SEPTEMBER 2005 • HEALTH DIVISION

Health Division Document 2005:3
Issue Paper on NHA

Policies in the Kenyan Health care sector

– Why are they so difficult to implement?

Content

The views and interpretations expressed in this document are the author's, and do not necessarily reflect those of the Swedish International Development Cooperation Agency, Sida.

Published by Sida 2005
Department for Democracy and Social development
Author: Anna H Glenngård, IHE, The Swedish Institute for Health Economics
Printed by Edita Communication AB, 2005
Art. no.: SIDA4872en
ISBN 91-586-8340-2
ISSN 1403-5545
This publication can be downloaded/ordered from www.sida.se/publications

1. Introduction

Since the time of independence, in 1963, the performance of the Kenyan economy has been mixed. During the 1960s the country performed well, but since then there has been a steadily decline in the economy. Average growth level during the past decade has been around 2 percent. The poor economic performance has led to an overall deterioration in the overall welfare among the Kenyan citizens (KDHS, 2003). Some 56 percent of the population live in poverty and there has been nearly no improvement at all in the health status among the population during the past decades (PHRplus, 2005).

Policies in the Kenyan health care sector are clearly aimed at improving the health for the entire population. In a previous report it was found that policy documents are well supported by data about e.g. expenditures on health and burden of disease. National Health Accounts (NHA), Public Expenditure Reviews (PER) and Kenyan Demographic and Health Surveys (KDHS) are examples of reports used for policy purposes in the health sector. However, it was noted in the report that even though health expenditure and other data are used for policy purposes in the Kenyan health sector, the policies are not followed. The reasons for policies not being implemented were not further explored in the report (Glenngård and Hjalte, 2004).

In the National Health Sector Strategic Plan (NHSSP) 1999–2004 it is clearly articulated that health services shall be concentrated to meet areas such as reproductive health, integrated childhood illnesses, increased immunisation, environmental health, HIV/AIDS and malaria. Yet, the KDHS, 2003, reveal that there has been a decline in both medical antenatal coverage and in child immunisation rate between 1998 and 2003. Regarding malaria, no more than 22 percent of the households had a mosquito net in year 2003, to be compared to the target of 60 percent in year 2006. Furthermore, the latest NHA and PER show that the development of expenditures and allocation to different levels of health care services in part goes against the policy goals stipulated in the NHSSP. The current proportion of expenditure on health as a share of total government spending, 8 percent, is well below the goal of 15 percent adopted by African leaders in the Abuja Declaration of 2001 (Kenya NHA 2001/2002).

The provision of health and medical care services in Kenya is dependent on donors. More than 16 percent of total expenditures on health originated from donors in year 2002 (Kenya NHA 2001/2002). During

2005, decisions about the future donor support to the Kenyan health sector are to be made. A new NHSSP, covering the years 2005–2010, was supposed to guide the donors in their future support to the health sector. However, this plan has been delayed and as a consequence some donors have chosen to extend their current support one more year and work out a new plan for support, which is to commence in year 2006. Overall, there seems to be a fatigue among the donors regarding the poor performance and failure to meet set policy objectives within the health sector (Kenya Consultative Group, 2005).

The purpose of this study is to explain some of the divergence between policy objectives and implementation of policies in the Kenyan health care sector. Next, this report gives some background information about health and social indicators in Kenya. Then, a brief description of policies and objectives in the health sector and evidence on the rate of implementation of these policies is presented. The presentation is primarily based on reports by the Ministry of Health (MoH) in Kenya and its collaborating partners. Possible explanations to the difficulties of implementing policies in the Kenyan health sector are outlined in the next section, based on interviews with representatives from the MoH in Kenya, donor organisations and organisations providing technical support to the MoH and on available policy documents. The interviews were conducted in Nairobi in March 2005. Finally, conclusions are drawn and possible future scenarios are presented.

