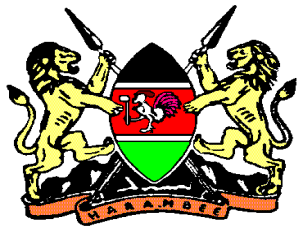

REPUBLIC OF KENYA

Ending Drought Emergencies:

Common Programme Framework for Human Capital

2014

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Key data

Country	Kenya	
Title	Ending Drought Emergencies Common Programme Framework: Human Capital	
Duration	July 2014 – June 2018	
Total budget	Kshs. 15,849 million	
Overall outcome	A more healthy, skilled, innovative, resourceful and motivated human capital in the ASALs.	
Expected results	1. The capacity and number of appropriately trained and experienced professionals working in ASAL counties increased. 2. Alternative interventions, including emerging technologies, in the provision of health, nutrition, WASH and education services integrated into current systems. 3. The demand for equitable and quality health, nutrition, WASH and education services increased through community education and empowerment.	
Focus area and population	Arid and semi-arid counties, approximately 15 million people (36% of the national population)	
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Acronyms

ARC	African Risk Capacity
ASALs	Arid and Semi-Arid Lands
CCT	Conditional Cash Transfer
CHU	Community Health Unit
CLTS	Community-Led Total Sanitation
CPD	Continuing Professional Development
ECD	Early Childhood Development
EDE	Ending Drought Emergencies
EFA	Education for All
EMIS	Education Management Information System
FPE	Free Primary Education
GER	Gross Enrolment Rate
HGSMP	Home-Grown School Meals Programme
HMIS	Health Management Information System
HRH	Human Resources for Health
IGAD	Intergovernmental Authority on Development
KDHS	Kenya Demographic and Health Survey
KESSP	Kenya Education Sector Support Programme
MDGs	Millennium Development Goals
MIS	Management Information System
MoEST	Ministry of Education, Science and Technology
MoH	Ministry of Health
MTP	Medium Term Plan
NACONEK	National Council on Nomadic Education in Kenya
NDCF	National Drought Contingency Fund
NDMA	National Drought Management Authority
NER	Net Enrolment Rate
ODL	Open and Distance Learning
ORS	Oral Rehydration Salts
PDNA	Post-Disaster Needs Assessment
SFP	School Feeding Programme
TSC	Teachers Service Commission
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WESCOORD	Water and Environmental Sanitation Coordination
WHO	World Health Organisation

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- Ministry of Health
- National Drought Management Authority
- Save the Children (representing the ASAL Alliance)
- United Nations Children's Fund (Kenya office)

1 Executive summary

This is the third of six common programme frameworks that have been developed to operationalise the Ending Drought Emergencies (EDE) Medium Term Plan, which is an integral part of the Kenya Vision 2030 Second Medium Term Plan for 2013-17.[1]

The status of social services in arid and semi-arid areas is generally well below that in the rest of Kenya. These counties have some of the lowest human development indicators in the country. Service provision has been under-resourced by the government, to the extent that critical services are irregular, unreliable and inadequate, of low quality, and too distant from those who need them.

The aim of this common programme framework is to develop a healthy, skilled, innovative, resourceful and motivated human capital which thus provides a strong foundation to increase resilience to drought. The framework has an integrated focus on basic social services, including health, nutrition, WASH (water, sanitation and hygiene), and education, including adult literacy and early childhood development (ECD).

There are three components: the first seeks to increase the number and capacity of appropriately trained and experienced professionals working in the region; the second will integrate alternative interventions into existing systems of service provision, including through the use of technology, so that service delivery is more appropriate to the regional context; and the third will increase demand for quality services through community education and empowerment.

This is a five-year framework with a budget of Kshs. 15,849 million.

[1] The others are on peace and security, climate-proofed infrastructure, sustainable livelihoods, drought risk management, and institutional development and knowledge management.

2. Situation analysis

Human capital is understood to be the resources and capabilities that help people be economically and socially productive. It can be strengthened by investing in education, training, health care or nutrition. A strong human capital base provides a foundation for sustainable and resilient livelihoods and economic growth. A healthy and productive workforce is essential for national development.

The link between human capital and drought resilience is clear. Educated and healthy people are better able to withstand shocks such as drought. Episodes of ill-health are the single biggest cause of people falling into poverty, while families with children in employment are less likely to suffer during crises. Research in Baringo County at either end of a 19-year period showed that households with secondary education were nearly a third less likely to use food aid, nearly 50 per cent more likely to have 'good' food availability, and to have annual cash savings more than five times higher.[2] Further, young people with good employment prospects are less likely to be drawn into conflict or anti-social behaviours.

Education for girls and women has a high correlation with positive health, nutrition and broader socio-political outcomes. Women who have attained secondary education give birth later and are more likely to take advantage of health services and ensure that their children are immunised. When women earn income, they reinvest ninety per cent in their families, while men reinvest only 30 to 40 per cent.[3] Women should therefore be a particular focus of education, vocational training and employment interventions.

The Constitution of Kenya 2010 sets out citizens' rights to basic services in education, health and nutrition; these are also upheld in other policy documents. Despite considerable progress in social service delivery in other parts of the country, arid and semi-arid counties still lag behind. There are a number of structural and social reasons why access to basic education and health services in these areas is more challenging. First, there is an acute lack of trained and experienced professionals. Many technical officers are employed from outside the area and staff retention is a problem. Training people from the region to fill technical and professional positions is an urgent priority. Second, services are not always appropriate to the social and cultural context, particularly that of pastoralism. Third, planning for basic services does not adequately accommodate or prepare for drought and other hazards which place a strain on systems. For example, services need to be flexible and ready to cope with increases in malnutrition and disease and pressures on school attendance.

[2] Little, P., Aboud, A. and Lenachuru, C., 2009, 'Can Formal Education Reduce Risks for Drought-Prone Pastoralists? A Case Study from Baringo District, Kenya'. *Human Organisation*, Summer 2009
[3] Fathalla, M. (2012) 'The White Ribbon Alliance for Safe Motherhood'

As a result, the disparities in education and health outcomes between ASAL counties and the rest of Kenya are acute. Innovative delivery mechanisms and accelerated investment will be required if constitutional obligations are to be met.

2.1 Sector analysis

The main sub-pillars of human capital are education (with particular emphasis on vocational and professional training), health (including public health interventions such as sanitation and hygiene promotion) and nutrition.

2.1.1 Education

Education indicators vary across the ASALs but are on average far below other parts of the country. Rates of primary enrolment and literacy are of particular concern since they are the foundation of the education system. Primary enrolment in several northern counties is still below 50% compared with the national average of 93%, while rates of female literacy in counties such as Mandera and Wajir are less than 10%.

