories to the health sector Code of Conduct, [19] should be made to account for funds they manage.
- Private providers of HIV/AIDS care should be monitored to ensure compliance with national policies and treatment guidelines for HIV/AIDS, considering the large OOP expenditure in the private sector.

[19] The Code of Conduct is a set a rules and regulation created by all stakeholders in the health sector (e.g., NGOs, government, donors) to govern the sector.

ANNEX A. REPRODUCTIVE HEALTH INDICATORS

	Antenatal care coverage (4+ visits) (%)		Births attended by skilled health personnel (%)		Perinatal mortality rate (per 1000)		Maternal mortality ratio (per 100 000)		Total fertility rate		Contraceptive prevalence (any method) (%)		Contraceptive prevalence (modern methods) (%)	
Country		**Year**		**Year**		**Year**		**Year**		**Year**		**Year**		**Year**
Benin	61	2001	65.5	2001	67	2000	850	2000	5.9	2000-05	18.6	2001	7.2	2001
Botswana	97	2001	94.2	2000	79	2000	100	2000	3.2	2000-05	40.4	2000	38.8	2000
Eritrea	49	2001	28.3	2002	42	2000	630	2000	5.5	2000-05	8.0	2002	5.1	2002
Ethiopia	10	2000	5.6	2000	57	2000	850	2000	5.9	2000-05	8.1	2000	6.3	2000
Ghana	69	2003	47.1	2003	45	2000	540	2000	4.4	2000-05	25.2	2003	18.7	2003
Kenya	52	2003	41.6	2003	53	2000	414	2003	4.9	2003	39.3	2003	31.5	2003
Malawi	55	2000	60.5	2002	43	2000	1,800	2000	6.1	2000-05	30.6	2000	26.1	2000
Mali	30	2001	40.6	2001	51	2000	1,200	2000	6.9	2000-05	8.1	2001	5.7	2001
Mozambique	41	1997	47.7	2003	76	2000	1000	2000	5.5	2000-05	16.5	2003	11.8	2003
Namibia	69	2000	75.5	2000	46	2000	300	2000	4.0	2000-05	43.9	2000	42.7	2000
Nigeria	47	2003	35.2	2003	86	2000	800	2000	5.8	2000-05	12.6	2003	8.2	2003
Rwanda	10	2001	31.3	2000	75	2000	1,400	2000	5.7	2000-05	13.2	2000	4.3	2000
Senegal	64	1999	57.8	2000	49	2000	690	2000	5.1	2000-05	10.5	1999	8.2	1999
South Africa	72	1998	84.4	1998	33	2000	230	2000	2.8	2000-05	56.3	1998	55.1	1998
Uganda	40	2000-01	39.0	2000	40	2000	880	2000	7.1	2000-05	22.8	2000-01	18.2	2000-01
Zambia	71	2001-02	43.4		56	2000	750	2000	5.7	2000-05	34.2	2001-02	22.6	2001-02

Source: WHO Reproductive Health Indicators Database and Country Demographic Health Surveys.

ANNEX B. NHA MATRICES

GENERAL FINANCING SOURCE X FINANCING AGENT (FSXHF)

		Financing Source (FS)										
		FS.1.1.1	FS.1.1.2	FS.1.2	FS.2.1.1	FS.2.1.2	FS.2.2	FS.2.3	FS.2.4.2	FS.3	FS.nsk	
Code	Financing Agent (HF)	Central Government Revenue	Regional and Municipal Government Revenue	Other Public Funds	Parastatal Employer Funds	Private Employer Funds	Household Funds	Non-profit Institutions Serving Individuals	Other Private Funds	Rest of the World Funds	Financing source not specified by any kind	Row Total
HF.1.1.1.1	Ministry of Health	18,765,296,234								6,285,634,866		25,050,931,100
HF.1.1.1.2	Office of President (incl. NACC)	460,079,305								756,705,768		1,216,785,073
HF.1.1.1.3	Other Ministries (Ministry of Education)											0
HF.1.1.2	State/Provincial Government	59,609,616	310,946,366	6,194,139		26,890,632	708,610			4,284,719		408,634,082
HF.1.2	Social Security Funds (NHIF)						2,632,570,016					2,632,570,016
HF.2.5.1	Parastatal Companies				748,811,129					187,673,618		936,484,747
HF.2.1.2	Private Employer Insurance Programmes	145,568,351	1,660,844		268,985,358	895,066,526	2,157,414,899		80,158,194		300,606,541	3,849,460,713
HF.2.2	Private Insurance Enterprises (other than social insurance)											0
HF.2.3	Household Out-of-Pocket						20,611,667,607					20,611,667,607
HF.2.4	Non-profit institutions serving individuals (NGOs)							64,990,232		12,843,535,942		12,908,526,174
HF.2.5.2	Private Non-Parastatal Firms and Corporations (other than health insurance)					1,341,509,017				36,712,500		1,378,221,517
HF.3	Rest of the World									1,814,676,693		1,814,676,693
HF.nsk	Financing agent not specified by any kind											0
	Column Total (THE)	**19,430,553,506**	**312,607,210**	**6,194,139**	**1,017,796,487**	**2,263,466,174**	**25,402,361,132**	**64,990,232**	**80,158,194**	**21,929,224,106**	**300,606,541**	**70,807,957,722**
HF.healthrelated	Financing agents for health related spending	1,567,918,512								1,025,458,539		2,593,377,051
	Column Total (NHE)	**20,998,472,017**	**312,607,210**	**6,194,139**	**1,017,796,487**	**2,263,466,174**	**25,402,361,132**	**64,990,232**	**80,158,194**	**22,954,682,646**	**300,606,541**	**73,401,334,773**

GENERAL FINANCING AGENT X PROVIDER (HFXHP)

