

Kenya

**Developing an integrated national
social protection policy**

**Social Security Department
International Labour Office
Geneva, September 2010**

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Foreword

In a meeting with Mr. Assane Diop, Executive Director, Social Protection Sector, ILO, in March 2010, the Permanent Secretary of the Kenyan Ministry of Labour, Mrs. Beatrice Naliaka Kituyi, requested that the International Labour Office (ILO) provide technical assistance in developing an integrated national social protection policy for Kenya.

In a formal request, the related terms of reference were specified by Dr. Sammy T. Nyambari, Labour Commissioner on 8 April 2010. It was agreed to provide the technical assistance in the form of an analysis based on desk research and an advisory mission.

Following the agreement, the ILO hosted a meeting on 8 June 2010 in Geneva with members of the Kenyan delegation to the 99th Session of the International Labour Conference to discuss the details of current social protection policies in Kenya.

The advisory mission to Kenya was undertaken from 28 June 2010 to 3 July 2010 by Ms. Xenia Scheil-Adlung, ILO Health Policy Coordinator and Mr. Axel Weber, Consultant.

This report presents an analysis of key information and data publicly available and provided during the mission and discussions with representatives of the Government, Labour Unions, Employers' Organizations, numerous national authorities in Kenya, the donor community and NGOs on Kenya's main social protection schemes and initiatives. It further provides advice with a view to achieving universal coverage and access to social protection benefits within the context of the Social Security (Minimum Standards) Convention, 1952 (No. 102) of the International Labour Organization, the Social Protection Floor Initiative and the Millennium Development Goals (MDGs).

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Acknowledgements

This report was drafted in the context of the request from the Government of Kenya to provide assistance in the development of an integrated national social protection policy. The team from the International Labour Office (ILO) that carried out related research underpinning the current report and the related mission to Kenya consisted of Mr. Axel Weber, ILO Consultant, Ms. Xenia Scheil-Adlung, Health Policy Coordinator, Social Security Department, ILO, Ms. Caitlin Grandison, ILO and Ms. In-Leng Ng, ILO.

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Abbreviations

ADB	Asian Development Bank
CBHI	Community Based Health Insurance
CBK	Central Bank of Kenya
CCT	Conditional Cash Transfer
DB	Defined Benefit
DC	Defined Contribution
DWCP	Decent Work Country Programme
DFID	UK Department for International Development
EAC	East African Community
EC	European Commission
ERS	Economic Recovery Strategy
GDP	Gross Domestic Product
GOK	Government of Kenya
GTZ	German Development Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit)
HSNP	Hunger Safety Net Program
ILO	International Labour Organization
ILC	International Labour Conference
ILFS	Integrated Labour Force Survey
IPEC	International Programme on the Elimination of Child Labour
KSH	Kenyan Shillings
MDG	Millennium Development Goals
MOL	Ministry of Labour
MGCS	Ministry of Gender, Children and Social Development
MOF	Ministry of Finance
MTP	Medium-Term Plan
NSC	National Steering Committee

NGO	Non-Governmental Organizations
NHIF	National Hospital Insurance Fund
NSSF	National Social Security Fund
NSPS	National Social Protection Strategy
OVC	Orphans and Vulnerable Children
P4H	Providing for Health Initiative
PPP	Public-Private Partnership
PRSP	Poverty Reduction Strategy Paper
RBA	Retirement Benefits Authority
SNT	Strategy for National Transformation
SPF-I	Social Protection Floor Initiative
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Executive summary

This report aims at assisting the Government of Kenya in designing an integrated National Social Protection Policy. It is based on an assessment of the existing social protection schemes for both formal and informal economy workers and their families.

Between 60 to 90 per cent of the Kenyan population – among them the poor, ill, unemployed and elderly, particularly those who are female – have an urgent need for social protection. This report identifies that there are i) significant gaps in social protection coverage, particularly for informal economy workers and their families ii) important deficits in access to benefits in kind and cash for those who are covered and iii) insufficient levels of benefit provided. Further, some of the contingencies outlined in ILO Convention No. 102 (Minimum Standards of Social Security), such as unemployment, are completely absent from social protection in Kenya.

The report reveals that Kenya's overall spending on social protection of less than 2 per cent of GDP, lags behind that of most developing countries that spend at least 3 per cent of their GDP. Further, social protection expenditure in Kenya is rather unbalanced with more than 57 per cent spent on pensions for former civil servants, whereas social pensions do not exist and expenditure on social assistance for the poor amounts to less than 5 per cent. In addition, efficiency and effectiveness in financing social protection is hampered by a fragmented scheme landscape and related low resource and risk pooling as well as scattered institutional and decision making frameworks.

Against this background, the development of an integrated national social protection policy should prioritise achieving universal coverage and providing access to at least essential benefits in health care and income support as outlined in the Social Protection Floor Initiative. The related strategic approach suggested by ILO includes i) focusing on key principles of social protection, mainly affordability at national and household level, accountability and sustainability ii) maximizing fiscal space, iii) increasing capacity for implementation and monitoring of reforms and iv) improving social dialogue.

Such an inclusive approach would require defining new roles for existing schemes, e.g. the NSSF and NHIF which should cover large population groups including workers in the informal economy and their families; Occupational schemes could play a complementary role; Income support through social assistance schemes should be unified and extended; and synergies among all schemes should be realized in order to maximize efficiency and effectiveness.

Based on preliminary ILO projections and the promising economic situation in Kenya, such a comprehensive national social protection policy could be successfully implemented and progress towards the Millennium Development Goals significantly accelerated.

1. Introduction

1.1 Background and objectives of the report

The overall objective of the present report is to provide support in achieving the goal of improving social protection in Kenya. Specifically, its purpose is to provide assistance to the Government of Kenya in developing an integrated social protection policy.

This report is based on information provided by stakeholders whom the ILO team discussed with, ministerial publications, independent research and analysis, and International Labour Office (ILO) publications. All available literature and documentation was collected and analyzed by the ILO. It must be mentioned, however, that use of data was limited, partly because it does not exist, and partly due to disclosure limitations. Consequently, any follow-up to this study should also invest in improving accessibility to and availability of core social protection data.

The report analyzes and assesses Kenya's social protection schemes in the formal and informal economy. It includes an evaluation of strengths and weaknesses of the current social protection system particularly concerning old age, health, and income support. The report takes into account the institutional set-up and regulatory frameworks. It also provides an appraisal of existing benefits given socio-economic conditions, financing arrangements and other aspects. All assessment and recommendations provided are derived with consideration to social security expertise, ILO perspectives, and Kenya's specific economic, social and political situation and current political debate regarding social protection. Overall, the assessment was carried out with a view to achieving universal coverage of social protection and a possible follow-up project.

More specifically, the terms of reference that were addressed in this report include:

- Undertaking a literature review on issues in social protection schemes by analyzing quantitative and qualitative data, as far as possible, regarding different population groups, gender, age, etc., with a view to effective access to benefits and conclude on priorities;
- Based on preliminary ILO projections and the promising economic situation in Kenya such a comprehensive national social protection policy could be successfully implemented and progress towards the Millennium Development Goals significantly accelerated;
- Assessing the existing institutional, financial, economic and political environment taking into account the formal and informal economy;
- Outlining the scope for extending social protection including to the workers in the informal economy, using mechanisms such as social assistance schemes, social insurance, Community Based Health Insurance (CBHI) and voucher schemes (e.g. vouchers for maternal health services or income support);
- Describing existing benefits and cost impacts of various options to extend effective coverage, taking into account different financing mechanisms, benefit packages, corresponding contribution/premium rates (estimation), subsidies necessary and identifying gaps in coverage for policy inclusion and future proposals;
- Evaluating possible institutional, administrative arrangements, and regulatory frameworks with the considerations of the potential role of the various national

authorities, the socio-economic situation, the financing arrangements and other related aspects;

- Assessing the advantages and challenges of different choices in the light of overall social protection policies, poverty reduction policies, social and economic contexts, and modelling basic costs for each option;
- Assessing the main areas where technical advice and skills development of stakeholders are needed to implement and/or extend social protection in the context of options suggested and providing a framework for the transition of the current National Social Security Fund (NSSF) Act to a fully-fledged pension scheme;
- Assisting in formulating and designing a National Social Protection Policy that is linked to the Social Security (Minimum Standards) Convention, 1952 (No. 102) of the International Labour Organization suited to the present and future social protection needs of Kenyans;
- Suggesting, as far as possible, geographical areas, sectors and/or population groups suitable for possible testing of options considered and conceptualizing a follow-up project with a view to needs, financial means, provision of quality health services, administrative aspects, potential support of stakeholders such as community organizations and others.

1.2 Social protection and its role for Kenya

The global need for social protection is undeniable. Not only is social protection a social and economic necessity for individuals and societies, but it has long been acknowledged as a human right. This right to social protection in the form of social security is enshrined in the ILO Declaration of Philadelphia (1944) as well as in the Universal Declaration of Human Rights adopted by the General Assembly of the United Nations in 1948. Unfortunately, four out of every five people worldwide still lack comprehensive and adequate coverage and more than half of the world's population is unable to access any type of protection at all.

Substantial evidence¹ exists suggesting that where peoples' social protection needs are unfulfilled, the result can be increased poverty, higher levels of exclusion from access to health care and education, low access to employment and productive activities, an increase in the prevalence of child labour and in the spread of disease, such as HIV/AIDS. As this report highlights in the following sections, Kenya, and all Kenyans have a great need for social protection, not only from a rights-based perspective, but also from a practical, development-oriented viewpoint, in order to curb the above effects.

Certain populations have an increased risk of experiencing and being susceptible to hazards, for example, economic shocks, natural disasters, loss of income or ill health. Unfortunately, in Kenya as in other nations, the poor have a tendency to be exposed to multiple risks at once, making them less able to deal with shocks when they hit. The lack of means to cope with a hazard or risk is what makes individuals and populations vulnerable. Furthermore, it is these groups who have the greatest access deficit to social security. Increased risk to lifetime contingencies such as ill health may be determined by

¹ ILO. 2010. *World Social Security Report 2010. Providing coverage in the time of crisis and beyond* (Geneva).

factors such as gender, age, income, health status, occupation and employment status. In order for policy makers globally and in Kenya to develop a social protection system that truly protects those in need, these vulnerable population groups must be identified and targeted accordingly.

Before introducing and analyzing Kenya's social protection system, it is useful to discuss what is meant by social protection and social security. Within ILO, the terms social protection and social security are in fact used as synonyms. However, the term social protection is used in institutions across the world with a wider variety of meanings than social security. Often, it is interpreted as having a broader character than social security (including, in particular, protection provided between members of the family or members of a local community), but it is also used in some contexts with a narrower meaning (understood as comprising only measures addressed to the poorest, most vulnerable or excluded members of society).

In this report reference is made to "social protection" as being interchangeable with "social security" as well as with "protection" provided by social security in case of social risks and needs. An extended operational definition of social security, based on ILO Conventions, can be found in Annex A.

The notion of social protection (or social security) adopted here covers all measures providing benefits, whether in cash or in kind, to secure protection, *inter alia*, from²:

- a) lack of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member;
- b) lack of access or unaffordable access to health care;
- c) insufficient family support, particularly for children and adult dependants;
- d) general poverty and social exclusion.

Social protection thus has two main (functional) dimensions, namely "income security" and "availability of medical care", which are specifically identified in the ILO Convention 102, the ILO Income Security Recommendation, 1944 (No. 67) and the Medical Care Recommendation, 1944 (No. 69), respectively, as *essential elements of social security*.

What distinguishes social protection from other social arrangements is that benefits are provided to beneficiaries without any simultaneous reciprocal obligation (thus it does not, for example, represent remuneration for work or other services delivered. However, for some social protection benefits contributions have to be paid). Further, it is not based on an individual agreement between the protected person and provider (as, for example, a life insurance contract) but the agreement applies to a wider group of people and so has a collective character with corresponding risk pooling and financing according to ability to pay.

The ILO has developed a series of Conventions on social security, the core being ILO Convention No. 102, which is generally regarded as a primary international standard and instrument for defining and extending social security. The Convention includes minimum requirements for coverage and cash benefit rates that are outlined in Annex B.

² ILO. 2010. *World Social Security Report 2010. Providing coverage in the time of crisis and beyond* (Geneva).

While ILO Convention No. 102 is the primary international standard-setting instrument in social security, some benefit levels and standards were extended or raised in subsequent Conventions on social security. These conventions include the Employment Injury Benefits Convention, 1964 (C121), Invalidity, Old-Age and Survivors' Benefits Convention, 1967 (C128), Medical Care and Sickness Benefits Convention, 1969 (C130), and in the Employment Promotion and Protection against Unemployment Convention, 1988 (C168). Each of these Conventions deals with one of the nine branches on social security, whereas Convention No. 102 sets standards in all of the nine areas. ILO Convention No. 102 and subsequent Conventions specify, for example³:

- Old-age benefit:
 - Periodical payments, at least 40 per cent of the reference wage;
 - The rates of periodical payments must be revised following substantial changes in the general level of earning and/or in the cost of living.
- Medical care:
 - Preventive care;
 - General practitioner care, including home visits;
 - Specialist care in hospitals or outside;
 - The essential pharmaceutical supplies as prescribed by medical or other qualified practitioners;
 - Hospitalization where necessary; and
 - Prenatal, confinement and postnatal care either by medical practitioners or by qualified midwives; and hospitalization where necessary.
- Family benefits:
 - (a) Either periodical payments; or
 - (b) The provision of food, clothing, housing, holidays or domestic help; or
 - A combination of (a) and (b) above.

Minimum amount for the total value of the benefits granted in the country.

- Unemployment benefit:
 - Periodical payments corresponding to at least 45 per cent of the reference wage.

Kenya has not yet ratified Social Security (Minimum Standards) Convention, 1952 (No. 102), nor subsequent Conventions 121, 128, 130, or 168. Currently, Kenya is not fulfilling the targets or minimum levels specified in the ILO Conventions.

³ ILO. 2002. *Standards for the XXIst Century. Social Security*. International Labour Standards Department, ILO, Geneva.

Social security benefits are typically provided through public institutions, although their delivery is often mandated and shared by private entities. As in Kenya, many private institutions (insurance, self-help, community-based or mutuals) can take responsibility for providing selected services or fulfilling selected social protection roles.

Depending on the category of applicable conditions, a distinction is made between non means-tested schemes (where the conditions of benefit entitlement are not related to the total level of income or wealth of the beneficiary and his or her family) and means-tested schemes (where entitlement is granted only to those with income or wealth below a prescribed threshold).

Another distinction that exists in the provision of benefits is a special category of “conditional” schemes. These schemes require beneficiaries (and/or their relatives or families) to fulfil certain conditions in order to receive their benefit, for example, requiring participation in prescribed public programmes, such as a specified health or educational programme. In recent years, schemes of this type have become known as Conditional Cash Transfer (CCT) schemes.

Regardless of branch, financing mechanism, or type of benefit provided, all the social security schemes and institutions in a country are inevitably interlinked and complementary in their objectives, functions and financing, and thus, form a national social security system. As all of these schemes and institutions work independently towards the same objectives, it is vital that the linkages between schemes be understood and expanded upon. The integration of Kenya’s current schemes is the objective of this report.

In any discussion on the extension of social protection, it is necessary to discuss the concept of the Social Protection Floor.⁴ The reference to a “socio-economic floor” and its relationship to social protection was first introduced in the report of the World Commission on the Social Dimension of Globalization, which stated that: “A minimum level of social protection for individuals and families needs to be accepted and undisputed as part of the socio-economic floor of the global economy”⁵. Since then, the term “social floor” or “social protection floor” has been used to mean a set of basic social rights, services and facilities that the global citizen should enjoy. The term “social floor” corresponds in many ways to the existing notion of “core obligations”, to ensure the realization of, at the very least, minimum essential levels of rights embodied in human rights treaties. This concept was adopted in the form of The Social Protection Floor Initiative, by the United Nations System Chief Executives Board in April 2009 as one of the nine key initiatives to address the current financial crisis. The ILO and the WHO are leading the initiative, which advocates for the development in all countries of a social protection floor consisting of two main elements that help to realize respective human rights:

- a) services: geographical and financial access to essential services such as water and sanitation, health, and education;
- b) transfers: a basic set of essential social transfers, in cash and in kind, as aid to the poor and vulnerable to provide minimum income security and access to essential services, including health care.

⁴ ILO; WHO. 2010. *The Social Protection Floor. A joint Crisis Initiative of the UN Chief Executives Board for Co-ordination on the Social Protection Floor* (Geneva).

⁵ ILO. 2004. *A fair Globalization: Creating opportunities for all*. Report of the World Commission on the Social Dimension of Globalization (Geneva).

In the context of its campaign to extend social security to all, the ILO is promoting the social transfer component of the social protection floor; this basic and modest set of essential social guarantees realized through transfers in cash and in kind could ensure a minimum level of income security and access to health care for all in need.

The basic set of guarantees in all countries, including Kenya, consists of the following:

- a) all residents have the necessary financial protection in order to be able to afford and have access to a nationally defined set of essential health-care services, in relation to which the State accepts the general responsibility for ensuring the adequacy of the (usually) pluralistic financing and delivery systems;
- b) all children have income security, at least at the nationally defined poverty level, through family/child benefits aimed at facilitating access to nutrition, education and care;
- c) all those in active age groups who are unable to earn sufficient income in the labour market should enjoy minimum income security through social assistance or social transfer schemes (such as income transfer schemes for women during the last weeks of pregnancy and the first weeks after delivery), or through employment guarantee schemes; and
- d) all residents in old age and with disabilities⁶ have income security, at least at the level of the nationally defined poverty line through pensions for old age and disability.

The level of benefits and scope of population covered (for example, age eligibility for old-age pensions) for each guarantee should be defined according to national conditions (potential fiscal space, demographic structure and trends, income distribution, poverty and inequalities, etc), political choices, characteristics of groups to be covered and expected outcomes. In no circumstance should the level of benefit be below that which ensures access to an adequate level of goods and services and which ensures a life of dignity.

The implementation of social protection in the form of a social protection floor is critical in the reduction of poverty and in laying the foundations for long-term peace and prosperity.

As this report highlights, Kenya has made achievements in establishing the basis of a basic social protection floor. However, substantial gaps in coverage – specifically of vulnerable populations – still exist and must be addressed.

There is also a link between social protection and the Millenium Development Goals (MDGs). As discussed later in the report, Kenya's performance in achieving the MDGs is not yet satisfactory.⁷ Progress towards the poverty and health system related goals would be strongly impacted by the development of an extended social protection floor. Specifically, extended social security coverage and access to social services and transfers would accelerate the achievement of the goals of eradicating extreme poverty and hunger, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases.

Given the many people in Kenya who face extreme poverty, increased risk of hazards – such as chronic illness or loss of income – and who lack the means to protect themselves,

⁶ This means a degree of disability that excludes them from labour market participation.

⁷ UNDP. 2005. *Millennium Development Goals in Kenya. Needs and Costs* (New York).

the need for the extension of the social protection floor in Kenya is irrefutable. As of August 27th 2010, which saw the promulgation of the new Kenyan Constitution, social security is recognized as a Constitutional right for all. It is against this background that the Government of Kenya wishes to develop a holistic strategy to meet the various challenges with respect to poverty and coverage with basic social protection.

2. Socio-economic environment and vulnerability of the population

2.1 Economic situation

In contrast to the majority of economies worldwide, recent economic developments in Kenya have “been promising and create optimism that Kenya will begin the new decade on an upward growth path.”⁸

Within the last ten years the GOK has made a series of significant changes and advances in macroeconomic management. The most significant advance was the reduction of the debt to GDP ratio from 60 per cent to 40 per cent between 2000 and 2008.⁹ Kenya, unlike many other developing countries, has additionally been able to de-link its fiscal policy from business cycle in the country; “Sound macroeconomic policies and progress made in reducing public debt-to-GDP ratios in the recent past gave the government some fiscal space to support higher levels of expenditure, while departing only moderately and temporarily from its fiscal anchor of a 40 percent ratio of debt to GDP.”¹⁰ The government has adopted an expansionary fiscal policy approach which includes stimulus targeted at agriculture and infrastructure.

Despite strong growth and momentum between 2004 and 2007,¹¹ Kenya’s economy has hard hit in 2008 following the post-election violence. Following this, the economy showed signs of recovery in the first quarter of 2009, with a growth rate of 3.9 per cent compared to a drop of 0.6 per cent in the first quarter of 2008. There are several issues which resulted from the post-election crises, which may take some time to fully correct and recover from, including the displacement of approximately 1% of the Kenyan population (300,000 people), loss of confidence on the part of investors and tourists, and damage to physical assets and social capital.¹²

Due to the success of de-linking fiscal policy from the business cycle, the Government was able to use tax and expenditure policies to stimulate the economy and mitigate the effects of the recession when the crises of 2008-09 hit.¹³ The Kenyan economy was thus more able to respond to the global economic crisis. The fiscal stimulus raised the ratio of debt to GDP marginally in 2009; however, the increase was small relative to the crisis impact on other countries.

⁸ WB. 2010. *Kenya Economic Update. Edition No. 2. Running on One Engine: Kenya’s uneven economic performance. With a special focus on the port of Mombasa* (Nairobi, Poverty Reduction and Economic Management Unit Africa Region).