2. Background

The Kenyan population has increased from 25.3 million to 32.3 million over the past 20 years, and the population density increased from 37 to 49 people per square kilometre between 1989 and 1999. About 80 percent of the population live in rural areas. The country is characterised by a young population. About half of the Kenyan population is below 15 years of age and no more than 3 percent is over 65. Despite policies targeted at improving health and reducing inequalities in health, there have been no major improvements in this area over the past 10 years (Table 1). Infant and child mortality is high; about one in every nine children dies before their fifth birthday (KDHS, 2003). Although 56 percent of the population live in poverty, the households contribution to total expenditures on health in 2002 were 51 percent (Kenya NHA 2001/2002).

Table 1. Selected demographic and health indicators for Kenya, 1993, 1998 and 2003

	1993	1998	2003
Population, total (million)	25,3	28,7	32,2
Life expectancy at birth, total (years)	57 (-92)	50 (97)	46 (-02)
Households contribution to total expenditures on health	53 (-94)	n/a	51 (-02)
Fertility rate (total births per woman)	5.4	4.7	4.8
Birhts attended by health staff (% of total)	45	44	41
Infant mortality (per 1,000 live births)	67	73	77
Child immunization against DPT (% of children under 12 months)	89	79	74
Under 5 mortality rate	93	110	115
Child malnutrition (% of children under 5)	23	22	19

Sources: World Development Indicators Database, World Bank, 2005; KDHS, 2003, Kenya NHA 1994 and 2001/02.

The country is divided into 8 provinces and 72 districts. Access to health and medical care is unequally distributed across the country, as is the fertility rate and the level of education (Table 2). Generally, the Central province and Nairobi account for the best values whereas the Northeastern province accounts for the worst (with the exception of HIV/AIDS prevalence).

Table 2. Selected demographic and health indicators for Kenya, by province 2003

	Nairobi	Central	Coast	Eastern	Nyanza	Rift Valley	Western	North Eastern
Fertility rate (total births per woman)	2.7	3.4	4.9	4.8	5.6	5.8	5.8	7.0
Population with no education (%)	10.0	12.0	37.8	21.2	18.3	28.6	18.2	86.8
Use of modern contraceptives (%)	44	58	19	38	21	25	27	0
Infant mortality (per 1,000 live birhts)	67	44	78	56	133	61	80	91
Under five mortality	95	54	116	84	206	77	144	163
Women who received no antenental care (%)	3.8	6.3	11.3	7.4	9.1	9.6	6.1	68.3
Birhts attended by health staff* (%)	79	67.9	33.8	38.6	38.6	37.3	29.4	8.5
Full child vaccination coverage (%)	63.1	78.5	65.8	65	37.6	55.5	50	8.8
Children with symptoms of ARI and/or fever (%)	54.9	68.5	56.6	40.9	68.3	52.3	86.9	33.1
Children with symptoms of ARI and/or fever taken to HCP (%)	56.3	45.9	58.3	53.3	40.5	47.1	34.2	26.7
Children with diarrhoea taken to HCP (%)	35	26.5	42.8	49.2	22.5	26.3	21.4	10.2
Households with at least one mosquito net (%)	37	16.2	34.2	16.8	32.1	11	19.8	37
Child malnutrition (% of children under 5)	6.3	14.6	25.4	21.2	15.6	22.8	19	n/a
Women underweight (BMI<18.5, %)	4.5	7.1	13.3	13	10.6	18.6	11.9	27.5

Source: KDHS, 2003. *Doctor and/or nurse/midwife

The health system is organised in a pyramidal structure and diagnosis and treatment is more advanced the higher up in the pyramid they are found. Basic primary care is to be provided at primary health care centres and dispensaries. District, sub-district and provincial hospitals are to provide secondary care, i.e. integrated curative and rehabilitative care. Third level care is provided at the general hospitals Moi and Kenyatta, located in Nairobi. Poor people in rural areas who are ill and choose to seek care, usually only have the option of treatment at primary care facilities. These facilities are often under-staffed, under-equipped and have limited access to medicines.

The Household Health Expenditure and Utilisation Report, 2003, reveals that among those Kenyans who are ill and do not choose to seek care, 44 percent were hindered by cost. Another 18 percent were hindered by the long distance to the nearest health facility. The major reasons for not seeking care at the nearest health facility were inability to pay for services and that medicine were believed not to be available.