		Financing Agent (HF)													
		HF.1.1.1.1	HF.1.1.1.2	HF.1.1.1.3	HF.1.1.2	HF.1.2	HF.2.5.1	HF.2.1.2	HF.2.2	HF.2.3	HF.2.4	HF.2.5.2	HF.3	HF.nsk	
Code	Provider (HP)	Ministry of Health	Office of President (incl. NACC)	Other Ministries (Ministry of Education)	State/Provincial Government	Social Security Funds (NHIF)	Parastatal Companies	Private Employer Insurance Programmes	Private Insurance Enterprises (other than social insurance)	Household Out-of-Pocket	Non-profit institutions serving individuals (NGOs)	Private Non-Parastatal Firms and Corporations (other than health insurance)	Rest of the World	Financing agent not specified by any kind	**Row Total**
HP.1.1.1	Gov't Hospitals	14,727,196,750				436,950,483	160,637,919	683,300,120		6,190,408,999	2,530,928,681	51,658,378	133,204,698		24,914,286,029
HP.1.1.2.1	Private for profit hospital					323,667,025	32,034,122	1,352,427,508		7,834,847,581			51,560,797		9,594,537,033
HP.1.1.2.2	Private hospitals NOT-FOR- profit (FBO)	13,623,973				345,244,826	6,961,953	568,268,146		2,294,251,162	513,733,948	8,577,187			3,750,661,195
HP.1.1.2.3	Private other hospitals														
HP.1.2	Mental Health and Substance Abuse Hospitals (Matheri Hospital, GilGil Hospital)	281,413,865													281,413,865
HP.1.3.1	Gov't speciality hospitals (Spinal Injury, Pumwani Maternity	51,977,687			102,240,646										154,218,333
HP.1.3.2	Private speciality hospitals														
HP.3.1-3.3	Offices of Physicians, dentists, nurses and clinical officers						536,478,464	660,836,653		1,763,257,394		1,263,019,946			4,223,592,456
HP.3.3.1	CHWs (includes public Health Officers)									45,750,428	451,441,343				497,191,771
HP.3.3.2	Traditional Healers									93,476,597					93,476,597
HP.3.4.5.1	Gov't Health Centers and dispensaries	3,899,660,819			306,393,436		4,869,930	46,476,270		795,003,913	963,300,492	3,124,467			6,018,829,327
HP.3.4.5.2	Private not-for-profit health centers and dispensaries including shops and pharmacies	5,535,614					2,828,740			651,405,545	2,780,289	1,814,873	40,567,313		704,932,373
HP.3.6	Providers of home health services														
HP.4.1	Dispensing Chemists							76,639,669		892,543,108	854,967,146				1,824,149,922
HP.5	Provision and administration of public health programs	2,404,885,307	917,655,149								7,147,770,928	36,712,500	270,322,960		10,777,346,844
HP.6	General health administration and insurance, other than capital formation for KEMSA	3,493,750,098	299,129,924			1,526,707,682	187,673,618	461,512,348			431,508,202		1,319,020,925		7,719,302,797
HP.6.1.1	Capital formation for KEMSA	169,800,000													169,800,000
HP.7	Other industries rest of the economy (school health services)										6,060,144				6,060,144
HP.9	Rest of the World						5,000,000					13,314,167			18,314,167
HP.nsk	Provider expenditure not specified by kind	3,086,987								50,722,881	6,035,000				59,844,868
	Column Total THE	**25,050,931,100**	**1,216,785,073**		**408,634,082**	**2,632,570,016**	**936,484,747**	**3,849,460,713**		**20,611,667,607**	**12,908,526,174**	**1,378,221,517**	**1,814,676,693**		**70,807,957,722**
HP.8.1	Research Institutions												186,441,080		186,441,080
HP.8.2	Education and training institutions	656,681,821									58,629,126				715,310,947
HP.8.3	Other institutions providing health related services	919,204,671									36,712,500		735,707,853		1,691,625,024
	Subtotal for health related	1,575,886,492									95,341,626		922,148,933		1,017,490,559
	Column Total: NHE	**26,626,817,591**	**1,216,785,073**		**408,634,082**	**2,632,570,016**	**936,484,747**	**3,849,460,713**		**20,611,667,607**	**13,003,867,800**	**1,378,221,517**	**2,736,825,626**		**73,401,334,773**

GENERAL FINANCING AGENTS X FUNCTION (HF X HC)

		Financing Agent (HF)													
		HF.1.1.1.1	HF.1.1.1.2	HF.1.1.1.3	HF.1.1.2	HF.1.2	HF.2.5.1	HF.2.1.2	HF.2.2	HF.2.3	HF.2.4	HF.2.5.2	HF.3	HF.nsk	
Code	Function (HC)	Ministry of Health	Office of President (incl. NACC)	Other Ministries (Ministry of Education)	State/Provincial Government	Social Security Funds (NHIF)	Parastatal Companies	Private Employer Insurance Programmes	Private Insurance Enterprises (other than social	Household Out-of-Pocket	Non-profit institutions serving individuals (NGOs)	Private Non-Parastatal Firms and Corporations (other than health insurance)	Rest of the World	Financing agent not specified by any kind	**Row Total**
HC.1.1	Inpatient curative care	8,801,834,298			69,447,195	1,105,862,334	89,472,038	1,762,576,656		9,087,509,194	5,231,665	51,355,263	134,529,960		21,107,818,603
HC.2	Services of rehabilitative care (counseling- Psychosocial support)										6,179,389				6,179,389
HC.1.3	Outpatient curative care	9,336,166,039			339,186,887		659,339,091	1,548,732,040		10,631,615,306	4,378,108,414	1,057,743,598	90,802,847		28,041,694,223
HC.1.4	Services of curative home care										53,204				53,204
HC.5.1.1.1-2	Pharmaceuticals (prescribed and over-the-counter)							76,639,669		892,543,108					969,182,776
HC.5.1.3	Other Medical non-durables										854,967,146				854,967,146
HC.5.2	Medical durables (including bednets)														
HC.6	Prevention and public health services (outreach)														
HC.6.1	Maternal and child health; family planning and counselling	668,839,838									113,469,094		116,001,238		898,310,170
HC.6.2	School Health Services										3,778,001				3,778,001
HC.6.3	Prevention of communicable diseases	804,711,595	509,585,290								3,495,240,508	36,712,500	154,321,722		5,000,571,615
HC.6.4	Prevention of non-communicable diseases	39,201,691									58,555,678				97,757,369
HC.6.5	Monitoring and Evaluation	478,133,093									204,150,870				682,283,963
HC.6.6	Training within public health programs	252,562,850									1,109,061,130				1,361,623,980
HC.6.9	All other miscellaneous public health services	161,436,239	149,476,395								8,994,125				319,906,759
HC.7.3	Technical support	42,093,808									478,105,692				520,199,500
HC.7.4	Admin other than TA and admin that cannot be disaggregated	3,523,753,658	557,723,388			1,526,707,682	187,673,618	461,512,348			2,169,911,446		1,319,020,925		9,746,303,065
HC.n.s.k	HC expenditure not specified by any kind	8,559,067									6,035,000	228,776,551			243,370,617
HCR.1	Capital formation for health care provider institutions	933,638,923									16,684,812	3,633,605			953,957,340
	Column Total THE	**25,050,931,100**	**1,216,785,073**		**408,634,082**	**2,632,570,016**	**936,484,747**	**3,849,460,713**		**20,611,667,607**	**12,908,526,174**	**1,378,221,517**	**1,814,676,693**	-	**70,807,957,722**
HCR.2	Formal education and training of health personnel	648,713,841									58,629,126				707,342,967
HCR.3	Research and development in health	860,212,431									36,712,500		922,148,933		1,819,073,864
HCR.n.s.k	HCR expenditure not-specified by any kind	66,960,220													66,960,220
	Sub total column	1,575,886,492									95,341,626		922,148,933		2,593,377,051
	Column Total NHE	**26,626,817,591**	**1,216,785,073**		**408,634,082**	**2,632,570,016**	**936,484,747**	**3,849,460,713**		**20,611,667,607**	**13,003,867,800**	**1,378,221,517**	**2,736,825,626**		**73,401,334,773**

