HEALTH DIVISION DOCUMENT 2002:3

Report on

Rural Integrated Health Services – Kenya

Written by
Gordon Tamm

SWEDISH INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY

Department for Democracy
and Social Development
Health Division

Author: Gordon Tamm, Swedegroup International Consultants AB, Jungmansgatan 33A, 413 11 Göteborg

Sida Representative: Tomas Lundström

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The original project document is very weak in guiding implementation. In practice this forced the concerned parties (the Technical Advisor, the HSRS, and Embassy Programme Officer) to spend much time in developing operational approaches, instruments, and procedures appropriate for promoting a decentralized health service. This led to low disbursement rates, causing concern at both Sida/DESO and MoH and (more importantly) considerable frustration at the district level..

Finding 2:

It is obvious that the original PD (and the sponsoring stakeholders Sida and MoH with it) overlooked the need for a substantive mobilization and launching phase in order to develop the approaches, procedures and instruments required for a decentralized support. In many respects the programme is now where the PD envisaged it to be at the end of 2000. The reason for this is primarily the lack of operational approaches and an unrealistic time projection in the PD.

Finding 3:

The implementation strategy currently being pursued by HSRS with respect to Phase 1 (which includes the current Sida assistance) of the National Health Strategy is in practice that of the nine key areas identified at the Mombasa workshop in March 2000. This has rendered the original Project Document largely meaningless as a guiding tool, even if still valid as a conceptual approach.

Finding 4:

The FMS developed by the programme provides a very valuable and critical tool for translating the decentralization policy of health services into practice. It is also a necessary precondition for a responsible and transparent disbursement of external funds to the district health services.

Finding 5:

Actual disbursements of Sida resources to the districts through the revenue (government, funds) stream or through AIA (Embassy, services/goods) had at the time of the mission yet not taken place. This has further undermined an already brittle credibility of the programme at the district level

Finding 6:

The proposal for a demand-driven procurement of drugs and medical supplies is in principle a clear step forward towards a sounder, decentralized, and need-based material supply system. However, it is doubtful whether Swedish laws governing public procurement makes it possible to contract the non-government body identified as the procurement agency without prior and open competitive bidding.

Finding 7:

The planning process initiated by the programme has resulted in a series of 6-month district plans and a principled plan for the central coordination and support services at HSRS. Although the plans clearly leave room for improvements in critical areas, they constitute a valuable platform for institutionalizing a rolling planning system at the district level. At the same time there is a risk that the draw-out planning process, and a concomitant lack of communication and triggering effects, has detracted some of the value of and commitment to the plans.

Finding 8:

Notwithstanding the critical observations raised in Finding 7 above, the main systems and procedures required for initiating a trial implementation at the district and HSRS level – Financial Management System (FMS), Procurement Guidelines, Work plans – are now in place. All of them provide a feasible and relevant starting point in strengthening decentralized management and improved supply lines of essential drugs and minor equipment.

Recommendations:

1. The validity of the current agreement extended by one year, i.e. up to June 30 2004. The extension should not imply any change in the overall budget ceiling for Sida's support

2. The nine key areas identified during the Mombasa workshop are recognized as the operational thrust of the HSRS and thereby of the Sida assistance for the current agreement period. Similarly, there should be a common understanding and agreement on when, and on what conditions/performance criteria, the Sida-assisted activities moves from an primary emphasis on the reform process to one of improving quality and scope of the actual health services.

3. An implementation strategy, including milestones and critical events, such as that found in Attachment 1 is adopted and made an amendment to the current agreement

4. District AIEs should be effected without further delay, as should actual disbursement of Sida funds to district accounts. There does not appear to be any valid reason why this should not be done within February 25.

5. The procurement of *supply services* that is currently planned through MEDS must comply with Sida procurement rules even if this may cause yet another delay in the supply stream to districts. In addition, the arrangement should include concrete steps to involve and expose KEMSA to the process of competitive procurement in order to pave the way for a possible

greater direct procurement of KEMSA at a later stage when they have the required financial and organizational capacity '

Operational momentum of the district health plans (Section 3)

Finding 9:

A programme aiming at decentralization of service provisions is extremely sensitive to staff and management turnover, particularly in its build-up before systems and routines have been fully tried and tested. This is likely to have negatively effected the commitment to the aims and objectives of the programme as well as the pace of implementation.

Finding 10:

Without corresponding funds available at the district level the Plans are as yet only 'letters of intent'. The sense of 'ownership' of the plans are still very weak This is a natural consequence of the fact that a programme of decentralized planning has to a large extent to be initiated from above. However, the lack of tangible responses to the plans from HSRS may endanger the potential of local ownership even in the medium term.

Finding 11:

The M&E system required to follow-up and learn from the momentum of the pilot efforts is largely lacking. The existing proposals emphasize either compliance (reports, financial statements, plans, etc) or else health information (morbidity, case loads etc). Neither of these bear on the purpose of the decentralization - to promote more effective, efficient, and locally accessible health services. As a consequence there is a real danger that Phase 1 will be regarded as yet another donor-imposed complicated way of accessing funds.

Recommendations:

6. The Embassy and HSRS should jointly seek to get acceptance for a more stable staff situation, including filling vacancies, in the pilot districts. This does not mean laying claim to the 'best and the brightest' but that every change in key positions is carefully considered for its impact on the pilot processes.

7. Once funds become available it is critical that the coming year is not filled with additional pointers and/or external constraints and that districts are given the opportunity to implement the plans (or fail to implement them) without additional interference. Similarly, while particularly the first 6 months of 2002 will imply a very active guidance and support from HSRS, it is important that districts are allowed to succeed or fail on their own accord.

8. An M&E 'task-force' is constituted to identify robust indicators of (a) absorption capacity, (b) efficiency of overall health service delivery, (c) effec-

tiveness of health services, and (d) reach/access. The indicators should be based on information already available at the district level, preferably reflecting large numbers of events to allow for imperfections in the existing data base

9. The 'task force' should be made of persons nominated for their personal talent and interest in information analysis. It should comprise no more than 5 people with representatives from district MROs, HSRS, and Treasury. A first set of such indicators should be available by mid-April 2002 for testing and breaking in.

An informal comment and suggestion on the M&E approach will be submitted separately to the HSRS by this Mission not later than March 5, 2002

Efficiency and effectiveness of the different levels of organization (section 4)

Finding 12:

The district level management and organization vary substantially. Work plans and associated budgets are clearly seen as external impositions (which is to be expected). Information, recording, financial management, and store/supply management reflect the problem with a centralized approach and are in themselves clear justifications for a concerted thrust towards decentralization.

Finding 13:

No clear guidelines or chain of events have been laid down as regards the fulfillment or otherwise of DHMTs with respect to absorption of, or reporting on, funds and goods received as part of the decentralized provision and procurement system.

Finding 14:

In general all teams exhibited a degree of frustration with the pace and direction of the programme, including the planning exercise. Lacking tangible evidence to the contrary there was a widespread doubt whether this programme was in any way different from other (preceding) donor-supported 'promises of brave new worlds'. However, these frustrations and doubts probably reflected a common complaint that there was little or no communication and follow-up from the central level (HSRS) about programme developments.

Finding 15:

HSRS has successfully (and in with the very active direct support from the TA as well as the Embassy PO) developed the key approaches and systems that are now being launched. However, it is yet to evolve a clear identity, mandate, and role as the spearhead of health reforms. Its presence (and therefore credibility) both at the central level and at district level is not very pronounced, and its capacity to take a firm supervisory role of the current phase of the reform process

(including 'mentoring' the WB and Sida assisted districts) is yet to be determined.

Finding 16:

During the initial mobilization period of Phase 1 the role and identity of the TA has been very fluid, marked by close interaction and 'partnership' with the Embassy PO as well as direct decisions in areas such as Sida AiA. This was primarily the consequence of the sub-standard initial project document that left the TA as well as the HSRS groping for operational inroads. It is, however, obvious that the active albeit vague role of the TA contributed substantially to the development of the systems and instruments now in place.

Finding 17;

The role of the Embassy has been very active throughout the launching phase of the programme. Although there are risks involved in such an approach, particularly as regards local/MoH ownership of the pilot reform activities supported by Sida, it has materially contributed to the programme now being able to move into an operational phase.

Finding 18:

The role and involvement of Sida HQ (i.e. DESO) has been clearly under-sized, forcing virtually all responsibilities for strategy and operational policy on to the Embassy. There is an obvious need for this to change as and when there is a change at the Embassy from an international Programme Officer to a national one in mid-2002.

Recommendations:

10. The district level management will require considerable support and hands-on guidance from the HSRS. The HSRS must therefore develop effective pro-active and responsive routines to supervise and assist the districts, especially during the first 6 months of trials of decentralized systems.

11. The HSRS must develop and speedily communicate 'rules of the game' to all districts (and itself) of Phase 1 - particularly as regards consequences of not reporting on time as well as response and communication routines of the HSRS vis à vis districts. These should specifically state that disbursements are made (a) based on submission of timely and accurate reports, and (b) effective supervisory and supportive services of the HSRS.

12. The HSRS must develop (i) a role and mandate definition of itself (preferably based on the Phase 1 concept along with the 'nine pillars' of Mombasa); (ii) internal job descriptions and delineation of responsibilities in order to cope with Phase 1.

13. Subject to the existence of these and their reflection in the work plan of HSRS, Sida should accept to financially assist HSRS' supervisory, monitoring, and HRD activities with respect to Phase 1 as a whole.

14. Should the development of instruments mentioned under (a) and (c) above indicate (as is likely) the need to strengthen HSRS's capacity and competence to assist and supervise the districts, particularly as regards FMS, the HSRS should avail itself, through Sida AiA, of the necessary consultant expertise to develop such capacity and competence.