⁹ Masha, Iyabo. 2010. “IMF Shocks Loan, Policy Changes Help Kenya’s Recovery.” International Monetary Fund. Available at: <http://www.imf.org/external/pubs/ft/survey/so/2010/car010810a.htm>.

¹⁰ Masha, Iyabo. 2010. “IMF Shocks Loan, Policy Changes Help Kenya’s Recovery.” International Monetary Fund. Available at: <http://www.imf.org/external/pubs/ft/survey/so/2010/car010810a.htm>.

¹¹ Masha, Iyabo. 2010. “IMF Shocks Loan, Policy Changes Help Kenya’s Recovery.” International Monetary Fund. Available at: <http://www.imf.org/external/pubs/ft/survey/so/2010/car010810a.htm>.

¹² WB. 2010. *Kenya: Country Brief*. Available at: <http://web.worldbank.org>.

¹³ IMF. 2010. *World economic outlook: Rebalancing Growth*. International Monetary Fund. (Washington, DC).

As indicated in Table 2.1, Kenya's GDP per capita has more than doubled over the last decade, rising from 409 US dollars per capita in 2000 to 938 US dollars by 2010, a change which is on par with, or ahead of that of comparable countries. Kenya's market-based economy operates within a liberalized external trade system, although exports remain low as a share of total GDP, and have in fact declined over the last five decades.¹⁴ Despite decreased investor-confidence as of 2008, the country is still generally perceived as investment friendly. Agriculture is the primary industry in Kenya, which has been affected by drought and the resulting energy, food and water crisis. Higher food prices affect consumption levels, although it is likely that aid will have a moderating effect on consumption declines. In the manufacturing sector, value-added has decreased, although wholesale, retail trade, transport and construction have recently recorded positive growth.¹⁵ Remittances represent a substantial proportion of Kenya's foreign inflows, and remittance transfers totalled 609,156 US dollars in 2009.¹⁶

Table 2.1. Gross domestic product per capita, current prices, (in US dollars)

	2000	2005	2010
Ghana	271	514	755
Kenya	409	560	938
Senegal	454	748	1,026
Tanzania	303	378	592
Uganda	255	320	515

Source: IMF, World Economic Outlook Database, April 2010

Kenya continues to face varied challenges including a weakening exchange rate, trade deficit, "pressure on the current account due to weak exports, remittances and tourism [and the] combination of output and employment losses," which, coupled the sharply rising inflation of 2008, had a strong impact on poverty in the country.¹⁷ Average annual inflation was increasing over the last years, from 18.5 per cent in the year up to June 2008 to 25.0 per cent in the year up to June 2009,¹⁸ before falling significantly until the end of 2009. It is expected that inflation will stabilize e.g. due to lower food prices resulting from improved weather.

Other promising trends include monetary policy reserves remaining within targets, interest rates staying stable, and the public debt preserving sustainability.¹⁹ The 2008/09 fiscal deficit remained within the 5.3 per cent of GDP target. Furthermore, Kenya was one of the

¹⁴ WB. 2010. *Kenya Economic Update. Edition No. 2. Running on One Engine: Kenya's uneven economic performance. With a special focus on the port of Mombasa* (Nairobi, Poverty Reduction and Economic Management Unit Africa Region).

¹⁵ WB. 2010. *Kenya: Country Brief*. Available at: <http://web.worldbank.org>.

¹⁶ Central Bank of Kenya. 2010. "Remittances from Diaspora." Available at: http://www.centralbank.go.ke/forex/Diaspora_Remit.aspx.

¹⁷ WB. 2010. *Kenya: Country Brief*. Available at: <http://web.worldbank.org>.

¹⁸ Central Bank of Kenya. 2009. *2009 Revised Annual Report*. Available at: http://www.centralbank.go.ke/downloads/publications/annualreports/cbk/RevisedAnnual_2009.pdf.

¹⁹ Central Bank of Kenya. 2010. *Monetary Policy Committee Meeting of January 26th, 2010: Enhancing the Transmission Mechanisms for Monetary Policy*. Nairobi.

few countries that grew faster in 2009 than in 2008.²⁰ The most recent estimates of Kenya's GDP growth were quite positive, at 4 per cent growth for 2010, and at 5 per cent predicted growth in 2011. This increase would bring Kenya back in line with the economic growth experienced from 2003 to 2007 before the 2008 crisis.

2.2 Demography

In 2008, Kenya had a total population of around 38.8 million²¹. Population estimates explicitly take into account the effects of excess mortality due to AIDS which impacts population statistics by presenting lower life expectancy, higher infant mortality and death rates, lower population growth rates, and changes in the distribution of population by age and sex than would otherwise be expected.

The age structure of Kenyans is as follows²²:

- 0-14 years: 42.5 per cent of the total population
- 15-64 years: 55.2 per cent of the total population
- 65 years and over: 2.3 per cent of the total population

Kenya's population grew at a rate of 2.6 per cent per annum. In 2008, the birth rate was 39 births and the death rate was 12 deaths per 1,000 population.

The overall migration rate was 13.2 per cent (including cross border and internal migration), with rural areas losing a large portion of their population to urban areas. Among the eight provinces, Nairobi, the Western and the Central provinces experienced the highest rates of out-migration with over 15.0 per cent. This is also reflected in the influx of population to urban areas, which saw a net gain in population in terms of in-migration. According to the UNHCR planning figures 2010-2011, in January 2010 Kenya was host to 448,000 refugees from neighbouring countries, including 352,000 from Somalia, 22,810 from Sudan, and 27,030 from Ethiopia²³.

According to household survey data, the average household size was 4.2 persons (3.3 persons in urban areas and 4.7 persons in rural areas). The infant mortality rate is 59.26 deaths per 1,000 live births. An estimated 32 per cent of Kenya's population is malnourished.

The life expectancy at birth in 2008 was as follows²⁴:

- total population: 54 years

²⁰ WB. 2009. *Kenya Economic Update. Edition No. 1. Still standing: Kenya's recovery from a quadruple shock. With a special focus on the food crisis* (Nairobi, Poverty Reduction and Economic Management Unit Africa Region).

²¹ WB. 2009. *Kenya at a glance*. Washington, D.C.

²² ILO. 2007. *Decent work Kenya. 2007-2011*. ILO's country programme for the Republic of Kenya (Geneva).

²³ UNHCR 2010. *UNHCR Country Operations Profile*.

²⁴ WHO. 2010. *Kenya: Health Profile*.

- male: 53 years
- female: 55 years

The total fertility rate in 2008 was 5 children born per woman.

There are various ethnic groups in Kenya. The main groups are the Kikuyu who represent 22 per cent, Luhya at 14 per cent, Luo at 13 per cent, Kalenjin at 12 per cent, Kamba at 11 per cent, Kisii at 6 per cent, Meru at 6 per cent, other Africans at 15 per cent, and non-African (Asian, European, and Arab) at 1 per cent of the population²⁵.

About 16.4 per cent of the Kenyan population over the age of 5 years is reported to have had no formal education at all. Those with primary education constituted 59.0 per cent of the reference population while 19.7 per cent had attained secondary education. Only 1.1 per cent had attained university education.

2.3 Labour market

Data measuring labour market trends in Kenya are unfortunately either limited or outdated. The most comprehensive labour statistics on unemployment are from the Integrated Labour Force Survey from 1998/1999 (ILFS).²⁶ According to this survey, there were 15.9 million persons aged 15 to 64 (the working population) of which 77.4 per cent were reported to be economically active. Most of the active population was between 24 and 34 years of age. About 14.6 per cent of those who were economically active were unemployed. Some 3.6 million persons were reported to be economically inactive, representing 22.6 per cent of the population aged 15-64 years. The majority of the inactive population were full-time students (47.3 per cent). Only 2.0 per cent of the inactive population reported being out of the labour force because they were retired.

Table 2.3.1 Employment statistics (in thousands), 2003-2007

	2003	2004	2005	2006	2007
Wage Employees	1,727.3	1,763.7	1,808.7	1,859.7	1,907.3
Self-employed and unpaid family workers	65.7	66.3	66.8	67.2	67.4
Informal economy	5,717.4	6,168.2	6,628.3	7,048.7	7,475.6
Total	7,510.4	7,998.2	8,503.8	8,975.6	9,450.3

Source: Government of the Republic of Kenya (2008). *Kenya Economic Survey 2008*. Kenya National Bureau of Statistics, Ministry of Planning and National Development. Nairobi.

The overall labour force participation rate for the population aged 15 to 64 years stood at 73.6 per cent. Urban areas had a higher labour force participation rate of 86.4 per cent, compared to rural areas with a rate of 73.8 per cent. Males had a slightly higher participation rate of 74.7 per cent compared to that of females, at 72.6 per cent. The results show that participation rates increase along the age spectrum to about 95.2 per cent for the

²⁵ Central Intelligence Agency. *The World FactBook*. Website. Available at www.cia.gov/library/publications/the-world-factbook/geos/ke.html.

²⁶ Kenya National Bureau of Statistics. 2010. *Labour Force 1998/9 Summary*. Available at <http://www.knbs.or.ke/>.

age group 40 to 44, before levelling out at 80.1 per cent for the age cohort 60 to 64 years. Also, participation rates tend to rise with the level of formal education, rising from 83.7 per cent for those with no education to over 98.8 per cent for those who have completed post-graduate education.

The number of employed persons aged 15 to 64 years stood at 10.5 million persons, giving an employment rate of 85.4 per cent. The overall male to female employment ratio was 1.08; however females dominated rural based small-scale farming and pastoralist activities, with a ratio of 0.67. Rural employment absorbed 70.1 per cent of those employed. The working population could largely be categorized into two groups: unpaid family workers (39.6 per cent) working mostly in rural areas and paid employees, concentrated largely in urban areas (33.4 per cent). Self-employed persons constituted 23.8 per cent of the employed. Of the three sectors of the economy, small-scale farming and pastoralist activities engaged the most people, with 42.1 per cent of those working. The informal economy employed 31.6 per cent of the total workforce, and the formal economy employed the remaining 26.3 per cent.

Most of those employed reported being skilled agricultural and fishery workers (37.3 per cent), largely self-employed and based in rural areas. Those who reported working as professionals were mainly in paid formal employment, and accounted for only 1.2 per cent of total employed persons. Agricultural activities absorbed 63.1 per cent of the employed persons. Other major employers included the service industry, followed by community, social and personal services accounting for 6.1 per cent of the employed. The industries employing the fewest people were private households with employed persons, and electricity and water supply. The number of females employed in activities that have been traditionally dominated by males (such as construction, mining and quarrying) was notably low. However, females were concentrated in agricultural activities, trades, and educational services.

Average earnings amounted to KSH 7,766 per month, with the main source of employees' remuneration being basic salary, making up 81.3 per cent of the overall earnings per person. Earnings in urban areas were almost double the average earnings in rural areas. There were significant disparities in earnings by gender, with female earnings and wages being significantly lower than their male counter parts in both rural and urban areas.

About 4.8 per cent of the 10.5 million working persons were under-employed. During the reference week of the survey, the majority of the underemployed worked between 18 and 25 hours. Males constituted 65.1 per cent of those who were under-employed.

The number of informal economy enterprises in Kenya was estimated at 2.7 million. About 70 per cent of those enterprises were based in rural areas. Many of the enterprises were engaged in wholesale and retail trades (64.5 per cent) and manufacturing activities (24.0 per cent). Males owned 53.0 per cent of the enterprises in rural areas, while females owned 55.3 per cent of the urban-based enterprises. The total number of workers in the informal economy was around 7.5 million in 2007. Most of the employees were self-employed (75.4 per cent), followed by wage employees (19.2 per cent).

Table 2.3.2 Informal economy workers according to area of activity (in thousands), 2003-2007

Activity	2003	2004	2005	2006	2007
Manufacturing	1,236.1	1,318.5	1,434.0	1,532.4	1,619.0
Building and Construction	163.8	173.7	190.2	204.2	215.0
Wholesale and retail trade, Services	3,356.3	3,632.4	3,890.8	4,131.6	4,386.8
Transport and	170.1	186.5	197.9	209.8	223.0

Communications					
Community, social and personal services	530.3	576.9	614.2	650.6	692.2
Others	259.8	280.2	301.2	320.1	339.6
Total	5,716.4	6,168.2	6,628.3	7,048.7	7,475.6

Source: Government of the Republic of Kenya (2008). Kenya Economic Survey 2008.

Kenya has long faced a serious problem with unemployment. In 1999, at the time of the labour force survey, there were 1.8 million unemployed persons aged 15 to 64 years, which resulted in an overall unemployment rate of 14.6 per cent. More recent estimates range from 12.7 per cent (for 2005/2006)²⁷ to 40.0 per cent (for 2008), which places Kenya 187th in the world.²⁸

Both labour participation rates and unemployment rates are higher in urban areas than in rural.²⁹ The urban unemployment rate stood at 25.1 per cent by 1999. Likewise, unemployment in the rural areas was high at 9.4 per cent, but less acute than in urban areas. The majority of the unemployed were youth and females. Most of the unemployed persons (94.2 per cent) had looked for paid employment during the survey's one-week reference period. It is also worth noting the shift from subsistence farming, as more jobs searchers were ready to start self-employment (mainly found in the expanding informal economy) than farming activities in the small-scale and pastoralist sector. The main mode of job search in both urban and rural areas was to ask friends or relatives (41.3 per cent), followed by directly approaching employers (32.8 per cent).

Youth unemployment is a particularly serious issue facing Kenya, with an estimated unemployment rate of double the adult average. As in many countries, the share of youth among the unemployed is high, and the proportion in Kenya has risen to 72 per cent.³⁰ Even where youth are employed, many face underemployment. Financial crises further aggravate this problem, with new entrants to the labour market more likely to incur job losses than their colleagues with greater seniority. Youth unemployment has strong negative social, economic and political impacts on Kenya; an indicator of this is that youth unrest due to unemployment was implicated as a major cause of the 2008 post-election violence.

In terms of labour relations and labour rights in Kenya, the situation is promising, although there does exist some scope for improvement.³¹ Kenya has a long history of autonomous trade unions, legally authorized freedom to associate and collectively bargain. There are currently 500,000 Kenyans being represented by trade unions. However, there still exists some resistance to unionization among employers, as well as a sub-optimal degree of

²⁷ Government of the Republic of Kenya. *Kenya Economic Survey 2008*. Kenya National Bureau of Statistics, Ministry of Planning and National Development. Nairobi.

²⁸ Central Intelligence Agency. *The World FactBook*. Website. Available at www.cia.gov/library/publications/the-world-factbook/geos/ke.html.

²⁹ Kenya National Bureau of Statistics. 2007. *Kenya Integrated Household Budget Survey (2005/2006)* (Nairobi).

³⁰ WB. 2010. *Project Appraisal Document on a Proposed Credit in the Amount of SDR 19.35 Million (US\$ 30 Million Equivalent) in Pilot Crisis Response Window (CRW) Resources to the Republic of Kenya for a Youth Empowerment Project* (Washington, DC).

³¹ Puddington, A (ed.). 2010. *Global State of Workers' Rights: Free Labor in a Hostile World* (Freedom House).

enforcement of labour laws. The right to strike is restricted. While the right to collectively bargain exists, the ability to freely collectively bargain is limited for some groups. Kenya's trade unions serve as representatives of the interests of workers and this allows for informed national and local social dialogue on a number of issues, including social security.

2.4 Income inequality and poverty

Despite long-standing attempts to improve growth, reduce inequalities and reduce poverty, far too many Kenyans are still living and dying in poverty. Many of them become trapped in chronic, long-term poverty that is inter-generational. This reality coupled with the essential stagnation of poverty reduction in the country has implications for Kenya's development goals.

In 2005/6, almost 47 per cent of Kenyans (17 million) were unable to afford the cost of buying the amount of calories sufficient to meet the recommended daily nutritional requirements and minimal non-food needs. The vast majority – 14 million – live in rural areas. Many of these people are very poor; indeed, almost one out of every five could not meet the cost of this minimal food bundle even if they spent their entire budget on food.³² The national poverty line in Kenya lies at US\$35 for urban and US\$16 for rural areas per adult per month.³³

As of 2005, the UNDP Human Poverty Index for Kenya was 37 per cent, having increased only marginally from 36.7 per cent in 2004. The HPI value for Kenya is lower than the income poverty level of 56 per cent, meaning that the incidence of income poverty in the country is higher than human poverty. Despite rapid economic growth in the last two years, human poverty appears to have deepened. This can be attributed to the growing structural inequalities in the HPI components, for example, access to health, water, doctors, and nutritional status of children.³⁴

Over the long term, little inroads have been made in reducing poverty over the past 25 years; the officially estimated poverty rate was 48 per cent in 1981. This record is not surprising in light of the weak growth performance over the period overall and high levels of inequality across households.

Inequality, measured across the distribution of household consumption, is high, especially when one compares the position of those at the top, to those at the bottom. In 2005/6, the consumption decile ratios of the top 10 per cent to the bottom 10 percent stood at 20:1 and 12:1 in urban and rural areas, respectively. This compares to 5:1 in Tanzania and 3.3:1 in Ethiopia, for example. There are also significant horizontal differences, across groups, in particular provinces.

Over the period from 1997 to 2005, labour productivity has risen, and there were falls in urban unemployment, which would normally have positive impacts on poverty, however,

³² WB. 2008. *Kenya Poverty and Inequality Assessment* (Washington, DC).

³³ World Water Assessment Programme. 2006. "Moving towards an integrated approach", in *The United Nations World Water Development, Report 2. Water: a shared responsibility* (Paris, UNESCO; New York, Berghahn Books, New York).

³⁴ UNDP. 2006. *Kenya National Human Development Report 2006. Human Security and Human development: A deliberate Choice* (New York).

low agricultural productivity remains a drag on the overall economy and on poverty reduction. For many – about 60 percent of workers – earnings are below the poverty line.

For many households in Kenya, shocks are a fact of life. This is especially the case for the poorest in the country. The most common shocks over the period 2000-2005 were, in order of importance, food price inflation, droughts and floods, illness, and death.

Average annual growth in the working age population is rapid, and exceeds the growth of new jobs. At the same time, dependency rates are high, and there continues to be a significant correlation between family size and poverty risk. Poverty in Kenya is multidimensional and includes aspects such as deprivation of knowledge and declines in life expectancy and quality of life.

Past efforts to reduce poverty in the country have often been unsuccessful due to a number of reasons, including poor implementation and lack of focus on specific targeted programmes. In order to combat this trend, the government therefore formulated further (some past, and some ongoing) initiatives, which are varied, and include:

- the National Poverty Eradication Plan (NPEP) 1991 – 2015 which stipulates the long term strategy to fight poverty over a 15-year timeframe;
- adoption of the MDGs, which aim at reducing the incidence of poverty both in the rural and urban areas by 50 per cent by 2015 and strengthening the capacity of the poor and vulnerable groups including aged persons;
- the Poverty Reduction Strategy Paper (PRSP) 2001 – 2004; and,
- the Economic Recovery Strategy for Wealth and Employment Creation 2003 – 2007.

Table 2.4 Inequality in distribution of consumption gains, 1997 – 2005/06

	1997	2005/06	Percentage change
Area			
Urban	4,436.59	5,493.96	23.8
Rural	1,962.94	1,993.21	1.5
Quintile			
Poorest	708.07	702.99	-0.7
2	1,159.83	1,268.59	9.4
3	1,680.82	1,846.75	9.9
4	2,439.84	2,778.18	13.9
Wealthiest	5,758.93	6,895.72	19.7
National	2,349.36	2,698.12	14.8

Source: WB estimates based on Kenya Integrated Household Budget Survey (2005/06), Welfare Monitoring Survey (1997).

Notes: Mean adult equivalent per capita expenditures. 1997 is adjusted to 2005/06 values using the ratios of the urban and rural poverty lines.

2.5 Gender

As in the majority of countries in world, gender issues, specifically inequalities and discrimination based on gender, persist in Kenya. Kenya remains a patriarchal society which has unfortunately meant that women “continue to be marginalized and discriminated against in almost all aspects of their lives, a situation which is reinforced by the existing laws and policies, as well as the socio-cultural factors”³⁵. Women in Kenya may face an inferior legal status in relation to marriage, inheritance, guardianship, property ownership, maintenance and other legal matters, which places them in a disadvantaged position economically and politically, which in turn compromises their ability to challenge their marginalization. This situation is, however, being increasingly questioned and challenged.³⁶

Unfortunately, the way in which certain social security benefits are provided is often gender-biased. Given the fact that, as we have seen, females are underrepresented in the formal labour market, they are also underrepresented in terms of social protection coverage.

Particularly, old-age pension coverage has a strong gender dimension. Women workers in the formal economy may have fewer years of work (and accordingly fewer contributions) due to many reasons including childcare or other care responsibilities. Further, many women are employed in jobs that pay low wages. As a result, pension benefits will be of lower levels than that for male workers.

In addition, women are often obliged to maintain certain levels of activity to compensate for declining intra-family support and the absence of universal pension schemes. Additionally, because life expectancy for women is higher than for men, women may be trapped in poverty, supporting this burden for a longer period of their lives. This means that a woman’s chance of losing her partner is higher, an economic contingency that may be compounded by the fact that women are less likely to remarry than men. In developing countries, women over 60 who have lost their partners greatly outnumber their male equivalents.³⁷ Not only does the loss of a spouse entail the loss of support and income, it can also lead to exclusion due to the stigma of widowhood.