GENERAL PROVIDER X FUNCTION (HP X HC) – PART I

		HP.1.1.1	HP.1.1.2.1	HP.1.1.2.2	HP.1.1.2.3	HP.1.2	HP.1.3.1	HP.1.3.2	HP.3.1-3.3	HP.3.3.1	HP.3.3.2	HP.3.4.5.1	HP.3.4.5.2	HP.3.6
Code	Function (HC)	Gov't Hospitals	Private for profit hospital	Private hospitals NOT-FOR- profit (FBO)	Private other hospitals	Mental Health and Substance Abuse Hospitals (Matheri Hospital, GilGil Hospital)	Gov't speciality hospitals (Spinal Injury, Pumwani Maternity Hospital)	Private speciality hospitals	Offices of Physicians, dentists, nurses and clinical officers	CHWs (includes public Health Officers)	Traditional Healers	Gov't Health Centers and dispensaries	Private not-for-profit health centers and dispensaries including shops and	Providers of home health services
HC.1.1	Inpatient curative care	8,912,991,951	5,466,168,096	2,144,916,223		278,055,872	121,424,882		486,789,484		474,156	3,307,633,888	361,297,314	
HC.2	Services of rehabilitative care (counseling-Psychosocial support)									6,179,389				
HC.1.3	Outpatient curative care	15,811,090,908	4,128,368,936	1,605,744,972			32,793,450		3,504,392,817	418,347,097	93,002,441	2,063,348,231	343,635,059	
HC.1.4	Services of curative home care									53,204				
HC.5.1.1.1-2	Pharmaceuticals (prescribed and over-the-counter)													
HC.5.1.3	Other Medical non-durables													
HC.5.2	Medical durables (including bednets)													
HC.6	Prevention and public health services (outreach)													
HC.6.1	Maternal and child health; family planning and counselling									72,612,080				
HC.6.2	School Health Services													
HC.6.3	Prevention of communicable diseases													
HC.6.4	Prevention of non-communicable diseases													
HC.6.5	Monitoring and Evaluation													
HC.6.6	Training within public health programs													
HC.6.9	All other miscellaneous public health services													
HC.7.3	Technical support													
HC.7.4	Admin other than TA and admin that cannot be disaggregated													
HC.n.s.k	HC expenditure not specified by any kind								228,776,551					
HCR.1	Capital formation for health care provider institutions	190,203,170				3,357,993			3,633,605			647,847,208		
	Column Total-THE	24,914,286,029	9,594,537,033	3,750,661,195		281,413,865	154,218,333		4,223,592,456	497,191,771	93,476,597	6,018,829,327	704,932,373	
HCR.2	Formal education and training of health personnel													
HCR.3	Research and development in health													
HCR.n.s.k	HCR expenditure not-specified by any kind													
	Column Total-NHE													

GENERAL PROVIDER X FUNCTION (HP X HC) – PART 2

		HP.4.1	HP.5	HP.6	HP.6.1.1	HP.7	HP.9	HP.nsk	HP.8.1	HP.8.2	HP.8.3	
Code	Function (HC)	Dispensing Chemists	Provision and administration of public health programs	General health administration and insurance, other than capital formation for KEMSA	Capital formation for KEMSA	Other industries rest of the economy (school health services)	Rest of the World	Provider expenditure not specified by kind	Research Institutions	Education and training institutions	Other institutions providing health related services	NHE Row Total
HC.1.1	Inpatient curative care						18,314,167	9,752,569				21,107,818,603
HC.2	Services of rehabilitative care (counseling-Psychosocial support)											6,179,389
HC.1.3	Outpatient curative care							40,970,312				28,041,694,223
HC.1.4	Services of curative home care											53,204
HC.5.1.1.1-2	Pharmaceuticals (prescribed and over-the-counter)	969,182,776										969,182,776
HC.5.1.3	Other Medical non-durables	854,967,146										854,967,146
HC.5.2	Medical durables (including bednets)											-
HC.6	Prevention and public healh services (outreach)											-
HC.6.1	Maternal and child health; family planning and counselling		825,698,090									898,310,170
HC.6.2	School Health Services					3,778,001						3,778,001
HC.6.3	Prevention of communicable diseases		5,000,571,615									5,000,571,615
HC.6.4	Prevention of non-communicable diseases		97,757,369									97,757,369
HC.6.5	Monitoring and Evaluation		682,283,963									682,283,963
HC.6.6	Training within public health programs		1,361,623,980									1,361,623,980
HC.6.9	All other miscellaneous public health services		319,906,759									319,906,759
HC.7.3	Technical support		410,298,232	109,901,268								520,199,500
HC.7.4	Admin other than TA and admin that cannot be disaggregated		2,064,804,167	7,561,698,898	119,800,000							9,746,303,065
HC.n.s.k	HC expenditure not specified by any kind			5,472,080				9,121,987				243,370,617
HCR.1	Capital formation for health care provider institutions		14,402,669	42,230,552	50,000,000	2,282,143						953,957,340
	Column Total-THE	1,824,149,922	10,777,346,844	7,719,302,797	169,800,000	6,060,144	18,314,167	59,844,868	-	-	-	70,807,957,722
HCR.2	Formal education and training of health personnel									707,342,967		707,342,967
HCR.3	Research and development in health								194,409,060			1,819,073,864
HCR.n.s.k	HCR expenditure not-specified by any kind										66,960,220	66,960,220
	Column Total-NHE								194,409,060	707,342,967		73,401,334,773

HIV FINANCING SOURCE X FINANCING AGENT (FSXHF)

		Financing Source (FS)										
		FS.1.1.1	FS.1.1.2	FS.1.2	FS.2.1.1	FS.2.1.2	FS.2.2	FS.2.3	FS.2.4.2	FS.3	FS.nsk	
Code	Financing Agent (HF)	Central Government Revenue	Regional and Municipal Government Revenue	Other Public Funds	Parastatal Employer Funds	Private Employer Funds	Household Funds	Non-profit Institutions Serving Individuals	Other Private Funds	Rest of the World Funds	Financing source not specified by any kind	
HF.1.1.1.1	Ministry of Health	870,026,291								1,909,351,520		2,779,377,810
HF.1.1.1.2	Office of President (incl. NACC)	460,079,305								756,705,768		1,216,785,073
HF.1.1.1.3	Other Ministries (Ministry of Education)											0
HF.1.1.2	State/Provincial Government	5,363,428	27,977,674	557,323		2,419,508	63,758			385,521		36,767,212
HF.1.2	Social Security Funds (NHIF)						54,753,672					54,753,672
HF.2.5.1	Parastatal Companies				7,528,776					45,941,928		53,470,704
HF.2.1.2	Private Employer Insurance Programmes	2,691,255	30,706		4,972,978	16,547,911	39,886,097		1,481,958		5,557,587	71,168,491
HF.2.2	Private Insurance Enterprises (other than social insurance)											0
HF.2.3	Household Out-of-Pocket						4,143,958,814					4,143,958,814
HF.2.4	Non-profit institutions serving individuals (NGOs)							48,637,457		10,064,210,107		10,112,847,564
HF.2.5.2	Private Non-Parastatal Firms and Corporations (other than health insurance)					3,799,964				103,992		3,903,956
HF.3	Rest of the World									334,235,564		334,235,564
HF.nsk	Financing agent not specified by any kind											0
	Column Total THE	**1,338,160,278**	**28,008,379**	**557,323**	**12,501,754**	**22,767,384**	**4,238,662,340**	**48,637,457**	**1,481,958**	**13,110,934,401**	**5,557,587**	**18,807,268,861**
HF.healthrelated	Financing agent that provide health related									842,355,520		842,355,520
	Column Total NHE	**1,338,160,278**	**28,008,379**	**557,323**	**12,501,754**	**22,767,384**	**4,238,662,340**	**48,637,457**	**1,481,958**	**13,953,289,921**	**5,557,587**	**19,649,624,381**
HF.AD	HIV financing agents that provide non-health item									851,827,772		851,827,772.43
	Column Total THAE	**1,338,160,278**	**28,008,379**	**557,323**	**12,501,754**	**22,767,384**	**4,238,662,340**	**48,637,457**	**1,481,958**	**14,805,117,693**	**5,557,587**	**20,501,452,153**