3. Effects of earlier policies in the health care sector

The Government of Kenya has addressed the issue of inequalities and poor performance in a number of policy documents. Kenya has also committed itself to achieving the Millennium Development Goals for health, i.e. to reduce the under five mortality by two thirds, reduce the maternal mortality ration by three quarters, and to halt and reverse the incidence of HIV/AIDS and malaria (United Nations webpage, 2005-04-29).

In the NHSSP 1999–2004, it is clearly articulated that health care services should be targeted at reducing differences in health status by providing good quality health care services that is accessible and affordable to the entire population. Yet, according to the KDHS, 2003, 25 percent of the sick Kenyans do not seek care due to different barriers and services are far from equitable distributed. The level of child immunisation was 57 percent in the country in 2003. While 79 percent of the children had full immunization coverage in the Central province the corresponding figure in the Northeastern province was only 9 percent. The average fertility rate is 4.9 children (2000–2003) per woman; 3.4 in the central province and as high as 7 in the Northeastern province. In addition, people in the Northeastern province are least educated; 93 percent of the women and 71 percent of the men have no education at all compared to 13 and 6 percent, respectively, for the country as a whole. Regarding antenatal care, about 90 percent of all Kenyan women received some services, either from a nurse, midwife or doctor but large differences across the country can be noted. More than 96 percent of the women living in Nairobi received antenatal services compared to 32 percent of the women living in the Northeastern province (see Table 2).

Health services shall be targeted at reproductive health, integrated childhood illnesses, increased immunisation, environmental health, HIV/AIDS and malaria, according to the NHSSP 1999–2004. However, there has been a rise in infant and under-five mortality between the years 1998 and 2003 and a continuous decrease in child immunisation levels over the past 10 years. Also the target of reducing child malnutrition by 30 percent over the period 1999–2004 is far from achieved. Regarding the target of improving environmental health, the access to clean water and sanitation remains a severe problem. Less than half of the population have access to such amenities. About 24 percent of the Kenyan households draw its drinking water from either rivers or streams and a majority of the households, 53 percent, are within 15 minutes of

their water source. Malaria morbidity and mortality ought to be reduced by 30 percent according to the plan and by 2006; 60 percent of the population ought to have at least one mosquito net. Still, in 2003, malaria was the most important diagnose in both outpatient and inpatient care, 43 and 41 percent of all patients, respectively. Overall, 22 percent of the households had a mosquito net in 2003. On the positive side, the fertility rate remains at a low level compared to other countries in the region. Similarly, the HIV/AIDS prevalence is also comparatively low (KDHS, 2003).

Kenya signed the Abuja Declaration in 2001 and thereby committed to allocate 15 percent of total government spending on health. According to the NHA 2001/2002 the proportion was no more than 8 percent in 2002. Thus, this objective has not been accomplished.

According to the NHSSP 1999–2004 overall resources should be reallocated from curative care at hospitals to primary and preventive care. By treating patients at the right level, capacity would be set free at the hospitals. However, data in the PER 2003 and the PER 2004 indicates that this has not happened. The PER 2003 shows that financial allocations to the two biggest hospitals in Kenya, Moi and Kenyatta located in Nairobi, increased from less than 14 percent in 2000/01 to almost 20 percent of the MoH recurrent expenditures in 2002/03.

The Kenyan 1994 NHA report revealed that households accounted for more than 53 percent of health care expenditure whereas the government financed less than 20 percent (Kenya NHA 1994). These findings where alarming, especially since more than half of the Kenyan population lived below poverty line. Still, in 2002 the Kenyan households contributed with some 51 percent of total expenditures on health although 56 percent of the population live in poverty (Kenya NHA 2001/2002). Some 44 percent of sick Kenyans who does not seek care are hindered by cost, according to the Household Health Expenditure and Utilisation Report, 2003. This does not correspond to the objective of providing good quality health care services that is accessible and affordable to the entire population.