The prevalence of discriminatory practices constitutes a persistent gap between the formal equality of men and women as recognized by national, regional and international legal frameworks, and the substantive equality that they should enjoy. Thus, a gendered perspective on human rights generally, and on equality and non-discrimination specifically, calls for an understanding of the historical, social and cultural circumstances, as well as the structural barriers that impede the realization of genuine equality, even though much of the existing human rights concepts, language and practice are weakened by male bias.

The improvement of the situation for women in Kenya is being monitored by the GOK in collaboration with UNDP in relation to MDG 3, which aims to promote gender equality

³⁵ Federation of Women Lawyers; International Women’s Human Rights Clinic. 2008. *Kenyan Laws and Harmful Customs Curtail Women’s Equal Enjoyment of ICESCR Rights: Supplementary Submission to the Kenyan Government’s Initial Report under the ICESCR, scheduled for review by the Committee on Economic, Social, and Cultural Rights during its 41st session* (Washington, DC).

³⁶ Creighton, C., Yieke, F. (eds.). 2006. *Gender Inequalities in Kenya* (Paris, UNESCO). Available at <http://unesdoc.unesco.org/images/0014/001458/145887e.pdf>.

³⁷ ILO. 2010. *World Social Security Report 2010. Providing coverage in the time of crisis and beyond* (Geneva).

and empower women. Notable developments in achieving this goal include the formation of the MGCS D whose mandates include gender mainstreaming in national development, and the formation of policies regarding gender. Additionally, affirmative action policies have been introduced in the public sectors in an effort to increase the hiring and promotion of women.

2.6 Health

Some of Kenya's health indicators are unfortunately worse than those of other African countries. The main causes of death in the country are HIV/AIDS and infectious diseases. Under-five mortality is high and the trend indicates that the health-related MDG targets will not be met. The progress on improvements to maternal health is similarly discouraging, with Kenya's maternal mortality rate remaining at an unacceptably high level. While maternal mortality figures vary widely by source and are highly controversial, the best estimates for Kenya suggest that approximately 14,700 women and girls die each year due to pregnancy-related complications. Additionally, another 294,000 to 441,000 women and girls suffer from disabilities caused by complications during pregnancy and childbirth each year. More details can be obtained from the WHO databases and the WHO's annual World Health Report.

Figure 2.6 Kenya health indicators

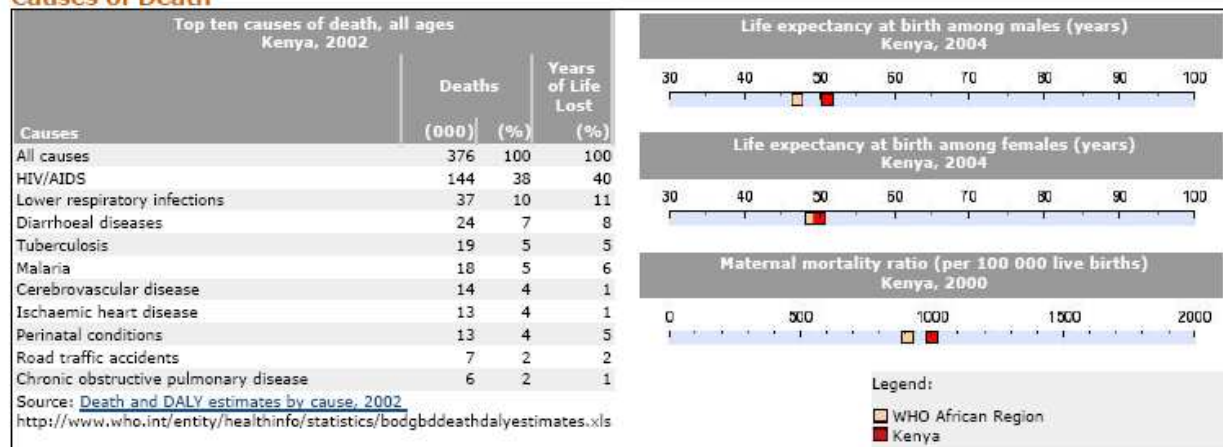
Causes of death in children under-5

Distribution of causes of death among children under 5 years of age Kenya, 2000-2003			Annual estimated proportions of death by cause for neonates Kenya, 2000		
Causes	Deaths ^b (%)	Regional average (%)	Causes	Deaths ^c (%)	Regional average ^c (%)
Total neonatal deaths	100	100	Total neonatal deaths	100	100
Neonatal causes ^a	24	26	Neonatal tetanus	3	9
HIV/AIDS	15	7	Severe infection ^a	26	27
Diarrhoeal diseases	16	17	Birth asphyxia	28	24
Measles	3	4	Diarrhoeal diseases	2	3
Malaria	14	17	Congenital anomalies	8	6
Pneumonia	20	21	Preterm birth ^b	26	23
Injuries	3	2	Others	8	7
Others	5	6			

a. Includes diarrhoea during neonatal period
b. Sum of individual proportions may not add up to 100% due to rounding.

a. Includes deaths from pneumonia, meningitis, sepsis/septicaemia and other infections during the neonatal period.
b. Includes only deaths directly attributed to prematurity and to specific complications of preterm birth such as surfactant deficiency, but not all deaths in preterm infants.
c. Sum of individual proportions may not equal 100% due to rounding.

Causes of Death



Source: <http://www.who.int/countries/ken/en/>.

Kenya's total expenditure on health as a percentage of GDP was 4.6 per cent in 2006, according to the 2009 World Health Statistics Report.³⁸ In 2006, Kenya spent 29 USD per capita on health services, several dollars below the 34 USD threshold which is recommended to be spent by countries to provide an essential health package for their citizens. The Abuja Declaration calls for spending of 15 per cent and the Economic Recovery Strategy outlines a target of 12 per cent budget spending on health. Evidently, current spending is still far below these targets.

As far as government spending is concerned, the Ministry of Finance sets three-year budget ceilings for each sector in Kenya. In practical terms, this means that the Ministry of Health, based on indications of the Ministry of Finance, creates a budget that will allocate funds for health expenditures rather than submitting a budget request based on actual needs. The Ministry of Health then disseminates the funds received through its District Health Management Boards.

There are two components in the Kenyan health budget – a recurrent budget which covers staff salaries, maintenance, and pharmaceutical procurement, and a development budget, which funds construction of new facilities and programme implementation. According to the WHO, the Government of Kenya covers about 38.7 per cent of the overall expenditures on health, while private expenditures account for 61.3 per cent of overall spending. In 2006, 80 per cent of private expenditures were out-of-pocket payments for health services.

Despite an increase in the absolute government health budget (nearly doubling between 2003/4 and 2007/8 from KSH 15.3 billion to KSH 34.4 billion),³⁹ it declined as a share of government spending. As on-budget donor funding has increased, government funding has been accordingly withdrawn: in 2004/5 the health budget including on-budget donor funding represented 7.66 per cent of government spending, falling to 7.3 per cent in 2007/8, and in 2002 government financing on health represented 8.0 per cent, but dropped to 5.2 per cent by 2006.⁴⁰

Kenya is currently experiencing an overall staff shortage of health care workers.⁴¹ These deficits have a large impact on the quality, availability, comprehensiveness, and accordingly, effective access to health care for many Kenyans. In 2007, staffing levels were estimated at 47,247, a number which lies far below the estimated minimum requirement of 72,234 staff. Shortages were found to be geographically concentrated and were particularly large in certain parts of the Coast, North Eastern, Rift Valley and Nyanza provinces. As expected, these are the regions with the lowest health indicators.

An additional challenge that exists in health human resources is ensuring productivity of the workforce and the delivery of quality services. Healthcare workers are salaried meaning that there exist a lack of incentives for increased productivity. Payment of salaries is however, effective in terms of cost containment and predictable budgeting.

³⁸ WHO. 2009. *World Health Statistics 2009*. Geneva.

³⁹ Ministry of Public Health and Sanitation and Ministry of Medical Services. 2009. *Healthcare Financing Policy and Strategy: Systems Change for Universal Coverage*. Draft.

⁴⁰ Ministry of Public Health and Sanitation and Ministry of Medical Services. 2009. *Social Protection in Health: Policy and Financing Strategy*. Nairobi: Government Printer.

⁴¹ Government of the Republic of Kenya. 2007. *Human Resources for Health Strategic Plan (2007/8-2009/10) (HRHSP)*. Draft.

The inequitable distribution of health care resources is not limited to human resources, but also applies to other health resources including facilities, and budgets for operations and management. Those areas which are generally under-served, particularly those that are rural, tend also to be under-resourced in terms of health resources. This is because “resource allocation is driven largely by existing infrastructure (although other population parameters are used)” and “allocations are based on bed utilization and outpatient cases. Though the district resource allocation criteria (RAC), provides a weight of 30 per cent for poverty, this mechanism needs to be strengthened if the current resource allocations are to favour under-served districts and population groups.”⁴²

Resource allocation is highly centralized in the public sector, which has meant that districts have limited flexibility to plan for the use of and allocate resources for themselves. Currently, the system for “budget and cash management remains inflexible, and tends to undermine the districts’ ability to utilize their budgets fully, resulting in the unavailability of services.”⁴³

The support that health facilities receive is often in kind, which creates further rigidity; inability to reallocate and disperse resources optimally, based on local knowledge of needs further leads to inefficiencies and an inability to improve availability of services. Additionally, it can contribute to low budget execution.

Budget execution of recurrent budgets has been relatively good, although challenges remain, as there have been continued problems with fully executing the drugs and medical consumables, as well as the purchase of plants and equipment.

Conversely, there has been under-spending in the case of development budgets; development spending represented only 40 per cent of the development budget in 2004/5. While there have been improvements in development spending, raising to 50 per cent in 2005/6, these relatively low levels may be a sign of troubles with absorption capacity. Furthermore, a recent health expenditure review “revealed that the Ministry of Health only spent about 33 per cent of the approved development budget.”⁴⁴

In addition to government funding, substantial funding is received from the more than 20 donors operating in the Kenyan health sector. The majority of these funds are dispersed through the public sector, including the Ministry of Health, NGOs, teaching and research institutions and other donor agencies. The support of many of these donor agencies is concentrated in particular areas. For example, a large proportion of programmes which are financed by donors have been focused on HIV/AIDS, specifically providing increased access to anti-retroviral therapy (ART). Additionally, a substantial amount of donor funding goes toward malaria and tuberculosis programmes.

Unfortunately, the majority of Kenyans are unable to access affordable health care. This access deficit is primarily due to poverty; as of 2003, 44 per cent of those who become ill did not seek health care due to a lack of consistency of funds.⁴⁵ In place of qualified

⁴² Ministry of Public Health and Sanitation and Ministry of Medical Services. 2009. *Social Protection in Health: Policy and Financing Strategy*. Nairobi: Government Printer.

⁴³ Ministry of Public Health and Sanitation and Ministry of Medical Services. 2009. *Social Protection in Health: Policy and Financing Strategy*. Nairobi: Government Printer.

⁴⁴ Ministry of Public Health and Sanitation and Ministry of Medical Services. 2009. *Social Protection in Health: Policy and Financing Strategy*. Nairobi: Government Printer.

⁴⁵ Government of the Republic of Kenya. 2003. *Household Health Expenditure and Utilisation Survey Report 2003*. Ministry of Health. Nairobi. Government Printer.

medical treatment, self-diagnosis is common, with 40 per cent of the poor population reporting having undertaken self-diagnoses when sick.⁴⁶ Self-diagnosis was particularly widely used in the Western (51 per cent of the poor), Eastern (42 per cent), and Nyanza (44 per cent) provinces, and is predominantly due to lack of finances.

A large proportion of total expenditure on health is private spending, which is usually un-pooled and in the form of out-of-pocket payments. The ILO, the WHO and other organizations acknowledge these financing mechanisms as inequitable as well as inefficient. Furthermore, “it is far from clear that such spending offers value for money; 69 per cent of private spending on out-patient care is on drugs, with little or no evidence as to whether this follows the practices of rational use of drugs.”⁴⁷

The share of private financing has, however, declined quickly in absolute and relative terms, (from 54 per cent in 2002 to 39.3 per cent in 2006) partly due to the increase in donor funding. In absolute terms, private spending dropped from KSH 30.8 to KSH 27.8 billion over those four years (a decrease of 9.8 per cent). There was also a decline in household spending as a percentage of health expenditures (51 percent to 36 per cent) and inflation-adjusted spending per capita (KSH 770 to KSH 713). The substantial decline in household spending “mirrors a significant increase in flow of development partner funds (especially from PEPFAR [the US President’s Emergency Plan for AIDS Relief]) to the sector.”⁴⁸

The poor spend less on health care than those who are better-off, however these expenditures account for a larger share of their household expenditure. When compared to the better-off, those who are poor were found to utilize health care services less, and were less likely to seek treatment when ill,⁴⁹ indicating that Kenyans are at risk for falling into the cycle of poverty and ill health.

2.7 HIV/AIDS

Thus far, Kenya has made remarkable progress in combating HIV/AIDS. Despite these recent gains in reversing the trend in its incidence and prevalence, HIV/AIDS still presents a major challenge in the country. The continued prevalence of the disease in the country is a threat to sustained progress in human development.

As those living with HIV/AIDS can remain asymptomatic for many years, the virus has the additional risk of spreading rapidly but silently across the country. Furthermore, there is still no vaccine and no easily affordable treatment for it. It is urgent that effective prevention and changes in behaviour and attitudes be adopted to combat HIV/AIDS and mitigate its effects on those living already with HIV/AIDS. Such actions are key to consolidating recent gains in reversing the country’s prevalence rates from 13.9 per cent to the current level of 6.7 per cent.

⁴⁶ Government of the Republic of Kenya. 2008. *Well-Being in Kenya: A Socio-Economic Profile*. Kenya National Bureau of Statistics. Nairobi.

⁴⁷ Ministry of Public Health and Sanitation and Ministry of Medical Services. 2009. *Social Protection in Health: Policy and Financing Strategy*. Nairobi: Government Printer.

⁴⁸ Ministry of Public Health and Sanitation and Ministry of Medical Services. 2009. *Social Protection in Health: Policy and Financing Strategy*. Nairobi: Government Printer.

⁴⁹ Ministry of Public Health and Sanitation and Ministry of Medical Services. 2009. *Social Protection in Health: Policy and Financing Strategy*. Nairobi: Government Printer.

An overview of Adult HIV prevalence by province is provided in the table below. It shows that highest percentages of people living with HIV are found in Nyanza followed by Nairobi.

Table 2.7 Adult HIV Prevalence, 2004

Province	Number HIV+	Male (%)	Female (%)	Total (%)
Nairobi	159,000	7.1	10.9	9.0
Central	124,000	2.3	8.9	5.6
Coast	84,000	4.8	6.6	5.7
Eastern	90,000	1.4	5.9	3.7
North Eastern	17,000	2.1	4.0	3.0
Nyanza	292,000	10.2	16.0	13.1
Rift Valley	207,000	3.5	6.6	5.0
Western	85,000	3.6	5.4	4.5
National	1,057,000	4.3	8.3	6.4

Source: Government of Kenya, 1998 and 2004. World Development Indicators Database. August 2005.

3. Social protection context

3.1 Social protection policies

At present, Kenya already has in place some social protection arrangements, which constitute a basic social protection floor for some parts of the population. However, given the gaps and scattered nature, the current level of social protection cannot be considered as sufficient compared to nationally and internationally agreed objectives, particularly with reference to the right to social security recognized in the new Constitution and to the MDGs. Large parts of the population are still unable to access the most necessary social security benefits even where schemes are already in place. In addition to extending Kenya's social protection floor horizontally, to ensure that all gaps are filled and all populations adequately covered, the eventual objective should be to extend social protection vertically, by increasing benefit levels beyond minimum levels and adequacy. It is this vertical extension that is critical to helping Kenya achieve its aim of becoming a middle-income country providing a high quality of life to all its citizens by the year 2030.

It is agreed by the Government of Kenya that social protection needs to be developed further. What has been less clear is the most effective and efficient way to do so. During recent consultations on social protection policy in Kenya, concerns have been expressed about the:

- effectiveness of social spending;
- need to link demand and supply side interventions to ensure that the poorest in the country have access to adequate basic services;
- need to reorganize social assistance interventions, to ensure that lessons are learned from past programmes; and
- importance of improving targeting approaches.

As expressed above, the most prominent challenges are extending population coverage and level of benefits. Another major issue going forward will be how to better link the existing schemes, which are currently scattered (especially those providing social assistance) and need realigning.

Social assistance and social insurance – e.g. in the field of old age and health – exist but provide limited access to in kind and cash benefits. Furthermore, they have low population coverage. The political challenge that exists here is to make related schemes more efficient and to expand coverage defined as access to social security benefits. Pensions and old age saving systems afford some level of income security to about one half of the employed in the formal economy, but problems with the administration and financial sustainability of these programmes limit their effectiveness and reforms are needed (especially as the large informal economy is outside the programme). Health insurance is the scheme with the largest coverage but administration costs are high and benefits are limited.

Progress is being made in the development of social protection policies for the ultra poor in Kenya, designed to meet the nutritional needs of the poor and vulnerable. First, there is a School Feeding Program, which is a GOK programme supported by the World Food Programme (WFP). This programme supports selected schools in unplanned urban settlements of Nairobi and in the most food-insecure sub-districts in Arid and Semi-Arid Lands (ASAL) areas with the lowest enrolment and completion rates and high gender disparities. In addition, there are Emergency Food-Aid programmes, which reach around

1.8 million people in ASAL areas as well as 250,000 refugees annually. Third, there is the Hunger Safety Net Program (HSNP), which is a pilot programme being implemented by the GOK with support from DfID. There is also a national drought contingency fund, which includes support from the World Bank (WB) funded Arid Lands Resource Management Project and the European Commission (EC).

Apart from individual shortcomings of the schemes, there exists a perceived general lack of coordination or holistic view of social protection policy. In this context, political debate regarding social protection has increased, both among Kenyan stakeholders and within and between international partners.

3.2 Current policy debate

Given the recognized need for social protection improvement, political attention and debate about reforming social protection systems has substantially increased in the last years. The debate about the need to reform social protection arose for various reasons; it is clear to all parties that progress on poverty reduction and on meeting the MDGs is too slow and that there are groups in the country whose poverty situation is getting worse; social protection spending is very low compared to Kenya's economic capacity; furthermore, even where funds are allocated, there is a general feeling that there is a mismatch of scattered schemes and that existing schemes are not efficient; and finally, the reform process so far has been very slow (for example, the many years of delays in reforms of the health insurance and pension schemes) and must be accelerated. The GOK has recently undertaken a series of measures to increase social protection, as described below.

The promulgation of the new Kenyan Constitution is the most notable change to social protection policy, as it recognizes social security as a right for all. Whereas under the previous Constitution, Kenyans without access to social security were unable to take action or seek recourse where their rights were violated, they may now do so. Importantly, and in line with international standards, it supports a rights-based approach to social security. This significant shift is important both symbolically and in practice for Kenyans. It also means however, that the GOK has a renewed obligation to the Kenyan population upon which it must act.

As part of ambitious economic, social and political objectives of Vision 2030, the GOK has recently finalized its Strategy for National Transformation (SNT) 2008-2012 as its Medium-Term Plan (MTP).⁵⁰

Several government ministries and national authorities have attempted to address gaps.

The Ministry of Gender, Children and Social Development (MGCSD) has drafted a social protection policy paper and a National Social Protection Strategy (NSPS).⁵¹ The objective is to harmonize social protection interventions in the country and assure a better-coordinated, effective and efficient social protection system in Kenya. In the long-term, the strategy aims to facilitate the development of a comprehensive social protection system. In the short and medium-term, the objective of the strategy is to meet the immediate needs of the poorest and most vulnerable, focusing primarily on the population living in extreme

⁵⁰ Government of the Republic of Kenya. 2007. *Kenya Vision 2030* (Nairobi).

⁵¹ Ministry of Gender, Children and Social Development, Kenya. 2010. *Capacity Building Strategy for Social Protection for the Ministry of Gender, Children and Social Development* (Nairobi).

poverty and those most vulnerable to income poverty due to external shocks. Additionally, the MGCSO has developed a capacity building strategy for social protection.⁵²

The Ministries of Public Health and Sanitation and Medical Services have prepared a document entitled “Social Protection in Health: Policy and Financing Strategy” that aims at extending health care coverage.

Further, terms of reference for a secretariat to oversee the completion of the National Social Protection Strategy and Policy Progress⁵³ were developed and a Ministerial Task Force has been created to develop a holistic approach to social protection.

A draft bill to convert the NSSF provident fund into a fully fledged pension fund has been developed.⁵⁴ The Ministry of Finance has commissioned an actuarial study to calculate the financial implications of making the Government Service Pension scheme a contribution financed funded scheme.

The current social assistance schemes are being expanded and developed further, especially the orphans and vulnerable children (OVC) and the urban cash transfer scheme.

Against this background, the Cabinet is aiming at developing a more holistic approach in social security that addresses the needs of various groups of the population and emphasizes coordination among all government ministries, national authorities, social partners and others involved in social security.