15. The posting of the TA to the HSRS is extended for another year.

16. The revised Job Description should clearly state that the TA is part of the HSRS only with no obligations or reporting routines to Sida/the Embassy. Direct professional contacts with the Embassy should be exceptions and

17. The main thrust of the advisory responsibilities of the TA should be in the areas of (i) decentralization (particularly), (ii) exploring synergy effects between different support streams, and (iii) innovations and exploratory activities (e.g. RDF, NGO involvement, etc), including internal competence development and HRD at the HSRS

18. quarterly meetings as envisaged in the Agreement should be held without fail, covering at least (i) the activities of HSRS in support of Phase 1, (ii) financial reports from 'Sida' districts and Sida-funded HSRS activities, (iii) overall progress of Phase 1

19. Sida HQ should participate in Annual Reviews, as well as in the 'milestone' events specified in the revised plan of implementation

Coordination of the National Health Sector Support Programme (section 5)

Finding 19 :

The WB credit and the Sida assistance are currently out of phase - having been initiated at different points of time, with different administrative arrangements and disbursements procedures, and different levels of involvement in ongoing processes. In itself this does not impact on the use of Sida assistance. But it does hamper the synergy effects and the capacity of HSRS to optimize the resources available for Phase 1 as a whole, in the bargain pushing the HSRS into being a donor programme manager rather than a reform process manager.

Finding 20:

The HSRS is yet to make its coordinating and communicative capacity felt at the district level, where complaints are generally very common as to lack of information on ongoing and planned actions.

Finding 21:

The considerably larger EU-assisted programme intended to cover 16 districts with an emphasis on central Kenya is yet to take final shape. It will be run along different organizational and managerial principles with its own Programme Management Unit run by an international consultant company who will ad-

minister direct support to the districts. Even so, its very scale will have a potential sectoral impact beyond that of the target districts.

Recommendations:

20. Apart from dovetailing the validity of the WB and Sida agreements to end mid-2004 (which should enable HSRS to undertake a 'synergy planning' for a possible next phase), the HSRS should develop joint monitoring and support plans for all the 14 Phase 1 districts (cf recommendations 2 (a) – (e) above)

21. The HSRS should develop routines and fixed visit schedules for communication with/between districts of Phase 1.

22. There is a need to generate effective coordinating procedures with the World Bank and Sida support, particularly as regards procedures and approaches in decentralized health systems

Other issues (section 6)

- The proposal to introduce *'rolling audits'* as outlined in the draft ToR is not recommended. Instead, based on the self-assessment of the HSRS of its capacity to provide adequate HRD and hands-on support to districts – particularly as regards FMS – the HSRS may require external (local) professional assistance to boost its capacity and competence to assist and supervise in this regard. Should HSRS choose not to do so it shall be assumed that it does have the required capacity. Should many/most of the districts fail to submit the required reports for the first and/or second quarter it will be taken as an indicator of failure by the HSRS as regards its mentoring obligations for Phase 1, in turn requiring a reconsideration of the form and volume of the Sida assistance to the HSRS.

- The collaborative arrangement between MOI and Linkoping stands for a considerable part of the overall Sida allocations to the health sector. It is strongly recommended that Linkoping is required to submit financial and progress reports on part with all other parties in the Sida assistance. Failure to do so should lead to a reconsideration of the collaboration in parts or in toto

- As past history tends to weigh on (or elevate) ongoing collaborations it is strongly recommended that the previous Sida assistance is accounted for and closed without delay.

Acronyms

AiA	Appropriations in Aid
AIE	Authorization to Incur Expenditure
DESO	Department of
DHMB	District Health Management Board
DHMT	District Health Management Team
EU	European Union
FMS	Financial Management System
GoK	Government of Kenya
HMIS	Health Management Information System
HRD	Human Resources Development
HSRS	Health Sector Reform Secretariat
KEMSA	Kenya Medical Supply Agency
LFA	Logical Framework Analysis
MoF	Ministry of Finance
MoH	Ministry of Health
MRO	Medical Research Officer
NGO	Non-Government Organization
PD	Project (or Programme) Document
PO	Programme Officer
RDF	Revolving Drug Fund
RIHSP	Rural Integrated Health Services Programme
Sida	Swedish international development cooperation agency
TA	Technical Advisor

1. The assignment – scope, approach, and method

The Sida assisted 'Rural Integrated Health Services Programme' was formally launched in July 2000. It aims at improving decentralized health services within key areas in 6 pilot districts. The agreed duration of the programme is 3 years (i.e. until end-June 2003) with a total Sida allocation of SEK 75 million.

The Sida/GoK agreement stipulated that a mid-term a review should be undertaken to assess the progress and, if necessary, recommend operational modifications or revisions. This review was to take place around January 2002. However, for various reasons the programme had by then only just started implementation. This delay suggested systematic flaws in the implementing system and/or the design of the programme, which in turn caused concern both at MoH and Sida/DESO. It was therefore decided that the mid-term review should be preceded by an independent mission to (a) assess the relevance and effectiveness of the implementation framework, (b) identify possible bottlenecks, and (c) make such recommendations to the GoK/Sida Mid-term Review as would facilitate a speedier and more effective implementation. The detailed Terms of Reference for the mission are found in Annex 1.

The mission was originally to comprise a team of combined international and national experts. However, due to difficulties in identifying and engaging suitable experts the mission was carried out as an exercise in 'participant observation'. Consequently, staff from the programme coordinating unit – the Health Sector Reform Secretariat (HSRS) – as well as the Ministry of Finance and Sida took part in the field assessments as resource persons. Although this approach was well in line with this being a 'facilitation mission' it nevertheless meant that the entire responsibility for the analysis, findings, and recommendations rested with the Team leader of the mission, who was also the only independent person/consultant in the team:

Team-leader:	*Gordon Tamm*, Swedish Project Development (Pvt) Ltd
Participant observer:	*Tomas Lundström*, Sida/DESO (also member of the Sida delegation to the Mid-term Review)[1]
Resource persons:	*Elisabeth Sjöberg*, Swedish Embassy (also member of the Sida delegation to the Mid-term Review)
	Dr A. Kahindi, Health Sector Reform Secretariat, MoH
	Claes Broms, Technical Adviser, HSRS/MoH Ms Emma Mburu, Treasury, MoF

The mission was carried out by way of an assessment of the available documents (see Annex 2), visits to 3 of the 6 Sida-assisted districts (see Annex 3)

[1] Mr Lundström was directly involved in some parts of the assessment such ads the drug supply system and of the roles and interactions of Sida HQ, the Embassy, and the TA. However, the responsibility for the conclusions and recommendations rest with the Team leader.

which included extensive interviews and group discussions with health staff and management, and interviews with central level stakeholders within and outside the MoH. At the end of the assignment the Team-leader had a debriefing discussion with the staff of the Health Sector Reform Secretariat. Before leaving Nairobi the Team-leader submitted a debriefing note (see Annex 4) to the MoH/Sida Mid-term Review Meeting on February 19, 2002

2. Overall assessment of the operational relevance and feasibility of existing implementation strategies

The strategy documents guiding the implementation of the programme at the time of this mission consisted, in chronological order of their formulation, of the following:

– GoK/MoH: *The National Health Sector Strategic Plan 1999-2004* (July 1999)

This is the overall guiding framework of the Health Sector in Kenya and consists of a an analysis of the sector along with priority areas, objectives, and specific targets to be attained by 2004

– GoK/MoH: *Project Document on Rural Integrated Health Services/Swedish Support to the Health Sector in Kenya*. Final Draft (March 2000)

This is the document governing the implementation of the Sida assisted programme reviewed by this mission. Focusing on the district health delivery system and the challenge of decentralization it outlines a programme of support to 6 'pilot districts' with the following components:

– Health systems development, incl. management, planning, monitoring, and financial administration

– Reproductive Health & Integrated Management of Childhood Diseases

– Environment Related Communicable Diseases

– Malaria Prevention and Control

– [MoH/HSRS: *Report of a Workshop on Decentralization, 13–16 March 2000.* (March 2000)

This is the report from, and findings of, a consultative workshop organized by HSRS to arrive at feasible operational approaches to the key challenge of the National Health Sector Strategic Plan – decentralization. Participants included representatives from MoH, NGOs, donors and other health professionals.

Although important it has no official standing as an officially binding or guiding document]

– GoK/MoH: *Rural Integrated Health Service Programme – Financial Management System Procedures Manual*, 6 Sida supported Districts Implementation Manual (December 2001)

This document, developed as part of the initial implementation of the programme, provides comprehensive and detailed procedures for the financial administration of the various flows of Sida assistance:

– Revenue contribution through MoH to the districts/provinces based on agreed plans and budgets

– Appropriation in Aid (AIA) that, pending finalization of further procedures, are administered by the Swedish Embassy and provided in kind (commodities or services) to the respective districts

This document also includes a 'Proposal on Demand Driven Procurement of Drugs, Medical Supplies and Equipment in Sida supported Districts' which is yet to be formally endorsed by the parties

– *GoK/MoH: Busia/Kuria/Nyando/Nandi/Koibatek/Kajiado District health Services Work plan 2001-2002* (various dates, 2001)

These are the documents that will guide the implementation of the programme at the 'field' level. They have been developed through a series of consultative workshops and consist of

(a) a situation analysis

(b) an outline of resource flows ('District Resource Envelope')

(c) a component-wise LFA

(d) a district budget

– *GoK/MoH: Rural Integrated Health Services Work plan – District, Province, Central Level (January 2002)*

This is a summary of the various district plans along with a central level (HSRS) plan for the period January-June 2002. Corresponding provincial plans are not included and will "be developed by the HSRS during Jan – June 2002".

2.1. Current priorities and performance against programme plans

Reviewing the documents existing at the time of launching the Rural Integrated Health Services Programme (RIHSP) the most striking feature is the lack of operational priorities, guidelines, procedures, and instruments. While this was to be expected as regards the National Health Sector Strategy, it is more surprising with respect to the approved Project/Programme document (PD).

The two carrying themes of the PD are:

(i) an emphasis on the administrative reform process, the core of which is identified as decentralization to and capacity building at the district level;

(ii) improvement of district health services in three priority areas: reproductive health, environment related communicable diseases, and malaria.

