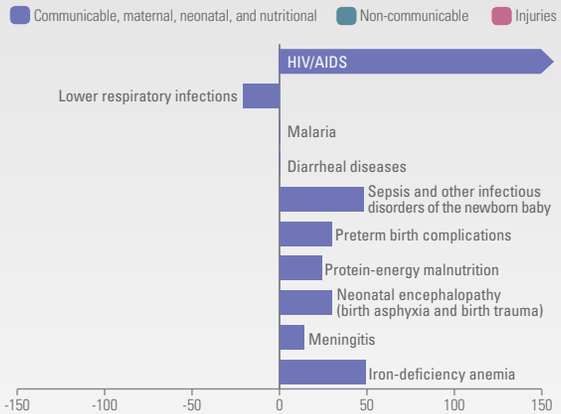
KENYA

The National Health Insurance Fund in Kenya covers mostly formal-sector workers: about 25% of poor people are estimated to have medical coverage. The burden of disease is overwhelmingly due to communicable diseases, with HIV infection as the number one cause of mortality and morbidity; progress towards achieving the health Millennium Development Goals has been limited. The availability of skilled health professionals is low and there is inequality in access, ranging from 20% to 80% from the poorest to the richest people. Urban-rural inequities are also significant, particularly for access to physicians. The devolution process underway will give authority over human resources for health to the counties, which may lead to differences in availability according to how counties set priorities for resources. On a positive note, the percentage of women physicians is quite high (about one third). Evidence also indicates good mechanisms for accreditation, regulation and licensing of the health workforce through the various professional councils, including requirements for continuous professional development for relicensing physicians, nurses and dentists. However policy mechanisms, intersectoral collaboration and human resource information systems need to be strengthened to enable successful planning and management of the workforce.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	40.9; 42; 4	(2010)
Average annual rate of population change (%)	2.7	(2010-2015)
Population living in urban areas (%)	24	(2011)
Gross national income per capita (PPP int. $)	1710	(2011)
Population living on <$1 (PPP int. $) a day (%)	–	
Total expenditure on health as a percentage of gross domestic product (%)	4.5	(2011)
General government expenditure on health as a percentage of total expenditure on health (%)	40	(2011)
External resources for health as a percentage of total expenditure on health (%)	38.8	(2011)
Life expectancy at birth (years) [all; female; male]	60; 61; 58	(2011)
Total fertility rate (per woman)	4.7	(2010)
Neonatal mortality rate (per 1 000 live births)	27	(2011)
Infant mortality rate (per 1 000 live births)	48	(2011)
Under-five mortality rate (per 1 000 live births)	73 [64-98]	(2011)
Maternal mortality ratio (per 100 000 live births)	360 [230-590]	(2010)
Births attended by skilled health personnel (%)	43.8	(2009)
Antenatal care coverage - at least one visit (%)	91.5	(2009)
Antenatal care coverage - at least four visits (%)	47.1	(2009)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	88	(2011)
Postnatal care visit within two days of birth (%)	42.1	(2009)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLS) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in 2010. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

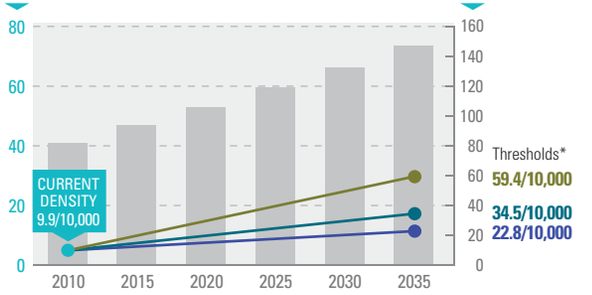
Feasibility of achieving thresholds: Most likely | Somewhat likely | Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

315% increase to meet 22.8/10 000 threshold

528% increase to meet 34.5/10 000 threshold

981% increase to meet 59.4/10 000 threshold



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS
(density per 10 000 population)

SUB-NATIONAL LOW	NATIONAL AVERAGE	SUB-NATIONAL HIGH
– Physicians	1.8 Physicians	– Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average (2.8:1).

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:		**REGULATE:**		**LICENSE/RE-LICENSE:**	
Dentists	✓	Dentists	✓	Dentists	✓
Midwives	✓	Midwives	✓	Midwives	✓
Nurses	✓	Nurses	✓	Nurses	✓
Pharmacists	✓	Pharmacists	✓*	Pharmacists	✓
Physicians	✓	Physicians	✓	Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?	✓*
Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?	✓*

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?	✓
informed by data and strategic intelligence?	✓*
addressing pre-service education?	✓*
addressing geographical distribution and retention?	✓*
addressing health workforce performance (e.g. competence, responsiveness and productivity)?	✓*
addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?	✓/✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?	✓
For which period?	2009-2012
Does the strategy/plan account for the financial costs and resource requirements to implement it?	✓

✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.