3.3 Millennium Development Goals

Kenya has been involved in MDG-related activities since September 2002, with the first national stakeholders’ workshop on the Millennium Development Goals was held. The workshop established a national MDG Task Force responsible for the campaign in Kenya. The 2003 MDG Progress Report for Kenya emphasized the fact that Kenya would be unlikely to meet the MDG targets by 2015 given the policy context and resource constraints.

This prediction prompted a cabinet directive to mainstream the MDGs into the policymaking, planning and budgeting of all Government Ministries, Departments and Sectors, and later lead to the establishment of the 2005 to 2008 project “Mainstreaming of MDGs in Kenya's Development Process.” As of February 2009, the MDG Programme had entered a transition period for the completion of the project, which aimed to: develop frameworks of action; deepen awareness of MDGs; improve mainstreaming capacity in planning and policy formation; establish tracking and reporting systems; undertake policy research and advocacy among stakeholders; as well as to support project management.⁵⁵

⁵² Ministry of Gender, Children and Social Development, Kenya. 2010. *Capacity Building Strategy for Social Protection for the Ministry of Gender, Children and Social Development* (Nairobi).

⁵³ Government of the Republic of Kenya. 2008. “Terms of Reference for the Mini Secretariat to oversee the completion of the National Social Protection Strategy and Policy Progress”, in *Economic Survey* (Nairobi).

⁵⁴ Government of the Republic of Kenya. 2007. *Supplement No. 80. Bills No. 36* (Nairobi, Kenya Gazette, Official law reports of the Republic of Kenya, 13th August 2007).

⁵⁵ Government of the Republic of Kenya. 2009. *Coordinating and Accelerating MDGs in Kenya's Development Process: Transition Period for the Completion of the Project: Mainstreaming MDGs in Kenya's Development Process (2005 - 2008) Jan-Dec, 2009*. (Nairobi).

The institutional framework on MDGs consists of several levels:

- At the policy level there is a National Steering Committee (NSC) chaired by the Head of Public Service and Secretary to the Cabinet. The Permanent Secretary in the Ministry of Planning and National Development is the Convener. The members of the National Steering Committee are Permanent Secretaries in the Ministries implementing MDG-related activities, representatives from development partners, civil society, and private sector.
- At the second level there is a Technical Committee responsible for the provision of technical oversight to the MDG process, which is chaired by the Permanent Secretary, Ministry of Planning and National Development.
- The actual work is carried out within the existing Sector Working Groups (SWGs). The national MDG Focal Point at the Ministry of Planning and National Development coordinates the whole process.

The achievement of the MDGs poses tremendous challenges. Despite some signs of economic recovery, the growth of the economy is still below the necessary growth rate of about 7 per cent needed to support implementation of MDG-related activities before 2015. A more detailed description of Kenya's progress on the MDGs is presented in Chapter 5 in the context of the overall assessment.

3.4 Political support, donor commitment and international partnerships

Over the last decade, particularly since 2003, support for social protection has grown in Kenya. Various strategy papers have been developed. The Government has implemented a series of development strategies on poverty reduction, promoting regional and individual equity, and providing increased access to services for all, in particular to the poor, across regions and income categories. The aim of these development strategies has been to provide a just and cohesive society that enjoys equitable and equal access to economic, social and political development and justice.

The Economic Recovery Strategy (ERS) of 2003, and more recently, the Kenya Vision 2030 of 2007 and various sector level policies and strategies have guided this process. Vision 2030 is founded on improved economic growth, which has then afforded and enhanced programmes that have provided increased access for all, and especially the poor, to education, health, water, housing, inputs, credit, and other services. This has increased the development and rehabilitation of infrastructure and access to devolved funds, improved public services and programmes that have supported households to build assets, to respond to adverse events and safety nets. This has also included the process of expanding access to market-based social protection services both through the public sector and in collaboration with the private sector.

Part of the impact has been the reduction of the number of those under the poverty line, down to 46 per cent in 2007; improved levels of enrolment in schools; improvement in some health indicators, in particular child mortality; the recovery and improved viability of a number of industries that many Kenyans, and in particular the poor, depend on, such as the dairy, tea, coffee and the sugar sectors; and increasing opportunities for income generation both through formal and informal employment. An increasing number of household and industries have started accessing social protection services, as the NHIF expanded its range of services towards more coverage and, and as the NSSF planned for extending services and enhancing savings for retirement, amongst others.

The objectives of the MGCSO's social protection policy are to:⁵⁶

- Promote the protection of the poor and vulnerable individuals and households from the impact of adverse shocks that are capable of pushing them into deeper poverty;
- Promote key investments in human and physical assets of poor households capable of ensuring their resilience in the medium-term and of stopping the intergenerational cycle of poverty in the long-term;
- Establish coherent and progressive social protection synergies that would ensure strong positive linkages to influence economic and social policies and risk management;
- Provide reference guidelines to all stakeholders in the design, implementation, monitoring and evaluation of social protection programmes and processes;
- Provide guidelines for cost-effective, predictable and sustainable interventions that benefit the recipients, implementers and financiers; and
- Establish an institutional framework with the mandate to initiate, coordinate, implement, monitor and evaluate national social protection programmes.

To further develop these suggestions a National Task Force has been established by the President.

The main Development Partners supporting social protection in Kenya are the World Bank, DFID, the United Nations Children's Fund (UNICEF) and GTZ. In addition, the ILO, the WHO and GTZ all support the development of social protection, through policy advice and capacity building.⁵⁷

The ILO has also been active in Kenya for some time, in a number of areas, including social health protection, youth unemployment and child labour. The main objective of the ILO is to promote opportunities for decent work for men and women worldwide, a goal which is undertaken through the ILO Decent Work Agenda. In addition to the promotion of rights at work, the creation of employment opportunities, and the strengthening of social dialogue, the enhancement of coverage and effectiveness of social protection for all is one of the four core elements of the Decent Work Agenda. In the area of social protection, in line with the objectives of the SPF-I, the ILO supports the provision of comprehensive social protection to as many people as possible with a view to achieving the objective of universal coverage.

In an effort to realize the objective of decent work, the ILO establishes Decent Work Country Programmes (DWCPs) in countries such as Kenya. DWCPs are programming tools meant to deliver on a limited number of priorities over a defined period with a view to integrating country characteristics and policies, constituents' priorities and ILO objectives. Kenya's DWCP runs from 2007 to 2011 and is developing strategies and targeted interventions towards:

⁵⁶ Ministry of Gender, Children and Social Development, Kenya. 2010. *National Social Protection Policy* (Nairobi).

⁵⁷ World Bank. 2009. *Project Appraisal Document on a Proposed Credit in the Amount of SDR 33 Million to the Republic of Kenya for a Cash Transfer for Orphans and Vulnerable Children Project* (Washington, DC).

- Youth empowerment, youth employment and elimination of child labour, particularly in its worst forms.
- Expanding and strengthening the principle of inclusion for enhanced influence of tripartite partners in the national and international framework.
- Expansion of social protection and the fight against HIV/AIDS at the work place.⁵⁸

The ILO International Programme on the Elimination of Child Labour (IPEC) supports efforts to progressively eliminate child labour globally, and is active in Kenya. The programme, created in 1992, aims to combat child labour to ensure that they can gain the skills and education necessary for a better future. The Government of Kenya and the ILO have together signed a Memorandum of Understanding regarding child labour. The ILO monitors the incidence of and trends related to child labour in Kenya. The overall goal of IPEC is to protect the rights children and to accelerate the fight against poverty through working towards the achievement of the MDGs.

In June 2008 the ILO developed TACKLE, a project aiming to tackle child labour through education in Kenya, and in 10 other countries across Africa, the Caribbean and the Pacific (ACP). The project is funded by the ILO with financial support from the European Community, and developed in agreement with the Committee of Ambassadors of the ACP Group of States. It's objection is to "reduce poverty by providing access to basic education and skills training for disadvantaged children and youth; and to strengthen the capacity of national and local authorities in the formulation, implementation and enforcement of policies to tackle child labour in coordination with social partners and civil society."⁵⁹

The ILO has also been active in Kenya as part of the Providing for Health Initiative (P4H). P4H comprises bi- and multilateral partner organisations (e.g. WHO, ILO, World Bank, GTZ, Agence Française de Développement (AFD) with a view to support countries in the area of social health protection focusing on the poor. P4H's work is country-specific and builds upon existing mechanisms, strategies and systems. P4H has been and remains an important partner for Kenya in developing social health protection. The Initiative funded and supported multiple undertakings including the finalization and dissemination of the Health Care Financing Strategy for the Ministry of Health in 2009, identifying methods for testing and social inclusion, advocating for health care financing reform, and engaging discussion between public, private and civil stakeholders.

The World Bank provides Kenya with operational support, and its current projects relating to social protection include the Cash Transfers for Orphans and Vulnerable Children Project, and the Kenya Youth Empowerment Project, both of which are described in more detail in the next chapter. The World Bank Institute (WBI) has also been supporting a series of workshops in Kenya on social protection issues. These have focused particularly on OVC issues.

The GTZ has also been involved with social health protection in Kenya. Two recent initiatives include plans to use a public-private partnership (PPP) for health care education, and a pilot project with DFID called "Health for All Kenyans through Innovation" (HAKI).

⁵⁸ Geren, B.L. 2007. "The Decent Work Agenda in Kenya", in: Simon Sigué (ed.). 2007. *Repositioning African Business and Development for the 21st Century. Peer-Reviewed Proceedings of the 10th Annual International Conference, held at: Speke Resort & Conference Centre Kampala, Uganda May 19-23, 2009.*

⁵⁹ ILO. No date. *Tackle Child Labour Through Education: Moving children from work to school in 11 countries.* International Programme on the Elimination of Child Labour (IPEC), ILO. Geneva. Available at www.ilo.org/ipecinfo/product/download.do?type=document&id=8511.

The need for the development of social protection systems has also become a recognized priority for the East African Community (EAC). In addition to the provisions of Article 120(c) of the Treaty for the Establishment of the East African Community, which stipulates a commitment to close cooperation in the “field of social welfare with respect to the development and adoption of a common approach towards the disadvantaged and marginalised groups, including children, the youth, the elderly and persons with disabilities through rehabilitation and provision of, among others, foster homes, health care education and training,”⁶⁰ EAC has recently released a proposal for the development of a Strategy on Social Protection.⁶¹ This Strategy would advocate for social protection systems supporting vulnerable populations in overcoming risks, towards the goal of a more equitable East Africa. The paper proposes identifying the most vulnerable groups through baseline surveys, targeting these groups, engaging non-state actors with whom EAC can work with going forward, and finally establishing a timeline and full working structure for a Regional Social Protection Strategy. While the Strategy is only in the planning stages, this proposal signifies a commitment towards the principles of equity and social justice through the provision of social security.

Social partners, employers and trade unions are committed to social protection and support a discussion on how to improve coverage and benefits, especially with a view to reaching the large informal economy. The Kenyan population also showed its broad support for a rights based approach to social security by voting “yes” to the new Constitution of the country.

⁶⁰ East African Community. 1999. *Treaty for the Establishment of the East African Community* (Arusha).

⁶¹ East African Community. 2010. *Proposed Strategy for Social Protection in the East African Community* (Arusha).

4. Current state of social protection programmes

4.1 Retirement benefit schemes

4.1.1 Description

As outlined in the table below, there is a multitude of old age pension schemes in Kenya. This has created a variety of institutional approaches that are scattered and fragmented. The retirement benefit schemes all are funded (with the exception of the civil service pension scheme, which is paid out of the current budget) and control a total asset of about KSH 250 billion which amounts to approximately half the size of the public budget. There are over 1,300 occupational schemes, 16 individual retirement schemes and the National Social Security Fund (NSSF). Moreover, there is a special pension system for public-sector employees, some occupational schemes and individual schemes. In terms of benefit payments, the largest scheme is the public pension scheme. Its annual budget is nearly five times the size of the NSSF.

Table 4.1.1.1 Pension schemes in Kenya

Scheme Type	National Social Security Fund	Public Service Pension Schemes	Occupational Schemes	Individual Schemes
Legal Structure	Act of Parliament	Act of Parliament	Established under Trust	Act of Parliament
Membership	Employees in formal economy establishments with 5+ employees excluding public service employees	All public service employees, including civil servants, teachers and disciplined forces. Separate scheme for armed forces	Formal economy workers in companies that operate retirement schemes	Open to all on voluntary basis
Funding	Funded	Non funded	Funded	Funded
Regulation	RBA	Act of Parliament	RBA	RBA

Source: Sundeep, 2008, and RBA Website.

Together, these schemes together provide coverage to 15 per cent of Kenya's labour force, of which most are in formal employment. In terms of membership, NSSF has the highest coverage with around 67 per cent of the total, followed by the Civil Service Pension scheme with 22 per cent and occupational schemes with 11 per cent. In terms of assets, however, the occupational schemes contribute 61 per cent of the total, followed by the NSSF with 38 per cent. The individual schemes are negligible in terms of membership (some 9,000 members compared to over 300,000 in the occupational schemes and over two millions in the NSSF).⁶² Of these employees, 91 per cent are employees of large companies.

In 2007, the Minister for Finance excluded pensioners aged 65 and above from taxation on their pensions. In 2008, the Minister for Finance further excluded individuals aged 65 and above from taxation of their lump sum retirement benefits. In addition to these exclusions,

⁶² Retirement Benefits Authority, 2007. *Individual Retirement Benefit Schemes in Kenya*. Available at <http://rba.go.ke/file/Individual%20Retirement%20Benefits%20Schemes.pdf>.

pensioners earning up to KSH 15,000 per month in pensions are excluded from taxation if they have other sources of income. If they have no other sources of income, pensioners enjoy tax-free pensions of up to KSH 26,000. Individuals who have worked for at least 10 years enjoy a tax-free lump sum of KSH 480,000.

National Social Security Fund

Organization

The largest social protection scheme in Kenya is the National Social Security Fund, founded in 1965. Employed persons, traders, self-employed persons, and some workers in the informal economy, including farmers are covered. Voluntary coverage is possible. Some types of casual workers are excluded.

The NSSF was established in 1965 by an Act of Parliament (Cap, 258 of the Laws of Kenya). It administers a provident fund scheme primarily for workers in the formal economy. The scheme is run by a Board of Trustees comprising the employers and workers unions and the Government. There are also three trustees from the professional sector. The Managing Trustee is the Chief Executive and is also a member of the Board.

The NSSF has a staff of 1600 with a branch network of 43 spread across the country. The branches carry out employer/employee registration, collection of contributions law enforcement and payment of benefits. They also follow up with defaulters, impose penalties and prosecute those who have failed to honour their obligations.

Coverage

The NSSF provides high levels of coverage in comparison to other pension schemes in Kenya. It covers primarily formal economy employees; in 2009, there were 2,143,000 wage employees in Kenya and of these, 1,182,552 were NSSF members.⁶³ Conversely, the informal economy had far more workers – 8,200,000 – and only 40,218 of them were NSSF members. The total coverage rate of the NSSF is approximately 20 per cent of workers.

The NSSF now covers all categories of employers. Most recently, (November 2009) coverage was extended to employers with 1 to 4 employees. As of April, 2010, there were 101,100 employers registered with NSSF.

As of April 2010, the scheme's cumulative membership was 4,272,853.

Funding

The NSSF is financed by employer-employee contributions, of 5 per cent of earnings, and subject to a combined ceiling of KSH 400 (amounting to KSH 200 for both the employer and the employee).

The contribution levels are as follows:

- Insured persons contribute 5 per cent of their monthly earnings. Voluntary contributors pay between KSH 100 and KSH 1,000. The maximum earnings for contribution calculation purposes are KSH 4,000:

⁶³ Government of the Republic of Kenya. 2009. *Kenya Economic Survey 2009*. Kenya National Bureau of Statistics, Ministry of Planning and National Development. Nairobi.

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- Self-employed persons pay 5 per cent of monthly earnings.
 - Employers pay 5 per cent of their monthly payroll.
 - The government sector pays no contributions.

Benefits

The NSSF is a typical provident fund. Currently, it does not pay pensions, but rather pays a lump sum upon retirement. Benefits are paid in one lump sum for the following categories:

- Old-Age Benefit/Retirement Benefit: paid to a member who is no longer employed, and can be claimed at the earliest age of 55 years, up until the age of 60 years;
- Withdrawal Benefit: paid to members at 50 years provided they are no longer in employment;
- Invalidity Benefit: there is no prescribed age limit, however a recognized medical practitioner must certify the member as being permanently incapable of working. Essentially, the benefit is a refund of the paid contributions;
- Emigration Grant: there is no prescribed age limit, however, the claimant must be permanently leaving Kenya. Essentially, the benefit is a refund of the paid contributions;
- Survivor's Benefit: paid to eligible dependants of a deceased NSSF member. Essentially, the benefit is a refund of the paid contributions;
- Funeral Grant: paid to the family of a deceased member in order to help bear the cost of funeral expenses. The refund of is currently set at KSH 2,500; and
- There are plans to introduce a mortgage plan.

The qualifying conditions for the old-age, disability, survivor and funeral benefits are described below:

- Old-age Benefit: age 60 and retired from insured employment. Regarding a drawdown payment, the benefit is paid at age 50 if they are not in insured employment or at any age if they are emigrating permanently.
- Disability Benefit: the fund member must be assessed with a total incapacity for performing any work. The disability is assessed by the fund member's doctor, a NSSF doctor, and the Director of Medical Services in the Ministry of Health.
- Survivor Benefit: paid for the death of the fund member before retirement. Eligible survivors are the spouse and orphans; in the absence of a spouse and orphan, other dependent relatives may receive the benefits.
- Funeral Grant: the deceased fund member must have made at least 3 months of contributions. The grant is paid to a dependant named by the deceased.

The benefit levels are:

- Old-age benefit: a lump sum equal to total employee and employer contributions plus interest (currently around 5 per cent) is paid. Regarding a drawdown payment,

the maximum lump sum is equal to total employee and employer contributions plus interest. The average amount paid lies around KSH 200,000, which equals less than two annual salaries. The maximum benefit paid so far was approximately KSH 1.2 million.

- Disability benefit: a lump sum equal to total employee and employer contributions is paid.
- Survivor benefit: a lump sum equal to total employee and employer contributions is paid.
- Funeral grant: an amount of KSH 2,500 is paid.

Portfolio of the NSSF

The provident fund is based on investments, which earn a return. It is invested in adherence to Retirement Benefits Authority regulations and now stands as indicated in Table 4.1.1.2:

Table 4.1.1.2 Investment Portfolio of the NSSF

	Percentage
Government Securities	7
Immovable Property	31
Cash Deposits in Financial Institutions	4
Fixed Deposit, Time Deposit and Tenant Purchase Scheme Depositors	4
Quoted Stocks (Nairobi Stock Exchange)	52
Unquoted Stocks	2
Total	100
Source: RBA.	

Total assets are about KSH 91 billion. The return on investment (ROI) of the portfolio lies around 12 per cent. The interest rate lies around 5 per cent.

Reform plans

The plan is to convert the provident fund into a pension scheme. A Conversion Bill has been drafted.⁶⁴ According to this Bill, the following changes are planned:

- To provide pensions instead of lump sums for a number of contingencies;
- To change the pensionable age to 60: and
- To make the scheme a funded scheme.

According to a study by the RBA, and outlined in Table 4.1.1.3, most of those surveyed would prefer a pension in place of a lump sum.

⁶⁴Government of the Republic of Kenya. 2007. *Supplement No. 80*. Bills No. 36 (Nairobi, Kenya Gazette, Official law reports of the Republic of Kenya, 13th August 2007).

Table 4.1.1.3 Retirement preferences

	Was a member of	Prefers	Proportion of group (%)
1.	Pension scheme	Pension scheme	88.4
	Pension scheme	Provident fund	7.2
	Pension scheme	Not aware	3.4
2.	Provident fund	Pension scheme	60.7
	Provident fund	Provident fund	32.1
	Provident fund	Not aware	7.1
3.	Not aware	Pension scheme	100.0
	Not aware	Provident fund	0.0
	Not aware	Not aware	0.0

Source: RBA: Report on Retiree's and Pensioner's Survey 2008.

The objective is to achieve a replacement rate of 15 per cent. The plan is to increase the contribution rate to 10 per cent (for each employer and employee).

Occupational schemes

There are a total of about 1,300 occupational schemes in the country, including both defined benefit (DB) schemes and defined contribution (DC) schemes.

On average, the DB schemes operate with a contribution of about 10 per cent, but struggle with low rates of return. The DC schemes have contribution rates of about 30 per cent. Replacement rates go up to 80 per cent but higher replacement rates often correspond with low salaries.

Often, the increases in pension do not match inflation, but rather depend on the financial performance of the respective fund. The RBA issues regulations on investments. According to these regulations, a maximum of 15 per cent can be invested off-shore (actually 5 per cent). Currently, 40 per cent are invested in Government security, 35 per cent in the stock market, and 6 per cent in real estate.

The civil servants pension scheme

Currently, there are 425,000 civil servants in the country and about 200,000 pensioners. The pension budget is KSH 25.2 billion. The scheme is funded from the public budget. Currently, there are no contributions paid. The pension formula is:

$$1/480 \times \text{last salary} \times \text{number of months in service}$$

One quarter of the benefit can be requested as a lump sum, and the rest will be provided as a monthly pension. The minimum pension is KSH 2,000, while the average pension is KSH 10,500. The pensions are adjusted annually according to the CPI. The regular retirement age is at 60 years of age, and early retirement can be requested at 50 years of age.