Poor educational indicators are a reflection of an education system which is inadequate and remote. Uptake is low due to the poor quality of education, disappointing results and employment prospects, and a number of social and cultural factors. These issues can be addressed through more appropriate and culturally sensitive delivery mechanisms, such as flexible timing that allows for mobility, distance learning, integrated Islamic education where relevant, and a secure learning environment, especially for girls.[4]

The school model of learning is strong in predictable and stable conditions, but it is less effective where there are high levels of discontinuity. In pastoralist areas, for example, the location of communities, student attendance and demand, and levels of human insecurity may all vary over time. The degree of disconnect is such that entering the formal education system has often meant that students do not return to their traditional way of life. Schools may be located far from communities and teach skills that are geared toward sedentary lifestyles. It is important to ensure that the curriculum does not alienate children from their communities and that it builds rather than diminishes social capital and community integrity. The key challenge is how to operate an inclusive education system in environments where key parameters cannot easily be controlled.

Educational opportunities are generally worse for girls than boys given the subordinate status of girls and women in most pastoralist societies. Just 10 per cent of the girls in Wajir who enrolled in Standard 1 in 2003 were still in school by Standard 8 in 2010.[5] As well as their domestic responsibilities, certain cultural practices such as female genital mutilation and

[4] Kratli, S. and Swift, J. (2010) 'Getting to the hardest-to-reach: A strategy to provide education to nomadic communities in Kenya through distance learning'

[5] Watkins, K. and Alemayehu, W. (2012) 'Financing for a Fairer, More Prosperous Kenya: A Review of the Public Spending Challenges and Options for Selected Arid and Semi-Arid Counties', Brookings Institution Working Paper 6

early marriage curtail girls' learning.[6] People with disabilities and minority groups face additional obstacles in accessing education.

There is acute understaffing in all social sectors, including education, because of the lack of locally qualified personnel and reluctance by those from outside the region to work in remote areas with poor infrastructure and social amenities. Efforts are needed to attract and retain staff and increase training opportunities for people from the ASALs.

Schools are very poorly resourced. For example, in 2011 the proportion of schools with computers was 1.3 per cent in Wajir, 2.3 per cent in Turkana and 3.3 per cent in Mandera.[7] The resource allocation for upkeep in low-cost boarding schools is only Kshs. 8 per child per day.

There are very few adult literacy centres in the ASALs and those that do exist are generally in urban centres. The distribution of adult literacy teachers is not equitable, with fewer teachers assigned to areas where literacy rates are lowest. There has been no government literacy campaign in Kenya since the 1970s. According to a survey carried out in 2007, adult literacy in the north-east was eight per cent (male 12.3 per cent and female 4.3 per cent), compared with a national average of 61.5 per cent.

Non-formal education and early childhood provision is extremely limited. There are also few institutions of higher learning which provide training in subjects relevant to the ASALs. There is no university in the north, and vocational and technical institutions are poorly equipped, particularly to provide science-based courses.

The government committed itself to meet the Education for All (EFA) goals and the Millennium Development Goals (MDGs) for education by 2015. Several measures were introduced in the past decade to meet these commitments. The shift to free primary education (FPE) launched in 2003, and later supported by education development partners through the Kenya Education Sector Support Program (KESSP), increased primary school enrolment from 5.9 million children in 2000 (3 million boys and 2.9 million girls) to 9.4 million children in 2010 (4.8 million boys and 4.6 million girls).[8] Despite this progress an estimated one million children are still out of school in Kenya, most of them in the ASALs.

Finally, professional and vocational training is particularly important in societies, such as those in the ASALs, where livelihoods are changing and new economic opportunities are emerging. Family and social networks play an important role in conveying and sustaining the skills needed for livelihoods such as pastoralism. However, new skills need to be nurtured so that livelihoods can be strengthened and sustainably adapt, the growing demand for services

[6] Kipuri, N. and Ridgwell, A. (2008) 'A Double Bind: The Exclusion of Pastoralist Women in the East and Horn of Africa', Minority Rights Group

[7] UWEZO Kenya (2012) 'Are our children learning? Annual Learning Assessment Report'

[8] Education for All End of Decade Report, p109. Other positive achievements attributed to KESSP include improved pupil-textbook ratios from 1 book for 15 pupils in 2002 to an average of 1 for 3 in 2011; increased primary to secondary transition rates from 45% in 2003 to 66.9% in 2010; and improved pupils' results in the Kenya Certificate of Primary Education examinations.

can be met, and those currently dependent on aid or social protection mechanisms can find more sustainable means of support.

2.1.2 Health, nutrition, hygiene and sanitation

Poor health status and malnutrition are among the biggest threats to the achievement of national development goals in the ASALs. They increase people's vulnerability to shocks, weaken their capacity to resist and recover, and keep the majority below the poverty line.

Children are clearly disadvantaged compared with other age groups and experience multiple deprivations of their rights. The survival of children and pregnant women is often used as a measure of success for development and human rights. The maternal mortality rate in parts of northern Kenya is more than seven times the national average. Child mortality rates are also high, at 80 per 1000 live births in the north-east.[9] Only 17 per cent of children in the north-east are delivered in health facilities, and only 31.6 per cent of mothers receive delivery assistance from skilled personnel. Less than half (48.3 per cent) of children in arid counties receive all their recommended vaccinations, against an average of 77 per cent for Kenya as a whole.[10]

Levels of stunting in Kenya have fluctuated over the past 20 years with no change noted in the past five years. Stunting was responsible for an economic loss of approximately Ksh 95 billion shillings in 2010.[11] If nothing is done then by 2030 the country will suffer even greater losses of approximately 704,771 deaths and Ksh 2.4 trillion.[12] The burden of these future losses is not evenly distributed: the prevalence of stunting ranges from one in five children in Mombasa and Isiolo to three in five children in Wajir. A child in Wajir is three times as likely to be stunted as a child in Kisumu, Isiolo or Embu.[13] Acute malnutrition, micronutrient deficiencies and stunting are associated with increased morbidity and mortality, unmanageable health expenses for poor households, and reduced school performance and productivity in adulthood. If these children survive, they never reach their full mental and physical potential. Malnutrition is an underlying cause in at least one-third of the 122,000 deaths of children under five each year.[14] If an economic case for action needs to be made, then based on an estimated cost of key nutrition interventions of US$ 96 per child, and estimating the income generated by these children were they to reach adulthood, the return for each dollar spent on nutrition would be between US$24 and US$75.[15]

Poor child survival, growth and development is also related to poor hygiene and sanitation practices which place children at an increased risk of diarrhoea and death. Approximately 19,500 Kenyans, including 17,100 children under five, die each year from diarrhoea. Nearly 90 per cent of this is directly attributed to poor WASH services and practices. Poor sanitation

[9] Republic of Kenya (2010) 'Kenya Demographic and Health Survey, 2008-09'
[10] UNICEF (2011) 'Northern Kenya Social Policy Data Summary'
[11] Save the Children (2012) 'A Life Free from Hunger: Tackling Child Malnutrition'
[12] Ministry of Health (2010) 'Nutrition Profiles'
[13] Kenya Integrated Household Baseline Survey (KIBHS), 2005-2006
[14] Ministry of Health (2010) 'Nutrition Profiles'
[15] Hoddinott, et al (2012)

costs Kenya US$324 million (equivalent to US$ 8 per person), and these costs are disproportionately borne by the poorest and by women and girls, who are the primary care-givers. The promotion of hand-washing and other hygiene measures is the single most cost-effective way to reduce diarrhoeal disease. However, the 2010 WASH baseline assessment revealed that the majority of households in the ASALs have inadequate access to safe water and sanitation and use inappropriate hand washing practices (Table 1). There is also a high prevalence of open defecation.