HIV FINANCING AGENT X PROVIDER (HFXHP)

		Financing Agent (HF)														
		HF.A Public Sector						HF.B Non Public Sector							HF.nsk	
		HF.1.1.1.1	HF.1.1.1.2	HF.1.1.1.3	HF.1.1.2	HF.1.2	HF.2.5.1	HF.2.1.2	HF.2.2	HF.2.3	HF.2.4	HF.2.5.2	HF.3	HF.nsk	HF.AD	
Code	Provider (HP)	Ministry of Health	Office of President (incl. NACC)	Other Ministries (Ministry of Education)	State/Provincial Government	Social Security Funds (NHIF)	Parastatal Companies	Private Employer Insurance Programmes	Private Insurance Enterprises (other than social insurance)	Household Out-of-Pocket	Non-profit institutions serving individuals (NGOs)	Private Non-Parastatal Firms and Corporations (other than health insurance)	Rest of the World	Financing agent not specified by any kind	HIV financing agents that provide non-health item	**Row Total**
HP.1.1.1	Gov't Hospitals	1,826,669,154				30,586,534	8,319,591	32,310,407		738,943,476	1,998,060,721	2,984,843	103,894,451			4,741,769,176
HP.1.1.2.1	Private for profit hospital									2,071,656,827	568,602		37,670,036			2,109,895,466
HP.1.1.2.2	Private hospitals NOT-FOR-profit (FBO)	544,959				24,167,138	391,495	33,280,932		333,260,300	646,216,452	471,582				1,038,332,858
HP.1.1.2.3	Private other hospitals															
HP.1.2	Mental Health and Substance Abuse Hospitals (Matheri Hospital, GilGil Hospital)															
HP.1.3.1	Gov't speciality hospitals (Spinal Injury, Pumwani															
HP.1.3.2	Private speciality hospitals															
HP.3.1-3.3	Offices of Physicians, dentists, nurses and clinical officers									168,546,358						168,546,358
HP.3.3.1	CHWs (includes public Health Officers)										256,863,151					256,863,151
HP.3.3.2	Traditional Healers									20,801,505						20,801,505
HP.3.4.5.1	Gov't Health Centers and dispensaries	394,787,619			36,767,212		584,392	5,577,152		624,368,254	773,350,518	374,936				1,835,810,084
HP.3.4.5.2	Private not-for-profit health centers and dispensaries	221,425					120,227			93,775,488	11,948,680	72,595	2,311,052			108,449,466
HP.3.6	Providers of home health care services															
HP.4.1	Dispensing Chemists									88,889,143	231,434,468					320,323,611
HP.5	Provision and administration of public health programs	538,412,738	917,655,149				44,055,000				3,827,436,047		190,360,025			5,517,918,959
HP.6	General health administration and insurance	18,741,915	299,129,924								2,364,052,852					2,681,924,692
HP.7	Other industries rest of the economy (school health services)										2,916,071					2,916,071
HP.9	Rest of the World															
HP.nsk	Provider expenditure not specified by kind									3,717,463						3,717,463
	Column Total THE	**2,779,377,810**	**1,216,785,073**		**36,767,212**	**54,753,672**	**53,470,704**	**71,168,491**		**4,143,958,814**	**10,112,847,564**	**3,903,956**	**334,235,564**			**18,807,268,861**
	HF Totals From FS x HF Table	2,779,377,810	1,216,785,073		36,767,212	54,753,672	53,470,704	71,168,491		4,143,958,814	10,112,847,564	3,903,956	334,235,564			18,807,268,861
HP.8.1	Research Institutions															
HP.8.2	Education and training institutions															
HP.8.3	Other institutions providing health related services										41,753,842		800,601,678			842,355,520
	Subtotal for health related										41,753,842		800,601,678			842,355,520
	Column Total: NHE	**2,779,377,810**	**1,216,785,073**		**36,767,212**	**54,753,672**	**53,470,704**	**71,168,491**		**4,143,958,814**	**10,154,601,406**	**3,903,956**	**1,134,837,243**			**19,649,624,381**
	HP AD															
HP.AD	HIV financing agents that provide non-health item										483,116,103				368,711,669	483,116,103.46
	Subtotal for non-health	0	0	0	0	0	0	0	0	0	483,116,103	0	0	0	368,711,669	**851,827,772.43**
	Column Total: THAE	**2,779,377,810**	**1,216,785,073**		**36,767,212**	**54,753,672**	**53,470,704**	**71,168,491**		**4,143,958,814**	**10,637,717,509**	**3,903,956**	**1,134,837,243**		**368,711,669**	**20,501,452,153**

HIV FINANCING AGENTS X FUNCTION (HF X HC) – PART I

		Financing Agent (HF)														
		HF.A Public Sector							HF.B Non Public Sector						HF.nsk	
		HF.1.1.1.1	HF.1.1.1.2	HF.1.1.1.3	HF.1.1.2	HF.1.2	HF.2.5.1	HF.2.1.2	HF.2.2	HF.2.3	HF.2.4	HF.2.5.2	HF.3	HF.nsk	HF.AD	
Function (HC)		Ministry of Health	Office of President (incl. NACC)	Other Ministries (Ministry of Education)	State/Provincial Government	Social Security Funds (NHIF)	Parastatal Companies	Private Employer Insurance Programmes	Private Insurance Enterprises (other than social insurance)	Household Out-of-Pocket	Non-profit institutions serving individuals (NGOs)	Private Non-Parastatal Firms and Corporations (other than health insurance)	Rest of the World	Financing agent not specified by any kind	HIV financing agents that provide non-health item	Row Total
HC.1.1	Inpatient curative care	755,616,732				54,753,672	4,748,461	39,218,430		2,088,493,203	366,217	2,443,007	119,766,200			3,065,405,922
HC.1.3	Outpatient curative care															
HC.1.3.1	STI Management**										1,277,501					1,277,501
HC.1.3.2	OI Treatment and monitoring (including TB)	4,778,973									396,075,518					400,854,491
HC.1.3.3	ART	850,879,995									1,303,583,841					2,154,463,836
HC.1.3.4	VCT	86,015,780									1,623,605,536		21,440,100			1,731,061,416
HC.1.3.5	PMTCT (service itself)	151,485,035									68,669,615					220,154,650
HC.1.3.6	Other (not specified outpatient visit)	373,446,642			36,767,212		4,667,243	31,950,061		1,966,576,467	276,386,716	1,460,950	2,669,239			2,693,924,530
HC.1.4	Services of curative home care										53,204					53,204
HC.2	Services of rehabilitative care (counseling-Psychosocial support)										6,179,389					265,068,701
HC.5.1.1.1-2	Prescribed and nonprescribed medicines.		258,889,312							88,889,143						88,889,143
HC.5.1.3	Other medical non-durables (incl. male condoms)										231,434,468					231,434,468