A survivor pension is paid at a rate of 100 per cent for 5 years. The orphan pension is one third of the regular pension.

There are plans to reform the public pension scheme. Key reforms will include:

- The introduction of a 15 per cent contribution for the employee and a 7.5 per cent contribution for the employer;
- The creation of a separate pension fund; and
- The establishment of a reserve fund and, in the long run, the transition to a funded scheme.

A long transition period is required until the pension scheme will be fully funded. In the mean time, it is planned to give people the choice between a funded and a pay-as-you-go (PAYG) arrangement.

It is planned to include all those over 45 in the new scheme and to leave the older staff in the former scheme.

Currently, the main concern for the Government is to hand over the pension funds to an independent institution, thereby losing influence. On the other hand, a recent actuarial study has shown that the annual increase in pension commitments of the public budget will go up to 15 per cent if there is no reform of funding. This means that the Government is under pressure to make employees contribute to their pension arrangement.

4.1.2 Performance assessment

NSSF

Given the description of the NSSF above, it can be observed that the performance of the NSSF, in terms of coverage, cost/benefit ratio, and return on investments is not convincing.

The total revenue from NSSF contributions is KSH 6.3 billion. This corresponds to about KSH 5,000 per paying member, per year. Table 4.1.2 provides an overview of the benefits paid in 2009 and 2008.

Table 4.1.2.1 NSSF benefits payable, 2009

	KSH'000	Percentage
Age benefits	1,060,390.00	41.5
Survivor benefits	303,432.00	11.9
Invalidity benefits	31,024.00	1.2
Withdrawal benefits	1,137,604.00	44.6
Emigration grant	12,818.00	0.5
Refunds	3,893.00	0.2
Funeral grant	3,295.00	0.1
Total	2,552,456.00	100.0

Source: NSSF, 2009.

As it can be seen, the largest proportion of benefits paid-out are for withdrawals. This tendency for beneficiaries to make withdrawals raises some questions concerning the quality of NSSF as a retirement instrument, given that withdrawal benefits normally benefit from no or lower interest rates. Furthermore, using ones withdrawal benefits means that one accesses their money before retirement, thereby reducing its function as old age security.

In general, the quality of the NSSF as a real retirement scheme can be debated, given that the only benefit is a lump sum. According to an RBA inquiry – the results of which are shown in Table 4.1.2.2 – nearly 50 per cent of the retirees use their lump sums for dependants and not for themselves

Table 4.1.2.2 Utilization of lump sum benefits

How lump sum was used	2008	2004	2003
Paid school fees for my dependants	49.58	22.8	21.9
Bought land/Bought a house/Built own resident property	36.67	24.2	25.1
Started a business	25.42	21.4	19.2
Invested in an already existing business	18.75	2.3	2.3
Paid off loans/Paid debts	16.67	4.7	5.0
Bought livestock/farming implements	13.33	0.0	0.0
Paid medical fees	12.50	1.4	3.2
Invested in the capital markets/other investment	8.33	2.8	5.9
Completed my mortgage	7.08	0.0	0.0
Bought a vehicle/Bought household/consumption goods	6.25	13.5	8.7
Saved in a bank	5.00	0.0	0.0
Other	5.00	0.0	3.2

Source: RBA Report on Retiree's and Pensioner's Survey, 2008.

The total administrative costs for the NSSF sum up to KSH 4.9 billion (3.7 billion without doubtful investments), a sum which is nearly double the amount of benefits paid or 78 per cent (59 per cent) of the contribution income. This level of administrative costs is far too high, and raises questions regarding the effective use of contributions.

The total investment income, or return on investment (ROI), is about 18 per cent. The interest on individual member's accounts was 2.5 per cent in 2009 and 4.8 per cent in 2008. These interest levels may indicate inadequacy in the usage of funds. It seems that the interests in favour of members could be significantly higher, if costs were to be reduced. Currently, these levels are not even high enough to account for changes in inflation. Due to these issues, the current situation of the NSSF could be examined in order to fully understand the reasons behind these issues, and to identify possibilities to improve current performance.

Analysis of the recent developments of the NSSF based on a 2008 report,⁶⁵ and on NSSF financial data found in Annex E, indicates the following:

- Contributions to the NSSF have increased. The income from contributions has more than doubled from KSH 2.2 billion in 2002 to KSH 6.3 billion in 2009;
- The level of benefit outgoing has remained static, between just over KSH 2 billion and KSH 2.5 billion in the last 10 years;
- The total reported assets of the NSSF increased from KSH 40 billion in 2002 to nearly KSH 100 billion in 2009; and
- Although there has been an improvement in operational efficiencies, the level of administrative and staff expenses remain high compared to country and international benchmarks, especially as the NSSF operates as a provident fund and does not disburse pension payments.

⁶⁵ Sundeep, K. Raichura. 2008. *Analytical Review of the Pension System in Kenya* (Nairobi).

The current level of benefits, given the low monetary ceiling on contributions, is inadequate. Indeed, at the current contribution levels, assuming a member contributed to the NSSF for 30 years, the amount available to sustain that member during retirement is projected to be less than the average earnings for two years. In order to provide a decent pension, at least six annual earnings are needed.

The benefits available to members are also impacted by the high costs of administration, the low investment returns and the even lower returns credited to members. Furthermore, there is no consistency between the rates of return earned and those credited to members' accounts;

The NSSF only provides lump sum benefits and there is no provision for annuitization. Unfortunately, there is a tendency for lump sum benefits to be poorly applied or squandered by beneficiaries, which in turn results in inadequate protection against poverty in old age. Additionally, the NSSF has a range of benefits that is quite limited; there is no pooling or sharing of risks and no minimum level or 'safety net' of benefits.

The level of contributions, which is effectively only 1.3 per cent of average earnings (and higher where earnings are less than national average earnings), can be regarded as affordable, but is by far too low for a decent old-age security system.

If the NSSF remains a defined contribution scheme, then measures should be taken to ensure that assets are in balance with liabilities by design. However, the differences in returns allocated to members vis-à-vis returns-earned can create mismatches between assets and liabilities; legislatively stipulated minimum annual credit to members of 2.5 per cent, regardless of net return earned, also impacts financial position. Hence, regularly evaluation of the asset-liability relationship is important.

The NSSF is not a pure defined contribution scheme, but overall ought to have the capacity to withstand major shocks. This would be subject to adopting a proper and more equitable basis of allocating net returns to members and asset liability management. Discussions with the NSSF indicate progress in a number of areas including increased computerization, improvements in processes, turnaround times for benefit payments and customer care standards. A new customer service charter was launched in 2007 and for the first time ever the NSSF published its financial statements for the year ending June 2007 in the print media.

In spite of these improvements and the significant changes that have been made at an institutional level, there remain concerns over the institutional structures at the NSSF and their effectiveness. Nevertheless, given its established structures and wide branch network of 35 regional offices, and provided that the institutional weaknesses are addressed, the NSSF can provide a good platform on which to implement further reforms of the Kenyan pension system. Reform of the NSSF and its conversion to a pension scheme has been a Government policy objective for some years. The Government's Economic Recovery Strategy for Wealth and Employment Creation 2003 – 2007 explicitly provides for the NSSF Act to be reviewed to convert the NSSF into an autonomous pension fund with an increased coverage and range of benefits. A bill to convert the NSSF into a social insurance pension scheme has been presented to Parliament and possible reform options for the NSSF have been the subject of debate with stakeholders.

Concerning the plans to convert the NSSF into a fully-fledged pension scheme the key parameters are:

- The current benefit level is about 1.5 annual salaries.
- To provide a replacement rate of 40 per cent, about four annual salaries reserve are needed, based on an average salary of 10,000 KSH and an average pension period

(unisex life expectancy) of 15 years, an interest rate of 6 per cent and an annual pension increase of 6 per cent.

- To fund such a reserve a 12 per cent contribution rate is needed (from employers and employees together, given an annual salary increase of 6 per cent).
- The administration costs (about 3 per cent according to international experiences) need to be added to this.

Table 4.1.2.3 Calculation of the needed pension reserve

Average annual salary (KSH)	120,000.00
Average replacement rate	40 per cent
Interest rate for benefits	6 per cent
Unisex life expectancy of pensioners	15
Annual pension increase	6 per cent
Present value of Reserve fund	466,187.95

Source: Authors' calculation based on NSSF data.

Table 4.1.2.4 Calculation of contribution rate

Reserve fund needed	466,187.95
Years contribution paid	35
Average salary	10,000.00
Average annual salary increase	6 per cent
Interest rate	6 per cent
Contribution rate	12 per cent

Source: Authors' calculation based on NSSF data.

The scenario described above does not yet include survivor and invalidity pensions. Given the unavailability of data, several assumptions are unable to be made which are necessary for relevant calculations. Data required for the development of appropriate and accurate assumptions and calculations includes:

- Number and life expectancy of survivors.
- Number of invalids, their kind of disability (degree) and life expectancy (for pensions).

Based on international experience, we can assume an additional 2 to 3 percentage points to the contribution rate in order to finance a decent scheme. Thus, the final contribution rate including these benefits and appropriate administration costs might be around 18 per cent of the salary.

To implement such a pension plan, a gradual shift from lump sum payment to pension is needed. A transition period, during which people could be given the choice between the two payment options, could be created. A feasible timeline for the plan would be:

- By 2012, introduce a pension scheme with a defined contribution rate of 15 per cent.
- Between 2012 and 2020 pay lump sums.
- By 2020, begin to pay pensions, starting with new pensioners.
- Between 2020 and 2025 give people the choice between lump sums and pensions (for those with pensions less than KSH 2,000).

Public pension scheme

The public pension scheme is by far the largest social protection scheme in the country in terms of costs, and currently dominates public expenditure on social protection. These large costs are not reflected in high coverage rates. The annual budget of the public pension scheme is KSH 25.2 billion. This amount is nearly five times the budget of the NSSF, however the NSSF covers nearly eight times as many people. The public scheme has an average (and very generous) replacement rate of around 90 per cent according to the pension formula after an active period of 35 years.

The budget of the public pension scheme constitutes more than half of the public expenses on social protection. The Government's intention to introduce a contribution for this scheme must be supported. If even half of the scheme's expenses were financed through contributions, then the resulting savings could feasibly be used towards the creation of a universal pension scheme. Such a scheme would be able to provide coverage and income security in old age to about 500,000 elderly people.

4.2 Health insurance schemes

4.2.1 Description

There are several schemes in Kenya that offer some degree of social health protection; the main schemes are the National Hospital Insurance Fund, some private insurance companies and health maintenance organization (HMOs), as well as some micro insurance schemes. By far, the largest scheme is the NHIF, which has approximately 10 million beneficiaries.

National Hospital Insurance Fund (NHIF)

Organization

The NHIF was founded in 1966. The current law pertaining to hospital insurance dates from 1998. The NHIF is a social health insurance system that provides medical benefits only.

The NHIF will register all eligible members from both the formal and informal economy. For those in the formal economy, it is compulsory to be a member. For those in the informal economy as well as retirees, membership is open and voluntary.

Following medical care provision, and after the members have been discharged from the hospital, claims are submitted by hospitals directly to the NHIF. The claims are examined by the Fund to ensure validity prior to payment. A claim can, however, be rejected, at which point the hospital will be informed accordingly to incorporate either the missing documents or to address the identified abnormalities. The majority of this process is now computerized. The Fund aims to pay claims within 14 days of the receipt of the claim from the hospitals. Members who opt to pay the bills to the hospital may launch a general claim directly to NHIF for reimbursement.

The Fund is in the process of converting contributors and their dependants into individual account holders and issuing them with photo cards. It is the hope that the photo cards will enhance service provision and help curb fraud. In addition, the database is undergoing changes, using electronic downloading of payroll information on a monthly basis. The administration costs of the fund are relatively high at 30 to 40 per cent.

Coverage

Those covered under the NHIF are employed persons earning at least KSH 1,000 a month, including public-sector employees and self-employed persons. The dependants of those insured are also covered. Voluntary coverage for persons earning less than KSH 1,000 per month is possible as well.

It is estimated that the Fund has about 2.5 million contributors with approximately 7.5 million dependants. Unfortunately, the NHIF premiums remain too high for the 20 per cent of the poor population who are unable to afford them.

Funding

The scheme is funded by government expenditure and through contributions. NHIF expenditure accounts for an estimated 12.26 per cent of social protection expenditure in Kenya (see Annex G) and an estimated 10 per cent of public health spending.⁶⁶ Contributions are based on the following structure:

- Insured persons pay a variable monthly contribution, depending on their income, of between KSH 140 and KSH 320 with an average premium of around KSH 240. Voluntary contributors pay a flat rate of KSH 160 per month (although there is a planned increase to KSH 300);
- Self-employed persons pay a variable monthly contribution of between KSH 140 and KSH 320; voluntary contributors pay a flat rate of KSH 160 per month;
- Employers pay no contribution; and
- Government pays no contribution.

Formal economy employees' contributions are deducted and remitted to the Fund by their employers. This is done by cheque or through e-banking. The employer gets a Certificate of Contributions Paid (CCP) book and official receipt from the NHIF.

For members under the voluntary category, they pay KSH160 per month (KSH1920 per year). For those in formal employment, contributions are made according to their income.

The Fund maintains an annual reserve of one third of the premiums collected.

The total revenue of the NHIF is around KSH 5.4 billion or about KSH 540 per capita. The structure of expenses is shown in the following table. It can be seen that the share of expenses used for benefits lies at 54 per cent, which is quite low.

Table 4.2.1 NHIF Cost Structure, 2008/2009

	Million KSH	Percentage
Benefits	2,812.87	54.2
Personnel costs	1,447.38	27.9
Administration expense	909.27	17.5
Board and conferences	17.94	0.3
Total	5,187.45	100.0

Source: NHIF. 2009. *Annual Report and Financial Statements 2009*.

⁶⁶ Government of the Republic of Kenya. 2010. *Social Protection in Health: Policy and Financing Strategy*. Ministry of Public Health and Sanitation and Ministry of Medical Services. Nairobi.

Qualifying Conditions

There is no qualifying period to be eligible for NHIF benefits; however, voluntary contributors must have at least 60 days of coverage to claim medical benefits and at least 6 months of coverage to claim maternity medical care.

Benefit levels

Although the NHIF provides both in-patient and out-patient care, current benefits only include in-patient hotel costs. Care is provided through three types of hospitals:

- Government hospitals (Category A).
- Private hospitals (Category B).
- High-cost establishments (Category C).

There are over 400 accredited hospitals in Kenya, which have over 40,000 beds.⁶⁷ The WHO estimates that there were an average of 14 hospital beds (including inpatient and maternity beds, and excluded cots and delivery beds) per 10,000 population between 2000 and 2009.⁶⁸ NHIF services are purchased from these facilities, which make up approximately 60 per cent of the total bed capacity in the country, with varying coverage proportions across provinces, ranging from 30 per cent of total beds in the North Eastern provinces, and 77 per cent in the Rift Valley.

Government hospitals are normally of a lower quality in terms of queues and availability of drugs, although this is mostly the case in Nairobi, whereas up-country they are the first choice. Those who can afford to do so will go to private hospitals.

Category A and B hospitals get special rates and thus can afford higher support values. The support values lie at over 50 per cent in government hospitals and significantly lower in category B and C hospitals. The government hospitals often have a waiver system, whereby very poor persons are treated free of charge.

The official co-payment scheme foresees the following user charges for outpatient treatment:

- Dispensary costs KSH 10.
- Health centre costs KSH 20.
- And higher categories can vary.

Free care is provided in government hospitals for certain illnesses, including tuberculosis, sexually transmitted diseases, and AIDS. Given the stigma associated with some of these illnesses, and the fact that many of them go undiagnosed, many Kenyans who are ill will not seek care.

The maximum duration of benefits is 180 days a year, but may be extended in the case of exceptional hardship.

⁶⁷ Government of the Republic of Kenya. 2010. *Social Protection in Health: Policy and Financing Strategy*. Ministry of Public Health and Sanitation and Ministry of Medical Services. Nairobi.

⁶⁸ WHO. 2010. *World Health Statistics 2010*. World Health Organization. Geneva.

Free inpatient treatment in government hospitals is provided to employed persons who are not covered by health insurance but who contribute to the National Social Security Fund. Government employees receive subsidized care at government facilities.

According to the schedule provided for in law, cost sharing exists in the form of refunded expenses for hospital and medical treatment for insured persons. Maximum reimbursement rates range from KSH 200 to KSH 2400⁶⁹ per hospitalized day, depending on the facility visited. Medical services provided abroad are reimbursed at KSH 750 a day.

Dependent children are entitled to up to 10 days of benefits up until age 18, or age 22 if still dependent.

Future plans

For the future, the NHIF has several areas where reforms are to be implemented:

- It is planned to expand the benefit scheme to include outpatient care. To finance this shift, an increase of contributions will be required to more than double the current contribution (to bring the average to around KSH 650).
- To introduce a contribution as a percentage of salary, with a cap.
- To reform the co-payment system and to introduce official co-payments instead of maximum rates of reimbursement.
- To include more hospitals in the contracting system.
- To increase coverage to include the entire informal economy.

Notably, however, there are no plans yet to introduce a subsidy from the public budget to cover the poor who cannot afford to pay the contribution.

Cash benefits: sick leave and maternity leave

Paid sick leave benefits are provided for under the 1976 Employment Act. The Act requires employers to pay 100 per cent of earnings for up to 2 months of sick leave. Some trade unions have negotiated alternative benefits with employers, for example, to pay 100 per cent of earnings for one, three or six months, and then pay 50 per cent of earnings for a period of equal duration.

Maternity benefits are also stipulated in the 1976 Employment Act. The Act requires employers to pay 100 per cent of earnings for up to 2 months of maternity leave. Some maternity medical benefits are also provided by employers.

Private health insurers and HMOs

There are various private health insurers in the country that mainly cater to those within the upper income brackets. These companies offer schemes with risk-based premiums and reimbursement schedules with caps. Some private insurers are organized as health maintenance organizations. About 500,000 Kenyans belong to private insurance schemes. Higher income groups take out private insurance, but many in lower income groups often

⁶⁹ Government of the Republic of Kenya. 2010. *Social Protection in Health: Policy and Financing Strategy*. Ministry of Public Health and Sanitation and Ministry of Medical Services. Nairobi.

cannot afford to do so due to high premiums and lack of low-cost options in private schemes.⁷⁰

Employer-based schemes

Various large employers provide health coverage for their employees through private health insurance. Apart from this, there are some employers that provide special health programs for their staff. One such scheme is the Serena Hotels Employee Wellness Programme. In partnership with the International Finance Corporation (IFC) and others, Serena Hotels has developed a Wellness scheme from its HIV/AIDS programme. The scheme was first developed in 2002 to reduce the spread of HIV/AIDS among workers and the local communities and improve worker productivity. Now, Serena offers subsidised medical services at the company's clinics, training of community wellness educators, free condoms, and provides free insecticide-treated mosquito bed nets in the community. Community members can access clinical services and receive free consultations, only having to pay for drugs. Further, nurses from the clinics conduct information sessions on HIV/AIDS and malaria at churches and schools.⁷¹

With HIV/AIDS continuing to affect all aspects of life in Kenya, including the workplace, domestic and international employers need a more pro-active approach in the health of their employees. One such example is at Unilever, where some 800 employees from Unilever and other companies participated in a weeklong event on HIV/AIDS education. The event was part of Unilever Kenya's 15-year-long campaign, which began in 2002, to educate its employees about the disease. The company subsidises its campaign, events, and resources in partnership with other companies. It offers voluntary counselling and testing of HIV/AIDS, and health checks for blood pressure, body mass index and diabetes are also given. Along with HIV/AIDS, tuberculosis is often featured in the campaign to highlight the links between the two diseases as well as the re-emergence of TB in Kenya. Through education and awareness, the company allows for an open forum and discussion of illness for employees hopefully diminishing the social stigma of the disease.⁷² Especially in low-income countries, only recently have private companies begun to push for more health initiatives relating to the specific needs of their employees. It is important that the private sector continues to play a role in providing health education, counselling, and other health-related measures to its employees. It complements and supports the benefits provided by health insurance.

Micro insurance schemes and voucher schemes

Recently, many micro insurance schemes have emerged to provide health to and to cover more households. One such scheme is that developed by the Kenya Women Finance Trust (KWFT). The scheme was developed in partnership with the National Health Insurance Scheme and the Co-operative Insurance Scheme (CIC). This scheme is based on a similar scheme, Bima ya Jamii ("health for the family") Insurance Policy, which is offered in a

⁷⁰ International Social Security Association (ISSA). 2008. *Kenya. Expansion of Coverage for Low-Cost Private Health Insurance*. Available at <http://www.issa.int/aiss/Observatory/Country-Profiles/Regions/Africa/Kenya/per cent28link per cent29/Reforms per cent201>.

⁷¹ Lutalo, M. 2007. "The Wellness Program of Serena Hotels, Kenya – A Case Study", in *HIV/AIDS – Getting Results* (World Bank Global HIV/AIDS Programme). Available at [http://www.ifc.org/ifcext/aids.nsf/AttachmentsByTitle/The+Wellness+Program+of+Serena+Hotels/\\$FILE/GR-Serena_Final_Aug29_07.pdf](http://www.ifc.org/ifcext/aids.nsf/AttachmentsByTitle/The+Wellness+Program+of+Serena+Hotels/$FILE/GR-Serena_Final_Aug29_07.pdf).

