Ministry of Medical Services

Ministry of Public Health and Sanitation

Strengthening Health Service Delivery

Report of the Taskforce constituted to address Health Sector issues raised by the Kenya Medical Practitioners, Pharmacists and Dentists Union

25th January 2012

Ministry of Medical Services

Ministry of Public Health and Sanitation

Afya House,
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Date : 02 February 2012

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Permanent Secretary
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Report of Task Force on Strengthening Health Service Delivery

In December 2011, you appointed us members of the Task Force to address Health Sector issues raised by the Kenya Medical Practitioners, Pharmacists and Dentists Union. The Task Force commenced its deliberations on December 14, 2011. The issues raised by the Union focused mainly on Strengthening Health Service Delivery in the public sector.

The Task Force has expedited the tasks as spelt out in the Terms of Reference. We examined and considered all the issues raised by the Union through a combination of approaches: desk reviews of important policy documents; discussions with the Union and relevant stakeholders and, gathering and collation of vital information, which was useful in analysing the situation in the public health sector.

Consequently, and in pursuance of the Return to Work Formula document signed on 12th December 2011 following the Doctors' Strike, I hereby wish, on behalf of the Task Force, to submit to you the Report for onward transmission to the Honourable Ministers for Medical Services and Public Health and Sanitation. The Report provides our findings and recommendations based on the Terms of Reference.

We are grateful for the honour and trust you bestowed upon us by appointing us members of the Task Force. It is our hope that the Government will find the recommendations we have made useful in addressing the problems facing the public health sector.

Musyimi, F. K. CBS.
Chairman
Task Force on Strengthening Health Service Delivery

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LIST OF ABBREVIATIONS

KMPDU	Kenya Medical Practitioners, Pharmacists and Dentists Union
RTWF	Return to Work Formula
NHSSP II	National Health Sector Strategic Plan II
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MSPS	Ministry of State for Public Service
KEML	Kenya Essential Medicine List
KEMSA	Kenya Medical Supplies Agency
CEO	Chief Executive Officer
EMMS	Essential Medicines and Medical Supplies
PMIS	Pharmaceutical Management Information Systems
PPB	Pharmacy and Poisons Board
NQCL	National Quality Control Laboratory
KNAS	Kenya National Ambulance Services
NICE (UK)	National Institute for Health and Clinical Excellence – United Kingdom
NIH (USA)	National Institutes for Health, United States of America

EXECUTIVE SUMMARY

Introduction

This is a report of the Taskforce that was established through the Return to Work Formula signed on 12th December 2011 to look into the Strengthening of Health Service Delivery following the doctors' strike. The Task Force had twelve members: six from the Union and six from the Government with a provision that the latter co-opt other members as appropriate. The Human Resources Management Department provided the secretariat services.

The report presents the findings of the Taskforce in line with its terms of reference. The report provides an in-depth analysis of the health system issues accompanied by a wide-range of recommendations.

This report is structured in four chapters. Chapter One is the Introduction which discusses the background information, mandate and terms of reference; Chapter Two gives details of the Return to Work Formula, its implementation status and the outstanding issues. Chapter Three identifies the Priority Health Care issues and gives recommendation on how to address them while Chapter Four provides the conclusion.

Key Findings

The findings of this report are organised around five key health systems building blocks: health facilities and infrastructure; Pharmaceutical services and medical supplies; Availability and functionality of diagnostic equipment; Human Resource Management and capacity building; Compensation of registrars on training; Stewardship and Management of Public Health Institutions; Financing of the public health sector and; performance management in the ministries of health.

Health Facilities and Infrastructure

Kenya has a wide range of health facilities distributed all over the country. Of these, publicly owned facilities include 274 hospitals, 600 health centres and 2,800 dispensaries. Over half of these facilities have old and dilapidated infrastructure. In addition, a significant number of the hospitals do not conform to current norms and standards having been upgraded from health centre status without concomitant improvement in facilities.

Over the last three years, two hundred and one (201) model health centres have been constructed /refurbished under the Economic Stimulus Package (ESP) while more than 80 hospital projects are at various stages of completion. Numerous small scale construction/ rehabilitated/ improvements works are also ongoing.

Pharmaceutical services and medical supplies

The supply of essential medicines and non-pharmaceuticals is inadequate due to insufficient funds. This make the health facilities undertake purchases using user fees revenues while patients are forced to do private out of pocket purchases, resulting in poor patient outcomes and inappropriate medicine use.

Current evidence shows that up to 30% of medicines in Kenya are counterfeit. This contributes greatly to increased morbidity and mortality and increased healthcare costs that ultimately reduce the performance of the health system.

Availability and functionality of diagnostic equipment

Most of medical equipment used in public health facilities are more than 20 years old (some double their lifespan) and therefore characterized by frequent breakdowns. Consequently, there are enormous risks to patients on account of misdiagnosis. Further, the inconsistent supply of laboratory reagents and supplies has compromised diagnostic quality hence impacted negatively on health outcomes.

In addition, most public hospitals do not have modern equipment such as dialysis machines, radiology equipment, laundry machines and theatre equipment.

Staffing levels using norms and standards

Overall, Kenya has 16 doctors per 100,000 population and 153 nurses per 100,000 population compared to WHO recommended minimum staffing levels of 100 doctors and 356 nurses per 100,000 population. Only a third of these are in the public service. Effectively therefore a third of the doctors cater for 57% of outpatient visits and 64% of all admissions in the country. In addition, the Kenya health system exhibits mal-distribution of health workers. Although minimum staffing norms are clearly described, they are rarely used.

Training of health personnel including specialists' training

The Ministry is currently receiving Kshs 88 million per year against requirements of Kshs 386.7 million to develop competency among the staff to offer quality services. The shortage of specialist personnel has, therefore, been worsened by inadequate budgetary provision.

Further, infrastructure development and the changing disease profiles have been inconsistently matched with human resource development with respect to specialists required to utilise the new infrastructure.

Compensation of registrars on training

The two national hospitals namely the Kenyatta National Hospital and the Moi Teaching and Referral Hospitals heavily depend on registrars' (both self sponsored and sponsored by employers in public/private) on training to provide health services. Unfortunately, the registrars work for lengthy periods without compensation.

Management in Public Health Institutions

There is concern that there is an apparent attempt to lock out doctors in management positions of health institutions. It is, however, noted that there is no change in policy in deploying health professionals to manage public hospitals.

Health Service Commission

The Health Sector Medium Term Plan of the Vision 2030 recognises that there is need to de-link the Ministries of Health (Medical Services, Public Health and Sanitation) from service delivery through the establishment of a Health Service Commission. This will make the Ministries focus on formulation of policies, standards, guidelines and regulation of delivery of health services.

Underfunding of the health sector

The overall allocations to the ministries of health have been, on average at about six percent level of total government budget in the last five years. This makes the health sector continue to be predominantly financed by private sector sources including households' out-of-pocket spending. High out-of-pocket spending on health care has the implication of dissuading Kenyans from seeking health care.

The Ministries of health have perennially been underfunded when benchmarked both by the Abuja declaration of 15% and by WHO target of $52 per capita. This has impacted negatively on health service delivery and made it unlikely to achieve MDG targets among other national and international targets.

Strengthening performance management in the ministries

There is concern that, allegedly, the Ministries of health have retained non-performing officers due to weak performance management system coupled with poor supervisory support. It was noted that vetting on appointment of some officers has not been optimally applied on recruitment and on promotion at all levels.

Key Recommendations

Health Facilities and Infrastructure

(a)Develop a comprehensive health sector investment plan.

(b) Revise and implement the infrastructural norms and standards.

(c)Develop and implement standardized health facility plans (master plans) for each level of care with the involvement of all stake holders.

(d) Identify, build and equip one hospital in each county to provide referral services.

(e)Treasury to allocate a total of about Kshs 62.87 billion over a period of three years starting with Kshs. 20.98 billions in the next financial year for revitalization of health infrastructure.

Pharmaceutical Services and Medical Supplies

(a) Introduce a revolving fund for KEMSA to procure EMMS.

(b) The Treasury to allocate approximately a total of Kshs. 48.75 billion covering three years towards procurement of EMMS starting with Kshs. 15.94 billion for FY 2012/13. This will ensure access to the entire Kenya Essential Medicine List (KEML), hence optimize patient outcomes and appropriate medicine use especially for the poor and vulnerable patients. This will also put an end to the perennial shortage of EMMS. KEML includes anticancer drugs, antiretrovirals and anti-tuberculosis drugs.

(c) KEMSA should fast track implementation of the current reforms to ensure focus on Good Procurement Practices and Good Distribution Practices that will guarantee performance. All positions should be competitively filled thereafter.

(d) Enhance the pharmaceutical management information system (PMIS) for accurate and reliable evidence based information for estimation of EMMS needs of the Kenyan people.

(e) Adequate funding for essential stationary and devices for drug administration e.g. prescriptions, treatment sheets, dispensing bottles, dispensing labels etc be provided to ensure appropriate medicine administration practices.

(f) Fast track the current reforms at the Pharmacy and Poisons Board (PPB) with a view to enhance autonomy, professionalism and performance in regulation. All positions should be competitively filled thereafter.

(g) Enhanced pharmaco-vigilance services both voluntary and mandatory for effective monitoring of adverse effects and counterfeit products in the Kenyan market.

(h) Enhanced quality assurance and quality control activities by PPB and NQCL to rapidly eliminate the production, distribution, storage and use of counterfeit medicines in Kenya. This is aimed at ensuring safety and quality of medicines and maximizing patient outcomes from medicine use.

(i) Therapeutic drug monitoring centres and toxicology laboratories in all county level hospitals to enable monitoring of medication therapy for safety, effectiveness and economic use of medicines and to improve toxicological patient management and research.

(j) National Patient Safety Agency: Medication errors are a significant cause of morbidity and mortality. Hence need for an investigating and reporting strategies and tools for mandatory or voluntary reporting. This will greatly improve medication safety as part of continuous quality improvement.

(k) A national therapeutics advisory committee that guides evidence based clinical practice in Kenya. This should be akin to NICE (UK) or National Institute of Health (USA). This will greatly improve patient outcomes.

(l) Medicine and poison information service – an effective evidence based information service that responds to the medicine and poison information needs of the patient, health care providers and the general public.

(m) Pharmaceutical Care defined as the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life needs to be adopted officially by the MOH. This will greatly improve patient outcomes, cost-effective use of medicines and hence the performance of the health system.

(n) Fast track the passing and implementation of Kenya National Pharmaceutical policy (July 2010) already submitted to cabinet in the next 3 months.

Availability and functionality of diagnostic equipment

(a) Provide adequate equipment as per standards and norms.