The National Strategy as well as the PD itself makes clear that little improvement in health services can be made unless the reform process (i.e. decentralization) gets under way. This view was also echoed in the deliberations of the Sida Project Committee prior to Sida's formal approval of the programme support. However, the PD provides no clue as to how these two themes are to be balanced over time. On the contrary, the 'Health Systems' component appears as

one among the 4 components to be pursued – the other three being directly concerned with specific health issues. As a consequence there was little to guide those directly involved in launching of the programme. The very notion of selecting 6 pilot districts reflected the fact that the primary challenge was one of providing a starting point for an effective decentralization in order to lay the basis for a gradual improvement of services, whereas the PD conveyed the image of a comprehensive improvement of, and more or less immediate disbursement to, district level health services[2].

Faced with this situation the parties involved with the implementation chose to concentrate on developing the procedures and systems required for a decentralized approach, in particular financial management/administration and result-based planning tools. This mission is firmly convinced that this approach was a very sound one, even though it led to low disbursement rates and seemingly low levels of activity.

Finding 1:

The original project document is very weak in guiding implementation. In practice this forced the concerned parties (the Technical Advisor, the HSRS, and Embassy Programme Officer) to spend much time in developing operational approaches, instruments, and procedures appropriate for promoting a decentralized health service. This led to low disbursement rates, causing concern at both Sida/DESO and MoH and (more importantly) considerable frustration at the district level..

Finding 2:

It is obvious that the original PD (and the sponsoring stakeholders Sida and MoH with it) overlooked the need for a substantive mobilization and launching phase in order to develop the approaches, procedures and instruments required for a decentralized support. In many respects the programme is now where the PD envisaged it to be at the end of 2000. The reason for this is primarily the lack of operational approaches and an unrealistic time projection in the PD.

It is interesting to note that at the very same time as the PD was being finalized (March 2000) a national workshop was organized by the HSRS to develop a practical plan of action towards the decentralization identified in the National Strategy as pivotal for improvements of the health sector. The workshop arrived at 9 priority areas:

(i) to review and revise existing *organizational structure*, including clear roles and responsibilities

(ii) to develop procedures and capacities of decentralized *planning and budgeting* functions

(iii) to develop and introduce a decentralized *financial management and administration system*

[2] The year-wise budget provided in the PD outlines a disbursement over components that assumes that Health System (i.e. the support to decentralized management, planning, and implementation capacity) matures enough during the first year to allow for a parallel (albeit increasing) implementation of the issue-specific health service components

(iv) to develop and introduce new procedures for improved *health care financing* at the district level

(v) to develop and introduce appropriate systems of *human resource management*

(vi) to define, and develop capacity for district-wise health profiles and priorities, in order to arrive at a *health service* based on prioritized district plans and health standards

(vii) develop capacity and procedures for a decentralized procurement of *drugs and medical services*

(viii) to develop the capacity and systems of *health management information* in order to transform districts form mere producers of data to the main users of information

(ix) develop and strengthen *linkages between government and non-government* health service providers

Although the development of systems, procedures, and tools developed so far find their echo in the PD, the actual efforts – and the priorities - mirror much more closely those identified during the Mombasa Workshop. When viewed against the problems afflicting the health service in Kenya as identified both in the National Strategy and in the PD itself, this is understandable. The programme implementers have accordingly opted to see the initial years of the Sida-assisted programme as one of focusing on decentralized management, planning, and administration played out within the health service system – rather than improvement of health service delivery as such. Although this Mission agrees with this approach it is likely that important stakeholders (Sida/DESO, MoH, District Health Management Teams) have not fully shared this view of the programme.

Finding 3:

The implementation strategy currently being pursued by HSRS with respect to Phase 1 (which includes the current Sida assistance) of the National Health Strategy is in practice that of the nine key areas identified at the Mombasa workshop in March 2000. This has rendered the original Project Document largely meaningless as a guiding tool, even if still valid as a conceptual approach.

2.2. Assessment of programme procedures and tools

As pointed out above the main effort so far has been to develop tangible approaches, systems and procedures for (a) a decentralized financial management/administration, including a demand-driven procurement system for drugs and equipment, and (b) an issue- (or activity-) based planning and budgeting system.

2.2.1. The Financial Management System

The *Financial Management System* (FMS)[3] is contained in a detailed 'procedures manual' that has been officially endorsed by both MoH and MoF as of December 2001. The corresponding reporting system has also been developed into a software and provided to the participating districts.

Given the long and dismaying history in Kenya of policy statements about decentralization the FMS is, even though it is as yet only confined to the Sida and World Bank assisted 14 pilot districts[4], probably the single-most important instrument to date in laying the groundwork for an effective decentralization of the health services. Although it is still some way from being owned and used, or even fully understood, at the district level (see below section 3) it provides a comprehensive system of procedures that should enable the district health management to assume a greater control of and accountability for its finances. As such it is also a necessary pre-condition for a responsible and transparent disbursement of funds to district operations. It might well be argued that it has been long in the making, but it is in the opinion of this mission of considerable importance that the FMS has been developed largely by the MoH/HSRS itself[5].

Finding 4:

The FMS developed by the programme provides a very valuable and critical tool for translating the decentralization policy of health services into practice. It is also a necessary precondition for a responsible and transparent disbursement of external funds to the district health services.

This being said the Mission has the following comments.

In spite of the fact that the officially endorsed procedures exist for transferring revenue funds provided by Sida from MoF to the districts this does not appear to have taken place. The Mission was given to understand that District Authority to Incur Expenditure (AIE) had not been properly issued, which in turn led to districts not being able to receive any of the funds provided by Sida. On the other hand it also appeared that there were still non-working routines both on the side of the Embassy (in transferring funds in time and/or notifying the MoF when this had been done) and MoF (in providing information as to the account into which the funds should be deposited by Sida). Whatever the case it is clear that the practical underpinning of the FMS has still some way to go even at the central level. This pertains both to the effectiveness or otherwise of the district AIEs and to the information and transparency surrounding the fund flows.

The same goes for the AIA support to districts administered directly by the Embassy (e.g. computers, vehicles, sundry equipment) which was yet (mid-February) to take off.

There *may* in both cases be perfectly reasonable explanations for this but the net result in both cases is that district units exhibit a very marked degree of frustra-

[3] Although it is called a 'management system' it is more in the nature of a financial administration system, as it covers accounting and reporting procedures but does not discuss resource mobilization or prioritization of budget allocations

[4] The FMS was originally developed for the World Bank project and with minor modifications regarding procurement routines adopted also in the Sida assisted districts.

[5] The long production time is partly due to an unsuccessful search for outside expertise before the HSRS decided on developing it on its own

tion. It appears to this Mission that an FMS, however perfect in itself, is no stronger than its owners allow it to be. And the best way to undermine it from the start is to avoid communicating what and when the real fund managers (Sida, The Embassy, MoH, MoF) do or do not do something – to each other, but more importantly to the district units.

Finding 5:

Actual disbursements of Sida resources to the districts through the revenue (government, funds) stream or through AIA (Embassy, services/goods) had at the time of the mission yet not taken place. This has further undermined an already brittle credibility of the programme at the district level

Furthermore, the FMS explicitly provides for a demand-driven procurement system of drugs and equipment (The FMS Procedures Manual, attachment 6). The key to this is the involvement of a non-government procurement agency (MEDS of Nairobi) that will procure and distribute to the respective districts medical supplies according to a set 'Commodity list' from which the various health units can order according to need. The reason for using a non-government agency as a supplier is that the relevant public sector undertaking – KEMSA – is not yet operational.

Although the Mission agrees in principle with the proposed system it is doubtful whether the agency in question can be contracted without open competitive bidding. The Sida procurement rules are binding for procurements in Kenya as well as in Sweden, and the projected aggregate value of the orders exceed the limits set for direct procurement by Swedish law.

Finding 6:

The proposal for a demand-driven procurement of drugs and medical supplies is in principle a clear step forward towards a sounder, decentralized, and need-based material supply system. However, it is doubtful whether Swedish laws governing public procurement makes it possible to contract the non-government body identified as the procurement agency without prior and open competitive bidding.

2.2.2. The Planning system

The planning system developed since the formal inception of the programme revolves around a series of structured planning formats based on LFA. In practice these plans have only been developed for the districts (and that too only for January – June 2002, and with varying degrees of detail and quality). Planning for and with the relevant provinces has not yet started, and the central level (HSRS) is still in a rudimentary form.

The actual momentum and use of the district plans will be discussed in section 3 below. However, when seen as tools that should guide implementation as well as provide clear and concise information to all stakeholders about the purpose, scope, and objectives of the programme activities, the Mission would like to make two observations.

First, given the fact that planning-by-objectives has never been part of the Kenyan district tradition the documents (and the process behind them) represent a

considerable achievement. It is true that the quality varies and that some critical sections (e.g. the 'District Situation Analysis' or baseline information) are generally weak. It is also true that they do not reflect the total resource flow (being primarily confined to Sida funds) and are therefore in no way reflecting the real position of the district health system. Provided that the HSRS (and Sida) will continue to push improvements with the District Health Management Team these weaknesses are, however, better seen as teething problems.

Second, the time taken to produce the plans – given their state of 'imperfection' – is equally considerable. In fact, with a take-off in April 2001 and carried by a successive series of consultative workshops it is still unclear whether the plans have ever been formally adopted or even regarded as reasonably completed. This problem is compounded by their stated period of validity (January-June 2002) as there does not seem to have been any formal communication of endorsement to the districts or other stakeholders prior to December 31, 2001, nor had any funds started to flow as mid-February, 2002.

The implication of this long and uncertain planning process is two-fold. On one hand there is a grave danger of waning interest among the district staff involved, a danger indeed for a programme aiming at empowering and mobilizing those very persons. On the other the lack of visible triggering effects of the plan itself – in terms of formal endorsement and consequent transfer of resources at of the start of the plan period – serves to ritualize the notion of decentralized planning at all levels. It is to this Mission imperative that once a planning process is initiated there must be a highly responsive communication and support system from 'the top'- focusing on closing gaps in time, decision-making, communication, and release of funds/resources. In this perspective the Mission is not entirely convinced that the very considerable time invested in the planning (incl. its re-current workshops and subsequent district-wise consultations) was worth the price paid in terms of credibility, interest, and quality.