4. Obstacles for implementation of policies

4.1. Findings from the evaluation of the NHSSP 1999–2004

In an evaluation of the NHSSP 1999–2004, by the Health & Economics Development Consortium (Hedc) it was found that there was a general weakness in all aspects of health policy support systems, which affected the overall implementation of policies (Hedc, 2004). The implementation of the plan has therefore been slow. More specifically, the following aspects were found to constitute problems for a successful implementation of the NHSSP:

- The preparation and dissemination of the plan was weak, which resulted in a lack of ownership and coordination. The plan did not reflect shared views and priorities by all concerned parties and therefore lacked the necessary commitment among key stakeholders to implement the plan effectively. Furthermore the plan was too general and lacked clarity in focus and benchmarks for monitoring evaluation.
- The plan did not include strategies of governance such as human resource rationalisation, financial management reform and legal and policy framework to support implementation of the plan.
- The plan lacked an implementation framework such as annual work plans, standard guidelines, institutional linkages and specific benchmarks for monitoring evaluation. This led to open-ended implementation where health service units had to develop their own plans of action with weak linkages to the NHSSP.
- The plan lacked clarity in the sense of who had the mandate to oversee implementation achievements, coordination, supervision, and monitoring of services.
- The plan lacked a national monitoring framework, which resulted in weak monitoring of performance in the programmes and health subsectors, such as human resource management, financial management, drugs and medical systems and resource accountability.

4.2. Findings from the interviews

The results from the interviews with representatives from the Ministry of Health, donor agencies and organisations providing technical assistance to the Ministry of Health support the findings by Hedc (2004). Generally, two major obstacles for implementing policies in the Kenyan health sector were discussed during the interviews.

The first major obstacle concerns operational management of policies. All respondents believed that the NHSSP 1999–2004 was too broad, which made operational management very difficult. The plan was based on academic discussions and constructed by consultants. The consultants did not consider practical operational management and did not succeed in bringing key decision maker on board. This lead to a lack of consensus among policy makers and among those who were to implement the plan, respectively. Linked to this, conflicting polices have been formulated, e.g. to cut back on recurrent costs at the MoH, implying a reduction the number of civil servants, while at the same time improve the quality of services and the follow-up and monitoring of policies.

The second obstacle concern decision makers confidence in the information that policies are based upon. The general opinion prior to the first round of NHA was that the government was the major contributor to health care financing in Kenya. However, the 1994 NHA revealed that households accounted for more than 53 percent of health care expenditure whereas the government financed less than 20 percent. Due to the rather unpleasant findings the policymakers did not officially approve the report and it was not completed and officially disseminated until year 2000. If the policy makers and those who are to implement policies do not believe that they have access to accurate data, two sets of problems appears. The first is that policies formulated may not be realistic. For example, the Abuja Declaration state that the budget for the health care sector should correspond to 15 percent of the governments total expenditures. The respondents expressed a believe that this declaration should not have been signed if policy makers have had access to data about the current situation at the time, i.e. that approximately 6 percent of the governments total expenditures was allocated to the health sector. The second problem has to do with political commitment. If policy makers do not believe that strategies are supported by 'hard proof' about the impact the existing allocation of resources have on the access and quality, it is hard to commit to changes in the allocation of resources. Note that other stakeholders, e.g. donors, had confidence also in the first round of NHA. It was primarily among government official that the data was regarded as not credible. This can, in part, be explained by the fact that the first NHA report revealed that households, not the government, were the main contributors to total health care expenditures.

The issue of re-allocation of resources from hospitals to primary and preventive care is of particular interest. Downsizing the budget of general hospitals require a strong and transparent leadership. Prior to the dissemination of the Household Expenditure and Utilisation Survey report decision makers were not convinced that such a re-allocation was a pro-poor strategy. It was argued that the hospitals were already underfunded. However, well-functioning preventive and primary care services would reduce the need for curative care, implying that improvement of such services would make resources available at the hospitals. Nevertheless, hospital care is presently regarded as very important among decision makers since patients turn to the hospitals when they do not receive proper primary care. Thus, this is a 'catch 22'-scenario. On the one hand, re-allocating funds from hospitals to primary and preventive care services would decrease the need for curative services at hospitals. On the other hand, such a re-allocation would lead to an inability to treat patients, who presently are in need of curative care services at the hospitals. Connected to this problem is the fact that any worsening of the situation at the general hospitals is much more visible to the public than

any improvement of the primary care services in the rural areas. Hence, strong political commitment is believed to be of major importance if to succeed with re-allocating resources from hospitals to primary and preventive services.