Several factors contribute to the poor status of health and nutrition in the ASALs, including:

- poor access to quality health care due to lack of awareness among communities about their health and the health services that exist;
- inadequate number of health facilities for the size of population;
- poor attitude of health workers;
- long distances between communities, settlements and health facilities (in places between 50-100 kms), compounded by poor infrastructure;
- scarcity of potable water, which compromises sanitation and hygiene;
- chronic food insecurity;
- depreciation of services during periods of crisis;
- lack of referral mechanisms for complicated cases and poor road network.

There is also an acute shortage of skilled human resources.[16] Staffing levels in the region are 50 per cent below WHO-recommended staffing norms. The current vacancy rate in ten counties of northern Kenya, assessed against establishment figures, is 79 per cent.[17]

Table 1: Status of water, sanitation and hygiene in selected ASAL counties [18]

County	No. health facilities needing improved water & sanitation development	No. health facilities currently supported by WASH programmes	% households with access to improved sanitation	% households with adequate / safe source of water	% population practising appropriate hand-washing behaviour
National average	n/a	n/a	32	59	
Mandera	15	5	n/a	39	25
Wajir	73	5	n/a	42	34
Garissa	50	5	1	25	42
Turkana	15	5	n/a	44	50
W. Pokot	27	5	15	19	59
Marsabit	72	0	34	33	61
Kitui	15	5	51	35	39

[16] Ministry of Health (2013) 'Services Availability Readiness Assessment (SARAM)'
[17] Capacity Kenya (2012) 'Human Resources for Health (HRH) Assessment of Northern Kenya'
[18] WHO/UNICEF (2012) Joint Monitoring Programme for the MDGs

Finally, the government's budgetary allocation for the health sector is still below the 15 per cent target stipulated in the Abuja Declaration of 2001. Even after the devolution of funds to counties and the creation of the Equalization Fund, allocations will be far below what is needed for basic services to be provided by skilled and well-resourced professionals.

Kenya has developed a number of policies and strategies to improve social services with a focus on equity, all of them aligned to the Kenya Vision 2030 Second Medium Term Plan 2013-17. These include the Health Policy Framework 2011-2030, the Health Sector Strategic Plan 2013-2018, and the National Human Resources for Health Strategy. Although some progress has been made in increasing access to essential services for the most deprived populations, this is insufficient and highly dependent on external humanitarian funding leading to short-term investment and short-term results. Numerous studies have been conducted in northern Kenya to identify the bottlenecks to service delivery and the measures needed to improve key elements of social services, namely human resources, equity in service delivery, generating demand, and quality.

2.2 Critical issues to address

2.2.1 Staff recruitment, training and retention

The human resource gap in the ASALs for teachers and health workers in public facilities and at the community level is critical and needs immediate action. Productive workers are leaving the service driven by concerns about a combination of personal, professional, social and economic needs: career development and advancement, the work environment, terms and conditions, remuneration, family considerations and standard of living.

Some of the strategies to address this may include:

- Adjusting terms and conditions and improving remuneration packages and living standards (both housing and social amenities). Examples of possible reforms include approval by the Public Service Commission for officers in certain counties to be employed on contract, thus creating more flexibility in recruitment, as well as incentives and affirmative action measures (such as fast-track training and development) for those willing to take contracts in certain counties. A first step would be to review experience in other countries which have faced similar challenges.
- Strengthening capacity in workforce planning and management, and introducing innovation in human resource systems where required. One example is moving experts on temporary missions to areas where their specialised skills are required. This has been successfully done with the treatment of obstetric fistulae, making access to this service available in remote areas through a formally organised outreach programme.
- Complementing qualified and experience staff with para-professionals.
- Expanding access to continuing professional development through distance learning.

The ASALs have substantial numbers of unemployed youth but are still importing many skills from other areas. Technical and vocational skills need building urgently to maximise

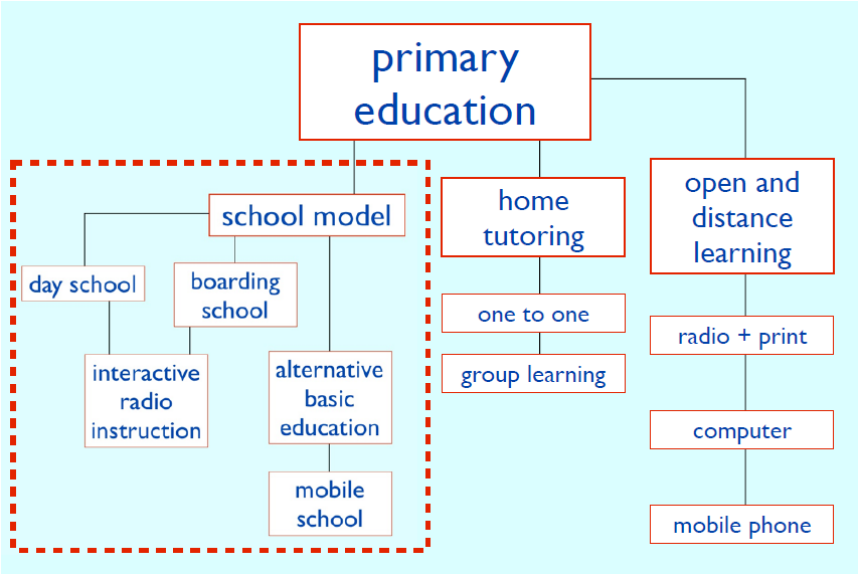
human resource capacity for both the public and private sector. This requires human resource planning that takes account of other developments in the region and responds to critical gaps. The pressure on human resources has increased with devolution, since critical professional functions (road engineers, statisticians, legal advisers, and so on) are now required at the county level.

2.2.2 Appropriate delivery models that promote equity in service delivery

Equity in service delivery requires special measures to reach the most remote and marginalised communities. 'Appropriate' delivery means mechanisms that not only reach the populations concerned but are also socially and culturally acceptable. This requires an understanding of the local context and close dialogue with communities. In the education sector, for example, appropriate delivery mechanisms may include complementary distance learning approaches for remote and mobile populations, flexibility in the timetable, culturally appropriate provision, single-sex provision, and integration with Koranic schools. Figure 1 illustrates some of the options for approaches that would complement, and be integrated with, the existing school-based system.

New developments in mobile phone technology and internet access present major opportunities to increase the skills and knowledge of professionals and improve the monitoring of remote services. Given limited staff resources and difficulties in providing relief cover, e-learning expands the possibilities for in-service training and professional development which might otherwise be denied.