Finding 7:

The planning process initiated by the programme has resulted in a series of 6-month district plans and a principled plan for the central coordination and support services at HSRS. Although the plans clearly leave room for improvements in critical areas, they constitute a valuable platform for institutionalizing a rolling planning system at the district level. At the same time there is a risk that the draw-out planning process, and a concomitant lack of communication and triggering effects, has detracted some of the value of and commitment to the plans.

It is clear that the existing plans need to be revised, if for no other reason than that the period covered by them has been superseded by events. It does not make sense to cling to 6-months plans when they are yet to become effective two months into the period they cover, nor does it make sense to initiate a new planning process before the end of the current plan period (i.e. before June 2002).

Finding 8:

Notwithstanding the critical observations raised in Finding 7 above, the main systems and procedures required for initiating a trial implementation at the district and HSRS level – Financial Management System (FMS), Procurement Guidelines, Work plans – are now in place. All of them provide a feasible and

relevant starting point in strengthening decentralized management and improved supply lines of essential drugs and minor equipment.

Recommendations:

1. The validity of the current agreement extended by one year, i.e. up to June 30 2004. The extension should not imply any change in the overall budget ceiling for Sida's support

2. The nine key areas identified during the Mombasa workshop are recognized as the operational thrust of the HSRS and thereby of the Sida assistance for the current agreement period. Similarly, there should be a common understanding and agreement on when, and on what conditions/ performance criteria, the Sida-assisted activities moves from an primary emphasis on the reform process to one of improving quality and scope of the actual health services.

3. An implementation strategy, including milestones and critical events, such as that found in Attachment 1 is adopted and made an amendment to the current agreement

4. District AIEs should be effected without further delay, as should actual disbursement of Sida funds to district accounts. There does not appear to be any valid reason why this should not be done within February 25.

5. The procurement of *supply services* that is currently planned through MEDS must comply with Sida procurement rules even if this may cause yet another delay in the supply stream to districts. In addition, the arrangement should include concrete steps to involve and expose KEMSA to the process of competitive procurement in order to pave the way for a possible greater direct procurement of KEMSA at a later stage when they have the required financial and organizational capacity.

3. Operational momentum of the District Health Plans

It should be said from the start that the present programme situation is heavily influenced by the fact that most activities until now have been preparatory and largely driven from above. This is in many ways unavoidable, but it does mean that the programme is still to make a dent in the everyday life of the various units. The District Health Plans are still in the process of finalization, at least in the sense of lacking formal endorsement and mutual understanding between HSRS and the respective districts about their status. Because of this and because of the fact that no programme funds or resources have as yet appeared at the district level they are currently more like 'letters of intent' than work plans.

The main activity so far with respect to the districts have been the planning process, and to some extent training in the routines associated with the recently finalized FMS and decentralized procurement system.

With little operational momentum to assess the Mission focused on the assessing the extent to which the districts visited were prepared to take on an active and responsible role in the decentralization of the health system: their understanding of the task, the composition and responsibilities of the District Health Management Teams and the key units involved in the initial phase

3.1. Capacity and staffing situation

Any attempt at assessing the potential efficiency and effectiveness of the implementing network is heavily influenced by the presence or otherwise of committed individuals. As there are as yet no systems or routines that are commonly used or broken in, it is the presence of these individuals that determines the potential of the programme. In fact, the Mission is convinced that much of the future will depend on the skills with which the central coordinating and supportive unit – the HSRS – is able to identify and support individual 'programme carriers', particularly at the district level and within the District Health Management Teams. This is all the more important as the programme has until now mainly focused on developing routines and procedures that have so far yielded little by way of tangible resources or improvements in the working conditions at the district level.

One aspect of this is the need for a relative stability in terms of staff turnover in the pilot districts. While the programme cannot legitimately claim that it should have access to specifically recruited qualified staff, the very emphasis on exploring decentralization means that it is very sensitive to drastic staff movements in the pilot districts. The Mission made an attempt to review the staff turnover of the 6 pilot districts. The admittedly scanty information made available[6] suggest-

[6] Only one district (Koibatek) of the 3 districts visited was able to provide reasonably comprehensive staff information. However, since the inception of the programme in 2000 it appears that the district health management team in 3 of the 6 districts have changed composition in key areas (incl. DMO)

ed that they were all subject to varying degrees of destabilizing staff turnover, which in turn accounted for highly varying degrees of programme understanding and commitment.

Finding 9:

A programme aiming at decentralization of service provisions is extremely sensitive to staff and management turnover, particularly in its build-up before systems and routines have been fully tried and tested. This is likely to have negatively effected the commitment to the aims and objectives of the programme as well as the pace of implementation.

Recommendation:

6. The Embassy and HSRS should jointly seek to get acceptance for a more stable staff situation, including filling vacancies, in the pilot districts. This does not mean laying claim to the 'best and the brightest' but that every change in key positions is carefully considered for its impact on the pilot processes.

3.2. Ownership and understanding of the district plans

An issue that was made clear from discussions with the DHMTs and staff at the district level was the vaguely perceived difference between this programme of decentralization and other vertical donor-sponsored programmes, past and present. The notion of local ownership of and accountability for the district plans is still very hazy, as are the associated 'rules of the game' that must go with an effective decentralization. By and large the view at the district level was less one of ownership and increased responsibilities and more one of (possibly) more reliable and timely supply of funds, materials, and equipment.

However, the low level of ownership of the district plans is not in itself a cause of concern: this was the first systematic attempt at planning that the district teams had been involved in and had as such to be initiated and 'pushed' from above. The concern lies much more with the ability of the HSRS, MoH, and Sida to follow up on the planning process and to maintain a communication with and feedback from the districts about the purpose of the pilot programme as well as the rules of the game. In doing so one must likewise avoid the role of the HSRS being one of project/programme management that takes on direct responsibility for implementation – the districts must be allowed to gain experience on their own with as few safety nets as possible.

Another striking aspect of the district situation (and one very vocally expressed by the various District Health Management Teams) is a sense of the Districts having very little information on the status of programme preparations. Having taken part in the formulation of the district plans the DHMTs were unclear as to the current status of 'their' plan, and even more so about the implications of it. Funds and resources were yet to appear even though the starting date (January 1, 2002) had come and gone. The sense of frustration clearly evidenced at

the district level was further compounded by the lack of consistent communication and information from the HSRS

Finding 10:

Without corresponding funds available at the district level the Plans are as yet only 'letters of intent'. The sense of 'ownership' of the plans are still very weak This is a natural consequence of the fact that a programme of decentralized planning has to a large extent to be initiated from above. However, the lack of tangible responses to the plans from HSRS may endanger the potential of local ownership even in the medium term.

Recommendation:

7. Once funds become available it is critical that the coming year is not filled with additional pointers and/or external constraints and that districts are given the opportunity to implement the plans (or fail to implement them) without additional interference. Similarly, while particularly the first 6 months of 2002 will imply a very active guidance and support from HSRS, it is important that districts are allowed to succeed or fail on their own accord.

3.3. Baseline information and M&E

Decentralization is undoubtedly a very complex process that has in many ways to be a guided learning-by-doing effort. Even so the Mission was struck by the *lack of systematic efforts to compile a base-line picture at the district level*. The 'situation analysis' of the respective District Plans were weak and inconsistent, and it was seldom clear what the starting point of the programme was. Updated staffing lists were hard to come by, information on the current extent and profile of the health service delivery system in the district was scanty – with respect to both the public, private, and NGO providers. Only in one case had the District Information Officer made attempts to develop a systematic overview of the reach and volume of services provided by the dispensaries and health centers, and that too as a personal initiative.

There is little doubt that the present status of the public health delivery system makes systematic information on the service provision (beyond the confines of the District Hospital) seem like a futile exercise. Even so, the very purpose of the pilot programme is to find ways to improve the efficiency, effectiveness and reach of those services in specific areas. It must therefore be possible to record more than anecdotal evidence of change in the service level with, initially at least, a focus on the prioritization, management and administration of resources (time, personnel, materials, funds).

A weakness of the proposed M&E system is that it assumes that there does in fact exist a working information management at the district level. With some notable exceptions (primarily in the form of personal efforts by dedicated and inquisitive staff) this is not so. The long period of erratic funding and gradual erosion of the local level health services has also led to the information system becoming equally erratic. If pilot reform activities are to lead forward to repli-

cable and sustainable experiences they have to rely on effective information systems. The Mission is therefore convinced that special efforts have to made, as part of this programme, to revamp and upgrade not only the M&E formats but (more importantly) the information management system itself. This should include establishment of baseline 'situation analysis' of the district health delivery system. It is important at this juncture to have a particular focus on the delivery system (rather than health intelligence e.g. about specific diseases)[7] as it is the efficiency of that system that is the primary focus of the first phase of the pilot effort.

Finding 11:

The M&E system required to follow-up and learn from the momentum of the pilot efforts is largely lacking. The existing proposals emphasize either compliance (reports, financial statements, plans, etc) or else health information (morbidity, case loads etc). Neither of these bear on the purpose of the decentralization - to promote more effective, efficient, and locally accessible health services. As a consequence there is a real danger that Phase 1 will be regarded as yet another donor-imposed complicated way of accessing funds.

Recommendations:

8. An M&E 'task-force' is constituted to identify robust indicators of (a) absorption capacity, (b) efficiency of overall health service delivery, (c) effectiveness of health services, and (d) reach/access. The indicators should be based on information already available at the district level, preferably reflecting large numbers of events to allow for imperfections in the existing data base

9. The 'task force' should be made of persons nominated for their personal talent and interest in information analysis. It should comprise no more than 5 people with representatives from district MROs, HSRS, and Treasury. A first set of such indicators should be available by mid-April 2002 for testing and breaking in.