A further point raised during the interviews was the weak linkage between the Ministry of Health and the districts. A general problem when implementing policies is that the priorities at the central and at the district levels are not harmonised. This might lead to a scenario where the government will allocate block grants according to its objectives but districts will use the funds according to priorities of their own. If the residents in the community favour education over health care, money will be concentrated to education regardless of the national policies. The objectives set at the national level should be linked to the priorities at the local level. There is a need to find a technical solution, which ensures that decisions at the district level correspond with overall policies and goals.

5. The way forward

Based on the interviews in this study and the evaluation of the NHSSP, a successful implementation of the next NHSSP (2006–2010) requires the following pre-conditions:

- Ensure that the plan is built on consensus among key policy makers.
- Develop annual work plans, guidelines and action plans to enable practical operational management of the plan.
- Develop clear benchmarks and timeframes of achievement for evaluation and clearly delegate a mandate to perform evaluations of implementation.
- Develop means to ensure that the priorities at the local level correspond to the objectives articulated in national policies, i.e. the NHSSP.

According to the interviews, some of the above suggestions are covered in the up-coming NHSSP 2005–2010. The respondents believed that the work on the NHSSP 2005–2010 is built on consensus among key policy makers to a higher degree than the former plan. Furthermore, the new NHSSP is to involve operational one-year interim plans. By the end of each fiscal year the operational plan for the up-coming year is to be laid down. Thus, the new plan is dealing with at least two important issues that were missing in the former, i.e. the lack of consensus concerning directions and strategies and the lack of specific targets, which makes the plan operational.

Regarding the lack of confidence in available data, policy makers view the second round of NHA as more accurate than the first round. Furthermore, the results of the Household Expenditure and Utilisation Survey are supported by a majority of policy makers. The objectives of the NHSSP 2005–2010 are more likely to be achieved due to primarily two things which were both lacking in the NHSSP 1999–2004: People are committed since they believe that the plan is built on accurate data and the plan is operational since it will be implemented in one-year phases.

In order for a national monitoring framework to be effective and to enable evaluation against specific targets, data from the health system as well as identification of specific benchmarks is required. The fact that policy makers now have a higher degree of confidence in the available data may have implications for the future demand for accurate data;

policy makers are more likely to demand data that they actually have confidence in. This development could improve data collection further and reinforce the success of the evaluation process of achievements in the health care sector.

Based on the interviews it seems difficult to re-allocate funds from hospital curative services to primary and preventive services. However, policy makers have committed themselves not to increase the budget for Kenyatta Hospital during 2006–2007. The primary care facilities in Nairobi are to receive more funding and equipment, e.g. ambulances so pregnant women can be referred to hospitals if necessary. The purpose is to channel patients to lower levels of care and thereby set free capacity at Kenyatta Hospital. Any extra funds allocated to the health care sector are to be used for primary and preventive services, e.g. funding of antiretroviral treatment of HIV and thereby set free hospital capacity by decreasing the burden of people with AIDS. Pre-payment schemes are to be implemented for hospitals to assure funding in a longer perspective.

6. Conclusions

The results from both the evaluation of the NHSSP 1999–2004 by Hedc and the interviews in this study suggest that a number of factors have hindered policy implementation in the Kenyan health care sector over the past 5 years:

- Lack of consensus and therefore commitment among policy makers.
- Lack of practical operational management of the NHSSP.
- Lack of means to monitor and evaluate the implementation of the NHSSP.
- Lack of confidence in available data among government officials.
- Catch 22 scenario regarding the re-allocation of resources from general hospitals to primary and preventive services.

According to the interviews some of these aspects were considered when preparing the NHSSP 2005–2010:

- A higher degree of consensus among key policy makers.
- Operational management is considered in the plan.
- Available data is viewed as more credible now compared to in the past.