Figure 1: Open and distance learning that complements school models of education



In health and nutrition, mobile outreach services can be combined with community-based services and citizen participation. The Ministry of Health used mobile clinics with considerable success until the 1990s, after which the system regressed. Mobile health clinics would enhance coverage in remote rural areas and are a better alternative to non-functional permanent facilities. An integrated community-based health strategy can be effective in

achieving high treatment coverage and high-quality care for sick children in the community. Community case management of malaria can reduce overall and malaria-specific under-five mortality by between 40 and 60 per cent. Oral rehydration salts (ORS) and zinc are effective against diarrhoeal mortality in the home and community settings, with ORS estimated to prevent between 70 and 90 per cent of diarrhoeal deaths. For widely scattered communities with limited access to health centres, strong and well-supported community health units are essential in delivering these services.

Community-Led Total Sanitation (CLTS) is an effective model for hygiene and sanitation behaviour change to reduce the incidence of disease; it also empowers communities to take action on preventative health with the support of Community Health Units (CHUs). Strong support for CLTS from the Ministry of Health and a well-coordinated road map has significantly reduced open defecation.

2.2.3 Capacity to expand and contract services in response to drought

An important part of strengthening human capital in drought-prone areas is enabling the expansion of services to meet additional demand during drought and their subsequent contraction. In the past this surge capacity has been provided by international humanitarian actors. Building this capacity into government service delivery mechanisms, together with agreed monitoring and trigger mechanisms, will facilitate earlier and faster response. More broadly, adaptive social services, i.e. those that are sustainable, flexible/scalable and cost-effective, are essential for both social protection and growth.[19]

2.2.4 Demand for health and education services

There are several barriers to health-seeking behaviour in remote areas. One is the high cost of doing so, while another is the preference for traditional health, nutrition and sanitation practices. The prevailing attitude in many communities is that seeking assistance from health professionals is a last resort; the value of appropriate hygiene, nutrition and health-seeking behaviour is not well recognised. Therefore intensive efforts are needed to create demand for health and nutrition services. Global experience suggests that this is best done through community-based health workers, which is well reflected in the Kenya Community Health Strategy. Unfortunately the roll-out of this strategy has been slow and uneven in the ASALs, and the number of trained and deployed CHUs is still low. For example, only ten out of a planned 72 CHUs are active in West Pokot.

Demand for education, on the other hand, is growing in the ASALs. Many women will prioritise spending on school fees above other household investments. However, the domestic burden in areas with long distances to water, fuel-wood and grazing means that many children and young people are denied opportunities for education. In order to increase demand still further, more effort is needed to reduce burdens on the household and ensure that services are culturally relevant and appropriate. Education officers should work with

[19] UNICEF (2014) 'Review of Adaptive Basic Social Services Provision to Reduce Disaster Risk of Populations Especially Children in Selected Horn of Africa Countries'

local education committees to promote the value of education and help families prioritise their participation.

2.2.5 Coordination and knowledge management

There are many agencies in the health and education sectors with diverse policies and mandates, leading to poor coordination of activities, inefficient use of resources, and ineffective provision. Strong coordination mechanisms are essential at both national and county level, including for sharing experience of new approaches. These mechanisms also need to adapt and scale up at times of crisis, when more actors and demands put extra strain on already overloaded government staff.

Kenya is going through a period of major institutional change, including the devolution of health services to county governments. An all-inclusive human capital strategy that reflects the collective and accumulated knowledge of stakeholders, and that sets out a clear agenda for action, may ensure coherence and sustain progress at a time when the operating environment is especially fluid.

2.3 Justification for the common programme

An important justification for this common programme framework is that the health, nutrition and education sectors all face common challenges in drought-prone areas. The framework provides an opportunity for stakeholders to understand these challenges and share evidence-based approaches. It will guide partners in designing cluster-wide programmes and integrated action plans. Opportunities for joint financing will be identified during the inception phase.

Further, health, nutrition and education outcomes are inextricably linked. Opportunities for integrated provision should be maximised. The education system provides an environment where important health and nutrition-related topics can be taught, such as appropriate health care practices, food production, home preservation and storage, food preparation, food safety and the importance of dietary diversity. A key strategy is to build the capacity of frontline staff, such as teachers, extension agents, health practitioners and other service providers, to incorporate health, nutritional and food safety considerations and messages into their routine work. Their knowledge and understanding must be adequate in both depth and scope to handle the many facets of health and nutrition.

One example of integrated provision is the School Feeding Program (SFP) and the Home-Grown School Meals Programme (HGSMP). Both these are having significant positive impacts on nutrition, learning outcomes and drought resilience. The SFP is an incentive for parents to enrol their children in schools. It increases the attention and concentration of students, producing gains in cognitive function and learning. Similarly, micronutrient deficiencies in school-age children which directly affect cognition, such as iodine and iron, can be addressed within the school environment, leading to better outcomes in both nutritional status and school performance.

Outside the school, adult literacy plays a critical role in changing the nutrition and health status of women, children and communities at large. There is also a positive correlation between mothers' education and infant health and survival. Adult literacy and basic education for girls are thus important parts of a drought-resilience strategy.

2.4 Contribution to relevant policies and sector priorities

This common programme framework actualises commitments made in Sessional Paper No. 8 of 2012 on the National Policy for the Sustainable Development of Northern Kenya and other Arid Lands (the ASAL Policy). The second objective of the Sessional Paper is 'to improve the enabling environment for development in ASALs by establishing the necessary foundations for development'. Part of this enabling environment is a stronger base of human capital.

The Basic Education Act, 2013, emphasises the need to respond to emergencies, ensuring gender equality and equity for the most marginalised communities. The Act also legalises the National Council on Nomadic Education in Kenya (NACONEK) whose mandate and strategic direction are being developed as a priority by the MoEST and its development partners. Once operationalised, NACONEK will fast-track education for children and communities in nomadic areas, drawing on experiences and pilots that are currently underway.

In implementing the measures set out in this framework, the Government and its development partners will contribute to the following policies and strategies:

- Basic Education Act, 2013
- Nomadic Education Policy, 2009
- National Education Sector Support Programme (NESSP), 2013-2018
- National School Health Policy, 2009
- 'Getting to the hardest-to-reach: a strategy to provide education to nomadic communities in Kenya through distance learning', March 2010
- Ministry of Education Strategic Plan, 2013-2018
- Kenya Health Policy
- National Health Sector Strategic Plan, 2013-2018
- National Human Resources Strategy, 2013-2017
- County Health Sector Strategic and Investment Plans, 2013-2018
- Road Map for Removing Open Defecation, 2010
- National Sanitation Strategy, 2010
- National Disaster Management Policy, 2012
- National Food and Nutrition Security Policy, 2011
- National Nutrition Action Plan, 2012-17

3 Programme framework

This common programme framework has an integrated focus on basic social services, including health, nutrition, WASH, and education. The EDE pillar on climate-proofed infrastructure will improve the infrastructure for water, while this pillar focuses on water safety and hygiene (including household water treatment).

The overall objective of the framework is: 'To contribute to a healthy, skilled, innovative, resourceful and motivated human capital'.

The framework has three components, summarised in Table 2 and in more detail in the results framework in Annex 1.