HIV FINANCING AGENTS X FUNCTION (HF X HC) – PART 2

		Financing Agent (HF)														
		HF.A Public Sector							HF.B Non Public Sector						HF.nsk	
		HF.1.1.1.1	HF.1.1.1.2	HF.1.1.1.3	HF.1.1.2	HF.1.2	HF.2.5.1	HF.2.1.2	HF.2.2	HF.2.3	HF.2.4	HF.2.5.2	HF.3	HF.nsk	HF.AD	
	Function (HC)	Ministry of Health	Office of President (incl. NACC)	Other Ministries (Ministry of Education)	State/Provincial Government	Social Security Funds (NHIF)	Parastatal Companies	Private Employer Insurance Programmes	Private Insurance Enterprises (other than social insurance)	Household Out-of-Pocket	Non-profit institutions serving individuals (NGOs)	Private Non-Parastatal Firms and Corporations (other than health insurance)	Rest of the World	Financing agent not specified by any kind	HIV financing agents that provide non-health item	Row Total
HC.6	Prevention and Pub. H. Services															
HC.6.1	MCH; FP and Counseling															
HC.6.1.1	PMTCT	46,438,369									25,518,859		22,027,500			93,984,728
HC.6.2	School health services										633,929					633,929
HC.6.3	Prevention of Communicable Diseases															
HC.6.3.1	VCT	2,731,410									461,084,016		36,712,500			500,527,926
HC.6.3.2	Blood Safety										25,518,859		23,698,835			49,217,694
HC.6.3.3	Post Exposure										1,286,269					1,286,269
HC.6.3.4	Info. Educ. Communic. Prog./Behavior Change	2,731,410	400,172,373								611,136,238					1,014,040,021
HC.6.3.5	STI Prevention	7,694,678									25,518,859		27,901,500			61,115,036
HC.6.3.6	Needle Exchange Program (Injection drug use- IDU)															
HC.6.3.7	Condom Distribution programs	1,365,705														1,365,705
HC.6.3.8	Other prevention programs (incl. TB) and prevention that cannot be disaggregated.	555,791									1,529,740,966		32,293,440			1,562,590,197
HC.6.3.10	ARV Programs										73,658,998		25,698,750			99,357,748
HC.6.5	Monitoring and Evaluation	476,895,375									204,150,870		22,027,500			703,073,745
HC.6.5.1	Sentinel Surveillance															
HC.6.5.2	Other monitoring										5,585,545					5,585,545
HC.7.3	General Technical Assistance	17,376,210									930,634,988					948,011,198
HC.7.4	Administration other than TA	1,365,705	557,723,388								1,433,417,865					1,992,506,958
HC.n.s.k	HC expenditure not specified by any kind															
HCR.1	Capital formation for health care provider institutions										13,092,731					13,092,731
HC.6.3.9	OI programs						44,055,000				192,862,554					236,917,554
HC.6.6	On the job training										670,920,124					670,920,124
HC.6.4	Non-communicable diseases										453,893					453,893
	Column Total THE	**2,779,377,810**	**1,216,785,073**		**36,767,212**	**54,753,672**	**53,470,704**	**71,168,491**	-	**4,143,958,814**	**10,112,847,564**	**3,903,956**	**334,235,564**	-	-	**18,807,268,861**
HCR.2	Education and training															
HCR.3	Research and development in health										41,753,842		800,601,678			842,355,520
HCR.n.s.k	HCR expenditure not specified by any kind															
	Sub total column										41,753,842		800,601,678			842,355,520
	Column Total NHE	**2,779,377,810**	**1,216,785,073**		**36,767,212**	**54,753,672**	**53,470,704**	**71,168,491**	-	**4,143,958,814**	**10,154,601,406**	**3,903,956**	**1,134,837,243**	-	-	**19,649,624,381**
HP.AD											483,116,103				368,711,669	851,827,772
	Sub total column	0	0	0	0	0	0	0	0	0	483116103.5	0	0	0	368,711,669	851,827,772
	Column Total THEA	**2,779,377,810**	**1,216,785,073**		**36,767,212**	**54,753,672**	**53,470,704**	**71,168,491**	-	**4,143,958,814**	**10,637,717,509**	**3,903,956**	**1,134,837,243**	-	**368,711,669**	**20,501,452,153**

HIV PROVIDER X FUNCTION (HP X HC) – PART I

		Provider (HP)																										
		HP.1.1.1	HP.1.1.2.1	HP.1.1.2.2	HP.1.1.2.3	HP.1.2	HP.1.3.1	HP.1.3.2	HP.1.3.3	HP.3.3.1	HP.3.3.2	HP.3.4.5.1	HP.3.4.5.2	HP.3.6	HP.4.1	HP.5	HP.6	HP.7	HP.9	HP.nsk		HP.8.1	HP.8.2	HP.8.3		HP.AD	
	Function (HC)	Gov't Hospitals	Private for profit hospital	Private hospitals NOT-FOR- profit (FBO)	Private other hospitals	Mental Health and Substance Abuse Hospitals (Mathari Hospital, GilGil Hospital)	Gov't speciality hospitals (Spinal Injury, Pumwani Maternity Hospital)	Private speciality hospitals	Offices of Physicians, dentists, nurses and clinical officers	CHWs (includes public Health Officers)	Traditional Healers	Gov't Health Centers and dispensaries	Private not-for-profit health centers and dispensaries	Providers of home health care services	Dispensing Chemists	Provision and administration of public health programs	General health administration and insurance	Other industries rest of the economy (school health	Rest of the World	Provider expenditure not specified by kind	THE Row Total	Research Institutions	Education and training institutions	Other institutions providing health related services	NHE Row Total	HIV financing agents that provide non-health item	THAE Row Total
HC.1.1	Inpatient curative care	725,217,931	1,626,926,282	277,191,477					5,582,537			407,559,194	22,937,501								3,065,405,922						
HC.1.3	Outpatient curative care																										
HC.1.3.1	STI Management**	1,277,501																			1,277,501						
HC.1.3.2	OI Treatment and monitoring (including TB)	220,549,068		93,718,487						9,646,638		76,940,297									400,854,491						
HC.1.3.3	ART	1,140,655,056		531,071,427						27,867,862		454,869,491									2,154,463,836						
HC.1.3.4	VCT	1,412,048,630	12,041,700							175,477,668		130,466,537	1,026,880								1,731,061,416						
HC.1.3.5	PMTCT (service itself)	218,865,818	568,602	720,230																	220,154,650						
HC.1.3.6	Other (not specified outpatient visit)	1,023,155,172	470,358,882	155,631,236					182,963,821	37,638,380	20,801,505	765,983,565	73,674,496							3,717,483	2,693,924,539						
HC.1.4	Services of curative home care									53,204											53,204						
HC.2	Services of rehabilitative care (counseling- Psychosocial support)									6,179,389						258,889,312					265,068,701						
HC.5.1.1.1-2	Prescribed and nonprescribed medicines														88,889,143						88,889,143						
HC.5.1.3	Other medical non-durables (incl. male condoms)														231,434,468						231,434,468						
-																											
HC.6	Prevention and Pub. H. Services																										
HC.6.1	MCH, FP and Counseling																										
HC.6.1.1	PMTCT															93,984,728					93,984,728						
HC.6.2	School health services																	633,929			633,929						
HC.6.3	Prevention of Communicable Diseases																										
HC.6.3.1	VCT															509,527,929					509,527,929						
HC.6.3.2	Blood Safety															49,217,694					49,217,694						
HC.6.3.3	Post Exposure Prophylaxis															1,286,269					1,286,269						
HC.6.3.4	Info. Educ. Communic. Prog./Behavior Change															1,014,040,021					1,014,040,021						
HC.6.3.5	STI Prevention Program															61,115,036					61,115,036						
HC.6.3.6	Needle Exchange Program (Injection drug use- IDU)																										
HC.6.3.7	Condom Distribution programs															1,365,705					1,365,705						
HC.6.3.8	Other prevention programs (incl. TB) and prevention that cannot be disaggregated.															1,562,590,197					1,562,590,197						
HC.6.3.10	ARV Programs															99,357,748					99,357,748						
-																											
HC.6.5	Monitoring and Evaluation															703,073,745					703,073,745						
HC.6.5.1	Sentinel Surveillance																										
HC.6.5.2	Other monitoring efforts															5,585,545					5,585,545						