⁷² Unilever. 2010. *Kenya: Fighting HIV/AIDS*. Available at <http://www.unilever.com/sustainability/casestudies/health-nutrition-hygiene/kenyafightinghivaids.aspx> (accessed on 14 June 2010).

partnership between the CIC and NHIF. It also functions as a voluntary scheme aimed at members of the CIC.

The KWFT scheme covers approximately 100,000 households. The premiums cost KSH 10 per day or KSH 3,600 per year, which is a reasonable rate for small business owners who receive service loans from KWFT starting at KSH 20,000 for businesses. Premiums are subsidized by the NHIF, which means that the KWFT scheme costs only one third of the standard NHIF scheme per day.

Regarding benefits, all in-patient expenses for the member and her family are included in the scheme. There are no exclusion clauses and chronic illness, maternity, and surgery costs above KSH 15,000 are also covered. However, similar to the public NHIF scheme, expenses must be incurred in an approved private, public, or mission hospital, and are covered for up to 180 days.

Another approach is used by KfW Entwicklungsbank. Rather than giving grants to the general health care system, KfW has been financing a voucher scheme since 2006.

Kenya's high rate of maternal mortality through childbirth complications and abortions led KfW to find alternate schemes. Less than 7 per cent of the 9 million people in the informal economy are insured. Those without insurance must pay out of pocket. The high cost of child birth means that many women are forced to give birth at home without professional supervision and often under unhygienic conditions. These women and their families can also not afford antenatal care which would give them information about their pregnancy, their health, and family planning leading to further issues of ill health among the poor in Kenya.

During the first phase of the project, 150,000 vouchers were handed out in three rural regions and in two Nairobi slums. In 2009, the second phase was launched to lay the foundations for a nation-wide program.

Bima Ya Jamii,⁷³ as mentioned above, is a micro insurance scheme for health which has been developed out of a partnership between The Co-operative Insurance Company of Kenya Limited (CIC) and The National Hospital Insurance Fund (NHIF) for the uninsured population in Kenya.

Bima Ya Jamii is an insurance package that costs KSH 3,650 per family per year. The benefits include doctor fees, bed charges, surgery, including food, X-ray and laboratory costs, prescribed drugs, maternity costs for normal and caesarean births

The principal member is the contributor. Children are covered from one-day old to 18-years old. Children between 18 and 25 years are covered if they are still dependent on their parents. There is no exclusion clause for HIV/AIDS or other pre-existing conditions. The policy has no upper age limit for the principal member and spouse. The policy is renewable every year immediately after expiry.

The insurance package is supplementary, not complementary to the NHIF scheme. Given the costs of the premium, it primarily targets the middle class of the informal economy, and less so the poor.

⁷³ CIC Insurance. *Micro Insurance*. Available at <http://www.cic.co.ke/Our-Policies/Micro-Insurance>.

4.2.2 Performance assessment

Kenya faces many of the same challenges in extending universal social health protection as other developing countries: low levels of public expenditure, limited coverage rates and even more limited access rates, high prevalence of out-of-pocket payments, and a corresponding tendency for populations to become part of the vicious cycle of ill-health and poverty. In order to understand how social health protection can be improved in the country, it is necessary to assess its current state.

The NHIF has contribution collections and other income combining to KSH 5.4 billion. Of this, 2.8 billion – over 50 per cent – are used for benefit expenses. The majority of the rest of this income is used to cover administrative expenses, a proportion that is very high by international standards. Additionally, the NHIF has large amounts invested in property and plant equipment (two annual incomes), which, according to the financial statements is not included as administrative expenses or adequate income from rent; as many premises are used by NHIF. These costs should however be reflected. With standardized accounting, large portions of these funds would be added to the administrative expenses and would, accordingly drive up administrative costs further by up to an additional KSH 1 billion.

Future options for the NHIF, excluding reduction of administrative expenses include:

- expansion of coverage to the informal economy;
- introduction of a support scheme for the poor;
- expansion of the benefit package to cover outpatient care;
- increase in the support value of the benefit package; and
- introduction of an affordable co-payment scheme.

The fact that the NHIF covers only inpatient care could possibly lead to high confinement rates; instead of seeking treatment at outpatient facilities, members may prefer to get confined, as it is more cost-effective, given that it is at least partly covered by NHIF.

Currently, the benefit expenses per capita lie around KSH 200 per year, or KSH 1,200 per year per paying member. If coverage is expanded to the whole country, this would cost approximately KSH 4.6 billion. This would be a good chance to create economies of scale as it can be assumed that this shift would not create more administrative expenses.

The actuarial contribution covering the entire costs (including administrative costs) currently lies at KSH 170 per month. Given the scenario mentioned above, these costs would be halved, lying around KSH 85 per month. This can be attributed to two factors:

- Economies of scale (no increase in administrative costs)
- The dependency ratio would decrease from 5 to 3 per paying member.

The decrease in the dependency ratio is reflected by the fact that currently NHIF calculated with a ratio of 4.8. However, if we put the entire labour force of 9.5 million in relation to the rest of the population, the dependency ratio decreases to 3. This might be due to the fact that in this scenario, all working family members would pay a contribution, meaning that there would be several paying contributors in each family. It is not clear how this issue is handled today.

Given the low levels of income in many Kenyan households, it is evident that not everybody will be able to pay a contribution. It is foreseeable that the poor will require assistance. If the state were to cover the contribution for the estimated 20 per cent hard core poor in the population, this would have a budget implication of KSH 1.5 billion.

The costs of the expansion of the scheme to outpatient care are very difficult to calculate. The reason is that specific cost data, which is unavailable, is necessary. While the NHIF estimates that this change would roughly double expenses, we are less sure about this. In other countries, the relationship of outpatient cost to inpatient cost per capita is about 1:3, meaning that inpatient care is three times more expensive than outpatient care. However, this largely depends on the respective support value, on which we have limited and inconclusive information. Recorded support values vary substantially, ranging from the very low (below 50 per cent of the actual costs of care paid by the NHIF) to complete (NHIF pays 100 per cent of the costs, at least in public hospitals). These discrepancies require further analysis. Due to these data limitations, we were unable to establish any scenarios about the consequences of an increase in the support value.

Concerning co-payments, the logic is that if there is a support value of 100 per cent and no space for out-of-pocket payments, at least in some facilities, there is room for the introduction of an official co-payment scheme. This, again, would only make sense to discuss with the availability of full information about the actual support value. If, for example, the NHIF pays maximum amounts only and still leaves part of the costs to the insured, there is no need to discuss co-payments.

Table 4.2.2 Model calculation for expansion of coverage

	KSH per year (2009)	KSH per month
Total contributions	5,079,569,956.00	
Total expenses	5,187,453,769.00	
Benefit expenses	2,812,868,248.00	
Other expenses	2,374,585,521.00	
 Total paying members	 2,500,000.00	
Family members	12,000,000.00	
Total beneficiaries	14,500,000.00	
Total labour force	9,500,000.00	
 Contributions per paying member	 2,031.83	 169.32
Per capita expenses for benefits	193.99	
 Estimated population (full coverage)	 38,000,000.00	
Coverage gap	23,500,000.00	
 Estimated additional benefit cost for 100 % coverage ⁷⁴	 4,558,786,470.90	
Total expenses at 100 % coverage ⁷⁵	9,746,240,239.90	
Estimated contribution for 100 % coverage ⁷⁶	1,025.92	85.49
Source: Authors' calculations, NHIF data.		

4.3 Employment injury schemes

4.3.1 Description

Organization

Kenya's basic employment injury scheme dates back to 1946 (and has since been repealed). The current laws regarding workmen's compensation date from 1974, and underwent amendments in 2007 with the creation of the Occupational Health and Safety Act (OSHA) and the Work Injury Benefit Act (WIBA). The system is based on the

⁷⁴ This amount is obtained by multiplying the coverage gap (23,500,000) by per-capita expense for benefits.

⁷⁵ This amount is obtained by adding the current total expense (5,187,453,769.00) and the estimated additional benefit cost for 100 % coverage (4,558,786,470.90). This implicitly means that the estimate is made on the assumption that no 'other' cost would be incurred to reach the non-covered population of 23,500,000.

⁷⁶ This is estimated by dividing the total expense at 100 % coverage by the total labour force (9,500,000).

principle of employer-liability, and normally involves the employer purchasing insurance with a private carrier.⁷⁷

The Ministry of Labour is responsible for enforcing the law, approves settlements, and pays benefits from funds deposited with it by employers.

Coverage

Those covered under the legislation are formally-employed persons in the public and private sectors. Non-manual employees earning more than KSH 4,000 per month, self-employed persons, casual workers, and family labourers are excluded.

Source of funds

The total cost is met by employers through the direct provision of benefits or insurance premiums. Those who are covered (the insured) bear no costs. The government is responsible only for the provision of insurance premiums for government employees.

Benefit levels

The benefit levels for each covered category are as follows:

- **Temporary Disability Benefits:** The benefit is equal to 50 per cent of the insured's earnings, up to KSH 540. The benefit is paid after a 3-day waiting period; the benefit is paid retroactively if the incapacity lasts for more than 3 days. The maximum total temporary disability benefit is KSH 240,000. The disability is assessed by the insured's doctor, an NSSF doctor, and the Director of Medical Services in the Ministry of Health. Benefits are adjusted periodically by the Minister of Labour.
- **Permanent disability benefit:** A lump sum equal to 60 months of the insured's earnings is paid for a permanent partial disability. The maximum total permanent partial disability benefit is KSH 240,000. The disability is assessed by the insured's doctor, a National Social Security Fund doctor, and the Director of Medical Services in the Ministry of Health. Benefits are adjusted periodically by the Minister of Labour.
- **Survivor Benefits:** A lump sum equal to 60 months of the deceased's earnings is paid to survivors who were fully dependent on the deceased; in the absence of fully dependent survivors, a reduced benefit is paid to survivors who were partially dependent. The minimum benefit is KSH 35,000. The maximum benefit is KSH 240,000.
- **Funeral grant:** A lump sum equal to the cost of the funeral is paid to dependants; the employer pays KSH 2,000 if there are no dependants. Benefits are adjusted periodically by the Minister of Labour.

⁷⁷ International Social Security Association(ISSA) and USA Social Security Administration (SSA). 2009: *Social Security Programs Throughout the World: Africa, 2009* (Washington D.C., Social Security Administration Office of Retirement and Disability Policy Office of Research, Evaluation and Statistics).

4.3.2 Performance assessment

Due to their recent implementation, the effects of the 2007 Acts relating to work injury have not yet been fully evaluated. There is also a lack of data on work injury and occupational disease, which will continue to impede evaluation and accordingly, appropriate policy changes.

Preliminarily however, the legislation provides a framework for the extension of coverage within the formal labour market. At present, the ILO estimates a legal coverage rate of some 13 per cent (1,200,000 Kenyans), which means a statutory coverage gap of nearly 90 per cent. As in most countries however, it is likely that many employment injuries will go unreported by employers, and benefits will not reach eligible workers. Furthermore, existing schemes do not protect those in the informal labour market against loss of productivity and income in the case of injury. For these individuals, protection is even more crucial, as their working conditions tend to be more hazardous.

The benefit adjustment by the Ministry of Labour is beneficial as it will allow for gradual improvements in replacement rates and maximum benefits paid as Kenya's social protection floor expands.

4.4 Social assistance and comparable income support schemes

4.4.1 Description

About 46 per cent of the Kenyan population live under the poverty line, and an estimated 20 per cent are chronically poor and food insecure. Classical social assistance programmes like conditional cash transfers could be used to target this part of the population. Although such programmes currently exist in Kenya, they are quite limited.

Poor households are often unable to respond to adverse events, even if traditional coping systems and market-based social protection services are in place. Traditional systems based on reciprocity depend on the same livelihood of its members that often only provides low incomes, low assets and low savings, and are thus themselves subject to adverse events. The insufficient resources provided by households, neighbourhoods, communities, or social organizations are therefore often unable to serve as a coping mechanism given the extent and frequency of adverse events. Access to market-based social protection, including health insurance, social security, retirement benefits, and asset insurance is extremely limited to the poor due to their low incomes and unviable livelihoods. Vulnerable traditional systems and the difficulties in accessing market-based systems thus reduce “the resilience of many poor households, and increases their dependence on external support from Government and other sources to sustain basic levels of food security and access to health and other basic services.”⁷⁸

The main social assistance programme in Kenya focuses on families with orphans or vulnerable children. The impetus for developing a cash transfer programme stemmed from the growing realization that some of the other elements of social protection in Kenyan society, especially family and communal mechanisms, were breaking down in the face of the growing HIV/AIDS pandemic.

⁷⁸ Ministry of Gender and Social Development. Kenya. 2010: *National Social Protection Policy*, Nairobi.

It is estimated that one in seven of all orphans of the African Region live in Kenya. This amounts to approximately 1.8 million Kenyan orphaned children under the age of 18 that have lost one or both parents as a result of death.⁷⁹ In recent years, the proportion of children in Kenya orphaned due to HIV/AIDS infections of their parents has risen dramatically. While about 9 per cent of orphans had lost their parents to HIV/AIDS in 1998, this proportion grew to 11 per cent in 2003, and has currently reached over 60 per cent.⁸⁰

The number of other “vulnerable children” whose “safety, well being and development are (for various reasons) threatened” or “who are emotionally deprived or traumatized”⁸¹ is also increasing. According to estimates of the National AIDS Control Council (NACC), there are approximately 600,000 vulnerable children in Kenya, many of whose parents are affected by HIV/AIDS, who are unable to work or support their children, or need treatment and care from family members. The total number of OVC in Kenya thus amounts to about 2.4 million.⁸²

The OVC programme is administered by the Ministry of Gender and Social Development and provides cash transfer of KSH 1,500 per month to eligible households. All households that apply for support through the programme are subject to a proxy means test, are not allowed to receive funds from other programmes and must have one orphan or vulnerable child under 18 years old living in the household.

Currently 82,000 households are covered in selected areas, corresponding to about 400,000 individuals. There are plans to expand to 100,000 households in 2010. The Ministry estimates that the total number of people in need is about 1 million.

The cash transfer is delivered through post offices or through district offices. There are also pilot programmes exploring other transfers methods, for example, through mobile phones.

The OVC programme began in 2004 with a small pre-pilot programme supported by UNICEF and the Swedish International Development Agency (SIDA) and managed by the Children’s Services Department of the MGCSD. The focus of the pre-pilot was on households that: were poor, had OVC and were not receiving benefits from other cash transfer programmes at that time. The pre-pilot provided benefits to 500 OVC in three districts provided lessons on targeting, selection procedures, implementation and costs, to be used for scaling-up the programme.⁸³

The second phase of the programme was launched in 2006 and was guided by the lessons learned from the pre-pilot. Phase 2 aims to extend the number of OVC who receive transfers, as well as to provide further information on the design, efficiency and impact of programme. It consists of the pilot programme in seven districts, as well as an extended

⁷⁹ UNICEF. 2005. *The State of the World’s Children 2006* (New York).

⁸⁰ WB. 2009. *Project Appraisal Document on a Proposed Credit in the Amount of SDR 33 Million to the Republic of Kenya for a Cash Transfer for Orphans and Vulnerable Children Project* (Washington, D.C.).

⁸¹ Government of the Republic of Kenya. 2005. *National Policy on Orphans and Vulnerable Children*, Final Draft November 2005 (Nairobi, Office of the Vice President and the Ministry of Home Affairs).

⁸² WB. 2009: *Project Appraisal Document on a Proposed Credit in the Amount of SDR 33 Million to the Republic of Kenya for a Cash Transfer for Orphans and Vulnerable Children Project*. Washington, D.C.

⁸³ World Bank (WB). 2009. *Project Appraisal Document on a Proposed Credit in the Amount of SDR 33 Million to the Republic of Kenya for a Cash Transfer for Orphans and Vulnerable Children Project* (Washington, DC).

programme in another 40 districts which was undertaken given the urgency of OVC needs, even before the pilot was completed.

OVC beneficiary households each receive KSH 1,500 per month. The beneficiaries are selected based on the same three criteria employed in the pre-pilot, however with more refined indicators. This is especially the case for the poverty criterion, which defines poor households as those that, due to lack of income, cannot provide for their basic needs (appropriate food, shelter, schooling, health care and clothing). The targeting of beneficiaries is clearly delineated in a five-step process which includes the involvement of community leaders.

When beneficiaries enrol in the programme, households receive relevant information regarding their entitlements as well as their responsibilities as beneficiaries. The pilot programme also includes research on the use of penalties as incentives regarding compliance with the co-responsibilities of the benefit, for example, sending the OVC to school and ensuring vaccination. The implementation arrangements, roles and responsibilities of the programme have been clarified and recorded, alongside the creation of a Management Information System. Additionally, the programme has incorporated a complaints and appeals mechanism.⁸⁴

There are some other social assistance programmes in Kenya; however they are substantially smaller than the OVC programme. One programme is to support the elderly, which was launched in 2009 and currently provides cash transfers to about 33,000 people. Another programme targets the urban poor with a food subsidy.

The government of Kenya has launched the pilot phase of the subsidy programme aiming to provide poor Kenyans with a monthly cash allowance to meet basic food needs. The government will be providing the cash allowance to 20,000 Kenyan families living in Nairobi slums. The pilot programme marks the first phase of the Saidia Jamii ('Help the Family') programme during which each household will be receiving KSH 1,500 per month, delivered through mobile phone transfer and electronic card system.

A second pilot phase will expand the programme to Kenya's second and fourth largest cities, Mombasa and Kisumu, where another 20,000 families will receive the subsidies. If successful, the results of these two pilot phases will inform the roll-out of the full Saidia Jamii programme into other urban areas in 2010.

The Kenyan food subsidy scheme is being implemented by the Kenyan government with the support of Oxfam and the World Food Programme (WFP). The pilot phase of the Saidia Jamii programme is being funded primarily by the Kenyan government, which will invest KSH 600 million (approximately US\$ 8 million), while the WFP will contribute about KSH 81 million (approximately US\$ 1 million).

'Community-based targeting' is to be used to select families, through a local community targeting committee. These will be composed of a local administration representative, the village chief, head teachers, community mobilizers, community elders, a city council representative, staff from other NGOs and other relevant actors. The committee will choose which households are eligible for support based on targeting criteria such as the presence of several elderly people, child household-heads or people living with terminal illness and no support.

⁸⁴ World Bank (WB). 2009. *Project Appraisal Document on a Proposed Credit in the Amount of SDR 33 Million to the Republic of Kenya for a Cash Transfer for Orphans and Vulnerable Children Project* (Washington, DC).

In order to prevent possible abuse, WFP will ensure that targeted households are registered in its database. WFP will also verify the registered database against a monthly disbursement list. Additionally, there will be monthly monitoring of randomly selected households to ensure their receipt of the entitlement. House-to-house calls will also be made to verify that recipients qualify for the subsidy.

The cash transfer programme will complement other existing government social safety net programmes including the OVC cash transfer programme and the Hunger Safety Net Program (HSNP).

The use of mobile phones for cash transfers is increasing in Kenya. In fact, Kenya was one of the first countries in the world to use mobile phones for cash transfers.⁸⁵ The service, called M-PESA, was developed by Safaricom Limited. M-PESA was first used for bulk cash transfers during the post-election emergency in early 2008 in the Kerio Valley. During the violence, communities in the Kerio Valley had their livestock looted, and were displaced. Cash transfers were seen as a way of overcoming the challenges posed by the terrain and the security situation in the provision and distribution of food aid. In all, 570 households were targeted with cash transfers. A total of KSH 3,600,000 was disbursed in two instalments.

4.4.2 Performance assessment

The main scheme of social assistance in the country is the OVC scheme. It pays a lump sum of KSH 1,500 to 82,000 households per month, which has a budget implication of KSH 1.5 billion. The total coverage of the scheme is about 410,000 people (5 persons per household). There are some other transfer programmes, the main of which is the food subsidy programme, with planned coverage of 40,000 households. The benefit level of this programme is the same as the OVC. Unfortunately, the schemes are too new, and there does not exist enough data to in order to judge their performance. There are, however, some general comments that can be made:

- There is a discrepancy between the funding for OVC mentioned by the Government (KSH 2.3 billion) and the costs that can be calculated from the benefit level of KSH 1,500 monthly and the number of beneficiaries (82,000), which is KSH 1.5 billion. There is no information on the actual administrative costs.
- The minimum pension in the public pension scheme is KSH 2,000. If this is an indication of minimum income, the benefit level of KSH 1,500 is very low. It is about KSH 300 per capita or KSH 10 per day. It is much less than the 1\$ per day per capita, which was for a long time the internationally accepted poverty line (which has since been shifted upward by the World Bank). Thus, the benefit does not seem to fulfil the requirements of an acceptable social assistance scheme. It should, however, be regarded as a minimum income to provide a very basic support.
- The coverage seems very low.