(b) Treasury to allocate an additional Kshs 12.55 billion for procurement of equipment in the next financial year (2012/13 FY).

(c) Enhance maintenance of equipment by providing an additional 10% of the allocation to equipment for maintenance.

(d) Partnership with private sector for lease of equipment as a stop gap measure.

(e) Revise and implement the equipment norms and standards. The proposed list of equipment for county hospitals is provided in Annex B.

National Ambulance service

(a) Set up the Kenya National Ambulance Services (KNAS) with county and national coordinating offices within the next 2 years.
(b) Recruitment and training of emergency care personnel. Pre-service training of emergency care to all cadres of medical personnel is paramount.
(c) Adequate funding to enable operation of the service on a 24 hour basis every day of every year. An allocation of Kshs. 1.3 billion is required for procurement of ambulances in the 201 constituencies for the financial year 2012/2013 (Table A4.2)
(d) Provision of adequate funding mechanisms for maintenance of this equipment.
(e) Integration of the KNAS with the disaster and emergency preparedness services.
(f) Provision and maintenance of utility vehicles to mitigate against use of ambulances for utility purposes.

Staffing levels using norms and standards

(a) Fill the existing vacancies to mitigate staff shortages in health facilities.

(b) Revise and implement the staffing norms and standards.

(c) Increase Government Recurrent budget allocation to health Ministries from the current Kshs 20 billion to about Kshs 39.75 billion in FY 2012/13 to reduce vacancy ratio. Therefore approximately Kshs. 19.75 billions will be required to recruit additional staff in the next financial year.

(d) The ministry implements strategies that promote equitable distribution of human resource for health. The task force recommended use of incentives such as hardship/rural allowance, harmonised house allowance, priority in scholarships, housing, security, etc to promote equitable distribution of health workers in rural and hardship areas;

(e) The ministries strive to provide competitive remuneration, benefits and working environments that promote voluntary retention of doctors and health workers in public service. The establishment of a Health service commission was recommended as the best strategy to achieve this.

Training of health personnel including specialist training

(a) Provision should be made to train 2,204 health staff (various cadres) in various specialities;

(b) That government ensures that the infrastructure development matches the human resource development;

(c) Increase budgetary allocation for training to about Kshs 387 million in the next financial year to cater for training needs;

(d) That the ministries provides and facilitates fellowship opportunities for doctors willing to sub-specialise;

(e) That the government actively pursues the WHO resolution on Human Resource for Health on bilateral agreements between the donor and recipient countries.

Compensation of registrars on training

(a) Registrars work as per the curriculum contact hours. Any hours worked above these curriculum hours should be appropriately compensated;

(b) While there may be various modes of compensation, the task force recommends that self sponsored registrars be considered for financial compensation.

(c) To comprehensively address the issues of Registrars, a Sub-committee be constituted immediately (not later than end of 31st January, 2012) comprising of representatives from the universities, referral hospitals, Government, Union and Registrars to address the following issues:

i) Determining the extra hours worked;
ii) Recommend appropriate financial compensation;
iii) Analyze cost implication and budgetary provision;
iv) Recommend appropriate date of implementation.

Management in Public Health Institutions

(a) Conduct an independent task analysis study to determine the requisite skills required for one to perform the duties of facility managers. This would guide any future appointment of officers to these positions

(b) Enhance the leadership and management competencies of medical personnel through continuous training to equip them with the skills to effectively perform at management positions.

Health Service Commission

(a) Carry out a constitutional amendment to enable formation of the Health service Commission with the involvement of all stakeholders.

Underfunding of the health sector

(a) Treasury to allocate additional funds for the two Ministries to implement a three year (2012/13-2014/2015) health stimulus package amounting to approximately Kshs. 217 billion.

(b) The treasury to increase progressively, at 2% per annum, the budgetary provision to the Ministries of health until we achieve the Abuja Target of 15%.

(c) For sustainable and affordable health care in the country, the Ministries of health to fast track implementation of the recently developed health financial strategy.

(d) That 1% of the total health budget is allocated to Research.

(e) Enact a national social insurance (NSHIF) bill to minimize the risk of financial catastrophe due to health spending and improve access within the next one year.

(f) Phase out cost-sharing as a financing mechanism over the next three years.

(g) Improve governance and regulatory framework to avoid wastage and increase performance.

Strengthening performance management in the ministries

(a) There is need to strengthen performance based management system.

(b) Encourage a culture of integrity by all staff in the health sector during training, recruitment and in-service. Strict vetting on the appointment of officers into service by the two ministries;

(c) Enforcement to the fullest extent of the law on officers caught stealing of property and supplies from public health facilities. e.g. medicines, equipment etc.

Despite the gains the health sector has made over the last 10 years, the sector remains heavily underfunded. The treasury needs to allocate at minimum an additional Kshs. 217 billion over the next three years to revamp health infrastructure, equipment, human resources and essential medicines and medical supplies. This will significantly improve access to quality health care services in the country and also accelerate the attainment of vision 2030 and the MDGs.

ACKNOWLEDGEMENTS

The Taskforce Members wish to most sincerely thank the Deputy Prime Minister and Minister for Finance, Hon Uhuru Kenyatta and the Minister of State for Public Service, Hon. Dalmas Anyango Otieno for bringing together the two parties involving Officials from the Ministry of Health and other Government Agencies and the Kenya Medical Practitioners, Pharmacists and Dentists Union and charting the way forward to resolve the Doctors strike.

The Members also wish to thank the following Authorised Officers:

i. The two Permanent Secretaries in the Ministries of Health for providing direction and necessary logistics for the Taskforce;

ii. The Permanent Secretary, Ministry of State for Public Service and the Secretary, Public Service Commission of Kenya for providing direction on various human resource issues;

iii. The Permanent Secretary, Ministry of Labour for providing guidance on industrial relations; and

iv. The Permanent Secretary, Treasury for providing funds to enhance the remuneration package and training requirements for the Doctors.

In undertaking the assignment, it was prudent that the Members consult Directors of both Kenyatta National Hospital and Moi Teaching and Referral Hospital. The Taskforce obtained valuable information from the consultations and we register our appreciation.

The Chairman of the Taskforce wishes to thank all the Members for their patience, good conduct and mature deliberations of the various issues.

Finally, special thanks go to the Joint Secretaries and the entire Secretariat Team for their commitment and hard work without which this Report

1. INTRODUCTION

1.1 Background

The Kenya Medical Practitioners Pharmacists and Dentists Union (KMPDU) issued a strike notice with effect from 5th December, 2011 the two Ministries of Health in their then letter dated 25th November, 2011.

Among the issues raised by the Union included inadequate health facilities, poor staffing and training, management of public health institutions, fair remuneration and underfunding of health care service delivery.

As a way to end the strike, a "Return to Work Formula (RTWF)" was signed between the KMPDU and the Ministries of Medical Services and Public Health and Sanitation. One of the clauses in the RTWF was that a Taskforce be constituted comprising representatives from the Union and Government to address issues raised by the Union that touch on policy and other matters. It was against this background that the two Permanent Secretaries constituted a Taskforce to look into issues that were raised by the union that culminated into the strike and recommend way forward. This report therefore defines its mandate, terms of reference and its recommendations.

1.2 Appointment of Taskforce Members

The two Ministries appointed a Chair and six (6) representatives from the Government and six (6) representatives from the Union as enlisted in the appendix D. The Taskforce also co-opted four (4) members from the Departments of Finance and Planning from the two Ministries of Health.

1.3 Mandate of Taskforce

In accordance with their terms of appointment, the Taskforce identified its mandate to deal with:

- Issues that touch on policy, heath care financing and other issues to reform the health sector.
- Implementation of the Return to Work Formula.

The issues involving policy touch on:

a) Appropriate health facilities.
b) Medical equipment and medical products.

c) Human resource.
d) Training.
e) Leadership and management.
f) Health sector financing.
g) Health Service Commission.

The Taskforce resolved that matters touching on terms and conditions of service with the exception of the issue of registrars be referred to the Negotiating Team.

1.4 Terms of Reference

The members therefore developed the following terms of reference to guide the process.

(a) Consider proposals presented by the Union and analyze what constitutes policy and industrial relations issues.
(b) Identify for implementation issues contained in the Return To Work Formula between the Union and the Ministries of Health.
(c) Develop cost implication of the prioritized area of investment in the health sector.
(d) Develop implementation framework on the prioritized areas.
(e) Identify any other pertinent issues that will improve the health sector service delivery.
(f) Develop modalities for compensating the Registrars working at the two Referral hospitals.
(g) Make recommendation on each of the issues raised by the Union.
(h) Compile the report within 7 days and submit it to the Ministers of Medical Services and Public Health and Sanitation.

1.5 Methodology

In order to undertake the mandate entrusted to the Taskforce and deliver on the Terms of reference, the team agreed that the following documents will be used as reference materials and would form the basis for deliberations:

(a) Return to Work Formula
(b) KMPDU Memorandum
(c) Zero Draft of the Health Laws
(d) Norms and Standards
(e) National Health Accounts
(f) Salary proposal by KMPDU
(g) NHSSP II
(h) Position Paper on implementation of the Constitution
(i) Desk reviews and
(j) The Constitution of Kenya

The documents were supplemented with written and verbal presentations that were discussed and adopted by the members in the number of meetings held. Apart from the

above reference materials, the team co-opted members as need arose. Members from Kenyatta National Hospital, Moi Teaching and Referral Hospital, Nairobi University and Moi University Medical Schools were also invited for discussion on various issues touching on training of Doctors.

1.6 Structure of the Report

This report is structured in four chapters. Chapter One is the Introduction which discusses the background information, mandate and terms of reference; Chapter Two gives details of the Return to Work Formula, its implementation status and the outstanding issues. Chapter Three identifies the Priority Health Care issues and gives recommendation on how to address them while Chapter Four provides the conclusion.

2. RETURN TO WORK FORMULA

The Return to Work Formula had eleven (11) clauses (See Appendix 3).