The education component of the framework focuses on the 14 arid and pastoralist counties where educational indicators are significantly below the national average, and where educational access, equity and quality are made more complex by factors such as mobility, distance, cultural attitudes and poor infrastructure.[20] The health, nutrition and WASH components focus on all 23 ASAL counties.

The proposed timeframe for this framework is five years, with a six-month inception phase during which the institutional arrangements will be operationalised and the first consolidated work plans agreed between the national and the county governments.

[20] Turkana, West Pokot, parts of Baringo, Samburu, Isiolo, Marsabit, Mandera, Wajir, Garissa, Tana River, Lamu, Kajiado, Narok and Laikipia.

Table 2: Description of the expected results

Key outputs	Description	Beneficiaries	Partners
Result 1: The capacity and number of appropriately trained and experienced professionals working in ASAL counties increased.			
1.1 National Council on Nomadic Education in Kenya (NACONEK) established and operational.	NACONEK will raise the profile of nomadic education and lead the roll-out of strategies in ASAL areas, including mobile and distance learning.	National institutions Counties Communities	National and county governments Development partners Private sector Communities
1.2 Health and Nutrition Council for ASALs established and operational.[21]	The Council will form or strengthen technical working groups on social services in each county in order to harmonise approaches and share best practice. It will also lead the delivery of health-specific results under this framework.		
1.3 A harmonised inter-county approach developed to address staff recruitment, training and retention challenges in ASALs.	A joint health and education strategy will be developed by the HR unit within the Health and Nutrition Council and by NACONEK that addresses the shared problem of recruitment, training and retention of professionals in ASALs. Staff assessment will be reviewed and HR plans developed to strengthen government staffing in ASAL counties.		
1.4 Affirmative action measures to increase access and funding for ASAL students in institutions of higher learning (secondary, tertiary and university level).	The Northern Kenya Education Trust (NoKET) will support students from 14 arid and pastoralist counties in secondary, tertiary and university education, particularly girls, in professions relevant to the development of the region. The budget is based on an estimate per county of 100 students at secondary level, 30 at tertiary, and 20 at university level. The Health and Nutrition Council will also develop a strategy and a provision for bursaries to be channelled through the same mechanism.		
1.5 Appropriate health referral mechanisms for ASALs promoted.	This will include the development of an ASAL-specific strategy and strengthening of referral systems from the community level upwards (including the involvement of schools) given the very high maternal mortality rates in ASALs and the lack of a referral system for pregnant women who require emergency specialised care. Specific measures will include the creation of an emergency and referral desk unit under the Health and Nutrition Council, the adaptation of the national referral strategy to the county context, and the strengthening of emergency and disaster risk management and referral services at the county level (including the provision of ambulances and air evacuation when necessary).		

[21] This will address health, nutrition and WASH issues.

Key outputs	Description	Beneficiaries	Partners
Result 2: Alternative interventions, including emerging technologies, in the provision of health, nutrition, WASH and education services integrated into current systems.			
2.1 E-health, including telemedicine, established in the ASALs.	The diagnosis of medical cases is a major challenge in the ASALs due to the vast distances between communities and health facilities and the acute shortage of human resources for health. Many cases that could have been prevented if diagnostic equipment were available lead to either death or disability. Diagnostic health service centres of excellence will be established in key locations within each cluster of counties, accompanied by the provision of equipment, training and internet-based support systems for health and nutrition professionals.	National institutions Counties Communities	National and county governments Development partners Private sector Communities
2.2 E-learning, distance learning and continuing professional development (CPD) specific for ASALs ongoing in partnership with universities and other training institutions.	This will involve establishing facilities in ASAL counties and public universities, with subsidised access for professionals in all areas of health and education, including adult education.		
2.3 Real-time monitoring of social services during emergencies and knowledge management systems in place.	The proposal is to strengthen data management, monitoring and feedback mechanisms (using mobile phone technology where feasible) for quality and functionality of services and to trigger rapid support in case of breakdown. Real-time monitoring will also contribute to accountability.		
2.4 Alternative interventions to increase community resilience to disasters modelled.	This will involve researching and introducing new community-based models of service delivery, as well as strengthening community-based nutrition, health and WASH surveillance within drought monitoring systems to trigger surge mechanisms.		
2.5 Surge mechanisms for health and education systems, which expand and contract services in drought periods, developed.	This will be taken forward in partnership with the EDE drought risk management pillar, in order to strengthen capacity at national and county levels to plan for, train and deploy additional resources in response to triggers (such as malnutrition rates or levels of school attendance).		
Result 3: The demand for equitable and quality health, nutrition, WASH and education services increased through community education and empowerment.			
3.1 Communities, including children, empowered and actively participating in the design and implementation of	Community participation in developing and monitoring services will be increased (such as through community education committees and CLTS) and communities empowered to hold service providers accountable.	Counties Communities	National and county governments

Key outputs	Description	Beneficiaries	Partners
high-impact, low-cost social services, including social intelligence reporting.			Development partners Private sector Communities
3.2 Community health services and mobile/integrated health and education outreach services funded and operational.	This will include measures to strengthen mobile and community-based systems, including mobile clinics and mobile schools, and ensure a regular supply of resources, including implementation of the community health communication strategy.		
3.3 Annual / semi-annual exchange programmes for communities from different counties to increase their capacity for resilience-building funded and operational.	Inter-county and inter-community dialogue and exchange will facilitate the spread and adoption of innovative and effective practices.		
3.4 A fund for conditional cash transfers for health and education services for vulnerable populations established.	Voucher systems within existing safety net mechanisms will increase access to services for the most vulnerable populations.		

4 Cross-cutting issues

4.1 Gender and diversity

Most pastoralist societies are highly differentiated along gender and generational lines and this has an impact on health and education outcomes. Women's subordinate position in society places limits on their public roles and their capacity to make decisions about their health. It may also expose them to violence both within and outside the household. The welfare of women and girls is further put at risk by environmental problems which increase the pressure of providing resources such as water and fuel-wood.

Urbanised young people often have different values and aspirations from their rural age-mates and their parents, but there are few opportunities for employment or career development, particularly in settlements in ASAL counties where economic options are limited. This underlines the importance of expanding access to vocational training and professional qualifications.

Urbanisation and growing economic differentiation are affecting the traditional systems and structures that once cared for vulnerable people. These social protection mechanisms are slowly breaking down leaving orphans and vulnerable children at risk. Various formal social protection mechanisms have been put in place, including free primary and free day secondary education, education bursaries, and cash transfers. However, those living with disabilities and with HIV/AIDS still face high levels of stigma.

4.2 HIV/AIDS

HIV/AIDS will be mainstreamed as a cross-cutting issue in all programmes and interventions. Prevalence rates are high in parts of the region, such as Turkana, Samburu, Marsabit and Isiolo counties. This has implications for human capital. Where necessary, services will be tailored to meet the particular needs of people living with HIV/AIDS.

4.3 Links with other EDE pillars

Peace and security: Fear of conflict keeps children from school and health centres closed. Effective peace building and conflict management is therefore critical to building human capital. At the same time, investments in human capital can stabilise societies: for example, education expands the choices open to young people vulnerable to radicalisation. Given the high levels of insecurity in some ASAL counties, all interventions must be conflict-sensitive and implementing agencies will be required to carry out risk analysis and develop risk management frameworks.