Assuming the figure of 7.6 million poor in the country and the household size of 5, it would follow that in order to cover all those who are poor, about 1.5 million households would need to be covered. The total budgetary implications for this coverage level would

⁸⁵ Datta, D. et al. 2008. "Mobile phone-based cash transfers: Lessons from the Kenya emergency response", in *Humanitarian Practice Network*, Overseas Development Institute). Available at www.odihpn.org/documents/humanitarianexchange.pdf.

be KSH 27 billion. All cost figures mentioned above do not include administrative costs. This means that a full and adequate social assistance programme would have substantially larger budget implications.

Table 4.4.2 Potential social assistance scenario

	Households	Persons	Costs (KSH)
Currently covered	110,000	550,000	1,980,000,000
Coverage gap	1,410,000	7,050,000	25,380,000,000
Total	1,520,000	7,600,000	27,360,000,000

Source: Authors' calculations, Ministry of Gender Data.

It is not clear to what degree all the 7.6 million people would be eligible to benefits according to current criteria. According to the Ministry of Gender, Children and Social Development, the target group of hard core poor is estimated to be much smaller in size – 200,000 households or 1 million people – which would reduce the total costs to KSH 3.6 billion.

In general, the social assistance schemes present in Kenya are very scattered and need substantial alignment in order to harmonize benefits, criteria and to avoid unnecessary costs.

4.5 Unemployment insurance and related schemes

There are currently no formal unemployment insurance schemes in the country. Unemployed people mainly depend on savings, on the extended family and perhaps on loans and withdrawals from NSSF (available for those older than 50). There is an extensive network of retraining programmes, although they are typically of rather low standard and poorly coordinated. Kenya's labour market regulations are mostly in place, but are poorly enforced.

Public works are generally very limited in scope, with the exception of the following programmes, which support a major campaign to curb Kenya's problem of mass youth unemployment: the Kazi Kwa Vijani (KKV) programme and the related Kenya Youth Empowerment Programme (KYEP). The KYEP is being supported by substantial funding from the World Bank and the International Development Association, and aims to provide access to targeted temporary employment programmes and to increase youth employability. This will be done over the next four years through the development of labour-intensive works and social services, the creation of private sector internships and training, and capacity building and policy development with the Ministry of Youth Affairs and Sports. The KYEP aims to provide paid employment to nearly 200,000 additional KKV beneficiaries.

Increasing youth employment and employability in the short term will have long term positive effects on family income stability, social unrest, human capital development and in breaking the cycle of intergenerational poverty. Furthermore the gradual formalization of the labour market will increase the number of those covered under employer-based social security schemes.

4.6 Other schemes

4.6.1 Background

There are a number of other schemes related to social security existing in Kenya, particularly micro insurance and micro finance schemes focusing on various risks.

4.6.2 Coverage

Currently there are about 75 registered micro finance schemes. The largest provider of micro-insurance is the Cooperative Insurance Company of Kenya (CIC), which provides access to a total of 300,000 Kenyans. The membership largely consists of people in the informal economy.

4.6.3 Risks covered

Risks covered include death and disability of the insured member, personal accident compensation and funeral benefits for the insured members and their families. For business people some micro insurers offer Insurance for property against risks such as Fire and Burglary.

5. Overall assessment of social protection in Kenya

5.1 Progress in social security towards achieving the MDGs

Globally, “there is little hope that the MDG targets will be reached without a decisive global move towards introducing a national social protection floor of basic social security benefits in countries where no such scheme exists or where they only have a limited coverage;”⁸⁶ the situation is unfortunately little different in Kenya, where the achievement of the MDGs poses tremendous challenges. Despite some signs of economic recovery, the growth of the economy is still below the necessary growth rate of 7 per cent needed to support implementation of MDG-related activities within the remaining decade to 2015.

Kenya’s progress on each of the MDGs is provided in Annex C. The main link between social protection and MDGs exists in the Goals of eradicating extreme poverty and hunger, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases (Goals 1, 4, 5 and 6). In all four of these areas, Kenya’s performance is not yet satisfactory. The table below shows the base line, the current situation and the target for each relevant MDG, with reference to one key indicator. While there have been improvements in moving towards the targets relating to poverty, maternal mortality, and under-five mortality, these improvements are not being made at an appropriate pace. Furthermore, the HIV prevalence rate – the primary indicator of MDG 6 – has actually increased since the MDG base line date of 1990 (although, it should be noted that the HIV prevalence rate peaked at 13 per cent in 2000/2001 and has since been declining).

Table 5.1 MDG performance Kenya

	Base line (1990)	Current level (2009)	Target	Selected Indicator
MDG 1	56 %	46 %	28 %	People living below the poverty line
MDG 4	90	74	33	Under 5 mortality rate (per 1,000 live births)
MDG 5	670	414	174	Maternal mortality ratio (per 100,000 live births)
MDG 6	5.1	7.4	-	HIV prevalence rate (% of the population)

Source: UNDP. MDGs Report Kenya..

Against this background, the Government of Kenya increased its emphasis on the role that social protection has to play in relation with development goals. Kenya’s Vision 2030 is a prime example of how social protection can be linked to economic development policies and strategies.

Because the MDGs are outcome-oriented, there exists substantial debate as to how, or by which process, these goals can be achieved. The ILO has adopted a series of Conventions on social security, which can be seen to provide this required process-orientation in order to address Kenya’s social protection needs and to achieve related MDGs (1, 4, 5 and 6). As outlined in Chapter 1, the core Convention on social security is Convention No. 102. Subsequent Conventions, including C. 121 (1964), C 128 (1967), C 130 (1969) and C 168 (1988), stipulate extended and higher standards and benefit levels.

⁸⁶ ILO. 2010. *World Social Security Report: Providing coverage in times of crisis and beyond* (Geneva).

Kenya has not yet ratified these Conventions. However, the Kenyan government has expressed strong commitment and the will to address the issues and aims at accelerating progress towards the ratification of Convention No. 102. In this context it is important to recall that universal coverage of social protection is a milestone towards the achievement of the MDGs by 2015.

5.2 Coverage and access gaps

Currently, social protection coverage is still very limited in Kenya, with coverage rates ranging from between 10 and 30 per cent depending on the risks regarded. As this report has outlined, the scheme with the highest coverage rates is the National Health Insurance Fund. The pension scheme is limited to public servants. Further, we find a limited number of occupational schemes in Kenya with low population coverage. The social assistance scheme as well as the micro insurance and micro finance schemes, are rather limited. There is no unemployment scheme.

The table below shows estimates of coverage in different contingencies of social protection and the corresponding coverage gaps. However, the numbers indicated are rough estimates given the lack of transparency on the multitude of scattered cash transfer schemes that exist in Kenya.

Table 5.2 Labour force and social protection coverage in Kenya

	Population In 1,000	Coverage		Coverage
		In 1,000	In percentage of reference group	
Population	37,538.82			
Labour force	9,450.30			
Formal employed	1,907.30			
Self employed	67.40			
Informal	7,475.60			
Coverage				
Pension				
Civil Service		311.86		
NSSF		1,200.00		
Occupational Schemes		155.93		
Total		1,667.79	18 %	82 %
Health Insurance				
NHIF members including voluntary		2,500.00	26 %	74 %
NHIF families		12,000.00		
Micro insurance (estimate)		300.00		
Total		14,800.00	39 %	61 %
Unemployment				
Total		-	-	-
Work accident		1,200.00	13 %	87 %
Social assistance				
Poor persons	7,507.76			
Social assistance recipients (estimate)		500.00	7 %	93 %

Source: NSSF, NHIF, World Bank, Statistical Office, Authors' calculations.

It can be observed that the coverage is highest in the health sector and lowest for social assistance. By social security branch the coverage gaps are estimated as follows:

- More than 60 per cent of the Kenyans are not covered against the risk of ill health.
- In the area of old age pensions, more than 80 per cent of the population have no protection.
- 100 per cent of the Kenyans are unprotected in case of unemployment.
- 87 per cent of the Kenyan workforce is uncovered in case of occupational injuries.
- More than 90 per cent of the population cannot expect any support through social assistance in the event of need due to poverty.
- The total social protection coverage gap ranges between 60 and 90 per cent depending on the risks regarded and even if covered, benefit levels remain low.

In order to raise the social protection floor, coverage and benefit levels must be expanded significantly, horizontally and vertically respectively, and efficiency and effectiveness must be enhanced.

In any attempt to identify and address social protection coverage deficits it is crucial that coverage be clearly defined and understood. The concept of social security coverage is multidimensional; first, there is a distinction between legal coverage and effective coverage. Legal coverage refers to those who should, by law, be covered by social security; effective coverage relates to those who actually receive benefits and this depends on how legal provisions are implemented in reality, for example, the number of those over 65 years who actually receive a pension benefit. Coverage in social security also refers to the scope, extent and levels of benefits as well as to the number of branches provided.

Unfortunately, even for Kenyans who are covered by social protection schemes, it must be highlighted that legal or formal coverage does not always lead to effective access, e.g. to health services. This is due to the fact that effective access is based on dimensions such as: availability of services in terms of infrastructure, health care workforce, medical products, etc. as well as information regarding these services; affordability of services, defined as the absences of barriers to accessing needed health care; financial protection, which includes minimizing out-of-pocket payments and providing income replacement during illness-related loss of productivity; and quality of care in both medical and social terms, for example, maintaining dignity during treatment. Within this context, it is suggested to assess social health protection coverage with a view to the effective access to affordable health services at a specified level of quality, and to financial protection against the economic burdens related to ill health.

5.3 Fragmented scheme landscape

One obstacle to coverage and effectiveness of social protection in Kenya is the scattered nature of the existing schemes. In principle, it is unproblematic to have various schemes that provide social protection. However, in this case, coordination has to be ensured in order to create synergies and avoid gaps in coverage. Further, the rules, terms and targets of individual schemes and of the system as a whole should be clarified with a view to achieving universal coverage. This, however, is not the case in Kenya:

- In the pension area, there exist a large number of schemes such as the NSSF, the occupational schemes, the public pension scheme and the individual schemes. This is costly, because all of them collect contributions through their own administrative structures and processes.
- In the health area, the NHIF is by far the largest scheme – however, it seems that it does not provide access to adequate and needed services for all those who are covered. It excludes those working in the informal economy and it is debatable why the NHIF enters into cooperation with micro insurance schemes rather than expanding its own coverage. Further, high co-payments, gaps in infrastructure and an insufficient number of health workers often create barriers to access to care for those in need that cannot be addressed only by micro insurance.
- The most scattered area is that of social assistance, where few people seem to be covered by a variety of different schemes that do not always provide access to the needed cash benefits. This bears the risks of uncoordinated benefits, doublings, and unnecessary costs in terms of for example means tests and delivery of benefits. In this area there lies a large potential gain in adopting a uniform approach and coordinating and merging the various schemes and initiative into a holistic basic income support scheme.

The fragmented approach in social protection leads to significant inefficiencies in achieving key objectives related to addressing the requirements of the populations most in need, governance, financing of social protection and allocation of funds.

5.4 Scattered institutional and decision making frameworks

There are numerous government ministries and national authorities that claim responsibility for social protection policies and related implementation. Currently, decisions about social protection are made in the following context:

- The health insurance is managed by the NHIF, which is under the purview of the Ministry of Public Health and Sanitation and Ministry of Medical Services
- The retirement scheme is managed by NSSF, which is under the purview of the Ministry of Labour. Similar to the various occupational and private schemes it is regulated by the Retirement Benefit Authority (RBA).
- The public pension scheme is managed by the Ministry of Finance and the Office of the Deputy Prime Minister.
- The main social assistance scheme (the OVC scheme) is managed by the Ministry of Gender, Children and Social Development.

Generally, it is not a problem to involve various institutions in the provision of social protection, especially as it is such a broad and encompassing policy area. Most countries around the world employ this structure. However, there are some issues to be considered:

- It is questionable whether it is good practice to have various institutions in charge of means testing and contribution collection. In most cases this is a waste of money and leads to overlaps and contradictions.
- The more institutions there are in charge, the more there is a need for coordination, which takes time and may lead to deadlocks. This creates the need to establish mechanisms that force decision making and lead to final decisions and avoid the waste of resources and time through endless processes.
- There is a need for the establishment of an information and communication culture. We witnessed several cases, where decision-making institutions did not share important documents and did not inform each other. This leads to deadlocks and unnecessary costs.

The MGCSD has developed a National Social Protection Policy document, which proposes steps and institutional setting to enhance social protection in Kenya. This document also foresees some institutional restructuring, for example introducing a National Social Protection Board in charge of coordination.⁸⁷

⁸⁷ Ministry of Gender, Children and Social Development, Kenya. 2010: *National Social Protection Policy* (Nairobi).

5.5 Efficiency and effectiveness in financing social protection

5.5.1 Resource pooling and burden-sharing

The collective pooling of risks is an important tool for fair burden-sharing and efficient financing and therefore constitutes a distinctive feature of rights-based social security. An example relates to social insurance that employs risk-pooling and burden-sharing; premiums are paid by insured workers and their employers in order "to cover the expenses incurred by persons affected by the occurrence of the relevant (clearly defined) contingency or contingencies."⁸⁸ In contrast, commercial-type insurance schemes calculate risk premiums individually, and do not employ burden sharing.

At present, resource-pooling and burden-sharing is very limited in Kenya. Social protection funding is low with an estimated 2 per cent of GDP (excluding public health expenditure). This counts for all major risks traditionally covered by social protection:

- In the area of old age there is very limited risk sharing as the main scheme is a provident fund that covers only a small share of the population.
- In the area of health the support value of the main scheme NHIF is unclear but at least there is a large institution of risk sharing covering about 30 per cent of the population. Unfortunately administration costs remain quite high.
- There is no risk sharing in the areas of accidental death and invalidity, unemployment and professional diseases. Also in the area of survivor benefits there is hardly any protection.

Overall, social protection financing needs to be more linked to efficiency and effectiveness as well as to be improved with a specific focus on risk-sharing mechanisms in order to achieve solidarity and promote equity by applying a rights-based approach. Kenya's national motto, *harambee*, can be understood to espouse the importance of pulling together, sharing burden, and of enhancing social solidarity. It is as important now as it ever was to embed these principles in a national social security policy.

5.5.2 Financing patterns of social protection

The current GDP of Kenya is KSH 2,250 billion, which represents about KSH 60,000 per capita. The 2010 expenditure on social protection is low with less than KSH 10 billion; this is especially low when compared to the overall public budget of KSH 524 billion.

The largest social security institutions, NSSF and NHIF combined have annual benefit expenses of less than KSH 5 billion, which represents less than 0.5 per cent of GDP. Together with occupational schemes, other insurance schemes including micro insurance and cash transfers (OVC has KSH 1.6 billion annual expenses), we estimate social protection to represent around 2 per cent of GDP. In comparison, most developing countries have at least 3 per cent of GDP expenditure for social protection. Developed countries like US, Japan, and those in Europe, spend at least 20 per cent of their GDP on social protection.

Key patterns of social protection financing can be summarized as follows:

⁸⁸ ILO. 2010. *World Social Security Report: Providing coverage in times of crisis and beyond* (Geneva).

- The current social protection expenditure is very low, with less than 2 per cent of GDP or around 6.2 per cent of the public budget.
- Expenditure on NSSF amounts to less than 15 per cent of total social protection expenditure and to just 12 per cent on NHIF. Instead, the bulk of expenditure is on public pensions, with more than 57 per cent of total social protection expenditure.
- Allocations for social assistance are as little as 4.9 per cent of social protection expenditure.

Table 5.5.2 Overview of key patterns of social protection financing in Kenya, 2010

GDP (KSH/constant prices)	2,250.000
Public budget	
• In billion KSH	524.00
• In per cent of GDP	23
Tax and contribution burden	
• In billion KSH	550
• In per cent of GDP	25
Total spending on social protection	
• In per cent of public budget	6.18
• In per cent of GDP	1.96
Total expenditure on social protection in per cent	
• NSSF	14.30
• Public Pensions	57.19
• Social Pensions	00.00
• NHIF	12.26
• Social Assistance	04.90
• Other (estimates)	11.35
Total	100
Source: Authors' calculations.	

6. Developing a comprehensive national social protection policy for Kenya

6.1 Overall objectives and strategic approaches

The new Constitution of Kenya stipulates that “The State shall provide appropriate social security to persons who are unable to support themselves and their dependants.” Within the context of the new Constitution, and given the current situation in the country as outlined in the previous chapters, there is a call for poverty reduction to range first among the objectives to be achieved.

The key strategy to achieving the objectives related to poverty reduction is to create a comprehensive social security policy with a broad and open perspective that is based on what exists, rather than building new schemes. This requires that

- Each scheme, structure and programme has its own mandate;
- Roles of schemes are clearly defined; and
- All systems are integrated into a broader concept and are coordinated with a view to ensuring universal coverage of social protection schemes.

The work carried out by the National Task Force on Social Security is the most important integration structure currently existing in this context. It ensures a broad dialogue among all involved government ministries, national authorities, labour unions and other stakeholders. To achieve long-term efficient, effective and sustainable solutions, it will be important to further broaden the dialogue and integrate discussions with e.g. neighbouring countries and relevant African organizations. This includes, for example, the East African Community, which aims at widening and deepening co-operation among the partner States in the field of social policies, amongst others, in order to create mutual benefits. Increased dialogue will also ensure that best practices are applied and cross-border issues – e.g. regarding migrants or health – can be sufficiently addressed by coordination and portability of rights.

The starting point for Kenya is the existing social protection landscape – covering the areas of old age, health and income support – that needs to be transformed into a comprehensive system efficiently addressing the key issues and challenges of the Kenyan population. This requires improvements both vertically and horizontally. This would entail extending legal coverage for the population, increasing benefit levels and closing social protection gaps on risks that are not sufficiently covered yet, such as unemployment, family allowances, maternity benefits, and other contingencies as stipulated in ILO Convention No. 102.

Besides the legislative work which is required in this context, it will be important to ensure that within a realistic time frame people in Kenya are served by efficient and effective social security administrations that are governed in an accountable and transparent way. This includes a key role for the government in setting the legislative framework and ensuring the functioning of the system with a view to economic and fiscal affordability and active involvement of all stakeholders such as employers, employees, women, representatives for vulnerable groups, etc.

The Decent Work Programme for Kenya points to the fact that “... with regard to social protection, the challenges are daunting. Some 80 per cent of Kenyans work in rural areas, mainly in small-scale farming and crop growing. Most live in large extended families whose members have worked together for generations on family farms. Accordingly, the

concept of social protection or security for that matter has not fully spread from the mostly urban formal economy to the rural farms and informal workplaces. Thus, extending social protection/ security coverage in the country will be challenging”.⁸⁹ The most promising way forward relates to the approaches outlined in the Social Protection Floor Initiative (SPF-I) led by ILO and WHO and supported in the context of ONE UN.

The SPF Initiative promotes a holistic and coherent view of national social protection systems as a key component of national development strategies. The initiative supports countries in identifying and closing crucial protection gaps through efficient measures that maximize the effects of scarce resources on the reduction of poverty and insecurity. One of the main objectives of the SPF-I is to ensure the concerted actions of UN agencies, national governments and stakeholders, as well donor agencies in an effort to alleviate the negative social impact of the crisis and increase the resilience of societies against the impact of future crises, including the implementation of automatic social and economic stabilizers.⁹⁰

The central objective of the Social Protection Floor Initiative is to facilitate and accelerate, as part of a country's National Social Protection Policy, the introduction or strengthening of sustainable social protection systems to provide essential services and cash transfers. These services and transfers are critical to mitigating the poverty and welfare consequences of the crisis, while at the same time providing a significant stimulus to the economy. The Social Protection Floor policies will build on, enhance and strengthen the social protection schemes already in place.⁹¹ The SPF-I policies advise to:

- identify essential social services and programmes that have quick impacts and can be scaled-up or introduced rapidly (e.g. nutrition programmes to address food insecurity, or cash transfers);
- identify core social sector spending to be maintained in order to preserve human development gains and longer term national development objectives;
- provide an estimate of the budgetary costs of these options and indicators necessary for monitoring.

The Government needs a long-term commitment towards universal access to a clearly defined basket of services of the highest quality. Given the available resources, this basket may initially be a limited set of interventions and services, which will be expanded as the economy grows. A dynamic process is envisaged in which each objective and the proposed critical path is reviewed and adjusted regularly to increase the likelihood of success. Important milestones have been set to ensure that at predictable times, tangible outcomes

⁸⁹ ILO. 2007. *Decent Work Kenya 2007-2011. ILO's Country Programme for the Republic of Kenya* (Geneva).

⁹⁰ ILO; WHO. 2010. *Social Protection Floor Initiative: The sixth initiative of the CEB on the global financial and economic crisis and its impact on the work of the UN system*. Manual and strategic framework for joint UN country operations. Available at <http://www.ilo.org/public/english/protection/spfag7download/background/spfframework.pdf>.

⁹¹ ILO; WHO. 2010. *Social Protection Floor Initiative: The sixth initiative of the CEB on the global financial and economic crisis and its impact on the work of the UN system*. Manual and strategic framework for joint UN country operations. Available at <http://www.ilo.org/public/english/protection/spfag7download/background/spfframework.pdf>.

accrue, and that they lead to concrete benefits for individuals, families or population groups.⁹²

The social protection systems need to be put into a legal framework, that is i) based on a sustainable financing and fiscal strategy, ii) adequately monitored to achieve the desired increase in the resilience of households and individuals against a range of endogenous and exogenous shocks and iii) able to serve as a basis for the build-up or strengthening of more comprehensive and self-sustained national social protection systems.