An informal comment and suggestion on the M&E approach will be submitted separately to the HSRS by this Mission.

[7] The WHO is supporting a special project on health intelligence and HMIS, the outcome of which will be gradually made accessible to the pilot districts at large.

4. Efficiency and effectiveness of the different levels of organization

The ToR required the mission to assess the efficiency and effectiveness of the different levels involved in the implementation of the programme. Literally speaking this was impossible as implementation – in the sense of tangible programme induced activities in the pilot districts – had not yet started. Instead discussions with the different units (central/HSRS, district and primary health units, and supportive bodies) focused on three aspects:

- the preparedness for and understanding of the programme tasks and objectives
- the capacity to play the role intended in the programme
- the relations, interactions, and communications between the various levels and units making up the 'programme family'

4.1. District Health Management Teams

The District Health Management Teams (DHMTs) constitute the nodal point of the entire programme: it is only through their active commitment, whatever their capacity at any given point of time, that a programme aiming at improved health service delivery can take off. However, it is unrealistic to assume that such a commitment and interest can be instilled in, or maintained by, the DHMT as a whole.

During the visits to the districts the Mission held group discussions with the respective teams, and interviewed individual members and key functionaries[8]. Based on these the following was found:

Finding 12:

The district level management and organisation vary substantially. Work plans and associated budgets are clearly seen as external impositions (which is to be expected). Information, recording, financial management, and store/supply management reflect the problem with a centralized approach and are in themselves clear justifications for a concerted thrust towards decentralization.

Finding 13:

No clear guidelines or chain of events have been laid down as regards the fulfillment or otherwise of DHMTs with respect to absorption of, or reporting on,

[8] In only two cases was it possible to meet with members of the District Health Management Board (DHMB). The most notable outcome of those discussions was the very marginalized position of the DHMB, with a constitution, composition and mandate that pre-dates and is out of step with an effective decentralized governance system. However, at the present juncture it seems prudent for the pilot programme not to take on a reform of the governance system beyond that of laying the foundation for a sound decentralized management.

funds and goods received as part of the decentralized provision and procurement system.

Finding 14:

In general all teams exhibited a degree of frustration with the pace and direction of the programme, including the planning exercise. Lacking tangible evidence to the contrary there was a widespread doubt whether this programme was in any way different from other (preceding) donor-supported 'promises of brave new worlds'. However, these frustrations and doubts probably reflected a common complaint that there was little or no communication and follow-up from the central level (HSRS) about programme developments.

Recommendations:

10. The district level management will require considerable support and hands-on guidance from the HSRS. The HSRS must therefore develop effective pro-active and responsive routines to supervise and assist the districts, especially during the first 6 months of trials of decentralized systems.

11. The HSRS must develop and speedily communicate 'rules of the game' to all districts (and itself) of Phase 1 - particularly as regards consequences of not reporting on time as well as response and communication routines of the HSRS vis à vis districts. These should specifically state that disbursements are made (a) based on submission of timely and accurate reports, and (b) effective supervisory and supportive services of the HSRS.

4.2. The Health Sector Reform Secretariat

The Health Sector Reform Secretariat (HSRS) is the main coordinating body of the Sida-assistance to the health reform as well as the parallel World Bank sponsored programme of decentralized health services in 8 districts.

In organizational terms the HSRS is a staff unit reporting to the Permanent Secretary, MoH. With respect to the Sida as well as World Bank assistance to the decentralized/district health services its main role is to coordinate, facilitate, and monitor the activities as well as to be the driving force of capacity building at the district and provincial levels. A main part of its work so far has been to develop the various procedures and systems required for a decentralized financial management and procurement system, and to guide (and quality control) the district planning process.

A review of the responsibilities allotted to the HSRS, discussions with the staff, and views expressed by the various district visited revealed the following.

First, in a very real sense it falls upon the HSRS to instill, develop, and maintain a momentum of the health reform process as a whole. Although it is clearly supported in this huge task by the senior-most officers of the MoH – the Permanent Secretary and the Director of Health Services – it is much less clear whether the main line departments recognize the critical role of the HSRS for the future of

the sector as well as for their own work. Although this is in some sense natural as the HSRS has neither directive/executive powers nor material resources, it gives the impression of the unit acting in a vacuum – and with it the reform process as a whole. An expression of this is that it seems to be looked upon as a Sida (and World Bank) project management unit rather than a reform secretariat coordinating exploratory reform efforts. In the process, the Sida (and World Bank) assistance to pilot activities at the district level appear as time-bound and vertical donor projects rather than as efforts to promote an integrated decentralization of health services.

Second, although the staff of the HSRS appears adequate for a step-wise promotion of the decentralization process, this is only so if there is a clear internal division of responsibilities and tasks. It is true that the very nature of the HSRS role means that some of its senior members may be called to participate in activities or meetings at one step removed from its core tasks. But this makes it all the more important that the internal activities and responsibilities are clearly allotted. Based on discussions with the staff the Mission is convinced that there is a clear and urgent need to review the workload and (re)define the specific tasks of each member.

The most serious consequence of the present fluid situation is that communication and hands-on interaction with the district health establishments suffer, which in turn erodes the credibility of the reform process as well as the HSRS itself. None of the districts visited were clear about the 'rules of the game' of the pilot activities, nor were they clear about the decision-making process or the actual time-plans (as distinct from the formal and frequently superseded ones).

Finding 15:

HSRS has successfully (and in with the very active direct support from the TA as well as the Embassy PO) developed the key approaches and systems that are now being launched. However, it is yet to evolve a clear identity, mandate, and role as the spearhead of health reforms. Its presence (and therefore credibility) both at the central level and at district level is not very pronounced, and its capacity to take a firm supervisory role of the current phase of the reform process (including 'mentoring' the WB and Sida assisted districts) is yet to be determined.

Recommendations:

12. The HSRS must develop (i) a role and mandate definition of itself (preferably based on the Phase 1 concept along with the 'nine pillars' of Mombasa); (ii) internal job descriptions and delineation of responsibilities in order to cope with Phase 1.

13. Subject to the existence of these and their reflection in the work plan of HSRS, Sida should accept to financially assist HSRS' supervisory, monitoring, and HRD activities with respect to Phase 1 as a whole.

14. Should the development of instruments mentioned under (a) and (c) above indicate (as is likely) the need to strengthen HSRS's capacity and competence to assist and supervise the districts, particularly as regards FMS, the HSRS should avail itself, through Sida AiA, of the necessary consultant expertise to develop such capacity and competence.

4.3. Technical Advisor

The Technical Advisor (TA) was posted to the HSRS as part of the Sida/MoH agreement governing the Swedish support to the sector. He took up his position in August 2000. The emphasis of his work is primarily on the Sida assistance, but as the Sida support is in turn intended to act as a spearhead for key aspects of the reform process as such the scope of his advisory role becomes similarly wider.

When the TA took up his position there was little to guide the work. As noted in section 2.1 the Project Document is very general and comprehensive with no operational strategy in terms of staggered activity plans or priorities. Although there had been previous Swedish advisors to the MoH as part of the earlier Sida health support, their work had been defined within a more narrow project context. Similarly, the HSRS does not seem to have had any clear definition of the advisory tasks: it shared the same problem of making operational sense of the PD, in addition to which the internal and external responsibilities was similarly not very well defined (see above section 2.3.3).

Under the circumstances it is the distinct impression of this Mission that the present TA has been very effective and provided valuable active support to the HSRS in its effort to launch the Sida assisted pilot programme. The role of and expatriate advisor is even under the best of circumstances very difficult as s/he has little or no executive powers, a considerable expectation to perform, but little by way of performance criteria and even less by way of recognition or credit . There is, however, no doubt that much of the considerable achievements of the programme so far in laying the groundwork for an effective decentralization system reflects the very active involvement of the present TA.

However, there is an obvious need to clarify the role and priority areas of the TA in the further development of the Sida-assisted reform processes, in line with the further clarification of the external and internal responsibilities of the HSRS itself.

First, the need to get the Sida-assistance into a operational shape, particularly as regards developing systems and routines for a financial and administrative decentralization, meant that the Swedish Embassy has been very intimately involved in virtually all stages so far. In the process the TA came to act as an active intermediary, sometimes appearing as a Sida representative as much as an internal member of the HSRS team. With the pilot programme now at the threshold of moving into a tangible support to the districts this needs to change so that the TA is firmly seen as an internal HSRS advisor rather than a Sida representative or watchdog. This does not mean that the TA should not act as vehicle for facilitating a Sida-MoH dialogue, but such a role should be firmly played out under the auspices of the Head of the HSRS rather than being assumed or activated by Sida/the Embassy.

Second, with the launching phase of the programme now over, it is important that the generalized advisory role of the TA gives way to a more focused one. While this should be determined by the internal clarification of roles and responsibilities of the HSRS referred to above it might in the view of this Mission include all or parts of (i) specific areas of decentralization (e.g. procurement and supply management), (ii) synergy effects of the Sida assistance and other sup-

port streams (e.g. World Bank, EU), (iii) innovations and exploratory activities (e.g. Revolving Drug Funds, NGO involvement), and (iv) internal competence development and HRD at the HSRS.

Finding 16:

During the initial mobilization period of Phase 1 the role and identity of the TA has been very fluid, marked by close interaction and 'partnership' with the Embassy PO as well as direct decisions in areas such as Sida AiA. This was primarily the consequence of the sub-standard initial project document that left the TA as well as the HSRS groping for operational inroads. It is, however, obvious that the active albeit vague role of the TA contributed substantially to the development of the systems and instruments now in place.