CLAUSES ON RETURN TO WORK FORMULA

NO.	CLAUSES	IMPLEMENTATION STATUS	OUTSTANDING ISSUES
	Clause I: KMPDU call off the strike.	• Strike called off on 14th December, 2011 and all members resumed duties.	• None
	Clause 2 & 3: Taskforce be established to address issues touching on policy.	• The Permanent Secretaries of MOMS & MOPHS constituted a Taskforce. The Taskforce commenced its work on 14th December, 2011, developed TORs and held Seven (7) sittings up to 22nd December, 2011 to address issues raised by the Union.	• Taskforce Report to be submitted to the Ministers of Medical Services and Public Health and Sanitation on or before 13th January, 2012.
3.	**Clause 4:** Negotiating Team be set within seven days to address industrial relations matters.	• The Permanent Secretaries are yet to sign the "Recognition Agreement" with the Union before the Negotiating Team is appointed. There are however issues touching on law and labour relations that have been raised by Attorney General's office.	• The Ministry of Labour has been requested to advise the signing authorities on issues raised by the Attorney General before signing.
4.	**Clause 5:** Payment of Extraneous Allowance in two phases. **Phase 1** – 1st December to June, 2012 – KShs.15, 000/- to KShs.20, 000/-. **Phase II** – 1st July,	• Treasury allocated KShs.1.153 billion which is below projected expenditure of KShs.2.137 billion. The two Ministries of Health have requested for additional funding. It is confirmed that the Deputy Prime Minister and Minister for Finance has approved the additional funding to cater for the shortfall. • Ministry of State for Public Service issued circular on 19th December, 2011 on to whom the allowance is payable to. As a result of clarification sought	• Shortfall of KShs.984, 940,000 required. • Treasury is yet to issue a letter to confirm additional funding to implement the allowance. • The Treasury has yet to allocate funds to cater the Extraneous and Call Allowances

NO.	CLAUSES	IMPLEMENTATION STATUS	OUTSTANDING ISSUES
	2012 – KShs.15,000/- to KShs.20,000/-	from MSPS, a circular will be issued to incorporate all cadres of Health Personnel who work in similar extraneous circumstance. • Data submitted to MSPS to issue Data codes and implement payment in the payroll.	to the officers in Moi Teaching and Referral Hospital and Kenyatta National Hospital.
5.	**Clause 6:** Government to avail KShs.200 million to cater for training of health workers as follows: • KShs.85 million for debts. • KShs.54 million for current training. • KShs.61 million for other training.	• The Ministerial Training Committees of the two Ministries of Health have already met and worked out modalities for disbursement of the allocated funds. • It was however recommended that the bulk of funds should be utilized to clear outstanding debts and fees for Doctors on training. • Older debts should be settled first.	• Work in progress. • Information on outstanding debts being collected and verified.
6.	**Clause 7:** Emergency Call Allowance of KShs.30, 000/- per month be paid w.e.f. December, 2011.	• MSPS issued a circular on 19th December, 2011 clarifying that the allowance will be paid to "Medical Officers" in Hospitals only. • A further circular issued on 22nd December, 2011 approving the allowance to be paid to Medical Officers in-charge of Provincial and District offices upon an appeal from the Ministries of Health. • The two Ministries of Health require KShs.469, 980,000 to implement the allowance and Treasury has been requested to provide funding. • Data submitted to MSPS to effect payment and provide IPPD codes.	• Treasury is yet to provide funding of KShs.469,980,000 to implement the allowance. • Pharmacists and Dentists were not covered by the circular. It was however recommended that the Ministry of State for Public Service issues a circular covering all doctors in public service.
7.	**Clause 8 & 9:**	• The Ministries of Health have requested for funding from Treasury to	• Treasury is yet to provide funding.

NO.	CLAUSES	IMPLEMENTATION STATUS	OUTSTANDING ISSUES
	Employment of 200 Doctors and provision of KShs.113 million for promotion of Doctors.	employ new Doctors and promote existing staff. • Indents have been prepared and submitted to PSC for advertisement but PSC is unable to proceed due to lack of funding from Treasury.	• The two Ministries have prepared an investment proposal regarding personnel and other resources in the health sector for funding.
8.	**Clause 10:** Victimization by either party on issues that gave rise to the strike.	• All officers resumed work unconditionally and no incident of victimization was reported.	• No outstanding issue.
9.	**Clause 11:** Parties to negotiate in good faith w.e.f. 14th December, 2011.	• The Government to set up a negotiating team to address industrial relations issues as instructed in the Return to Work Formula;	• Negotiating Team yet to be established. • The Union to prepare their proposal for Collective Bargaining Agreement; • Signing of the Recognition Agreement is required to facilitate commencement of negotiations.
10	**Other issues**	With regard to the 93 interns who had their salaries stopped, the matter was agreed upon and is being handled administratively.	83 cases have been resolved and 10 are outstanding.

Return to work formulae has been partly implemented but the task force recommends that the government should implement all the clauses of the return to work formula.

3. PRIORITY HEALTH CARE ISSUES

3.1 Status of Health Facilities and Infrastructure

Kenya has a wide range of health facilities distributed all over the country. Currently, publicly owned facilities in Kenya include 274 hospitals, 600 health centres and 2,800 dispensaries. Over half of these facilities have old and dilapidated infrastructure and its worse for hospitals some of which were constructed in the 1920s.

It is worth noting that, most of the existing hospitals do not conform to current norms and standards having been upgraded from health centre status in the last 3-4 years with respect to staffing, infrastructure and equipment. Accessibility to these health facilities (if one uses a 5 km radius as a yardstick) is estimated at 52 per cent (Kenya Integrated Budget Household Survey, 2006) nationally.

So far, 201 model health centres have been constructed /refurbished under the economic stimulus package while more than 80 hospital projects are at various stages of completion. Numerous small scale construction/ rehabilitated/ improvements works are also ongoing during this financial year.

However, forty-seven county hospitals (level 5) and 121 level four hospitals and 1,000 model health centres (level 3) are yet to be built. It is imperative that these health facilities are constructed to significantly improve access to each level healthcare.

RECOMMENDATIONS

(a) Develop a comprehensive health sector investment plan.

(b) Revise and implement the infrastructural norms and standards.

(c) Develop and implement standardized health facility plans (master plans) for each level of care with the involvement of all stake holders.

(d) Identify, build and equip one hospital in each county to provide referral services.

(e) Treasury to allocate about Kshs 20.98 billion in the next financial year for revitalization of health infrastructure (see details in Annex A).

Table A1.0 in Annex A provides a summary of additional resources required by the two Ministries to implement the six priority areas over a period of three years. Table A1.1

(MOMS), Table A1.2 (MOPHS) provide details on additional funding required for construction and rehabilitation of health facilities over a period of three years.

3.2 Pharmaceutical services and medical supplies

Medicines and medical supplies are a vital component of medical care. To maintain a regular supply of these inputs, effective public commodity supply management is important.

Currently, supply of essential medicines and non-pharmaceuticals is inadequate due to insufficient funds. This makes the health facilities undertake their own purchases using user fees revenues, which is not sustainable. Patients are also forced to do private out of pocket purchases, resulting in poor patient outcomes and inappropriate medicine use e.g. under-dosage and drug resistance.

The Kenya Essential Medicines list (KEML) is not fully adhered to with respect to supply of medicines in leading to a mismatch between the medicines supplied and the medicine needs for each level of care. Consequent to this poor adherence to the entire KEML, the medicine needs of the Kenyan population are not met.

The Ministries of Health currently receives about 50 per cent of the required funds for pharmaceuticals and non pharmaceuticals. The situation is worse for the ARVs which, are funded at 90 per cent level by Development Partners.

Based on WHO estimates, about US$ 1.5-2 per capita is required to provide essential medicines in a basic health care package. Currently the MOH allocation stands at US$ 1.1 per capita (or 2 billion annually) which is not sufficient.

Funding for essential stationery and devices for drug administration e.g. prescriptions, treatment sheets, dispensing bottles, dispensing labels etc is not adequate. As a result medicine administration is not optimal with the consequent risk of poor health outcomes.

Current evidence shows that up to 30% of medicines in Kenya are counterfeit (WHO fact sheet; Counterfeit medicines. 2006). This contributes greatly to increased morbidity and mortality and increased healthcare costs that ultimately reduce the performance of the health system.

RECOMMENDATIONS

(a) Introduce a revolving fund for KEMSA to procure Essential Medicines and Medical Supplies (EMMS).

(o) The Treasury to allocate approximately Kshs 15.9 billion shillings towards procurement of EMMS during FY 2012/13 (see Annex A, Table A1.0). This will ensure access to the entire KEML hence optimize patient outcomes and appropriate medicine use especially for the poor and vulnerable patients. This will also put an end to the perennial shortage of EMMS. KEML includes anticancer drugs, antiretrovirals and anti-tuberculosis drugs. Specific annual requirements for each Ministry for a three year period are provided in Annex A: Tables A3.1 (MOMS) and A3.2 (MOPHS).

(b) KEMSA should fast track implementation of the current reforms to ensure focus on Good Procurement Practices and Good Distribution Practices that will guarantee performance. All positions should be competitively filled thereafter.

(c) Enhance the pharmaceutical management information system (PMIS) for accurate and reliable evidence based information for estimation of EMMS needs of the Kenyan people.

(d) Adequate funding for essential stationary and devices for drug administration e.g. prescriptions, treatment sheets, dispensing bottles, dispensing labels etc be provided to ensure appropriate medicine administration practices.

(e) Fast track the current reforms at the Pharmacy and poisons board (PPB) with a view to enhance autonomy, professionalism and performance in regulation. All positions should be competitively filled thereafter.

(f) Enhanced pharmaco-vigilance services both voluntary and mandatory for effective monitoring of adverse effects and counterfeit products in the Kenyan market.

(g) Enhanced quality assurance and quality control activities by PPB and National Quality Control Laboratory (NQCL) to rapidly eliminate the production, distribution, storage and use of counterfeit medicines in Kenya. This is aimed at ensuring safety and quality of medicines and maximizing patient outcomes from medicine use.

(h) Therapeutic drug monitoring centres and toxicology laboratories in all county level hospitals to enable monitoring of medication therapy for safety, effectiveness and economic use of medicines and to improve toxicological patient management and research.

(i) National Patient Safety Agency: Medication errors are a significant cause of morbidity and mortality. Hence need for an investigating and reporting strategies and tools for mandatory or voluntary reporting. This will greatly improve medication safety as part of continuous quality improvement.

(j) A national therapeutics advisory committee that guides evidence based clinical practice in Kenya. This should be akin to National Institute for Health and Clinical Excellence (UK) or National institute of health (USA). This will greatly improve patient outcomes.

(k) Medicine and poison information service – effective evidence based information service that responds to the medicine and poison information needs of the patient, health care providers and the general public.

(l) Pharmaceutical care defined as the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life needs to be adopted officially by the MOH. This will greatly improve patient outcomes, cost-effective use of medicines and hence the performance of the health system.

(m) Fast track the passing and implementation of Kenya National Pharmaceutical policy (July 2010) already submitted to cabinet in the next 3 months.