Climate-proofed infrastructure: Better infrastructure facilitates service delivery by making services more accessible and improving the working environment for professionals. Equally, investments in human capital will maximise the impact of capital investments – for example, health promotion increases the impact of interventions in water supply, and literacy

programmes do the same for ICT. Further development of innovative and cost-effective approaches using emerging technologies should be based on careful evaluation and dissemination of lessons learned.

Sustainable livelihoods: Productive livelihoods require a skilled and healthy workforce, while good health and education expand economic options and opportunities. Higher incomes generated by more secure livelihoods create surpluses that can be invested in education and protect against ill-health.

Drought risk management: Better drought risk management will decrease expenditure on humanitarian aid, thus freeing up funds for long-term investment in areas such as human capital. Nutrition-sensitive programmes make a substantial contribution to the reduction of drought vulnerability, while the education system can be an effective vehicle for disseminating drought messages. Scalability of existing programmes and services will be an area of particular collaboration between the human capital and drought risk management pillars of the EDE, with the latter supporting the development of models which the former will then apply.

Finally, nutrition is a multi-sectoral issue to which all the EDE pillars will contribute. An improvement in nutritional status is one of the indicators against which the EDE will be evaluated.

5 Risk management

The principle risks associated with this framework, and the measures being taken to mitigate them, are shown in Table 3.

In addition, a number of general assumptions may be made about the likelihood of achieving the objectives of this programme:

- By aligning the common programme framework to county and national development priorities, the chances of success are increased.
- Allowing communities to prioritise their needs and identify bottlenecks, strategies and interventions is key to success.
- Pooling of resources (such as time, finance, and technical expertise) and targeting of interventions will increase efficiency and effectiveness.
- The high level of commitment of the national and county governments, local communities and partners provides a strong impetus to make the programme succeed.
- Counties are demonstrating a commitment to participatory prioritisation of community needs through their County Integrated Development Plans.

Table 3: Risks and mitigating measures

	Risk	Mitigating measures
1	Cross-border challenges such as disease outbreaks and influx of populations that overwhelm services.	▪ Health information systems will monitor cross-border risks and prompt the necessary action to arrest them. ▪ Regular coordination and cross-border social sector forums will facilitate better understanding of challenges and harmonisation of response. ▪ The sixth pillar of the EDE, on institutional development and knowledge management, is responsible for ensuring that inter-county structures are adequately supported and operating effectively.
2	Government capacity to deliver the proposed programmes.	▪ The framework prioritises improvements in capacity to deliver services, so that this risk should reduce over time. ▪ The framework provides a collaborative mechanism for harmonised support by private sector providers and development partners to complement government capacity.
3	Increase in population due to high fertility rate.	▪ Better access to services delivered through this pillar, and better livelihood security delivered through the other pillars of the EDE, will deliver the conditions that over time lead to a reduction in fertility rates.
4	High level of under-development associated with poor infrastructure, with few facilities and long distances between communities and services.	▪ Close collaboration with the infrastructure pillar of the EDE will maximise the impact of infrastructure investments for human capital.
6	Multiple risks presented by drought, insecurity and poverty.	▪ Close collaboration with the drought risk management pillar of the EDE will ensure a collaborative response to drought conditions. ▪ The multi-sectoral nature of the EDE creates opportunities to ensure the integration of nutrition sensitivity in other sectors.

6 Institutional arrangements

6.1 Programme management and implementation

There will be two levels of implementation, illustrated in Figure 1:

1. **National level:** A National Steering Committee for the human capital pillar will be chaired by the Ministry of Education and co-chaired by UNICEF. Its members will include the MoEST, MoH, relevant directorates and development partners. It will oversee the planning, implementation and review of all activities and promote the mobilisation and efficient use of resources. It will also work to ensure that ASAL-specific needs and priorities are addressed through national sector plans. The National Steering Committee will have sub-committees representing the specific sectors: education, health and nutrition. The health and nutrition sectors will meet regularly to harmonise their interventions since they are both under the MoH. The chair and co-chair of the committee will also be members of the overall EDE National Steering Committee.

2. **County level:** the County Executive for Health, the County Chief of Health, the County Director for Health and the County Director of Education will work with implementing partners and communities within a County Human Capital Group. This will be a sub-committee of the EDE County Steering Committee and will coordinate implementation and supervise monitoring and evaluation of activities. It will also work to ensure that ASAL-specific needs and priorities are addressed through county sector plans. It will submit quarterly reports to the County Steering Committee and relevant partners, and advise it of issues arising from the field.

6.2 Coordination mechanisms

The EDE Steering Committees at the national and county levels will ensure effective co-ordination between the EDE pillars. Coordination will be further strengthened by sector-specific forums, including:

- NACONEK, which will have coordination, resource mobilisation and implementation functions.
- The ASAL Health and Nutrition Council, chaired by the Director of Health and bringing together health, nutrition and sanitation actors at the national level.
- Technical working groups (for example on nutrition) at the county level, with inter-sectoral group sessions at regular intervals.
- WESCOORD (Water and Environmental Sanitation Coordination) meetings at national and county levels.

6.3 Monitoring and evaluation

The National Steering Committee for the human capital pillar will ensure that appropriate monitoring, evaluation and reporting mechanisms are in place and applied by all implementing partners. This will be done within the framework of the overall monitoring and evaluation systems for the EDE Common Programme Framework, which will be designed,

facilitated and supported by its sixth pillar. The targets and timeframes for each indicator in the results framework (Annex 1) will be agreed with partners within the first six months of implementation.

7 Resources

7.1 Funding level

The total budget for the programme is Kshs. 15,849 million (Annex 1), although this will be refined during the inception phase. Since health services are now largely devolved, further work is needed to determine the precise funding situation in each county. Within the education sector, development partner assistance has already been mapped;[22] this will be analysed to draw out ASAL-specific investment and included in the EDE investment mapping tool which is being developed under the sixth EDE common programme framework on institutional development and knowledge management. By December 2014, i.e. after the first six months of implementation, a clearer picture of financing needs will have been established.

7.2 Sources of funding

The principal funding contributions will be from:

- County governments, particularly in health, which is now a devolved function.
- National government, particularly in education, which for the most part remains a national function.
- Development partners
- Civil society organisations, particularly in areas of innovation.
- Private sector providers, more likely in the health sector than in education.