Recommendations:

15. The posting of the TA to the HSRS is extended for another year

16. The revised Job Description should clearly state that the TA is part of the HSRS only with no obligations or reporting routines to Sida/the Embassy. Direct professional contacts with the Embassy should be exceptions and

17. The main thrust of the advisory responsibilities of the TA should be in the areas of (i) decentralization (particularly), (ii) exploring synergy effects between different support streams, and (iii) innovations and exploratory activities (e.g. RDF, NGO involvement, etc), including internal competence development and HRD at the HSRS

4.4. The Swedish Embassy and Sida/DESO

As with the TA, the role of the Embassy PO has been very active and direct in the mobilization phase of the Sida assistance (and for the same reasons). However, the strategic support role – inter alia with respect to providing the assistance with an operational strategy and launching momentum – has been very weak or non-existent by Sida/HQ. As of the approval of the PD and the subsequent MoH-Sida agreement the Embassy has received little, if any, guidance and support from DESO in Stockholm. This is remarkable given the concerns voiced at Sida about the justification for continued support to the health sector support to Kenya.

Communication between the Embassy on one hand and MoH and HSRS on the other have been very frequent, at formal as well as informal levels. In addition, the Embassy PO has been a visible and active participant in the various workshops organized by the HSRS and has frequently accompanied the TA in visits to the districts. Indeed, the direct involvement of the Embassy in the development of the programme has gone considerably beyond what is normal elsewhere. There is a certain risk that this weakens the 'local ownership' of the programme. But it should also be stressed that the very involvement in ongoing activities of the HSRS and the district planning has no doubt contributed to the mobilization phase ultimately producing the required operational approaches and procedures.

As of the start up of field level pilot activities it is important that the programme is allowed to 'settle in' and that the involvement of the Embassy is routinized and run in accordance with the provisions laid down in the PD and Sida/MoH agreement, e.g. as regards quarterly consultations etc.

In perspective the very active Embassy involvement was fortunate also from another point of view. As of mid-2002 the position of a programme-funded international Programme Officer (Health) at the Embassy will cease and be replaced by a national officer. Although this does not mean a downgrading of the Embassy's capacity to maintain a technical/professional dialogue with the MoH/HSRS, it does mean a downgrading in terms of its capacity to interact at a policy and strategy level. With the programme now set to move into an operational trial phase this is not likely to have a negative influence on the collaboration. But at the same time it does raise the issue of Sida/HQ's (i.e. DESO's) capacity to establish and maintain a supportive policy and strategic dialogue, a capacity that will have a greater importance with the change to a national officer at the Embassy.

Finding 17;

The role of the Embassy has been very active throughout the launching phase of the programme. Although there are risks involved in such an approach, particularly as regards local/MoH ownership of the pilot reform activities supported by Sida, it has materially contributed to the programme now being able to move into an operational phase.

Finding 18:

The role and involvement of Sida HQ (i.e. DESO) has been clearly under-sized, forcing virtually all responsibilities for strategy and operational policy on to the Embassy. There is an obvious need for this to change as and when there is a change at the Embassy from an international Programme Officer to a national one in mid-2002.

Recommendations:

18. quarterly meetings as envisaged in the Agreement should be held without fail, covering at least (i) the activities of HSRS in support of Phase 1, (ii) financial reports from 'Sida' districts and Sida-funded HSRS activities, (iii) overall progress of Phase 1

19. Sida HQ should participate in Annual Reviews, as well as in the 'milestone' events specified in the revised plan of implementation

5. Coordination of the National Health Sector Support Programme (NHSSP) and its effect on the absorption and utilization of Sida assistance

Although not formalized as a programme the efforts to assist the MoH to move the National Health Strategy forward with the assistance of various donors has come to take on the character of an umbrella effort of coordination and loose consultative planning discussions – the National Health Sector Support Programme. Again it is the HSRS which is the nodal point for this at the MoH. In effect it is of critical importance that all such external support to the reform of the sector is increasingly coordinated if any one them is not going to be an ineffective and isolated dead-end. This is certainly so with respect to the Sida support along with the parallel support provided by the World Bank. Piloting district trials at decentralized health services without a clear coordination and efforts towards commonality of approach and systems would spell only confusion in the end.

The assistance provided by Sida (with a focus on 8 districts) and the World Bank (8 districts) has been called the first phase of the NHSSP, a phase characterized by its focus on decentralization of health service provisions as a necessary precondition for any decisive improvement of the scope and technical quality of the health services as such. .

Based on discussion with representatives of the World Bank, the European Commission, Sida, and the HSRS the Mission found the following:

Finding 19 :

The WB credit and the Sida assistance are currently out of phase - having been initiated at different points of time, with different administrative arrangements and disbursements procedures, and different levels of involvement in ongoing processes. In itself this does not impact on the use of Sida assistance. But it does hamper the synergy effects and the capacity of HSRS to optimize the resources available for Phase 1 as a whole, in the bargain pushing the HSRS into being a donor programme manager rather than a reform process manager.

Finding 20:

The HSRS is yet to make its coordinating and communicative capacity felt at the district level, where complaints are generally very common as to lack of information on ongoing and planned actions.

Finding 21:

The considerably larger EU-assisted programme intended to cover 16 districts with an emphasis on central Kenya is yet to take final shape. It will be run along different organizational and managerial principles with its own Programme

Management Unit run by an international consultant company who will administer direct support to the districts. Even so, its very scale will have a potential sectoral impact beyond that of the target districts.

Recommendations:

20. Apart from dovetailing the validity of the WB and Sida agreements to end mid-2004 (which should enable HSRS to undertake a 'synergy planning' for a possible next phase), the HSRS should develop joint monitoring and support plans for all the 14 Phase 1 districts (cf recommendations 2 (a) – (e) above)

21. The HSRS should develop routines and fixed visit schedules for communication with/between districts of Phase 1.

22. There is a need to generate effective coordinating procedures with the World Bank and Sida support, particularly as regards procedures and approaches in decentralized health systems

6. Other issues

- The proposal to introduce *'rolling audits'* as outlined in the draft ToR is not recommended. Instead, based on the self-assessment of the HSRS of its capacity to provide adequate HRD and hands-on support to districts – particularly as regards FMS – the HSRS may require external (local) professional assistance to boost its capacity and competence to assist and supervise in this regard. Should HSRS choose not to do so it shall be assumed that it does have the required capacity. Should many/most of the districts fail to submit the required reports for the first and/or second quarter it will be taken as an indicator of failure by the HSRS as regards its mentoring obligations for Phase 1, in turn requiring a reconsideration of the form and volume of the Sida assistance to the HSRS.
- The collaborative arrangement between MOI and Linköping stands for a considerable part of the overall Sida allocations to the health sector. It is strongly recommended that Linköping is required to submit financial and progress reports on part with all other parties in the Sida assistance. Failure to do so should lead to a reconsideration of the collaboration in parts or in toto
- As past history tends to weigh on (or elevate) ongoing collaborations it is strongly recommended that the previous Sida assistance is accounted for and closed without delay.

Annexes

1. Terms of References

2. List of documents consulted

3. Itinerary

4. Debriefing note

Annex 1

Embassy of Sweden, Nairobi, 18 january, 2002, U11 Bke/1.2.3.-0

Elisabeth Sjöberg, *Programme Officer for Health*

Terms of reference for mid-term review of the support to the health sector in Kenya; rural integrated health services 2000–2003

1. Background

Kenya has supported the health sector in Kenya's since 1974. The government of Kenya presented a National Health Sector Strategic plan in July 1999. This plan is outlining future development of the health sector in Kenya and is guidance for how to decentralise the delivery of health services in the country. The National Health Sector Strategic plan has been the foundation for the Swedish agreement regarding support to the health sector for the period 2000-2003. The main objectives for the program are to:

(a) Support and strengthen capacity and management within the Ministry of health in the decentralisation process at national, provincial and district level

(b) Support and strengthen health service delivery at district level within the priority areas identified in the NHSSP; Malaria, HIV/AIDS, Communicable diseases, Reproductive Health, EPI and IMCI.

In the foreword to the NHSSP the minister for health, Mr. Kalweo expresses the concerns of the Ministry to the process as "The Government is fully committed to decentralising the authority for decision making, resource allocation and management of health services to the district and facility levels. It is expected that apart from equity and efficiency considerations, the decentralisation strategy will allow greater participation of the community in the running of health services including the implementation of essential clinical and public health packages."

The Ministry of Health decided that the decentralisation should be introduced in a phased manner. Fourteen districts were selected to become the Phase 1 districts, 8 with additional support from the World Bank and 6 with additional support from Sida. The districts selected for supports from Sida are: Kajiado, Koibatek, Nyando, Nandi, Busia and Kuria.

The total amount for support to the health sector during the period July 2000 to June 2003 is 75 million SEK. The funds are disbursed in different ways as:

- Revenue contribution to districts based on District Health Plans.
- Revenue contribution to provinces based on Provincial Health Plans

– AIA contribution to headquarter, provinces and district to system development and capacity building.

– AIA contribution to build up a demand driven system for procurement of drugs

The implementation of the IRHS program is delayed. The needed changes within the ministry for development of budget systemand manuals to develop district and provincial health plans was not finalised until current fiscal year. A minimum of the allocated support from Sida has been disbursed within the new agreement. The discussions between the World Bank and the Ministry of Health has delayed and the agreement was first to be declared in effectiveness 8 September 2001.

2. Reason for Mid term review

The Specific Agreement stipulates that a Mid Term Review should be carried out towards the end of the second year of the agreement period. The review should concentrate on how the Swedish supported program relates to the reform process in Kenya. (See Annex 1).

The program is not working satisfactorily and it is important to analyse the reasons behind this and give suggestions for changes or reasons to change expectations on probable results. For this reason the intended Mid Term Review will be a facilitation mission. It will as such concentrate on identifying possible bottlenecks and put forward recommendations on ways to overcome these.

3. The Task

The main areas of concerns are to:

I. Based on the Project document and the manuals for implementation, like Manual for District Health Plans, Manual for Provincial health Plans, Manual for Financial Management System, structure of a demand driven system for procurement of drugs, analyse and assess the operational relevance and feasability of the existing implementation strategies.

II. Analyse and assess the efficiency and effectiveness at the different levels of the organisation entrusted with implementation of the Sida assisted programme.

III. Analyse the role of the Technical Advisor in the HSRS in relation to organisation, capacity and identify problem areas and hindrances for an effective use of the TA.