3.3 Availability and functionality of diagnostic equipment

Availability and functionality of diagnostic and medical equipment is critical in treatment. Most of medical equipment used in public health facilities are more than 20 years old (some double their lifespan) and therefore characterized by frequent breakdowns. Furthermore, most public hospitals do not have modern equipment such as dialysis machines, radiology equipment, laundry machines and theatre equipment. It is noteworthy that:

i) The available equipment falls far short of the required numbers.
ii) Of those available, about 50% of the equipment is too old to pass required standards. Consequently, there are enormous risks to patients on account of misdiagnosis.
iii) Maintenance of equipment has been inadequate.
iv) Staffs skilled in maintenance are inadequate at the district levels and rarely available at lower levels.
v) Where these staffs exist, they are not supported by the necessary tools, consumables or financial resources.
vi) There is inconsistent supply of laboratory reagents and supplies, which compromise diagnostic quality, thus negatively affecting health outcomes.

RECOMMENDATIONS

(a) Provide adequate equipment as per standards and norms.
(b) Treasury to allocate an additional Kshs 12.55 billion for procurement of equipment and in the next financial year (2012/13 FY)
(c) Enhance maintenance of equipment by providing an additional 10% of the allocation to equipment for maintenance.
(d) Partnership with private sector for lease of equipment as a stop gap measure.
(e) Revise and implement the equipment norms and standards. The proposed list of equipment for county hospitals is provided in Annex B.

The three year funding required by the two ministries to improve on equipment through procurement and preventive maintenance is provided in Annex A Tables A4.1- A4.2.

3.4 National Ambulance service

Evidence shows that outcomes of healthcare are affected by three delays: i.e. delay to decide to seek healthcare at household level; delay to reach a health facility; and delay to get treatment at the health facility. The second delay in practice can only be addressed by establishing an effective ambulance system.

While there has been attempts to ensure availability of ambulances in almost every district, it is noted with great concern that;

(i) A significant proportion of these ambulances are defective.
(ii) Where present they are often used as utility vehicles due to the lack of functional utility vehicles.
(iii) Lack of an effective communication system that ensures access to these ambulances by Kenyans in need and the co-ordination of these ambulance services in responding to these emergency care needs in their areas.
(iv) Limited capacity of human resource in emergency care
(v) Resources are not consistently available to enable operation of the ambulances on a 24hr basis e.g. fuel.
(vi) Lack of an integrated approach of ambulance services with disaster response and emergency preparedness.

Consequently, there is urgent need to establish a countrywide ambulance service (nationally and county based) that is readily available to respond and provide emergency medical services to the vulnerable in all settings including the urban areas, intercity highways and in the remote rural areas.

This service will improve both the care and management of accident victims and acutely ill persons contribute to reduction in the unit cost of healthcare and reduce complications and mortality. This will consequently improve quality of life and the social and economic status of all Kenyans.

RECOMMENDATIONS

(g) Set up the Kenya National Ambulance Services (KNAS) with county and national coordinating offices within the next 2 years.
(h) Recruitment and training of emergency care personnel. Pre-service training of emergency care to all cadres of medical personnel is paramount.
(i) Adequate funding to enable operation of the service on a 24 hour basis every day of every year. An allocation of Kshs. 1.3 billion is required for procurement of ambulances in the 201 constituencies for the financial year 2012/2013 (Table A4.2)
(j) Provision of adequate funding mechanisms for maintenance of this equipment.
(k) Integration of the KNAS with the disaster and emergency preparedness services.
(l) Provision and maintenance of utility vehicles to mitigate against use of ambulances for utility purposes.

The three year funding required to improve on the national ambulance service is provided in annex A table A4.1-A4.2.

3.5 Staffing levels using norms and standards

The importance of human resources in health needs not be over-emphasised. Overall, Kenya has 16 doctors per 100,000 population and 153 nurses per 100,000 population against the WHO benchmarks of 100 doctors per 100,000 and 356 nurses per 100,000 population. Furthermore, only a third of these are in the public service while two thirds are in the private sector. Effectively therefore a third of the doctors cater for 57% of outpatient visits and 64% of admissions serviced by the public sector (Household health expenditure and utilization survey report, 2007).

The staff requirement for the MOPHS as per the new staff establishment is 71,023 posts while for MOMs is 43,000 posts. Of the approved establishment, about 39,165 positions are filled, leaving 74,858 positions vacant.

Therefore, current evidence demonstrates that the Kenya health system is understaffed and exhibit mal-distribution of health workers. Although minimum staffing norms are clearly described[1], they are rarely used, resulting in uneven distribution of available staff. The purpose of norms and standards for human resources for health is to qualify the expected types of staff cadres needed at each level and to quantify the numbers of the different identified staff cadres needed at every level of care.

RECOMMENDATIONS

(a) Fill the existing vacancies to mitigate staff shortages in health facilities.

(b) Revise and implement the staffing norms and standards.

(c) Increase Government Recurrent budget allocation to health Ministries from the current Kshs 20 billion to about Kshs **39.75** billion in FY 2012/13 to reduce vacancy ratio. Therefore approximately Kshs. 19.75 billions will be required to recruit additional staff in the next financial year.

(d) The ministry implements strategies that promote equitable distribution of human resource for health. The task force recommend use of incentives such as hardship/rural allowance, harmonised house allowance, priority in scholarships, housing, security, etc to promote equitable distribution of health workers in rural and hardship areas.

(e) The ministries strive to provide competitive remuneration, benefits and working environments that promote voluntary retention of doctors and health workers in public service. The establishment of a Health service commission was recommended as the best strategy to achieve this.

1 Ministry of Health: *Norms and Standards for Health Service Delivery*

(f) Improve working environment by providing well-lit, well-ventilated office space, office furniture, office equipment, and stationary for all doctors in the ministry within the next three years.

The additional requirements for human resources for health are presented in Annex A - Tables A5.1 and A5.2 for MOMS and MOPHS respectively.

3.6 Training of health personnel including specialist training

Training and development of the Human Resources for Health (HRH) is one of the most critical functions of government. It is through this that the critical shortage of specialists of various cadres in various fields will be addressed. In addition it is only through this training that specialized services may be accessible to Kenyans especially the poor and vulnerable. On the other hand it is mainly through training that an employee develops the specific job-related skills that will ensure effective performance and help the employee to grow in his/her career.

The Ministry is currently receiving Kshs 88 million per year against requirements of Kshs 386.7 million to develop competency among the staff to offer quality services. The shortage of specialist personnel has, therefore, been worsened by inadequate budgetary provision.

In addition infrastructure development has been inconsistently matched with human resource development with respect to specialists required to utilise the new infrastructure.

Furthermore, needs are not only changing but also increasing, owing particularly to changing disease profiles, for example, rise in non-communicable diseases. Hence, the training of health professionals must keep abreast of all the trends that impact on health care, especially the changing disease profiles and global human resource trends.

RECOMMENDATIONS

(a) Annual provision should be made to train 2,204 health staff (various cadres) in various specialities each year.
(b) That government ensures that the Human resource development matches the infrastructure development, i.e., whenever new facilities are built or equipped, staff should be recruited and trained to run the facilities.
(c) The Government should put emphasis on training health professionals (doctors, nurses etc) in specialised areas (renal, ICU, new born care, cancer etc) so as to facilitate decentralisation of service delivery;

(d) Increase budgetary allocation for training to about Kshs 386.7 Million in the next financial yr to cater for training needs. Details are presented in Annex A, Tables A6.1-A6.2.
(e) That the ministries provides and facilitates fellowship opportunities for doctors willing to sub-specialise.
(f) That the government actively pursues the WHO resolution on Human Resource for Health on bilateral agreements between the human resource for health donor and recipient countries.

3.7 Compensation of registrars on training

Postgraduate medical training is highly intertwined with service provision. The two national hospitals- the Kenyatta National Hospital and the Moi Teaching and Referral Hospitals heavily depend on registrars' on training who work for lengthy periods beyond the stipulated hours provided by their curricula without compensation.

The Taskforce examined proposals contained in the Report of the Inter-ministerial consultative meeting between the Registrars and the two Referral Hospitals and noted that there were two categories of Registrars:

- Self sponsored.
- Sponsored by employers in public/private.

In order to get further insights into the issues affecting Registrars, the Taskforce invited the CEOs of Kenyatta National Hospital and Moi Teaching and Referral Hospital, the Principal of the College of Health Sciences, University of Nairobi and the Dean of Moi University, School of Medicine for discussions.

The representatives of the training institutions and the referral hospitals concurred with the task force that registrar's on training work beyond the stipulated hours provided by the curricula and hence there is need to compensate them for the extra hours worked.

RECOMMENDATIONS

(a) The task force recommends that the registrars work as per the respective curriculum contact hours. Any hours worked above these curriculum hours should be appropriately compensated;
(b) While there may be various modes of compensation, the task force recommends that self sponsored registrars be considered for financial compensation. The criteria for determining the academic and work hours should however be done by the training institutions and referral hospitals;
(c) To comprehensively address the issues of Registrars, a Sub-committee be constituted immediately (not later than end of 31st January, 2012) comprising of representatives

from the universities, referral hospitals, Government, Union and Registrars to address the following issues:

i) Determining the extra hours worked.
ii) Recommend appropriate financial compensation.
iii) Analyze cost implication and budgetary provision.
iv) Recommend appropriate date of implementation.

(d) On a long-term basis, there should be a shift in the model of specialist training in Kenya towards hospital based training with the county hospitals acting as centers of excellence.

3.8 Management in Public Health Institutions

There is concern that there is a push by the Ministry to lock out doctors in management positions. An assurance was given that in Kenya, there is no change in policy in deploying health professionals to manage public hospitals. Of further concern were the inadequate training opportunities in leadership and management such as induction, supervisory, senior management and strategic leadership and development program trainings as other civil servants.

RECOMMENDATIONS

(a) Conduct an independent task analysis study to determine the requisite skills required for one to perform the duties of facility managers. This would guide any future appointment of officers to these positions
(b) Enhance the leadership and management competencies of medical personnel through continuous training to equip them with the skills to effectively perform at management positions.

3.9 Health Service Commission

The Health Sector Medium Term Plan of the Vision 2030 recognises that there is need to de-link the Ministries (Medical Services, Public Health and Sanitation) from service delivery through the establishment of a Health Service Commission[2]. The Ministries will then focus on policies, standards; guidelines and regulation of delivery of health services.

[2] Health Sector, Medium Term Plan, 2008-2012

RECOMMENDATION

(a) A constitutional amendment be carried out to enable formation of the Health service Commission with the involvement of all stakeholders. A proposed draft bill is attached in Annex C.

3.10 Underfunding of the health sector

The allocations to the ministries of health have been, on average at about six percent level of total government budget in the last five years against the Abuja target of 15 percent**.** The health sector continues to be predominantly financed by private sector sources (including by households' out-of-pocket (OOP) spending), although the private sector share of total health expenditure has decreased from a high of 54 percent in 2001/02 to 37 percent in 2009/10. High out-of-pocket spending on health care has the implication of dissuading Kenyans from seeking health care.