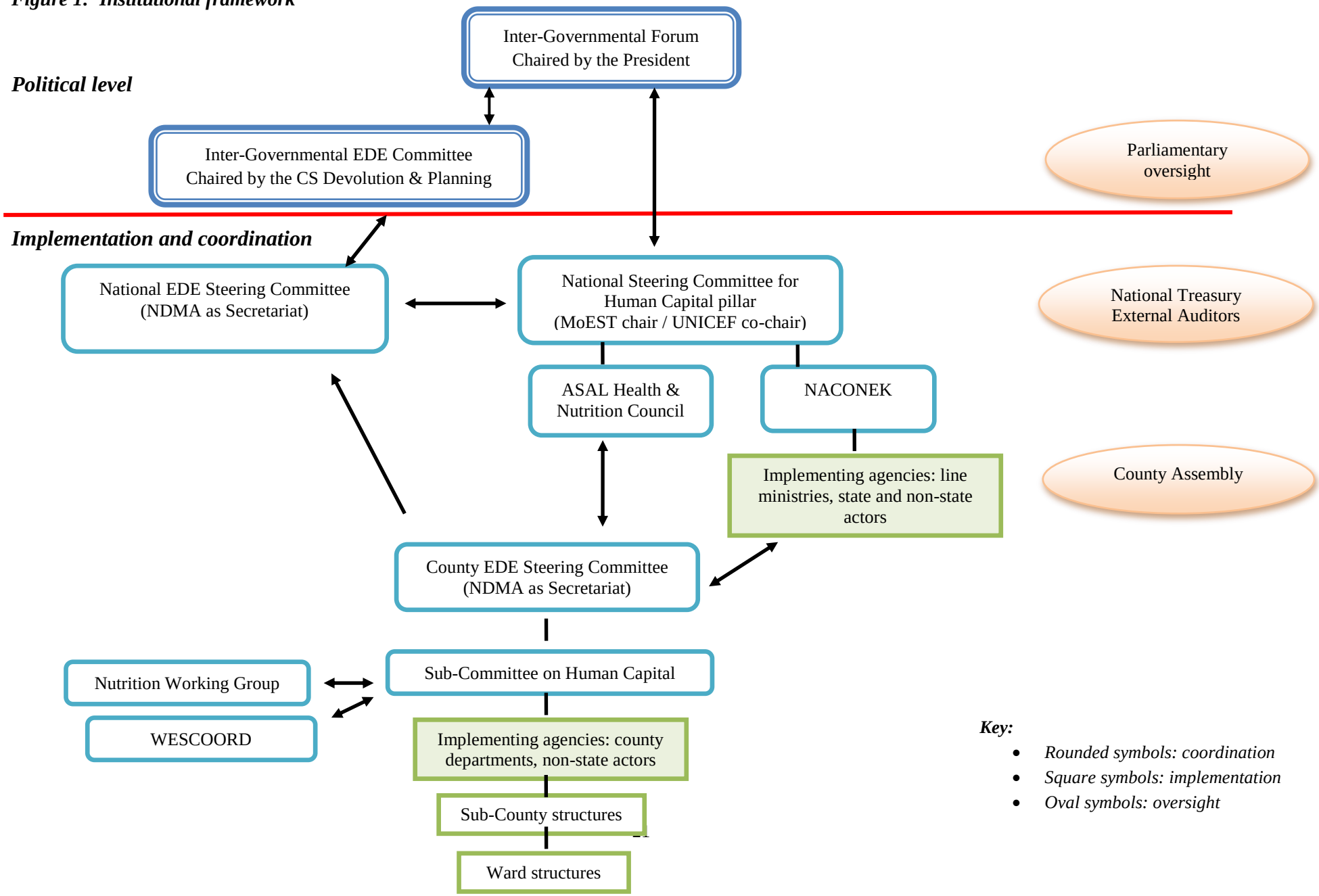
7.3 Fund flow

The flow of funds will be coordinated through the National Steering Committee for the human capital pillar. Two key mechanisms are anticipated:

- Through the sector ministries (MoEST and MoH), using the existing sector-wide approach funding mechanisms and the Health Services Support Fund. Within these, the possibility of establishing a specific basket for the finance for this framework will be explored. Both ministries have the flexibility to handle multi-sectoral funding.
- Through partners (UN agencies, NGOs).

[22] 4Ws mapping by development partners working in education, version 5, July 2014

Figure 1: Institutional framework



Annex 1 Results framework

	OVI	MOV	ASSUMPTIONS
GOAL (BY 2022)			
Communities in drought-prone areas are more resilient to drought and other effects of climate change, and the impacts of drought are contained.	Number of people requiring food assistance as a result of drought emergencies.	KFSSG food security assessments	▪ Investments made across all pillars of the EDE, and functional links established between the pillars. ▪ Alternative sources of finance established and operational, such as the NDCF and ARC, and scalability mechanisms in place. ▪ Adequate economic, political and climatic stability.
	% of children under five stunted in each of the 23 most drought-affected counties.	Health sector MIS	
	Value of livestock lost in drought compared with previous drought episodes.	Post-Disaster Needs Assessment	
	Kenya manages drought episodes without recourse to international emergency appeals. (Yes/No)	GoK and UN documents	
OVERALL PILLAR OUTCOME			
A more healthy, skilled, innovative, resourceful and motivated human capital in the ASALs.	▪ % increase in public officers retained in ASAL counties for three years or more. ▪ % schools achieving national target for teacher/pupil ratios at primary and secondary levels. ▪ Increase in private sector employment opportunities. ▪ % increase in students from ASAL counties entering public universities.	HRH surveys TSC Annual Reports Economic surveys Transition rate	▪ Rate of attrition in public sector positions is matched by successful recruitment. ▪ Effective interventions by other EDE pillars lead to increase in formal or informal employment opportunities in ASALs.
SPECIFIC RESULTS			
The capacity and number of appropriately trained and experienced professionals working in ASAL counties increased.	▪ % increase in recruited and trained professionals in ASAL counties.	Newspaper adverts Skills surveys Establishment records HRH records & surveys	▪ Working conditions in the ASALs continue to improve through investments by other pillars (security, infrastructure). ▪ Interested applicants take advantage of these improving conditions.

	OVI	MOV	ASSUMPTIONS
			▪ Employment freeze is lifted.
Alternative interventions, including emerging technologies, in the provision of health, nutrition, WASH and education services integrated into current systems.	▪ % increase in access to basic services (education, health, nutrition).	Routine county monitoring	▪ Connectivity in ASALs continues to improve.
The demand for equitable and quality health, nutrition, WASH and education services increased through community education and empowerment.	▪ % increase in primary & secondary enrolment. ▪ % increase in attendance at health facilities.	GER, NER Routine county reporting	▪ Other result areas under this pillar are successful in expanding access to quality services.
OUTPUTS			
Result 1: The capacity and number of appropriately trained and experienced professionals working in ASAL counties increased.			
1.1 National Council on Nomadic Education in Kenya (NACONEK) established and operational.	▪ Council members & Secretariat appointed. ▪ No. of programme or policy initiatives implemented. ▪ Three Technical Training Centres designated & upgraded as centres for nomadic education. ▪ Adequate budget allocated by Ministry and financed by National Treasury.	NACONEK Annual Reports Printed estimates	▪ MoEST maintains its commitment to nomadic education
1.2 Health and Nutrition Council for ASALs established and operational.[23]	▪ Council registered. ▪ Strategic plan approved. ▪ Staff appointed. ▪ Adequate budget allocated by Ministry and financed by National Treasury.	Certificate of registration Council Annual Reports Printed estimates	▪ MOH recognises the role of the Council and its potential to enhance the achievement of sector objectives. ▪ Council secures the support of county governments.
1.3 A harmonised inter-county approach developed to address	▪ Strategy developed and approved. ▪ No. of officers benefiting from the retention	NACONEK and Health & Nutrition Council	▪ Strategy secures the support of the inter-governmental forum and committee.