Although implementation of the objective to shift resources from hospital care towards primary and preventive services seem to be very difficult the conditions for success in the area of implementing policies in the Kenyan health care sector appears to have improved. Whether the stated objectives of reducing inequalities in health status and provision of good quality health care services to the entire Kenyan population will be achieved remains to be seen.

References

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

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

Glenngård A. H. and Hjalte, F., 2004. "Issue Paper on NHA – The Case of Kenya, Zambia and Mali", Health Division Document 2004:3, Swedish International Development Cooperation Agency, Stockholm.

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

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

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

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

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

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

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

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

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

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

Interviews
Tomas Maina, Institute of Policy Analysis and Research, Nairobi.
Steven Muchiri, Ministry of Health, Nairobi.
Pär Vikström, Swedish International Development Cooperation Agency, Nairobi.
Abebe Alebachew Asaf, ETC Crystal, Nairobi.
Nzioki Kibua, Institute of Policy Analysis and Research, Nairobi.

Sida

2005-09-28

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

1997:6 Strategy for Development Cooperation
Sexual and Reproductive Health and Rights

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

2002:4 Sweden's Development Co-operation with WHO
– a Strategy for the Period 2002–2005

2003 Health is Wealth – A Short Version of Sida's Policy for Health and Development. (Spanish)

2004 Health is Wealth – A Short Version of Sida's Policy for Health and Development. (Russian)

2004 Working in Partnership with UNODC/UNDCP
A Swedish Strategy Framework for 2004–2007

Issue Papers

1998:1 Maternal Health Care, by Staffan Bergström

1998:2 Supporting Midwifery, by Jerker Liljestrand

1998:3 Contraception, by Kajsa Sundström

1998:4 Abortion, by Kajsa Sundström

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)

Continues

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: sida@sida.se

Sida

List of Health Division Documents

Issue Papers cont.

2002	Sexuality – a super force. Young people, sexuality and rights in the era of HIV/AIDS by Anna Runeborg
2003:2	Human Resources for Health and Development, by Jenny Huddart
2004:3	Issue paper on NHA; the case of Kenya, Zambia and Mali, by Anna Glenngård and Frida Hjalte
2005:2	Issue Paper on NHA; Findings from a study of regional NHA networks by Anna H Glenngård and Frida Hjalte
2005:3	Issue Paper on NHA Policies in the Kenyan health care sector by Anna H Glenngård

Facts and Figures

1995/96	Facts & Figures 95/96 Health Sector Cooperation
1997	Facts & Figures 1997 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
2003:1	Facts & Figures 2002 Health Sector
2004:1	Facts & Figures 2003 Health Sector
2005:1	Facts & Figures 2004

Fact Sheets

1997	Hälso och sjukvård
1997	Reformer inom hälsosektorn
1997	Rätten till sexuell och reproduktiv hälsa
1997	Befolkning och utveckling
1997	Ungdomshälsa
1997	Handikappfrågor
1999	Aidsbekämpning i Uganda
1999	Förebyggande insatser mot drogmissbruk
1999	Insatser mot familjevåld i Centralamerika
1999	Bättre mödrahälsovård i Angola
1999	Utbildningssamarbete Kenya-Linköping
2001	Sveriges stöd till Hiv/Aids-insatser – 2001

Fact Sheets cont.

2002	Fler välutbildade barnmorskor ger tryggare förlossningar
2002	Femina skapar het debatt om sex och hiv
2002	Rent vatten ger bättre hälsa och ökad jämställdhet

Sida Evaluations

98/14	Expanded Programme on Immunization in Zimbabwe
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.
00/2	Reaching out to Children in Poverty
00/21	The Protection, Promotion and Support of Breastfeeding
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

Continues

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: sida@sida.se

Sida

List of Health Division Documents

Country and Regional Health Profiles

1995 Angola
1995 Bangladesh
1995 El Salvador
1995 Ethiopia
1995 Guatemala
1995 Guinea Bissau
1995 Honduras
1995 India
1995 Kenya
1995 Laos
1995 Nicaragua
1995 Vietnam
1995 West Bank/Gaza
1995 Zambia
1995 Zimbabwe
2000:4 Uganda
2000:5 West Africa