With regard to financial sustainability of investments in the health sector, public sector financing has remained constant in real terms over the last decade, at about 29 percent of total health expenditure, while the contribution of donors to total health expenditure has more than doubled, from 16 percent in 2001/02 to 35 percent in 2009/10.

The Ministries of health have perennially been underfunded when benchmarked both by the Abuja declaration of 15% and also by WHO target of $52 per capita. East African countries that have achieved these targets include Rwanda (16%) and Tanzania (18%). This has impacted negatively on health service delivery and made it unlikely to achieve MDG targets among other national and international targets.

RECOMMENDATIONS

(a) Treasury to allocate additional funds for the two Ministries to implement a three year (2012/13-2014/2015) health stimulus package amounting to approximately Kshs. 217 billion. The breakdown of the financial requirements by year is shown in Annex A, Tables A1.0 – A1.3;
(b) The treasury to increase progressively, at 2% per annum, the budgetary provision to the Ministries of health until we achieve the Abuja Target of 15%;
(c) For sustainable and affordable health care in the country, the Ministries of health to fast track implementation of the recently developed health financing strategy;
(d) That 1% of the total health budget is allocated to Health Research;
(e) Enact a national social insurance (NSHIF) to minimize the risk of financial catastrophe due to health spending and improve access within the next one year;
(f) Phase out cost-sharing as a financing mechanism over the next three years;
(g) Improve governance & regulatory framework to avoid wastage and increase performance.

3.11 Strengthening performance management in the ministries

There was concern that the Ministries of Health have retained non-performing officers due to a weak performance management system coupled with poor supervisory support.

It was noted that Public Service Virtues like integrity, patriotism and other ethical values have not been mainstreamed in making appointments and promotion and hence the need to integrate them.

RECOMMENDATIONS

a) There is need to strengthen performance based management system.

b) Encourage a culture of integrity by all staff in the health sector during training, recruitment and in-service.

c) Enforcement to the fullest extent of the law on officers caught stealing property and supplies from public health facilities. e.g. medicines, equipment etc.

4. CONCLUSION

This report provides a unique opportunity for Kenyans to make radical and progressive changes in the way health services are delivered. The improvements proposed are in the best interest of Kenyans, in terms of safety, best practice and quality of health service delivery.

Despite the gains the health sector has made over the last 10 years, the sector remains heavily underfunded. The treasury needs to allocate at minimum an additional Kshs. 217 billions over the next three years to revamp health infrastructure, equipment, human resources and essential medicines and medical supplies. This will significantly improve access to quality health care services in the country and also accelerate the attainment of vision 2030 and the MDGs.

Improvements are both necessary and possible and there is a genuine willingness by all stakeholders to work together towards achieving them. Finally, the implementation of these proposals offers an opportunity to improve significantly the value for money of health care expenditure. The two Ministries of Health will be restructured to conform to the letter and the spirit of the constitution of Kenya 2010 in which, Kenyans have a right to the highest attainable standards of health including reproductive health.

REFERENCES

1. Health Sector: Medium Term Plan, Vision 2030
2. Health sector strategic plans (MOMS and MOPHS)
3. The Kenya Constitution, 2010
4. MoH, Kenya National Health Accounts, 2009/10
5. Human Resource Strategy for the Health Sector (dates)
6. Draft Position paper on the new constitution
7. Draft Health Policy Framework
8. Health Financing strategy
9. MoH, Staffing and infrastructure norms
10. MOMs, Business Plan
11. KMPDU proposals: equipment, health financing, pharmaceutical issues, health service commission and health laws.

ANNEXES

ANNEX A: Resources required to revamp the Public Health System FYs 2012/13 – 2014/2015

Table A1.0: Summary of resource requirements for Ministries of Health (MOMS and MOPHS) by priority area (Kshs. Millions)

	Output/Outcome Area	2012/2013	2013/2014	2014/2015	Total 3 years Budget (ksh.Million)
1	Improved Infrastructure thro' Construction & Rehab.of Buildings	20,980	20,980	20,914	**62,873**
2	Improved Commodity Management and Supplies	15,942	16,239	16,565	**48,747**
3	Improved Equipment and Ambulance Vehicles	13,836	8,740	8,640	**43,819**
4	Strengthened Human Resource Management	19,751	19,751	19,751	**59,252**
5	Improved Human Resource Capacity through Training	387	865	862	**2,114**
6	Strengthened Management and Governance Structures	75	75	75	**224**
	Total Budget (Kshs. Millions)	**70,970**	**66,650**	**66,808**	**217,030**

Table A1.2: Summary of resource requirements for MOPHS (Kshs. Millions) by priority area

	Output/Outcome Area	2012/2013	2013/2014	2014/2015	Total 3 years Budget (ksh.Million)
1	Improved Infrastructure thro' Construction & Rehab.of Buildings	14,674	14,674	14,634	**43,982**
2	Improved Commodity Management and Supplies	11,642	11,939	12,265	**35,847**
3	Improved Equipment and Ambulance Vehicles	7,746	7,724	7,624	**23,095**
4	Strengthened Human Resource Management	15,875	15,875	15,875	**47,624**
5	Improved Human Resource Capacity through Training	318	796	793	**1,907**
6	Strengthened Management and Governance Structures	64.75	64.75	64.75	**194.25**
	Total Budget (Kshs. Millions)	**50,320**	**51,073**	**51,257**	**152,650**

Table A1.3: Summary of resource requirements for MOMs by priority area (KSh. Millions)

	Output/Outcome Area	2012/2013	2013/2014	2014/2015	Total 3 years Budget (ksh.Million)
1	Improved Infrastructure thro' Construction & Rehab.of Buildings	6,306	6,306	6,280	**18,891**
2	Improved Commodity Management and Supplies	4,300	4,300	4,300	**12,900**
3	Improved Equipment and Ambulance Vehicles	6,090	1,016	1,016	**20,724**
4	Strengthened Human Resource Management	3,876	3,876	3,876	**11,628**
5	Improved Human Resource Capacity through Training	69	69	69	**207**
6	Strengthened Management and Governance Structures	10	10	10	**30**
	Total Budget (Kshs. Millions)	**20,651**	**15,577**	**15,551**	**64,380**

Table A2.1: MOMS - Construction and Rehabilitation of Buildings

Output 1 - Improved Hospital Infrastructure	Qty	Unit Cost KSh million	2012/2013	2013/2014	2014/2015	TOTAL BUDGET (KSh. million)
Construction/re-facing 20 hospitals yearly at 200 million[1] each countrywide.	20	200	4,000	4,000	4,000	12,000
Rehabilitate 50 Theatres countrywide yearly @ 5 million each	50	5	250	250	250	750
Complete and equip 5 stalled theatres yearly @ Ksh10 million each	5	10	25	25	-	50
Rehabilitate 70 Mortuaries country wide @ 5 million each	70	5	70	70	70	210
Rehabilitate 100 Laundry rooms in the country at 5 million per year	100	5	100	100	100	300
Buy major equipment for needy 10 hospitals per year @ 100 million	10	100	1,000	1,000	1,000	3,000
Construction of 100 rooms/buildings for HMIS @ 5 million each	100	5	100	100	100	300
Technical assistance to develop 200 hospital Master Plans @Kshs 50,000 for survey.	200	0.05	0.5	0.5	-	1
Construction of 200 modern incinerators for garbage management in hospitals @4 million each.	200	4	160	160	160	480
Construction of two rooms per hospital for neonates in 200 hospitals @ 5 million per hospital	200	5	200	200	200	600
Construct/renovate 200 delivery rooms @ 5 million	200	5	200	200	200	600
Construction of mortuaries in 100 hospitals @ 10 million	100	10	200	200	200	600
Sub Total			**6,306**	**6,306**	**6,280**	**18,891**

Table A2.2: MOPHS - Construction and Rehabilitation of Buildings

OUTPUT/Activities	Qty	Amount KSH (MILLIONS)	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
Output 1 - Improved Infrastructure						
Construction of 2 vaccination centres per constituency over next 3 years.	2	290	290	290	290	**870**
Replacement of 100 vaccine refrigerators per year	100	0	25	25	25	**75**
Equip ONE NEW immunizing facility per constituency per year	210	0	73	73	73	**218**
Construction & equipping of 35 county vaccine depots in next 3 years	35	3	117	117	117	**350**
Rehabilitate District and facility pharmacies to include temperature regulations and meet the WHO standards on Good Storage and Distribution practices	210	0	50	50	10	**110**
Construction of postnatal ward for mothers in level 2 and 3 in 20 facilities per year @ 5million each	200	100	200	200	200	**600**
Construction of antenatal ward for mothers in level 2 and 3 in 20 facilities per year @ 5million each	200	100	200	200	200	**600**
Construct/renovate 200 delivery rooms in level 2 and 3 @ 5 million	200	100	200	200	200	**600**
Construction/expansion of the MCH/FP rooms to allow for integration of the services for 20 facilities per year @ 2.5 million	200	50	100	100	100	**300**
Completion of ESP health facilities	100	5,000,000	500	500	500	**1,500**
Rural health facilities rehabilitated and upgraded , maintained and equipped	2,000	5,000,000	10,000	10,000	10,000	**30,000**
Technical assistance to develop primary health facilities Master Plans and prototype	1,000	20,000	20	20	20	**60**
Construction of 200 modern incinerators for garbage management in health facilities @4 million each.	200	2,000,000	400	400	400	**1,200**
Community Health Units Established and made functional	2,500	1,000,000	2,500	2,500	2,500	**7,500**
Sub Total			**14,674**	**14,674**	**14,634**	**43,982**

Table A3.1: MOMS – Commodity Management and Supplies

OUTPUT/Activities	Qty	Unit Cost KSh million	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
Laboratory Reagents to 200 hospitals @ 5 million each	200	1,000	200	200	200	600
Supply of drugs @ 2 billion per year	1	2,000	2,000	2,000	2,000	6,000
Supply of non pharm @Kshs 1.8 billion per year	1	1,800	1,800	1,800	1,800	5,400
ARVs Revolving fund of 300 million per year	1	300	300	300	300	900
Sub Total			4,300	4,300	4,300	12,900