[23] This will address health, nutrition and WASH issues.

	OVI	MOV	ASSUMPTIONS
staff recruitment, training and retention challenges.	package. ▪ Reduction in vacancy rates.	Annual Reports	
1.4 Affirmative action measures to increase access and funding for students from ASALs in institutions of higher learning (secondary, tertiary, university).	▪ % increase in transition rates to secondary, tertiary & university	GER, NER, NAT, transition rate, completion rate	▪ Appreciation of the need for affirmative action for ASAL counties is maintained.
1.5 Appropriate health referral mechanisms for ASALs promoted.	▪ Emergency & referral desk unit established under the Health & Nutrition Council. ▪ No. of counties with approved referral strategies.	Health & Nutrition Council Annual Report County Annual Reports	▪ Close collaboration between Health & Nutrition Council and county governments.
Result 2: Alternative interventions, including emerging technologies, in the provision of health, nutrition, WASH and education services integrated into current systems.			
2.1 E-health, including telemedicine, established in the ASALs.	▪ No. of e-health centres established and operational in ASAL counties. ▪ No. of centres in ASAL counties with remote diagnostic health services established. ▪ No. of health professionals making use of remote diagnostic services.	Report on e-health roll-out Health & Nutrition Council Annual Report	▪ Curriculum for e-health training is approved. ▪ Connectivity in ASALs continues to improve. ▪ Willingness of health professionals to adopt new
2.2 E-learning, distance education and CPD specific for ASALs ongoing in partnership with universities and other training institutions.	▪ Distance learning project tested and evaluated. ▪ No. of students enrolled in open university.	NACONEK Annual Report Reports from universities & training institutions	▪ E-learning and distance learning are regarded as offering quality services comparable to other delivery mechanisms.
2.3 Real-time monitoring of social services during emergencies and knowledge management systems in place.	▪ Real-time data on education and health in emergencies available.	EMIS / HMIS dashboards	▪ EMIS / HMIS continue to be strengthened at national and county level.
2.4 Alternative interventions to increase community resilience to disasters modelled.	▪ Integration of DRR and peacebuilding in curriculum. ▪ No. of alternative interventions tested.	Curriculum materials	▪ Effective partnerships built with community-based organisations.

	OVI	MOV	ASSUMPTIONS
2.5 Surge mechanisms for health and education systems, which expand and contract services in drought periods, developed.	▪ No. of programmes successfully adapting during periods of drought.	Evaluation reports	▪ Collaboration and mutual learning with EDE pillar on drought risk management.
Result 3: The demand for equitable and quality health, nutrition, WASH and education services increased through community education and empowerment.			
3.1 Communities, including children, empowered and actively participating in the design and implementation of high-impact, low-cost social services (health, nutrition, WASH, ECD and education), including social intelligence reporting.	▪ No. of schools compliant with child-friendly standards. ▪ No. of schools with active child cabinets. ▪ Level and quality of community participation in health management structures, social accountability initiatives & social intelligence reporting.	EMIS Social intelligence reports	▪ Continuity in government policy on child government and child-friendly schools.
3.2 Community health services and mobile/integrated health and education outreach services funded and operational.	▪ No. of alternative schools (mobile, low-cost boarding) functioning effectively. ▪ No. of arid & pastoralist counties with mobile health services functioning effectively. ▪ % of community health units operational in ASAL counties. ▪ No. of counties implementing Community Health Strategy.	Evaluation reports EMIS HMIS	▪ Willingness of national and county governments to innovate. ▪ Community education programmes encourage open and innovating thinking so that demand is not constrained by existing models of service delivery.
3.3 Annual / semi-annual exchange programmes for communities from different counties to increase their capacity for resilience-building funded and operational.	▪ No. of exchanges taking place. ▪ Level of co-financing of exchange activities (by communities or county governments).	Exchange reports Routine county monitoring	▪ Exchanges are carefully planned to ensure maximum benefits. ▪ Effective mechanisms for reflection and dissemination of exchange experiences.
3.4 A fund for conditional cash transfers for health and education services for vulnerable populations established.	▪ Fund established. ▪ Stronger evidence base for effectiveness & benefits of CCTs in ASALs.	Studies & evaluation reports	▪ Willingness of partners to explore the use of CCTs.

Annex 2 Budget, 2014-18

	Activities	Education sector (Kshs. m)	Health sector (Kshs. m)	Total (Kshs. m)
Result 1: The capacity and number of appropriately trained and experienced professionals working in ASAL counties increased.				
	1.1 National Council on Nomadic Education in Kenya (NACONEK) established and operational.	266.3	0	**266.3**
	1.2 Health and Nutrition Council for ASALs established and operational.	0	120.9	**120.9**
	1.3 A harmonised inter-county approach developed to address staff recruitment, training and retention challenges.	72	73	**145**
	1.4 Affirmative action measures to increase access and funding for students from ASALs in institutions of higher learning (secondary, tertiary, university).	844.3	594	**1,438.3**
	1.5 Appropriate health referral mechanisms for ASALs promoted.	0	2,760.3	**2,760.3**
	Sub-total	**1,182.6**	**3,548.2**	**4,730.8**
Result 2: Alternative interventions, including emerging technologies, in the provision of health, nutrition, WASH and education services integrated into current systems.				
	2.1 E-health, including telemedicine, established in the ASALs.	0	10,203.6	**10,203.6**
	2.2 E-learning, distance education and CPD specific for ASALs ongoing in partnership with universities and other training institutions.	89.9	0	**89.9**
	2.3 Real-time monitoring of social services during emergencies and knowledge management systems in place.	0	264	**264**
	2.4 Alternative interventions to increase community resilience to disasters modelled.	5.5	5.5	**11**
	2.5 Surge mechanisms for health and education systems, which expand and contract services in drought periods, developed.	3.5	3.5	**7**
	Sub-total	**98.9**	**10,476.6**	**10,575.5**

	Activities	Education sector (Kshs. m)	Health sector (Kshs. m)	Total (Kshs. m)
Result 3: The demand for equitable and quality health, nutrition, WASH and education services increased through community education and empowerment.				
	3.1 Communities, including children, empowered and actively participating in the design and implementation of high-impact, low-cost social services (health, nutrition, WASH, ECD and education), including social intelligence reporting.	16.5	16.5	**33**
	3.2 Community health services and mobile/integrated health and education outreach services funded and operational.	0	379	**379**
	3.3 Annual / semi-annual exchange programmes for communities from different counties to increase their capacity for resilience-building funded and operational.	2.5	2.5	**5**
	3.4 A fund for conditional cash transfers for health and education services for vulnerable populations established.	126	0	**126**
	Sub-total	**145**	**398**	**543**
TOTAL		**1,426.5**	**14,422.8**	**15,849.3**