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

2001 Hälsa – en nyckel till utveckling
– New edition 2003 –

2001 Jord för miljarder

2002:3 Rural Integrated Health Services – Kenya,
by Gordon Tamm

2002 Health – a Key to Development

2002:5 A follow up of the components for Swedish support in Burma/Myanmar, Cambodia, China (Yunnan Province), Laos and Vietnam

2003 Hälsa – en nyckel till utveckling

2004 Ending gender-based violence:
A call for global action to involve men

2004:2 Sidas arbete med SRHR 1994–2003
En sammanfattning av utvärderingen
"Sida Evaluation 04/14"

2004 Human Resources for Health – Overcoming the Crisis. Joint Learning Initiative

2005 Poniendo fin a la violenca de género:
Un llamado a la acción global para involucrar a los hombres

Continues

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: sida@sida.se

Sida

List of Health Division Documents

Consultancy Reports

Conditional Grants for Health Sector Support in Uganda
December 1998

Health Systems Development in Uganda – what could Sweden do within the context of a Sector Wide approach?
December 1998

Review of Regional Organisations/Networks Working in the Area of Hiv/Aids in Eastern and Southern Africa
August 1998

SPANe – Sida partnership on adolescents network
January 1999

SPANe – Part 1: Purpose and aim of SPANe, and Part 2: Proceedings from the 2nd SPANe workshop, 19–21 october 1998 in Harare, Zimbabwe
January 1999

Swedish NGOs working with International Drug Control Issues
January 1999

Hiv/Aids in Botswana
September 1999

Resultatanalys av Sidas stöd till insatser mot narkotika 1997–1999 (Swedish)
Oktober 1999

Resultatanalys av Sidas stöd till Hälsa och Miljö inklusive Tobaksbekämpning (Swedish)
November 1999

The Maternal Health Programme in Angola
November 1999

Hiv/Aids in Bangladesh
December 1999

Hiv/Aids in Tanzania
December 1999

Continued Sida support of Hiv/Aids work within the health sector in Uganda
March 2000

Hiv/Aids in Guatemala and Honduras
March 2000

The teachers' training in sexuality education project in Malawi
March 2000

SPANe – Report from the 3rd SPANe workshop, october 11–13 1999, in Cape Town, South Africa. "Truth Time Now"
April 2000

Appraisal of ESCAP-project
May 2000

A Fact-Finding Mission on the Health Sector in Albania, Kosovo and Macedonia
June 2000

Hiv/Aids – a gender-based response
June 2000

African Youth Forum of the United Nations System
December 2000

Sida Seminar on Sector-Wide Approaches for Health
February 2001

Informal bilateral meeting on Global Health Initiatives
March 2001

Adolescent Sexuality in Africa – from Traditional Rites to Contemporary Sexuality Education
April 2001

Assessment report of RAINBO's Africa program
April 2001

Assessment report of UNICEF Anti-Female Genital Mutilation Campaign in Eritrea November 6–14, 2000
April 2001

Partner Consultation on National Health Accounts
June 2001

Review of Sida support to policy and organisational development, with particular focus on institutional collaboration in Zambia
July 2001

A Background Study on UNDCP
March 2002

Strengthening the obstetric nurse in Nicaragua
October 2001 and March 2002

Estudio independiente de pre-evaluacion y situacion para el fortalecimiento de la enfermera obstetra en Nicaragua
Octobre 2001 y Marzo 2002

Femina Health Information Project
February 2002

HIV/AIDS och utvecklingssamarbete
2003

Human Resources and Sustainable Capacity Building for Health and Development
March 2003

Overview of Sida's Work Against Trafficking in Human Beings
May 2005

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: sida@sida.se

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.

SWEDISH INTERNATIONAL
DEVELOPMENT COOPERATION AGENCY

SE-105 25 Stockholm Sweden
Phone: +46 (0)8 698 50 00
Fax: +46 (0)8 20 88 64
sida@sida.se, www.sida.se