HIV PROVIDER X FUNCTION (HP X HC) – PART 2

		Provider (HP)																							
		HP.1.1.1	HP.1.1.2.1	HP.1.1.2.2	HP.1.1.2.3	HP.1.2	HP.1.3.1	HP.1.3.2	HP.1.3-3.3	HP.3.3.1	HP.3.3.2	HP.3.4.5.1	HP.3.4.5.2	HP.3.6	HP.4.1	HP.5	HP.6	HP.7	HP.9	HP.nsk		HP.8.1	HP.8.2	HP.8.3		HP.AD	
	Function (HC)	Govt Hospitals	Private for profit hospital	Private hospitals NOT-FOR- profit (FBO)	Private other hospitals	Mental Health and Substance Abuse Hospitals (Mathari Hospital, GIGI Hospital)	Govt speciality hospitals (Spinal Injury, Pumwani Maternity Hospital)	Private speciality hospitals	Offices of Physicians, dentists, nurses and clinical officers	CHWs (includes public Health Officers)	Traditional Healers	Govt Health Centers and dispensaries	Private not-for-profit health centers and dispensaries	Providers of home health care services	Dispensing Chemists	Provision and administration of public health programs	General health administration and insurance	Other industries rest of the economy (school health	Rest of the World	Provider expenditure not specified by kind	THE Row Total	Research Institutions	Education and training institutions	Other institutions providing health related services	NHE Row Total	HIV financing agents that provide non-health item	THAE Row Total
HC.7.3	General Technical Assistance																948,011,198				948,011,198						
HC.7.4	Administration other than TA															259,593,464	1,733,913,494				1,992,506,958						
HC.n.s.k	HC expenditure not specified by any kind																										
HCR.1	Capital formation for health care provider institutions												10,810,589					2,282,143			13,092,731						
HC.6.3.9	OI programs															236,917,554					236,917,554						
HC.6.6	On the job training															670,920,124					670,920,124						
HC.6.4	Non-communicable diseases															453,893					453,893						
	Column Total-THE	4,741,769,176	2,109,895,466	1,638,332,858	-	-	-	-	166,546,358	256,863,151	20,801,505	1,835,810,884	108,449,466		220,323,611	5,517,918,559	2,681,924,892	2,916,071	-	3,717,463	18,907,269,661						
HCR.2	Education and training																										
HCR.3	Research and development in health																							842,355,520	842,355,520		
HCR.n.s.k	HCR expenditure not specified by any kind																										
	Column Total-NHE																							842,355,520	19,649,624,181		
AD.1.1	Social support services (NACCM of Home affairs/NGOs)																									67,786,828	67,786,828
AD.1.1.1	Support to widows																										
AD.1.1.2	In-kind benefits to PLWHA																										
AD.1.1.3	Psychosocial support to families																									19,086,728	19,086,728
AD.1.2	Non-health services to orphans and vulnerable children																										
AD.1.2.1	School fees (AIDS orphans)																										
AD.1.2.2	Psychosocial support to orphans and vulnerable children																									226,966,074	226,966,074
AD.1.2.3	Grants to families taking care of orphans & vulnerable children																									54,586,097	54,586,097
AD.2	Policy Advocacy																									215,488,015	215,488,015
AD.3	Non-health IEC																									60,995,919	60,995,919
AD.4	Empowerment and organization																									75,659,535	75,659,535
AD.5	TRAUMA SERVICES & SUPPORT ON POST RAPE CASES																									32,348,229	32,348,229
	Column Total THAE																									752,847,426	20,402,471,807

RH FINANCING SOURCE X FINANCING AGENT (FSXHF)

		Financing Source (FS)										
		FS.1 Public Funds			FS.2 Private Funds					FS.3	FS. nsk	Row Total
		FS.1.1.1	FS.1.1.2	FS.1.2	FS.2.1.1	FS.2.1.2	FS.2.2	FS.2.3	FS.2.4.2	FS.3	FS.nsk	
Code	Financing Agent (HF)	Central Government Revenue	Regional and Municipal Government Revenue	Other Public Funds	Parastatal Employer Funds	Private Employer Funds	Household Funds	Non-profit Institutions Serving Individuals	Other Private Funds	Rest of the World Funds	Financing source not specified by any kind	
HF.1.1.1.1	Ministry of Health	2,879,013,391								1,222,901,913		4,101,915,305
HF.1.1.1.2	Office of President (incl. NACC)											0
HF.1.1.1.3	Other Ministries (Ministry of Education)											0
HF.1.1.2	State/Provincial Government	47,215,373	20,983,255	417,992		1,814,631	59,095,662			289,141		129,816,055
HF.1.2	Social Security Funds (NHIF)						558,649,284					558,649,284
HF.2.5.1	Parastatal Companies				31,492,568					22,577,944		54,070,512
HF.2.1.2	Private Employer Insurance Programmes	31,683,270	361,486		58,545,252	194,813,188	469,566,074		17,446,606		65,427,671	837,843,548
HF.2.2	Private Insurance Enterprises (other than social insurance)											0
HF.2.4	Non-profit institutions serving individuals (NGOs)							820,023		763,348,822		764,168,845
HF.2.3	Household Out-of-Pocket						2,359,867,925					2,359,867,925
HF.2.5.2	Private Non-Parastatal Firms and Corporations (other than health insurance)					14,368,852				393,226		14,762,078
HF.3	Rest of the World									147,598,578		147,598,578
	Column Total (THE)	**2,957,912,035**	**21,344,742**	**417,992**	**90,037,820**	**210,996,671**	**3,447,178,946**	**820,023**	**17,446,606**	**2,157,109,625**	**65,427,671**	**8,968,692,131**
HF.healthrel	Financing agent that provide health related									55,796,444		55,796,444
	Column Total (NHE)	**2,957,912,035**	**21,344,742**	**417,992**	**90,037,820**	**210,996,671**	**3,447,178,946**	**820,023**	**17,446,606**	**2,212,906,069**	**65,427,671**	**9,024,488,575**
HF.AD	Non health related financing agent									20,928,656.04		20,928,656.04
	Column Total (TRE - includes non Health)	**2,957,912,035**	**21,344,742**	**417,992**	**90,037,820**	**210,996,671**	**3,447,178,946**	**820,023**	**17,446,606**	**2,233,834,725**	**65,427,671**	**9,045,417,231**

RH FINANCING AGENT X PROVIDER (HFXHP)