Table A3.2: MOPHS – Commodity Management and Supplies

	Qty	Unit Cost KSh million)	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
Annual supply of Infant (EPI) vaccines (annual population growth of 03%)	1	695	695	716	738	2,150
Annual supply of other (non-EPI) vaccines	1	200	200	200	200	600
Annual supply of syringes & disposal boxes	1	160	160	160	160	480
Supply of drugs @ 2 billion per year	1	2,000	2,000	2,000	2,000	6,000
Supply of non pharm @Kshs 1.8 billion per year	1	1,800	1,800	1,800	1,800	5,400
Supply of therapeutic and supplementary feeds @ Ksh 1.5 billion per year	1	1,500	1,500	1,500	1,500	4,500
ARVs Revolving fund of 1.5 billion per year	1	7,500	150	1,500	1,500	4,500
Procure Male Condoms	00m	4	424	466	512	1,402
Procure Female Condoms	3m	100	363	399	439	1,202
Anti-malarial Drugs and Testv Kits and	1	1,020,000	1,020	1,020	1,020	3,060
HIV Testing Commodities	3m	500	1,980	2,178	2,396	6,554
Sub Total			11,642	11,939	12,265	35,847

Table A4.1: MOMS - Equipment Requirements

OUTPUT/Activities	Qty	Unit Cost KSh million	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
Equip 15 large hospitals with dialysis machines @ 15 million shillings each	15	15	5,000	5,000	5,000	15,000
Computers, servers, networking - OPD, Labs, stores, IP for 100 hospitals @ 100million per hospital.	100	1,000	200	200	200	1,000
Theatre equipment for 100 hospitals @ 20 million each	100	2,000	400	400	400	2,000
4 Dialysis machines for 20 hospitals @ 2 million each	20	180	36	36	36	180
Cash registers for 100 hospitals @ Ksh500,000	100	50	17	17	17	51
Laundry Machines for 100 hospitals @ Ksh5 million each	100	500	100	100	100	500
Procure and install 250 incubators @ 1million each	250	250	110	110	110	220
Procure at least 200 rescusatiers and 200 oxygen concentrators @ 1 million	200	200	100	100	100	200
Procure 200 photo therapy units @ 750,000	200	1	50	50	50	150
Delivery kits - 200 @ 10,000 each for 1 million deliveries	200	2	1	1	1	2
Delivery beds 200 @ 500,000	200	20	7	7	7	21
Laboratory equipment for 200 needy hospitals @ 2 million each	200	400	80	80	80	400
2 Mortuary coolers @Ks 10 million for 100 hospitals	100	1,000	200	200	200	1,000
Sub Total			6,090	1,016	1,016	20,724

Table A4.2: MOPHS - Equipment Requirement and Vehicles

	Qty	Unit Cost KSh million	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
Procurement of 35 lorries – (2 tonne each) for distribution of vaccines to districts from county depots over next 3 years	35	1	35	35	35	105
New health facilities established and equipped	200	20,000,000	4,000	4,000	4,000	12,000
Complete and equip 201 at Ksh3.8million each	201	4	764	764	764	2,291
Purchase new ambulances in 210 constituencies	257	5,000,000	1,285	1,285	1,285	3,855
Establish model health resource centres with complete e-learning equipment	10	2	20	20	20	60
Procure motor cycles for use by Chews	2500	200,000	500	500	500	1,500
Procure 50 CD4 machines and reagents @ Ksh2 million each	50	100	100	100	-	200
Equip health centers and dispensaries with basic pediatric (child health) equipments as per attached list	100	2	200	200	200	600
Procure and install 250 incubators @ 1million each	250	1	250	250	250	750
Procure 200 photo therapy units @ 750,000	200	1	150	150	150	450

	Qty	Unit Cost KSh million	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
Delivery kits - 200 @ 10,000 each for 1 million deliveries	200	0	2	2	2	6
Delivery kits – for 200 facilities, 5 kits per facility per year @ 10,000 each	200	0	10	10	10	30
Delivery beds 200 @ 500,000	200	1	100	100	100	300
Family planning equipment for 200 level 2 and 3 facilities @ 12,000 each	200	0	24	2	2	29
Cervical cancer screening equipment for 200 level 2 and 3 facilities per year @ Ksh 25 000	200	0	5	5	5	15
Cervical cancer treatment equipment for 10 level 2 and 3 facilities per year @ Ksh 500,000	10	1	5	5	5	15
Basic Emergency Obstetric Care (BEOC) equipment for 100 level 2 and 3 facilities per year @ Ksh 50,000	100	0	5	5	5	15
Equipment and job aids for 50 community midwives per year @ K sh 25,000	50	0	1	1	1	4
Equip 200 hospitals with modern Jikos @ 1 million	200	1	100	100	100	300
Equip 200 hospitals with serving trollies and utensils @ 500,000	200	1	50	50	50	150
Equip health facilities with anthropometric equipment @ 140,000 for 1000 facilities (hospitals, health centre and dispensaries)	1000	0	140	140	140	420
Sub Total			7,746	7,724	7,624	23,095

Table A 5.1: MOMS – Strengthen Human Resource Management

OUTPUT/Activities	Qty	Unit Cost KSh million	2012/13	2013/14	2014/15	TOTAL BUDGET (KSh million)
Recruit 100 Medical records officers @ 50,000/month	100	50	60	60	60	180
Recruit 70 Accountants @ 50,000/month	70	42	42	42	42	126
Recruit 500 Lab. Technologists @ 45,000/month	500	270	270	270	270	810
Recruit 70 Procurement officers @ 50,000/month	70	42	42	42	42	126
Recruit 1,909 Medical officer @ 150,000/month	1,909	102,000	240	240	240	720
Recruit 500 Pharmacists @ 102,000ksh/month	500	102,000	100	100	100	300
Recruit 21, 732 Nurses @ 35,300/month	21,732	35,300	1,841	1,841	1,841	5,523
Recruit 3,526 Clinical Officers @ 35,300 /month	3,526	35,300	299	299	299	897
Recruit 3000 Pharmaceutical Technologist @ 35,300 /month	3,000	35,300	422	422	422	1,266
Recruit 292 Dentists @ 102,000 /month	292	102,000	71	71	71	213
Recruit 196 Dental Technologists @ 34,300 /month	196	35,300	17	17	17	51
Recruit 753 COHOs @ 28,700 /month	753	28,700	52	52	52	156
Recruit 100 Accounts clerks/General clerks @ 50,000/month	100	60	60	60	60	180
Recruit 100 Anaesthetists @ 150,0000 month	100	180	180	180	180	540
Recruit 100 Specialists @ 150,000 month	100	180	180	180	180	540
Sub Total			3,876	3,876	3,876	11,628

Table A 5.2: MOPHS - Strengthen Human Resource Management

OUTPUT/Activities	Qty	AMT KSH (M)	2012/2013	2013/2014	2014/2015	TOTAL BUDGET
Output 3- Strengthen Human Resource Management						
Recruit 150 nutritionists @ 50,000 per month every year	150	1	90	90	90	270
Recruit 2100 midwives @ 35,300/ month	2,100	890	890	890	890	2,670
Recruit 100 Reproductive Health clinical officers @ 150,000 month	100	180	180	180	180	540
Extreneous Allowances for HWs	1.0	2,074	2,074	2,074	2,074	6,222
720 DANIDA Health Workers on contract	720	0	275	275	275	825
Absorption of 90 Contract staff	90.0	0	14	14	14	43
47 PHOs	47	1	26	26	26	77
Filling of Additional created positions of Health Personnel 1/3 0f 1259 posts	1,259	0	371	371	371	1,113
Government Chemist & Radiation protection vacancies	1.0	49	49	49	49	148
Promotion of Drs	1.0	23	23	23	23	68
Implementation of pending promotion for other cadres	1.0	141	141	141	141	422
Implementation of emergency call allowance	1.0	53	53	53	53	159
Recruit of 1000 clinical officers @8,395 PM	1,000	0	361	361	361	1,083
Add maintenance of exising staff	1.0	7,608	7,608	7,608	7,608	22,823
Economic stimulus Health workers (development budget)	1.0	3,720	3,721	3,721	3,721	11,162
Sub Total			15,875	15,875	15,875	47,624

Table A 6.1: MOMS – Training requirements for Human Resources

OUTPUT/Activities	Qty	Unit Cost KSh million	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
Training of 20 nurses on dialysis @ 300,000 per course	20	6.0	6	6	6	18
Training 8 doctors on ICU specialist @ 1 million each per year	8	8.0	8	8	8	24
Training 8 oncology staff @ 2 million each per year for 4 years	8	16.0	16	16	16	48
Training 16 Nephrologists @ 1.2 million per year for 1 year	16	19.2	0	0	0	0
Training Radio physicist 6 @ 2 million per year	6	12.0	12	12	12	36
Training 40 clinical officers anaesthetics @ 240,000 each	40	9.6	10	10	10	30
Training 20 nurses on anaesthesia @ 350,000 per year	20	6.0	6	6	6	18
Paediatric nurses 20 @ 360,000 per officer	20	6.2	6	6	6	18
MMED Psychiatry	**4**	**1.0**	**4.0**	**8.0**	**12.0**	**24.0**
ICU nurses 10 per year @ 100,000	10	1.0	1	1	1	3
Theatre nurses 20 per year @ 200,000 per officers	20	4.0	4	4	4	12
Sub Total			73	77	81	231

Table A6.2: MOPHS – Training requirements for Human Resources

	Qty	Unit cost Kshs. M	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
Training of nurses on dialysis @ 300,000 per course	5	0.3	2	6	6	14
Doctors training mph @700,000	5	0.7	4	35	37	75
Obstetrics and Gynaecology	5	0.8	4	14	16	34
Internal Medicine	5	0.8	4	14	16	34
surgery	5	0.8	4	14	16	34
Radiology	4	1.0	4	14	16	34
paediatrics	4	0.8	3	14	16	33
Pathology	4	1.0	**4**	11	12	27
Anaesthesiology	5	1.0	5	17	19	41
Epidemiology	5	0.6	3	10	11	24
Ophthalmology	4	0.8	3	9	10	22
ENT Specialists	4	1.0	4	11	12	27
Dermatologist	4	1.5	6	17	19	42
MMED Psychiatry	**4**	**1.0**	**4.0**	**8.0**	**12.0**	**24.0**
Theatre nurses	10	0.2	2	4	4	11
Renal nursing	10	0.2	2	2	2	7
Intensive care nurses	10	0.1	1	1	1	4
Oncology nurses	10	0.4	4	4	4	11
Paediatrics nurses	10	0.4	4	8	8	19
Neonatology nurses	10	0.4	4	4	4	11
Mph other cadres e.g. clinical officers, nurses	10	0.6	6	14	16	36
Training 20 nurses on anaesthesia	20	0.4	7	6	6	19
Training of Paediatrics Clinical officers	10	0.1	1	2	2	6
Clinical officers reproductive health	10	0.2	2	2	2	5
orthopaedics training for clinical officers	10	0.2	2	2	2	5
Training 10 Ophthalmic Clinical Officers in Cataract Surgery	10	0.2	2	2	2	7
Training of 10 Clinical officers in Dermatovenerology	10	1.5	15	16	17	48
Training Nephrologists @ 1.2 million per year for 1 year	5	1.2	6	20	20	46
Training Radio physics 6 @ 2 million per year	3	2.0	6	12	12	30
Training clinical officers anaesthetics @ 240,000 each	15	0.2	4	10	10	23