IV. Identify and analyse problems and obstacles in the co-ordination of the reform process insofar as it relates to the absorbtion and utilisation of the Sida assisted activities (alt Sida's assistance, e.g. realtions between: MoH – donors, donors – donors, MoH – HSRS – districts. The analysis should build on project documents, minutes from meetings and interviews.

V. Analyse and assess operational momentum of the District Health Plans in the six Sida supported districts and their alignment with the strategies outlined in the NHSSP.

VI. Identify and assess the role of the Swedish Embassy in promoting an effective decentralisation. The assessment should be built on interviews with representatives from the districts.

VII. make an overall assessment of the present momentum and direction of the Swedish support to the health sector in Kenya.

VIII. Recommend to Sida and GoK subsequent modifications that may be required to strengthen the Rural Integrated Health program regarding:

- Implementation strategies
- Modes for disbursement of funds
- The role of the Program officer for health, the role of the Technical Advisor

4. Methodology, Evaluation team and Time schedule

One of the core objectives to perform the Mid Term Review is to assess how far the reform process has been implemented and the sustainability and quality of the process. It is essential that this process include officers within the Ministry of Health at all tiers in the organisation. It is important that these actors are given an opportunity to analyse problems, alternative models and possible changes. The evaluation must therefore be carried out in an interactive and participatory way. The proposed schedule for the Mid Term Review is as follows:

Assignment	Time	Participants
1. Study of background material	1 week	Consultant
2. In districts Interviews District health Management teams	1 week	Consultant/ DHMT
3. In MoH/HQ Interviews HSRS/PS/TA	3 days	Consultant/ MoH personnel
4. Donor community Interviews	3 days	Consultant/Sida DFID, WB, EU, Danida, WHO
5. Report	1 1/2 Week	Consultant
6. Seminar	1 day	Consultant, Moderator MoH/HQ Districts/Sida
7. Mid term Review Rapporteur MoH/HQ	1 day	Consultant, Districts/Sida

The consultant will make his or her own travel arrangements to and from Kenya. The Swedish Embassy/MoH will assist in arranging local travels and facilitate access to relevant officials and organisations.

5. Reporting

The Mid Term Review report shall be written in English. Format and outline of the report shall follow the guidelines in Sida Evaluation Report – a Standardised Format (see Annex 2). Five copies of the draft report shall be submitted to

Sida not later than …….. Within two weeks after receiving Sida's and MoH's comments on the draft report a final version in 10 copies, and on diskette (or electronically) shall be submitted to Sida no later than…….

The assignment includes also a presentation of the report during the Mid Term Review in Kenya …..***Possible dates 18–20 February***……..2002

Annex 2

List of documents consulted

MoH: The National Health Sector Strategic Plan 1999–2004. July 1999

MoH: Project Document on Rural Integrated Health Service (RIHS). Final Draft. March 2000

MoH: Rural Integrated Health Service Programme: Financial Management System – Procedures Manual. Dec. 2001

MoH/HSRS: Report of a Workshop on Decentralisation ('The Mombasa Workshop'). March 2000

MoH/HSRS: Rural Integrated Health Services Work plan Jan–June 2002 (District, Province, Central Level). January 2000

MoH: Busia/Kuria/Nyando/Nandi/Koibatek/Kajiado Districts: District Health Services Work plan 2001–2002 (drafts). Various dates, 2001

MoH/HSRS: Monitoring and Evaluation of District Work plans' (draft). No date

RoK/IDA: Development Credit Agreement – Decentralized HIV/AIDS and Reproductive Health Project. March 2001

Sida: In-depth Assessment Memo ("Bedömnings-PM"), Rural Integrated Health Services. June 2000

Sida: Protocol of the Project Committee – Health sector support to Kenya. June 2000

Annex 3

Itinerary

February 3	Arrival of Gordon Tamm and Tomas Lundström to Nairobi
February 4	Mission joined by Dr Kahindi (MoH), Mr Broms (TA/ MoH), Mrs Sjöberg (Swedish Embassy), Mr Okworo (IDS) Travel to Kisumu
February 5	Visit Busia District. Discussions and interviews with DHMT and district health staff.
February 6	Visit to Nyando District Discussions and interviews with DHMT and staff Interview member of DHMB Visit dispensary
February 7	Visit to Koibatek District Discussions and interviews with DHMT and staff Discussions with members of DHMB
February 8	Visit Lake Bogoria. Internal discussions
February 9	Return to Naoribi
February 10	Nairobi. Internal work
February 11–14	Meetings/discussions with * Permanent Secretary, MoH * Director of Health Services, MoH * European Commission * World Bank Country Office * MEDS * RPM * Swedish Embassy * Head and staff of HSRS
February 15–18	(G Tamm in Sweden) Internal work: review of findings and preparation of debriefing note
February 19	Mid-term Review Meeting. Presentation and discussion of consultant's Debriefing Note

Annex 4

Sida support to the health sector in Kenya Mid-term assessment and facilitation mission Main findings and recommendations

1. Overall assessment of momentum and direction as well as operational relevance and feasibility of existing implementation strategies

Finding:

Original project document very weak in guiding implementation. In practice this forced the concerned parties (HSRS and Embassy PO) to spend much time in developing operational approaches, instruments, and procedures appropriate for promoting a decentralized health service. In addition, it lead to unreasonable expectations at both Sida/HQ and MoH, along with frustrations at the district level.

Finding:

The implementation strategy currently being pursued by HSRS with respect to Phase 1 (which includes the current Sida assistance) of the National Health Strategy is in practice that of the nine key areas identified at the Mombasa workshop in March 2000. This has rendered the original Project Document largely meaningless as a guiding tool, even if still valid as a conceptual approach.

Finding:

The main systems and procedures required for initiating a trial implementation at the district and HSRS level – Financial Management System (FMS), Procurement Guidelines, Workplans – are now in place. All of them provide a feasible and relevant starting point in strengthening decentralized management and improved supply lines of essential drugs and minor equipment.

Finding:

Disbursements to districts through revenue lines as well as through AIAs have as yet to start, causing a noticeable credibility gap at district and lower levels.

Recommendations:

(a) The validity of the current agreement extended by one year, i.e. up to June 30 2004. The extension should not imply any change in the overall budget ceiling for Sida's support

(b) The nine key areas identified during the Mombasa workshop are recognized as the operational thrust of the HSRS and thereby of the Sida assistance for the current agreement period.

(c) An implementation strategy, including milestones and critical events, such as that found in Attachment 1 is adopted and made an amendment to the current agreement

(e) District AIEs should be effected without further delay, as should actual disbursement of Sida funds to district accounts. There does not appear to be any valid reason why this should not be done within February 25.

2. Efficiency and effectiveness of the different levels of organisation

Finding:

The district level management and organisation vary substantially. Workplans and associated budgets are clearly seen as external impositions (which is to be expected). Information, recording, financial management, and store/supply management reflect the problem with a centralized approach and are in themselves clear justifications for a concerted thrust towards decentralization.

Finding:

No clear guidelines or chain of events have been laid down as regards the fulfillment or otherwise of DHMTs with respect to absorption of, or reporting on, funds and goods received as part of the decentralized provision and procurement system.

Finding:

HSRS has successfully (and in close cooperation with the Embassy PO and the TA) developed the key approaches and systems that are now being launched. However, it

is yet to evolve a clear identity, mandate, and role as the spearhead of health reforms. Its presence (and therefore credibility) both at the central level and at district level not very pronounced, and its capacity to take a firm supervisory role of Phase 1 (including WB and Sida assisted districts) is yet to be determined.

Recommendations:

(a) The district level management will require considerable support and hands-on guidance from the HSRS. The HSRS must therefore develop effective pro-active and responsive routines to supervise and assist the districts, especially during the first 6 months of trials of decentralized systems.

(b) The HSRS must develop and speedily communicate 'rules of the game' to all districts (and itself) of Phase 1 – particularly as regards consequences of not reporting on time as well as response and communication routines of the HSRS vis à vis districts. These should specifically state that disbursements are made (a) based on submission of timely and accurate reports, and (b) effective supervisory and supportive services of the HSRS.

(c) The HSRS must develop (i) a role and mandate definition of itself (preferably based on the Phase 1 concept along with the 'nine pillars' of Mombasa); (ii) internal job descriptions and delineation of responsibilities in order to cope with Phase 1.

(d) Subject to the existence of these and their reflection in the workplan of HSRS, Sida should accept to financially assist HSRS' supervisory, monitoring, and HRD activities with respect to Phase 1 as a whole.

(e) Should the development of instruments mentioned under (a) and (c) above indicate (as is likely) the need to strengthen HSRS's capacity and competence to assist and supervise the districts, particularly as regards FMS, the HSRS should avail itself, through Sida AiA, of the necessary consultant expertise to develop such capacity and competence.

3. Role of Technical Advisor

Finding:

During the initial mobilization period of Phase 1 the role and identity of the TA has been very fluid, marked by close interaction and 'partnership' with the Embassy PO as well as direct decisions in areas such as Sida AiA. This was primarily the consequence of the sub-standard initial project document that left the TA as well as the HSRS groping for operational inroads. It is, however, obvious that the active albeit vague role of the TA contributed substantially to the development of the systems and instruments now in place.

Recommendation:

(a) The posting of the TA to the HSRS is extended for another year

(b) The revised Job Description should clearly state that the TA is part of the HSRS only with no obligations or reporting routines to Sida/the Embassy. Direct professional contacts with the Embassy should be exceptions and

(c) The main thrust of the advisory responsibilities of the TA should be in the areas of (i) decentralization (particularly procurement and supply management), (ii) exploring synergy effects of the support streams (WB, Sida), and (iii) innovations and exploratory activities (e.g. RDF, NGO involvement, etc), including internal competence development and HRD at the HSRS

4. Coordination of the reform process (Phase 1) and its effect on the absorption and utilization of Sida assistance

Finding:

The WB credit and the Sida assistance are currently out of phase – having been initiated at different points of time, with different administrative arrangements and disbursements procedures, and different levels of involvement in ongoing processes. In itself this does not impact on the use of Sida assistance. But it does hamper the synergy effects and the capacity of HSRS to optimise the resources available for Phase 1 as a whole, in the bargain pushing the HSRS into being a donor programme manager rather than a reform process manager.