		Financing Agent (HF)									
		HF.A Public Sector				HF.B Non Public Sector					
		HF.1.1.1.1	HF.1.1.2	HF.1.2	HF.2.5.1	HF.2.1.2	HF.2.4	HF.2.3	HF.2.5.2	HF.3	
Code	Provider (HP)	Ministry of Health	State/Provincial Government	Social Security Funds (NHIF)	Parastatal Companies	Private Employer Insurance Programmes	Non-profit institutions serving individuals (NGOs)	Household Out-of-Pocket	Private Non-Parastatal Firms and Corporations (other than health insurance)	Rest of the World	**Row Total**
HP.1.1.1	Gov't Hospitals	3,036,379,332		157,302,174	25,653,949	75,261,425	265,032,004	858,445,965	11,653,342	31,747,727	4,461,475,917
HP.1.1.2.1	Private for profit hospital			194,200,215	10,567,400	533,653,208		435,188,397		17,937,672	1,191,546,892
HP.1.1.2.2	Private hospitals NOT-FOR- profit (FBO)	817,438		207,146,896	2,452,021	223,999,798		256,493,392	2,827,534		693,737,079
HP.1.1.2.3	Private other hospitals										
HP.1.2	Mental Health and Substance Abuse Hospitals (Matheri Hospital, GilGil Hospital)										
HP.1.3.1	Gov't speciality hospitals (Spinal Injury, Pumwani Maternity Hospital)		102,240,646								102,240,646
HP.1.3.2	Private speciality hospitals										
HP.3.1.3.3	Offices of Physicians, dentists, nurses and clinical officers							540,182,519			540,182,519
HP.3.3.1	CHWs (includes public Health Officers)						3,723,696	2,272,602			5,996,298
HP.3.3.2	Traditional Healers						47,479,764				47,479,764
HP.3.4.5.1	Gov't Health Centers and dispensaries	627,703,822	27,575,409		450,478	4,929,117	86,697,044	160,438,371	281,202		908,075,444
HP.3.4.5.2	Private not-for-profit health centers and dispensaries	498,205			261,664		81,294,859	97,788,551		4,339,418	184,182,697
HP.3.6	Providers of hom based care services										
HP.4.1	Dispensing Chemists							8,859,898			8,859,898
HP.5	Provision and administration of public health programs	220,304,522					128,586,282				348,890,804
HP.6	General health administration and insurance	216,211,986			14,685,000		151,355,196			93,573,762	475,825,944
HP.7	Other industries rest of the economy (school health services)										
HP.9	Rest of the World										
HP.nsk	Provider expenditure not specified by kind							198,230			198,230
	Column Total THE	**4,101,915,305**	**129,816,055**	**558,649,284**	**54,070,512**	**837,843,548**	**764,168,845**	**2,359,867,925**	**14,762,078**	**147,598,578**	**8,968,692,131**
HP.8.1	Research Institutions										
HP.8.2	Education and training institutions										
	Column Total: NHE	**4,101,915,305**	**129,816,055**	**558,649,284**	**54,070,512**	**837,843,548**	**764,168,845**	**2,359,867,925**	**14,762,078**	**147,598,578**	**8,968,692,131**
HP.AD	Non health provider						13,219,031			7709625	20,928,656.04
	Column Total (TRE - includes non Health)	**4,101,915,305**	**129,816,055**	**558,649,284**	**54,070,512**	**837,843,548**	**777,387,876**	**2,359,867,925**	**14,762,078**	**155,308,203**	**8,989,620,787**

RH FINANCING AGENTS X FUNCTION (HF X HC)

		Financing Agent (HF)												
		HF.1.1.1.1	HF.1.1.1.3	HF.1.1.2	HF.1.2	HF.2.5.1	HF.2.1.2	HF.2.2	HF.2.4	HF.2.3	HF.2.5.2	HF.3	HF.nsk	
Code	Function (HC)	Ministry of Health	Other Ministries (Ministry of Education)	State/Provincial Government	Social Security Funds (NHIF)	Parastatal Companies	Private Employer Insurance Programmes	Private Insurance Enterprises (other than social insurance)	Non-profit institutions serving individuals (NGOs)	Household Out-of-Pocket	Private Non-Parastatal Firms and Corporations (other than health insurance)	Rest of the World	Financing agent not specified by any kind	Row Total
HC.1.1	Inpatient curative care	2,909,814,133		102,240,646	558,649,284	34,672,215	776,516,131		1,303,294	1,121,253,138	13,591,991	49,521,255		5,567,562,087
HC.1.1.1	Deliveries													
HC.1.1.2	Sterilizations (incl. sterilizations, deliveries)													
HC.1.1.3	Other services (e.g. treatment of cancers assoc. with reproductive tract etc)													
HC.1.3.8	Outpatient curative care that cannot be disaggregated	369,071,259		27,575,409		4,713,297	61,327,417		162,875,131	61,618	1,170,087	4,503,561		631,297,779
HC.1.3.5	FP counseling and issuance of commodities	152,765,194							48,224,503					200,989,698
HC.1.3.5.1	Condoms as part of outpatient care									203,998,084				203,998,084
HC.1.3.5.2	IUDs as part of outpatient care									28,970,995				28,970,995
HC.1.3.5.3	Other commodities									754,439,312				754,439,312
HC.1.3.6	Prenatal and postnatal care								190,779,807	242,284,881				433,064,688
HC.1.3.7	General Gynecology (routine examinations, treatment of reproductive tract infections)	22,027,500												22,027,500
HC.4	Ancillary services to medical care (incl. for prenatal and antenatal care)													
HC.4.1	Clinical laboratory													
HC.4.2	Diagnostic Imaging													
HC.4.3	Transport for emergency obstetric care (that is officially reimbursed or paid for)													
HC.5	Medical goods dispensed to outpatients													
HC.5.1	Pharmaceuticals and other medical nondurables													
HC. 5.1.1.1-2	Pharmaceuticals- prescribed and non-prescribed (incl oral contraceptives, prenatal vitamins etc.)									8,859,898				8,859,898
HC.5.1.3	Other medical nondurables (female condoms)													
HC.6	Prevention and public health services													
HC.6.1.4	MCH; FP and counseling (incl. IEC, public awareness campaigns etc) that cannot be disaggreated, other	82,482,935							17,983,273					100,466,208
HC.6.1.2	FP program (including contraceptive distribution programs)	118,541,790							59,466,076					178,007,866
HC.6.1.3	Maternal Health programs	19,279,797												19,279,797
HC.6.1.2.1	Elimination of unsafe abortions													
HC.6.5	Monitoring and evaluation (e.g. DHS)								5,585,545					5,585,545
HC.6.5.1	Sentinel surveillance													
HC.6.5.2	Other monitoring													
HC.6.9	All other miscellaneous public health services													
HC.7.3	Technical Assistance								30,477,897					30,477,897
HC.7.4	Admin other than TA and admin that cannot be disaggregated	216,211,986				14,685,000			166,428,687			93,573,762		490,899,435
HC.n.s.k	HC expenditure not specified by any kind													
HCR.1	Capital formation for health care provider institutions	211,720,711							81,044,633					292,765,344
	Column Total THE	**4,101,915,305**		**129,816,055**	**558,649,284**	**54,070,512**	**837,843,548**		**764,168,845**	**2,359,867,925**	**14,762,078**	**147,598,578**		**8,968,692,131**
HCR.2	Education and training of health personnel													
HCR.3	Research and development in health								55,796,444					55,796,444
HCR.n.s.k	HCR expenditure not specified by any kind													
	Column Total NHE	**4,101,915,305**		**129,816,055**	**558,649,284**	**54,070,512**	**837,843,548**		**819,965,289**	**2,359,867,925**	**14,762,078**	**147,598,578**		**9,024,488,575**
AD.1	Female and male circumcision													
AD.2	Programs designed to eradicate gender based violence								10,936,888			7,709,625		18,646,513
AD.3.	Programs designed to address sexual trafficking.								760,714					760,714
AD.4	Programs designed to address harmful sexual practices								1,521,429					1,521,429
	Column Total (TRE - includes non Health)	**4,101,915,305**		**129,816,055**	**558,649,284**	**54,070,512**	**837,843,548**		**833,184,320**	**2,359,867,925**	**14,762,078**	**155,308,203**		**9,045,417,231**