	Qty	Unit cost Kshs. M	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
CLINICAL Pharmacy	5	1.0	5	12	14	31
MSC Pharmaceutics	5	1.0	5	6	7	18
Pharmaceutical Analysis	5	1.0	5	6	7	18
Msc Epidemiology	2	0.7	1	16	18	35
infectious disease control	3	0.7	2	2	2	7
MPH	10	0.6	6	7	8	21
Biostatistics	1	0.8	1	1	1	3
Virologist	1	0.8	1	1	1	3
Microbiologist	1	0.8	1	1	1	3
Parasitologist	1	0.8	1	1	1	3
Med .lab Scientist	4	0.8	3	3	4	10
Clinical officer -Paediatrics	2	0.2	0	0	1	1
Clinical officer Lung and Skin	10	0.2	2	4	5	11
Masters in Business Management (Pharmacists)	2	0.8	2	2	2	5
Blood transfusion sciences	2	0.8	2	2	2	5
General Nutritionists dietician	3	0.6	2	2	2	6
MSc Community Health	3	0.7	2	2	3	7
MPH in HP	5	0.7	4	5	6	14
MPH- Food Safety	10	0.7	7	16	18	41
MSC Water Safety and Analysis	5	0.7	4	5	6	14
MSC Vector And Vermin Control	5	0.7	4	5	6	14
MSC Pollution Control	10	0.7	7	16	18	41
MSC Micro- Biology	5	0.7	4	5	6	14
MSC Occupational Health And Safety	10	0.7	7	8	90	105
MSC Epidemiology	10	0.7	7	16	18	41
Diploma Upgrading	50	0.2	10	75	80	165
MPH	10	0.7	7	160	18	185
MSC Community Health	5	0.7	4	5	6	14
Post Basic	50	0.2	10	20	25	55
Health Systems	3	0.7	2	9	11	22
Secretarial Management			9	9	9	27

	Qty	Unit cost Kshs. M	2012/2013	2013/2014	2014/2015	Total Amount Kshs Millions
	30	0.3				
Diploma In HR Management	5	0.2	1	1	1	3
Human Resource Officers MBA-HR	3	0.5	2	2	2	5
Leadership And Management For Senior And Middle Level	100	0.1	14	14	14	42
Middle Level Management	100	0.1	14	14	14	42
Supervisory Management	300	0.1	18	18	18	54
Project Management	3	0.5	2	2	2	5
Diploma HR	3	0.2	1	1	1	2
TNA		-	6	6	6	18
Training Supervision		-	2	2	2	6
E-Induction	1,000	-	8	8	8	24
MBA - HR Management	1	0.4	1	1	1	2
MBA Finance	3	0.4	1	1	1	4
MBA Accounts	3	0.4	1	1	1	4
CPA	3	0.2	1	1	1	4
MBA Supply Chain Management	3	0.4	1	1	1	4
DIPLOMA In Supply Chain Management	3	0.2	1	1	1	2
MBA Accounts	1	0.4	0	0	0	1
CPA	1	0.4	0	0	0	1
MSC IN ICT	2	0.4	1	1	1	2
MSC Economic-Planning	2	0.4	1	1	1	2
Masters in Public Health	3	0.4	1	1	1	4
MSC Radiation	3	0.8	2	2	2	7
MSC	3	0.8	2	2	2	7
TOTAL			**322**	**804**	**805**	**1,931**

ANNEX B: Proposed List of Equipment for County Hospitals

GENERAL PHYSICAL EXAMINATION EQUIPMENT

- Thermometers, measuring tape, BP machines
- Anthropometric equipment: weighing scales, heightometers,
- Stethoscopes, Reflex hammers.
- Penlights, tuning forks, snellen eye charts,
- Otoscope/ophthalmoscope sets etc.

RADILOGY EQUIPMENT

- One 3 Tesla MRI machine
- One 64 slice Ct scan Machine
- Two Ultra sound machines with Echocardiographic capabilities
- One 3D Echocardiaographic machine
- One portable X-ray Machine
- One table top (fixed) X ray machine
- One dental X-ray
- One mammogram machine

LABORATORY EQUIPMENT

- Complete hematology panel
- Complete immunology panel
- Complete biochemistry panel
- Complete microbiology panel – cultures to include fungal and viral
- Full capability for pathological examination including histology and cytology
- Capacity for complete hormonal assay
- PCR for wide range of illness from viral to mycobacterial
- Enzyme and protein assays – complete
- Basic routines

OTHER EQUIPMENT

- Electroencephalographic machine (s)
- Electrocardiographic machine (s)
- ECT Machine
- Two ambulances
- Two cryotherapy machines per hospital

SPECIALISED UNITS

- THEATRES – 6 fully equipped and functional theatres. Full anesthetic setup for all forms of anaesthesia, complete patient monitoring setup, working theatre lights, available operation packs and kits, state of the art sterilization sub unit. All theatres built with strict infection control in mind.
- ICU - 20 bed ICU with piped oxygen and suction to every bedside. Each bedside with a state of the art patient monitor and ventilator machine. Each bed to be electrical with a ripple mattress and a warmer. At least 6 of the Units should be full isolation units. The facility to be built with strict infection control in mind.
- DIALYSIS UNIT – 10 conventional dialysis machines plus two CRRT machines. Fully equipped dialysis centre with its own water plant and patient controlled electrical chair. The facility to be built with strict infection control in mind.
- BURNS UNIT – 20 Bed burns unit with strict infection control in mind and all units isolated
- BLOOD TRANSFUSION UNIT – Fully equipped to collect, screen, store and distribute blood.

PHARMACEUTICAL EQUIPMENT

- Electronic tablet/capsule counters (80m), Labeling machines, medical fridges (20m), Temperature gauges, quality control equipment (NQCL, KEMSA, minilabs).
- Aseptic Preparation Cabinets
- Chemotherapy Reconstitution Cabinets
- Extemporaneous Compounding equipment
- Water filters and purifiers (UV)
- Surveillance cameras for all pharmacies
- Therapeutic drug monitoring centres in all county level hospitals
- Toxicological laboratories in each county hospital.
- Class 2 biological safety protective equipment.
- Infusion pumps.

ANNEX C: A Proposed Draft Bill of the Constitution of Kenya (AMENDMENT), 2012

ENACTED by the Parliament of Kenya, as follows-

Short title.

1. This Act may be cited as the Constitution of Kenya (Amendment) Act, 2012

Amendment of Article 230 of the Constitution

2. The Constitution is amended in Article 230 (b)

a) In clause (vi), by deleting the word "and" immediately after the semi-colon

b) In clause (vii), by inserting the word "and" immediately after the semi-colon

c) By inserting a new clause immediately after clause (vii)-

(viii) the Health Service Commission

Amendment of Article 234 of the Constitution.

3. The Constitution is amended in Article 234 (3) (c),

a) In clause (iv), by deleting the word "or",

b) by inserting the following new clause immediately after clause (iv)-

(v) Health Service Commission; or

Amendment of Article 235 of the Constitution.

4. The Constitution is amended in Article 235 (2) by inserting the expression "or the Health Service Commission" before the full stop.

Insertion of Part 4, Article 237A in Chapter 13 of the Constitution.

5. The Constitution is amended-

a) by inserting the following new Part immediately after Article 237-

Part 4- Health Service Commission

b) by inserting the following new Article 237A under this part-

237A (1) There is established a Health Service Commission

(2) The Commission consists of-

(a) a chairperson, who shall be a health professional with at least 15 years of distinguished service in their profession;

(b) Two persons nominated by health professionals associations

(c) Two persons nominated by health professionals unions

(d) The principal secretary responsible for health

(e) One person nominated by the Public Service Commission

(f) Two other persons nominated by the president to represent the public

(3) The functions of the Commission are-

(a) To register trained health workers;

(b) To recruit and employ registered health workers;

(c) To assign health workers employed by the Commission for service in any public Hospital or health facility;

(d) To promote and transfer health workers according to service need;

(e) To exercise disciplinary control over health workers employed by the Commission; and

(f) To terminate the employment of health workers in the health service

(4) The Commission shall-

(a) continuously set and review the standards of education and training for persons entering the health service;

(b) continuously review the demand and supply of health workers

(c) advise the national and county governments on matters relating to the health professions and health service delivery

(d) advise the government on policy and other activities necessary to achieve and maintain constitutional and other legal provisions on health rights

(e) prepare periodic reports on the Commission's activities, as well as progress reports on the attainment of health rights as provided for in the constitution

(f) Liaise, where necessary, with other persons or agencies in order to fulfil its mandate

Amendment of Article 248 of the Constitution

6. Article 248 (2) is amended

(a) In paragraph (i), by deleting the word "and" immediately after the semi-colon

(b) In paragraph (j), by replacing the full stop with a semi-colon, followed immediately by the word "and"

(c) By inserting the following new paragraph immediately after paragraph (j)-

(k) The Health Service Commission

Implementation provisions.

7. Subject to the provisions of the Constitution, the President shall take the necessary steps to ensure that this Act is fully implemented within six months of enactment of this Act.

MEMORANDUM OF OBJECTS AND REASONS

The Bill aims at providing for a Health Service Commission to manage the human resources for health in Kenya, and to give full effect to the constitutional provisions on health rights. The Bill further seeks to provide for a mechanism for coordination of health policy implementation at the different levels of government, providing a link in health service delivery between the central and devolved governments.

The Bill proposes to amend Article 230 on the composition of the Salaries and Remuneration Commission to provide for the representation of the Health Service Commission by inserting a new clause (viii) to this effect.

The Bill proposes to amend Article 234 of the Constitution to include the Health Service Commission among the Commissions exempted from the provisions of Article 234 clauses (1) and (2), which relate to the functions and powers of the Public Service Commission. This will give the Health Service Commission operational independence to carry out its mandate.

The Bill further proposes to amend Article 235 of the constitution by including the expression "or the Health Service Commission " to clause (2). The effect of this amendment is to ensure that all health professionals in the public service are under the control of the Health Service Commission in order to ensure uniformity in qualification and functions at all levels of government.

The Bill proposes to introduce a new Part 4 in chapter 13 of the Constitution, to provide for the Health Service Commission. Under this part, the new proposed Article 237A provides for the composition, functions and powers of the Health Service Commission.