Finding:

The HSRS is yet to make its coordinating and communicative capacity felt at the district level, where complaints are generally very common as to lack of information on ongoing and planned actions.

Recommendation:

(a) Apart from dovetailing the validity of the WB and Sida agreements to end mid-2004 (which should enable HSRS to undertake a 'synergy planning' for a possible next phase), the HSRS should develop joint monitoring and

support plans for all the 14 Phase 1 districts (cf recommendations 2 (a) – (e) above)

(b) The HSRS should develop routines and fixed visit schedules for communication with/between districts of Phase 1.

5. Operational momentum of the District Health Plans

Finding:

Without corresponding funds available at the district level the Plans are as yet only 'letters of intent'. However, once funds become available it is critical that the coming year is not filled with additional pointers and/or external constraints and that districts are given the opportunity to implement the plans (or fail to implement them) without additional interference. Similarly, while particularly the first 6 months of 2002 will imply a very active guidance and support from HSRS, it is important that districts are allowed to succeed or fail on their own accord.

Finding:

The M&E system required to follow-up and learn from the momentum of Phase 1 is largely lacking. The existing proposals emphasize either compliance (reports, financial statements, plans, etc) or else health information (morbidity, case loads etc). Neither of these bear on the purpose of the decentralization – to promote more effective, efficient, and locally accessible health services. As a consequence there is a real danger that Phase 1 will be regarded as yet another donor-imposed complicated way of accessing funds.

Recommendation:

An M&E 'task-force' is constituted to identify robust indicators of (a) absorption capacity, (b) efficiency of overall health service delivery, (c) effectiveness of health services, and (d) reach/access. The indicators should be based on information already available at the district level, preferably reflecting large numbers of events to allow for imperfections in the existing data base

The 'task force' should be made of persons nominated for their personal talent and interest in information analysis. It should comprise no more than 5 people with representatives from district MROs, HSRS, and Treasury. A first set of such indicators should be available by mid-April 2002 for testing and breaking in.

An informal comment and suggestion on the M&E approach will be submitted separately to the HSRS by this Mission not later than March 5, 2002

7. Role of the Swedish Embassy

Finding:

As with the TA, the role of the Embassy PO has been very active and direct in the mobilization phase of the Sida assistance (and for the same reasons). However, the strategic support role – inter alia with respect to providing the assistance with an operational strategy and launching momentum – has been very weak or non-existent by Sida generally (HQ and Embassy). Communication with the MoH and HSRS has been mostly informal as well as frequent, with weak back-stopping by or interaction with Sida HQ. At the same time it should

be stressed that the very involvement in ongoing activities of the HSRS and the district planning has no doubt contributed to the mobilization phase ultimately producing the required operational approaches and procedures.

Recommendations:

(a) quarterly meetings as envisaged in the Agreement should be held without fail, covering at least (i) the activities of HSRS in support of Phase 1, (ii) financial reports from 'Sida' districts and Sida-funded HSRS activities, (iii) overall progress of Phase 1

(b) Sida HQ should participate in Annual Reviews, as well as in the 'milestone' events specified in the revised plan of implementation

8. Other issues

Recommendation:

The proposal to introduce *'rolling audits*' as outlined in the draft ToR is not recommended. Instead, based on the self-assessment of the HSRS of its capacity to provide adequate HRD and hands-on support to districts – particularly as regards FMS – the HSRS may require external (local) professional assistance to boost its capacity and competence to assist and supervise in this regard. Should HSRS choose not to do so it shall be assumed that it does have the required capacity. Should many/most of the districts fail to submit the required reports for the first and/or second quarter it will be taken as an indicator of failure by the HSRS as regards its mentoring obligations for Phase 1, in turn requiring a reconsideration of the form and volume of the Sida assistance to the HSRS.

Recommendation:

The procurement of *supply services* that is currently planned through MEDS must comply with Sida procurement rules even if this may cause yet another delay in the supply stream to districts

In addition, the arrangement should include concrete steps to involve and expose KEMSA to the process of competitive procurement in order to pave the way for a possible greater direct procurement of KEMSA at a later stage when they have the required financial and organisational capacity

Recommendation:

The collaborative arrangement between MOI and Linkoping stands for a considerable part of the overall Sida allocations to the health sector. It is strongly recommended that Linkoping is required to submit financial and progress reports on part with all other parties in the Sida assistance. Failure to do so should lead to a reconsideration of the collaboration in parts or in toto

Recommendation:

As past history tends to weigh on (or elevate) ongoing collaborations it is strongly recommended that the previous Sida assistance is accounted for and closed without delay.

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2002-11-07

List of Health Division Documents

Strategies/Policies

1997:1 Policy for Development Cooperation Health Sector – Replaced by Sida's policy for Health and Development, 2002 –

1997:2 Política para la Cooperación para el Desarrollo Sector Salud

1997:3 Position Paper Population, Development and Cooperation

1997:4 Positionspapper Befolkning, utveckling och samarbete

1997:5 Marco de Referencia para la Cooperación para el Desarrollo Población, Desarrollo y Cooperación

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1997:7 Estrategia para la Cooperación para el Desarrollo Salud y Derechos Sexuales y Reproductivos

1997:8 Handbook for mainstreaming A Gender Perspective in the Health Sector

1999 Investing for future generations. Sweden's International Response to HIV/AIDS

2000:2 Guidelines for Action – Illicit Drugs and Swedish International Development Cooperation

2001:1 Hälsa & Utveckling, Fattigdom & Ohälsa – ett folkhälsoperspektiv by Göran Paulsson, Ylva Sörman Nath and Björn Ekman

2002 Health is Wealth – Sida's Policy for Health and Development

2002 Health is Wealth – A Short Version of Sida's Policy for Health and Development

Issue Papers

1998:1 Maternal Health Care, by Staffan Bergström

1998:2 Supporting Midwifery, by Jerker Liljestrand

1998:3 Contraception, by Kajsa Sundström

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1998:5 Female Genital Mutilation, by Beth Maina-Ahlberg

1998:6 Adolescent Sexuality Education, Counselling and Services, by Minou Fuglesang

1998:7 Discrimination and Sexual Abuse Against Girls and Women, by Mary Ellsberg

1998:8 Health Care of the Newborn, by Ragnar Thunell

1998:9 Men, Sexuality and Reproductive Health, by Beth Maina-Ahlberg, Minou Fuglesang and Annika Johansson

1998:10 Illicit Drugs and Development Cooperation, by Niklas Herrmann – Replaced by 2000:2 –

1999:3 Socio-economic Causes and Consequences of HIV/AIDS by Stefan de Vylder – Replaced by 2001:5 –

2000:1 HIV/AIDS in the World Today – a Summary of Trends and Demographic Implications by Bertil Egerö and Mikael Hammarskjöld

2001:2 Health and Environment by Marianne Kjellén

2001:3 Improving Access to Essential Pharmaceuticals, by IHCAR

2001:5 A Development Disaster: HIV/AIDS as a Cause and Consequence of Poverty by Stefan de Vylder

2001:6 National Health Accounts – Where are we today? by Catharina Hjortsberg

2001:7 Ideas work better than money in generating reform – but how? by Alf Morten Jerve

2002:2 Health and Human Rights by Birgitta Rubenson

2001 Aids: The Challenge of this Century by Bertil Egerö, Mikael Hammarskjöld and Lise Munch

2002 Health Sector Reforms: What about Hospitals? by Pär Eriksson, Vinod Diwan and Ingvar Karlberg (NHV report 2002:2)

2002 Sexuality – a super force. Young people, sexuality and rights in the era of HIV/AIDS by Anna Runeborg

2002:3 Rural Integrated Health Services – Kenya By Gordon Tamm

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www.sida.se, e-mail: info@sida.se

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Health Sector

1999:2 Facts & Figures 1998
Health Sector

2000:3 Facts & Figures 1999
Health Sector

2001:4 Facts & Figures 2000
Health Sector

2002:1 Facts & Figures 2001
Health Sector

Fact Sheets

1997 Hälso och sjukvård
1997 Reformer inom hälsosektorn
1997 Rätten till sexuell och reproduktiv hälsa
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1999 Insatser mot familjevåld i Centralamerika
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1999 Utbildningssamarbete Kenya-Linköping
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2002 Rent vatten ger bättre hälsa och ökad jämställdhet

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2000:5 West Africa

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99/10 Working with Nutrition. A comparative study of the Tanzania Food and Nutrition Centre and the National Nutrition Unit of Zimbabwe

99/11 Apoyo de Asdi al Sector Salud de Nicaragua. Prosilais 1992–1998

99/36 Support to Collaboration between Universities. An evaluation of the collaboration between MOI University, Kenya, and Linköping University, Sweden

2000 Webs Women Weave. An assessment commissioned by Sida 4 organisations networking for sexual and reproductive health and rights.

01/03 Tackling Turmoil of Transition. An evaluation of lessons from the Vietnam-Sweden health cooperation 1994 to 2000

01/32 Review of PAHO's project. Towards an integrated model of care for family violence in Central America. Final report

02/13 Sida's Support to the Reproductive Health and TANSWED HIV Research Programmes in Tanzania

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Other documents

1999:1 **Report on: World Youth Conferences in Portugal August 1998, by Wanjiku Kaime-Atterhög and Anna Runeborg**

2000:6A **Framtid Afrika – Huvudrapport**

2000:6B **Annex to Framtid Afrika – Health Support in Africa – Country Reports**

1998 **Gender and Tuberculosis**

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SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
Address: S-105 25 Stockholm, Sweden. Office: Sveavägen 20, Stockholm
Telephone: + 46 (0)8-698 50 00. Telefax: + 46 (0)8-20 88 64
www.sida.gov.se e-mail: info@sida.se