RH PROVIDER X FUNCTION (HP X HC) – PART I

		Provider (HP)																								
		HP.1.1.1	HP.1.1.2.1	HP.1.1.2.2	HP.1.1.2.3	HP.1.3.1	HP.1.3.2	HP.3.1-3.3	HP.3.3.1	HP.3.3.2	HP.3.4.5.1	HP.3.4.5.2	HP.3.6	HP.4.1	HP.5	HP.6	HP.7	HP.9	HP.nsk		HP.8.1	HP.8.2	HP.8.3		HP.AD	
	Function (HC)	Govt Hospitals	Private for profit hospital	Private hospitals NOT-FOR- profit (FBO)	Private other hospitals	Govt speciality hospitals (Spinal Injury, Pumwani Maternity Hospital)	Private speciality hospitals	Offices of Physicians, dentists, nurses and clinical officers	CHWs (includes public Health Officers)	Traditional Healers	Govt Health Centers and dispensaries	Private not-for-profit health centers and dispensaries	Providers of hom based care services	Dispensing Chemists	Provision and administration of public health programs	General health administration and insurance	Other industries rest of the economy (school health services)	Rest of the World	Provider expenditure not specified by kind	Row Total	Research Institutions	Education and training institutions	Other institutions providing health related services	NHE Row Total	Non health provider	TRE Row Total
HC.1	Services of curative care																									
HC.1.1	Inpatient curative care	3,318,454,156	1,070,733,697	582,531,068		102,240,646		439,549	1,303,294		404,171,288	87,688,390								5,567,562,087						
HC.1.1.1	Deliveries																									
HC.1.1.2	Sterilizations (incl. sterilizations, deliveries)																									
HC.1.1.3	Other services (e.g. treatment of cancers assoc. with reproductive tract etc)																									
HC.1.3.8	Outpatient curative care that cannot be disaggregated	397,470,800	33,272,797	14,262,440							183,723,975	2,567,766								631,297,779						
HC.1.3.5	FP counseling and issuance of commodities	139,991,646							744,739	47,479,764	12,773,548									200,989,698						
HC.1.3.5.1	Condoms as part of outpatient care	115,145,299	31,701,406					18,571,904			38,579,474									203,998,084						
HC.1.3.5.2	IUCs as part of outpatient care	23,758,274									5,212,721									28,970,995						
HC.1.3.5.3	Other commodities	111,327,308	22,268,918	50,173,692				483,030,389			83,174,757	4,464,247								754,439,312						
HC.1.3.6	Prenatal and postnatal care	269,784,721	33,570,073	46,769,879				38,140,677	3,948,265		32,235,182	8,417,660							198,230	433,064,688						
HC.1.3.7	General Gynecology (routine examinations, treatment of reproductive tract infections)	22,027,500																		22,027,500						
HC.4	Ancillary services to medical care (incl. for prenatal and antenatal care)																									
HC.4.1	Clinical laboratory																									
HC.4.2	Diagnostic Imaging																									
HC.4.3	Transport for emergency obstetric care (that is officially reimbursed or paid for)																									
HC.5	Medical goods dispensed to outpatients																									
HC.5.1	Pharmaceuticals and other medical nondurables																									
HC. 5.1.1.1-2	Pharmaceuticals- prescribed and non-prescribed (incl oral contraceptives, prenatal vitamins etc.)													8,859,898						8,859,898						
HC.5.1.3	Other medical nondurables (female condoms)																									

RH PROVIDER X FUNCTION (HP X HC) – PART 2

		Provider (HP)																										
		HP.1.1.1	HP.1.1.2.1	HP.1.1.2.2	HP.1.1.2.3	HP.1.3.1	HP.1.3.2	HP.3.1-3.3	HP.3.3.1	HP.3.3.2	HP.3.4.5.1	HP.3.4.5.2	HP.3.6	HP.4.1	HP.5	HP.6	HP.7	HP.9	HP.nsk		HP.8.1	HP.8.2	HP.8.3		HP.AD	
	Function (HC)	Gov't Hospitals	Private for profit hospital	Private hospitals NOT-FOR- profit (FBO)	Private other hospitals	Gov't speciality hospitals (Spinal Injury, Pumwani Maternity Hospital)	Private speciality hospitals	Offices of Physicians, dentists, nurses and clinical officers	CHWs (includes public Health Officers)	Traditional Healers	Gov't Health Centers and dispensaries	Private not-for-profit health centers and dispensaries	Providers of hom based care services	Dispensing Chemists	Provision and administration of public health programs	General health administration and insurance	Other industries rest of the economy (school health services)	Rest of the World	Provider expenditure not specified by kind	Row Total	Research institutions	Education and training institutions	Other institutions providing health related services	NHE Row Total	Non health provider	TRE Row Total
HC.6	Prevention and public health services																									
HC.6.1.4	MCH, FP and counseling (incl. IEC, public awareness campaigns etc) that cannot be disaggreated, other														100,466,208					100,466,208						
HC.6.1.2	FP program (including contraceptive distribution programs)														178,007,866					178,007,866						
HC.6.1.3	Maternal Health programs														19,279,797					19,279,797						
HC.6.1.2.1	Elimination of unsafe abortions																									
HC.6.5	Monitoring and evaluation (e.g. DHS)														5,595,545					5,595,545						
HC.6.5.1	Sentinel surveillance																									
HC.6.5.2	Other monitoring																									
HC.6.9	All other miscellaneous public health services																									
HC.7.3	Technical Assistance															30,477,897				30,477,897						
HC.7.4	Admin other than TA and admin that cannot be disaggregated														45,551,388	445,348,047				490,899,435						
HC.n.s.k	HC expenditure not specified by any kind																									
HCR.1	Capital formation for health care provider institutions	63,516,213									149,204,498	81,044,633								292,765,344						
	Column Total THE	4,461,478,847	1,104,846,802	603,737,879		102,240,846		140,183,619	6,806,268	47,179,764	908,875,444	184,183,687		8,868,806	348,880,864	475,826,844			198,350	8,868,893,431						
HCR.2	Education and training of health personnal																						55,796,444	55,796,444		
HCR.3	Research and development in health																									
HCR.n.s.k	HCR expenditure not specified by any kind																									
	Column Total NHE																						9,074,488,575	9,074,488,575		
AD.1	Female and male circumcision																									
AD.2	Programs designed to eradicate gender based violence																								18,646,513	18,646,513
AD.3	Programs designed to address sexual trafficking																								760,714	760,714
AD.4	Programs designed to address harmful sexual practices																								1,521,429	1,521,429
	Column Total - TRE																								20,928,656	9,045,417,231

ANNEX C: REFERENCES

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