The Bill also proposes to amend Article 248 of the Constitution by including the Health Service Commission in clause 2 of this Article. This will ensure that the Health Service Commission will be considered as one of the Constitutional Commissions, governed and regulated by the relevant provisions in the Constitution.

Finally, the Bill proposes to set a time-frame for full implementation of the proposed amendments by providing that the President shall ensure that the Commission is fully functional within six months of the enactment of the Act. This is in keeping with the spirit of the Constitution of Kenya, 2010, which provided a timeline for all legislation and actions provided for in the Constitution.

The enactment of this Act shall occasion additional expenditure of public funds, which shall be provided for in the estimates.

Minister for Medical Services/Minister for Public Health and Sanitation.

Article 230 of the Constitution of Kenya which it is proposed to amend-

Salaries and Remuneration Commission.

230. (1) There is established the Salaries and Remuneration Commission.

(2) The Salaries and Remuneration Commission consists of the following persons appointed by the President-

(*a*) A chairperson;

(*b*) One person each nominated by the following bodies from among persons who are not members or employees of those bodies-

(i) The Parliamentary Service Commission;

(ii) The Public Service Commission;

(iii) The Judicial Service Commission;

(iv) The Teachers Service Commission;

(v) The National Police Service Commission;

(vi) The Defence Council; and

(vii) The Senate, on behalf of the county governments;

(*c*) One person each nominated by-

(i) An umbrella body representing trade unions;

(ii) An umbrella body representing employers; and

(iii) a joint forum of professional bodies as provided by legislation;

(*d*) One person each nominated by-

(i) The Cabinet Secretary responsible for finance; and

(ii) The Attorney-General; and

(*e*) one person who has experience in the management of human resources in the public service, nominated by the Cabinet Secretary responsible for public service.

(3) The Commissioners under clause (1) (*d*) and (*e*) shall have no vote.

(4) The powers and functions of the Salaries and Remuneration Commission shall be to-

(*a*) set and regularly review the remuneration and benefits of all State officers; and

(*b*) Advise the national and county governments on the remuneration and benefits of all other public officers.

(5) In performing its functions, the Commission shall take the following principles into account-

(*a*) The need to ensure that the total public compensation bill is fiscally sustainable;

(*b*) The need to ensure that the public services are able to attract and retain the skills required to execute their functions;

(*c*) The need to recognise productivity and performance; and

(*d*) Transparency and fairness.

Article 234 of the Constitution of Kenya which it is proposed to amend-

Functions and powers of the Public Service Commission.

234. (1) The functions and powers of the Commission are as set out in this Article.

(2) The Commission shall-

(*a*) subject to this Constitution and legislation–

(i) Establish and abolish offices in the public service; and

(ii) Appoint persons to hold or act in those offices, and to confirm appointments;

(*b*) Exercise disciplinary control over and remove persons holding or acting in those offices;

(c) Promote the values and principles mentioned in Articles 10 and 232 throughout the public service;

(*d*) Investigate, monitor and evaluate the organisation, administration and personnel practices of the public service;

(*e*) Ensure that the public service is efficient and effective;

(*f*) Develop human resources in the public service;

(*g*) Review and make recommendations to the national government in respect of conditions of service, code of conduct and qualifications of officers in the public service;

(*h*) Evaluate and report to the President and Parliament on the extent to which the values and principles mentioned in Articles 10 and 232 are complied with in the public service;

(*i*) Hear and determine appeals in respect of county governments' public service; and

(*j*) Perform any other functions and exercise any other powers conferred by national legislation.

(3) Clauses (1) and (2) shall not apply to any of the following offices in the public service–

(*a*) State offices;

(*b*) An office of high commissioner, ambassador or other diplomatic or consular representative of the Republic;

(*c*) An office or position subject to–

(i) The Parliamentary Service Commission;

(ii) The Judicial Service Commission;

(iii) The Teachers Service Commission;

(iv) The National Police Service Commission; or

(*b*) An office in the service of a county government, except as contemplated in clause (2) (*i*).

(4) The Commission shall not appoint a person under clause (2) to hold or act in any office on the personal staff of the President or a retired President, except with the consent of the President or retired President.

Article235 of the Constitution of Kenya which it is proposed to amend-

Staffing of county governments.

235. (1) A county government is responsible, within a framework of uniform norms and standards prescribed by an Act of Parliament**,** for–

(*a*) Establishing and abolishing offices in its public service;

(*b*) Appointing persons to hold or act in those offices, and confirming appointments; and

(*c*) Exercising disciplinary control over and removing persons holding or acting in those offices.

(2) Clause (1) shall not apply to any office or position subject to the Teachers Service Commission.

Article 248 of the Constitution of Kenya which it is proposed to amend-

Application of Chapter fifteen- Commissions and Independent Offices.

248. (1) This Chapter applies to the commissions specified in clause (2) and the independent offices specified in clause (3), except to the extent that this Constitution provides otherwise.

(2) The commissions are-

(*a*) The Kenya National Human Rights and Equality Commission;

(*b*) The National Land Commission;

(*c*) The Independent Electoral and Boundaries Commission;

(*d*) The Parliamentary Service Commission**;**

(*e*) The Judicial Service Commission;

(*f*) The Commission on Revenue Allocation;

(*g*) The Public Service Commission;

(*h*) The Salaries and Remuneration Commission;

(i) The Teachers Service Commission; and

(*j*) The National Police Service Commission.

(3) The independent offices are—

(*a*) The Auditor-General; and

(*b*) The Controller of Budget.

ANNEX D: List of Taskforce members

NAME	DESIGNATION	MINISTRY/DEPARTMENT	SIGNATURE
1. Mr. F. K. Musyimi	Secretary/Admin. [Chairman]	MOPHS	
2. Dr. S. K. Sharif	DPHS	MOPHS	
3. Dr. Wycliffe Mogoa	DDMS	MOMS	
4. Dr. Annah Wamae	SADMS	MOPHS	
5. Mr. A. A. Nyanchoga	DD/HRM	MOMS	
6. Mrs. Hannah Kimemia	DD/HRM	MOPHS	
8. Ms. Wanjira Wairegi	SAD/HRM	PPSRRB	
9. Mrs. Eunice Kigen	DD/Budget	Finance	
10. Mr. Geoffrey A. Omondi	DLC	Labour	
11. Mrs. Judith Nyakawa	DCFO	MOPHS	
12. Mr. Geoffrey Kimani	DCE	MOMS	
13. Nzoya Munguti	DCE	MOPHS	
14. Mr. J. T. Gechaga	DD/HRM	MSPS	
15. Mr. Martin Mosiria	SAS	MOMS	
17. Mr Peter Macharia	DD/HRM	PSC/K	

ANNEX D (List of taskforce members) Continued

NAME	DESIGNATION	MINISTRY/DEPARTMENT	SIGNATURE
UNION MEMBERS			
1. Dr. Boniface Chitayi	Secretary General/KMPDU		
2. Dr. Victor Ng'ani	Chairperson	KMPDU	
3. Dr. P. K. Kilonzo	Member	KMPDU	
4. Dr. J. O. Nyakiba	Member	KMPDU	
5. Dr. Nelly Bosire	Member	KMPDU	
6. Dr. Lukoye Atwoli	Member	KMPDU	
OTHER CO-OPTED MEMBERS	(IN ATTENDANCE)		
Prof Isaac Kibwage		UoN	
Mr David Njoroge	SAD/HRM	MOMS	
Dr H.M. Irimu	SAD	KNH	
Dr Simeon Monda	DD/Curative Services	KNH	
Mrs L. I. Shitakha	DD/Admin Services	KNH	
Dr Omar Aly	DD/Curative Services	MTRH	
Prof Paul Ayuo	Dean	Moi University, Sch of medicine	

ANNEX E: RETURN TO WORK FORMULA

RETURN TO WORK FORMULA

BETWEEN

THE KENYA MEDICAL PRACTITIONERS, PHARMACISTS AND DENTISTS UNION (KMPDU)

AND

MINISTRY OF MEDICAL SERVICES & MINISTRY OF PUBLIC HEALTH AND SANITATION

The parties meeting under the Chairmanship of the Deputy Prime Minister and Minister for Finance, Honourable Uhuru Kenyatta and in the presence of the Minister of State for Public Service who is also the acting Minister for Medical Services, Honourable Dalmas Anyango Otieno have agreed on this 12th Day of December, 2011 at the Afya House Boardroom as follows:

1. That the Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPDU) call off the strike to enable their members resume duties immediately.
2. That a Taskforce is to be established to look into a range of issues that touch on policy and other matters. This will comprise six representatives from the Union side and six representatives from the Government side. However, Government may co-opt other relevant members.
3. The Taskforce to commence work on 14th December, 2011 for a period of seven (7) working days during which it will prepare terms of reference and submit a report to the Ministers of Medical Services and Public Health and Sanitation.
4. The Government to set up a negotiating team within seven (7) days to address industrial relations related matters.
5. The Government has offered the following Extraneous Allowances ranging from KShs.30,000 – 40,000 per month with effect from 1st December, 2011 to be phased out as follows:

- First instalment from 1st December, 2011 – KShs.15,000 – 20,000.
- Second instalment from 2nd July, 2012 – KShs.15,000 – 20,000.

6. The government is to avail KShs.200 million to cater for training of health personnel as follows:
    - KShs.85 million for debts
    - KShs.54 million for those currently in training and,
    - KShs.61 million for other training needs.
7. Emergency Call Allowances of KShs.30,000 per month with effect from December, 2011.
8. Employment of two hundred (200) Doctors.
9. KShs.113 million for promotion of Doctors.
10. That there will be no victimization by either party on issues giving rise to the strike.
11. That the parties have agreed to negotiate in good faith with effect from 14th December, 2011.

Signed For and on Behalf of Employer:

…….

Ngari M. W. (Ms.), CBS
Permanent Secretary
Ministry of Medical Services

……

Mark K. Bor, CBS
Permanent Secretary
Ministry of Public Health and Sanitation

Signed For and on Behalf of Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPDU)

……

1. Dr. Victor Ng'ani (Chairman)

.....

2. Dr. Boniface Chitayi (Secretary General)

Witnessed by

……..

Ms. Beatrice Naliaka Kituyi, CBS

Permanent Secretary

Ministry of Labour

……..

Mr. Titus M. Ndambuki, CBS

Permanent Secretary

Ministry of State for Public Service

……

Mr. Francis Atwoli (Secretary General) Central Organization of Trade Union (COTU)

In the presence of

……

Hon. Dalmas Anyango Otieno, EGH, MP

Minister of State for Public Services &

Acting Minister for Medical Services

Date this ……. Day of December, 2011