This approach also allows for the acceleration of the achievement of the MDGs. To achieve these goals within the stipulated timeframe, it is important that the GOK moves with speed in implementing macroeconomic policies that increase growth and adopt practical strategies for eradication of poverty.

Against this background, the strategic approach that is suggested regarding the development of a comprehensive national social protection policy for Kenya is composed of the following components:

- **Principles and reform challenges**
- **Maximizing fiscal space**
- **Increasing capacity for implementation and monitoring**
- **Improving social dialogue**

Implementing the approach will require additional research, data development and/or will need to be piloted.

6.2 Principles and reform challenges

6.2.1 Establishing principles for policy design and defining roles of schemes

When developing and implementing a comprehensive national social protection policy some key aspects need to be prioritized. They include the:

- Agreement on key principles to be applied in social protection policies that form the basis for strategies and reforms; and the
- Development of appropriate definitions of roles and mandates of public and private schemes.

Regarding the first aspect, possible points for discussion among all stakeholders in social protection include the following principles, which underlie the suggestions provided in this chapter:

- **Affordability:** Regardless of which solutions are envisaged, they have to be affordable for the target population and for the state budget. Especially as the poor have very limited resources to spend for social protection, all concepts have to take

⁹² Ministry of Health and Sanitation, Kenya. 2009. *Social Protection in Health: Policy and Financing Strategy* (Nairobi).

into account their ability to pay. Concerning the state budget, fiscal space is discussed in this report and in general it can be said that there is room for improvement, also in an international comparison. In the end, the state budget has to be used to solve affordability issues of the poor.

- **Sustainability:** Similarly, regardless of which solutions are envisaged, they must be sustainable. Affordability in this regard is one aspect of sustainability. Only affordable solutions will be sustainable. Sustainability refers not only to the amount of funding, however, but also to the method of funding, the costs, the effectiveness of administration and widespread support for the system.
- **Accountability:** Accountability involves acknowledging and assuming the responsibility that comes with policies, actions, and decision-making. It is an aspect of governance that is discussed widely in all countries, in relation to the responsibility, liability and answerability of governing bodies in both the public and private sector, as well as in not-for-profit organizations. Institutions dealing with social protection must be accountable to the general public and to their members. In order to ensure accountability and good governance, they must make their accounts, targets and performance public. Additionally, those financing the systems (for example, contributors and international donors) can observe what they get for their money.
- **Conditionality versus non-conditionality:** This refers to different concepts of cash transfers. There are examples of non-conditional cash transfer programs and conditional cash transfers around the world (for example, in Pakistan and Mexico, respectively). Conditionality involves aligning the payment of a benefit to certain conditions that have to be fulfilled, such as sending children to school or ensuring regular health care. While conditionality can play a part in ensuring outcomes, limitations in availability of corresponding services and difficulties in verifying the fulfilment of conditionality may curtail the feasibility of this approach. Only where availability of services and verification are guaranteed, does conditionality makes sense.
- **Targeting versus universalism:** Targeting means that the beneficiaries of a scheme have to be selected. Universalism means that practically everybody is entitled to the benefit. In most cases, targeting takes the form of either means testing or self-targeting. Means tests are expensive and have inclusion and exclusion errors. This is why self-targeting may be a preferred method, and is common with all types of benefits that require some action to avail of them (food for work, applications, etc.). The effect is that those who are better off will not undergo the necessary steps to access the benefits as opposed to those in need. However, exclusion errors may remain if those eligible for benefits are insufficiently informed about their entitlements.
- **Inter-ministerial/multi-sectorial social protection processes:** To establish a functional and holistic social protection system requires complex processes, which include a multitude of stakeholders. Isolated standalone projects and initiatives are not helpful and can even damage the positive outcome. This is why coordinated processes are required.

Social security provision is, in its essential nature, a public responsibility. This has been acknowledged by the GOK through its current commitment in the form of numerous social protection policy initiatives, and for example, the commissioning of this report. The public nature of social security means that even where social security is provided through private entities, it should ideally be mandated, directly controlled and thoroughly regulated by the

GOK. Unfortunately, this is currently not the case, as many schemes operate independently and privately, and with the public schemes operating without coordination.

As highlighted in this report, between 60 and 90 per cent of the population in Kenya is in need of at least basic social protection. There are various technical challenges in achieving the desired outcomes in social protection. The main technical challenges lie in reforming the retirement and health protection scheme and the inclusion of the informal economy. Addressing both of these issues will require a lot of innovative ideas and a stepwise, inclusive agenda.

In order to address the scattered nature of both public and private schemes, it is suggested to come to a convergence process, in which roles of schemes are newly defined:

- The main pension scheme should be the NSSF (for everybody. It could even be discussed that public servants become member of the NSSF and that the public pension scheme assumes a complementary role).
- Occupational and other schemes should still play a role, but more complementary in nature.
- The various social assistance schemes should be unified into one main scheme with several branches and target groups. However, benefits should also be analyzed as to the possibility of standardizing and unifying them.
- The NHIF should increase coverage and thus create a situation in which other schemes, especially micro- and community-based scheme offer complementary coverage. In any case, given their continued efforts to provide coverage, they should also have a place in the system.
- Synergies among schemes should be realized, unifying, for example, tasks like service to members and contribution collection. There is no need to have so many institutions collecting contributions.

Considering the introduction of new elements to close gaps e.g. regarding unemployment and other contingencies, it is advised to take a step-by-step approach that starts by including all those in need of income support in social assistance schemes as a first step and when appropriate funds become available to address related gaps.

Currently, the economic situation in Kenya is rather promising, especially as Kenya is among those African countries with the best economic perspectives. Current issues are inflation and deficit, although inflation is expected to lower and there have been successful measures to reduce the deficit. There is definitely room for improvement of social protection given the low contribution burden on employers and workers when considering international comparison. Also State-funded measures are still possible. An issue will be to convince decision makers and stakeholders to invest more funds into social protection and to realign the focus of public spending. To enable a smooth transition, lending might be an option.

6.2.2 Reforming Pension Schemes

In the field of old-age pensions, two major changes could be considered:

- A shift from the present provident fund to a contribution-based pension scheme.
- The development of a universal pension scheme.

The shift to a fully-fledged pension scheme based on contributions would require a transition period and a great deal of awareness-raising among people who are accustomed to the current provident fund scheme. Moreover, the increase from currently less than two annual salaries reserve fund to over four annual salaries reserves will require a substantial increase in contributions (the NSSF calculates with 15 per cent, however, ILO predicts that this will not be sufficient to ensure a decent replacement rate). In order for this shift to be successful, for benefit levels to be sufficient, and to ensure the compliance of all parties, substantial discussions with employers and workers will need to take place. Another issue is the modality of the inclusion of the large informal economy.

A successful transition to a fully-fledged pension scheme would need to address various questions:

- How to deal with people who have been members of the provident fund scheme for many years? Would they still receive lump sums? Would people be given the choice between a lump sum and a pension? This would not be the rationale of a pension scheme, but including all existing beneficiaries into a single pension scheme would lead to many very small pensions.
- The issues regarding benefit levels as well as those regarding coverage. How can all workers currently excluded from the scheme be included in the new pension scheme?

The creation of a universal pension scheme is in fact a viable option for the GOK. Such a shift would require government allocations of the size of 1 per cent of GDP. This is a relatively low share of GDP to be spent for a change that would substantially improve social protection coverage in Kenya. A universal pension would make this a viable option, and would also encompass the informal economy.

Generally, a social pension scheme would help to overcome the coverage issue and the poverty reduction issue. It would not, however, address the problem of old age income of the non-poor and would have a substantial budgetary implication. For example, a social pension of KSH 2,000 for 1 million pensioners would cost KSH 24 billion per year, which represents less than 5 per cent of public budget (see Table 6.2.2). This measure would however reduce the need for other poverty reduction measures like social assistance as well as basic contribution financed pensions. Thus, it would require fewer contributions for the pension scheme and less budgetary allocations for social assistance. Universal pensions are an option worth considering and “deserve a lot more attention than they have received to date as a way to provide at least some support to the rural older people. The pension holds great promise that no one will face poverty in old age”.⁹³

Table 6.2.2 Annual estimates of benefit payments of a social pension scheme in Kenya, in billion KSH

Level of monthly pension, KSH	Number of recipients				
	200,000	400,000	600,000	800,000	1,000,000
1,000	2.4	2.8	7.2	9.6	12.0
1,500	3.6	7.2	10.8	14.4	18.0
2,000	4.8	9.6	14.4	19.2	24.0
2,500	6.0	12.0	18.0	24.0	30.0

Source: Authors' calculations.

⁹³ Keizi, L.K. 2006. *Barriers to Pension Scheme Participation by Workers in the Informal Economy* (Retirement Benefit Authority). Available at www.rba.go.ke/Publications/Research%20paper%202002-2006.pdf.

Regarding the effectiveness of different types of schemes, it can be said that “a Constitutional provision of a means-tested social assistance scheme to cover those outside the formal old age pension system and are poor, would certainly extend coverage of the system. The scheme will be provided under the laws as a universal and non-contributory scheme as it aims at the poorest groups. However, the provision of universal pensions in Kenya’s pension laws and in particular in the Constitution to guarantee basic income floor to the elderly would have the potential to achieve full coverage of the target groups. The advantage of the universal pension scheme which is funded by general tax revenues is that it does not carry social stigma and it avoids administrative costs associated with means-testing.”⁹⁴

It is suggested to discuss both options: changing the existing provident fund scheme to a fully-fledged pension scheme and the introduction of a social pension scheme. An example of a social (universal) pension scheme may be found in Mauritius.

If the decision to change to a fully-fledged pension scheme is taken, it will be important to:

- invest in awareness-raising through social protection education;
- make a decision regarding how to deal with the issue of very small pensions and lump sums;
- improve administrative costs and interests on members accounts; and
- look into issues regarding the large amount of withdrawals, investigate the reasons, improve the image and conditions of the NSSF and reduce possibilities of withdrawal. A high withdrawal rate will reduce risk-sharing among pensioners.

Regardless of possible future transition, there are a number of ways in which the current provident fund can be improved. In particular, it is recommended to take the following steps in order to improve equity, effectiveness and efficiency:

- To undertake a thorough actuarial analysis about the possibilities to substantially increase the interests on members accounts, at least above the CPI.
- To substantially reduce administration costs to less than 30 per cent.
- To improve benefits for survivors (that is, to not only refund the contributions paid but to also provide a decent interest rate).
- To consider the introduction of benefits in case of disability.

Another issue that requires some attention is that of the transition of the civil servants pension scheme to a contribution-financed scheme. This would affect around 200,000 current pensioners and 425,000 civil servants. Again, in this case the question would be how to deal with current pensioners and with people close to pension age.

Given the Government’s objective to put in place a fully funded scheme, it is important to consider the vast amounts of funds that would be required. For example, funding the current pension requirement would require a reserve of about KSH 200 billion. To fund future pension entitlements of today’s civil servants would require up to KSH 500 billion (exact calculations can only be made with adequate information about the underlying

⁹⁴ Nyakundi, D.B. 2009. *Pension Coverage in Kenya. Legal and policy Framework Required to enhance Pension Coverage in Kenya* (Nairobi). Available at <http://ssrn.com/abstract=1374975>.

parameters). For each pensioner a reserve of about 8 to 10 annual salaries is needed to fund the current replacement rates. The problem is not the future allocations to the reserve fund but rather how past entitlements can be dealt with, both with respect to current pensioners and with respect to those who have already acquired pension rights.

According to our view, the only feasible option is to phase-in a new scheme gradually replacing budget funding by contribution financing. A contribution rate based on a defined benefit should be calculated, but gradually the scheme should move to a defined contribution scheme. This could occur by paying the pensions from two sources: from the reserve fund (as far as the reserve has been built up) and from the public budget. This would substantially reduce the burden on the public budget and would at the same time create space, for example, for a universal pension scheme or for additional social assistance benefits.

6.2.3 Reforming social health protection

In the field of NHIF, the following areas require attention:

- **To increase coverage.** This would take two forms: to campaign for coverage of the informal economy and to support the coverage of the poor. In order to reach the informal economy it is suggested to explore possibilities of how to lower the planned premium of KSH 300 for voluntary members. The current intention to double the contribution will create an additional obstacle, especially for persons with low incomes. Furthermore, it is suggested to use all available channels, including cooperatives, associations and other organizations to increase membership. Special schemes with contribution discounts could be a possible option for group membership. Awareness campaigns could be conducted. Finally, for the poorest 20 per cent, a state subsidy combined with means-testing should be introduced. In a first step, the means-testing procedure of the OVC programme could be used. Actually, the sponsored programme could be linked to the OVC programme. Currently, GTZ and DFID are piloting a programme to waive user fees for the poorest segments of the population and to pay for the NHIF health card. The experiences of this pilot could be used to study the possibilities of introducing such a system nationwide.
- **To monitor the support value in A, B and C providers.** This could be done through the claims processing in the form of sample inquiries among members. The objective would be to get a representative understanding of the out-of-pocket payments incurred by NHIF members. This would pave the ground for future amendments in benefits and co-payments.
- **To substantially reduce the administration costs and to increase the current pay-out rate** of 56 per cent. For this purpose, a thorough evaluation of the entire administration should be conducted. Synergies and redundancies should be identified as well as gaps and defaults in services to members. In the interim, to curb costs, the need to hire new staff should be analyzed.
- **The current real estate portfolio should be analyzed** in terms of ROI. Returns should be either income or costs (administration costs for rent of buildings) and be recorded accordingly. ROI below the interest rate for state bonds should lead to separation from the objects.
- **The expansion of the benefit package to outpatient care** should be supported. However, this should not lead to an increase in the premium of more than 30 per cent. This could be achieved through the thorough and informed shaping of

reimbursed benefits, direct billing with preferred providers, adequate provider payment mechanisms and the introduction of user charges or co-payments.

- **An analysis of existing provider payment mechanisms** is suggested in order to evaluate possible alternatives, which could lead to improved care and perhaps reduced costs.
- **To introduce referral systems**, which would act as gatekeepers.
- **To use public and private purchasing.**
- **To introduce regulations for private insurers** including voluntary health insurance.

The main focus of a reform of the current system is to cover the whole population if possible and to improve the cost-benefit ratio.

6.2.4 Extending social assistance schemes

In general, the government should be supported in its endeavour to address extreme poverty through cash transfer programs and potentially introduce voucher schemes. Concerning the existing social assistance programs, it is suggested to conduct an analysis of the existing programs to increase understanding on the following issues:

- The final number of potential beneficiaries. There seems to be a discrepancy between the official number of hard core poor and the projected number of potential beneficiaries of the cash transfer programs.
- The effectiveness of the targeting.
- Administrative efficiency and possibilities to streamline and merge scattered services.
- Actual use of funding and actual relief provided.

For the existing programs, it is suggested to discuss the introduction of conditionalities. Another potential consideration for reform, as mentioned above, is the creation of a universal pension scheme. This would make a substantial contribution to poverty reduction, especially among the elderly and their families.

Finally, it is recommended to expand and to streamline the existing programs in order to develop a holistic and comprehensive approach. The budget allocations for social assistance should be increased substantially, but not without optimizing the existing structures and delivery mechanisms. The proposed steps are important in order to improve the current schemes before additional funding is allocated.

6.3 Financing and fiscal space

6.3.1 Preliminary scenario of a social protection budget

A primary question in any discussion of Kenya's social protection system must be: how much financial space is currently available and how much could be made available to implement the necessary reforms? The response to this question requires some estimations in order to make projections of current and of future revenues and expenditures of the

various social protection schemes. Furthermore, it is necessary to work with assumptions that are in line with recent socio-economic developments and that are consistent with long-term national plans and policies.

The social budget methodology developed by the ILO is an approach that is frequently used in this context.⁹⁵ Given the limited data available on the Kenyan social protection schemes, only a rough social protection budget based on some preliminary scenarios can be presented herein. The scenarios include, as much as possible, expenditure incurred by different institutions that provide social protection, as well as some sources of expenditure e.g. taxes and contributions that constitute the main source of financing social protection in Kenya. The many cash and in kind benefits which are financed by donors and NGOs are not reflected. Despite limitations, the information provided here may serve to support the ongoing decision-making process and as a tool to visualise broadly the effects of reform approaches.

This preliminary scenario and projection of Kenya's social protection budget for the next 10 years (from 2010 to 2020) is shown in Annex G. The projection is based on the following:

1. Economic valuables:

- Real growth rate of annually 7 per cent from 2011 which is in line with current economic development.
- A declining inflation rate which stabilizes at 8 per cent from 2014 onwards, given the positive perspectives of Kenya's economy forecasted by the World Bank and IMF.
- The public budget to increase from 23 per cent of GDP to reach 28 per cent in 2019 resulting from various reforms to be undertaken and can be justified by comparison with international benchmarks.

2. Beneficiaries:

Given the current reform plans of the government, the following tentative assumptions on the developments in beneficiaries were used:

- **NSSF:** Increasing annually by 0.5 million from 1.8 million in 2010 to reach 6.8 million in 2020.
- **NHIF:** Increasing annually by 15 per cent from 10 million in 2010 to reach 40.46 million in 2020.
- **Social assistance:** Increasing annually by 30 per cent from 0.15 million in 2011 to reach 1.59 million in 2020.
- **Public pension:** Increasing annually by 5 per cent from 0.20 million in 2010 to reach 0.33 million in 2020.
- **Social pension:** Increasing annually by 0.06 million from 0.5 million in 2012 to reach 0.98 million in 2020.

3. Individual average amount:

⁹⁵ See, for example, Cichon, M. et al (2004), and Scholz, W. et al (2000).

Increases in individual average amounts of benefits are tentatively assumed to reflect current reform plans, most notably the introduction of a fully fledged pension scheme in the NSSF, the introduction of a universal pension scheme funded from the public budget, and the introduction of contributions for the public pension scheme, which will provide for 10 per cent of the total public pension financing. More specifically, increases are tentatively assumed as follows:

- **NSSF:** Increasing annually by 17 per cent in real terms from 3,500 KSH in 2010 to reach 16,800 KSH in 2020.
- **NHIF:** Increasing annually by 8 per cent in real terms from 540 KSH in 2010 to reach 1,170 KSH in 2020.
- **Social assistance:** No increase (1,500 KSH per month, meaning only price indexation).
- **Public pension:** Increasing annually by 7 per cent in real terms from monthly 10,500 KSH in 2010 to reach monthly 20,700 in 2020.
- **Social pension:** Starting at a monthly amount of 1,500 KSH in 2011, increasing by the estimated real growth rate of 7 per cent in 2012, and with no increase in real terms as of 2013.

4. Total expenditure:

Total expenditure is calculated as the product of the above-mentioned assumptions under (2) and (3). This does not include indications made in Annex G regarding other expenditure ('others') which is estimated as the bulk amount starting with 5 billion KSH in 2010, increasing annually by 10 per cent to reach 12.97 billion KSH in 2020.

A summary table of key results on expenditure is presented below. It compares the current situation in 2010 with the projected situation in 2015 and 2020. In assessing these preliminary projections, several important trends can be observed.

Table 6.3.1 Preliminary projections of social protection (SP) expenditures, selected years

	2010 (%)	2015 (%)	2020 (%)
SP expenditure as % of public budget	6.18	8.33	8.81
SP expenditure as total % of GDP	1.96	4.11	7.12
Scheme expenditure as % of total SP expenditure			
NSSF	14.30	25.92	37.01
NHIF	12.26	12.54	15.26
Social Assistance	4.90	6.06	9.26
Public Pension	57.19	35.44	26.13
Social pension	0.00	13.72	8.14
Other (estimates)	11.35	6.33	4.20
Total	100.00	100.00	100.00

Source: Authors' calculations.

First, it is important to note that the projected increase in the share of the public budget dedicated to social protection is very moderate – despite the comparatively low social protection expenditure of less than 2 per cent of GDP in 2010. It also remains quite low,

increasing by 2.15 per cent in the next five years (from 6.18 per cent in 2010, to 8.33 per cent in 2015), with additional increases in the following five years (up to 8.81 per cent in 2020). This is especially notable given the assumed reforms and substantial changes in coverage.

This modest increase is due to that fact that the scenarios involve the introduction of far greater contributions (in public pensions and the NSSF). Overall, the scenario shows that a moderate financial commitment can have an enormous improvement on social protection coverage and benefits.

The scenario also highlights that total social protection expenditure as a percentage of GDP can – and must – increase considerably in the next ten years, from the current 1.96 per cent to 7.12 per cent of GDP by 2020.

Given the assumptions described above, the relative importance (in terms of expenditure only) of each scheme changes substantially. Most notably, the relative expenses of the public pension scheme are reduced from 57.19 per cent of total social protection expenditures in 2010, down to 35.44 per cent in 2015 and dropping to 26.13 per cent by 2020.

This development is due to the increase in expenditure for the other branches of social protection. The share of social protection expenditure spent on the NSSF more than doubles, climbing from 14.30 per cent in 2010 to 37.01 per cent by 2020. Additionally, the introduction of a social pension would account for 13.71 per cent of social protection spending in 2015, but drop to 8.14 per cent in 2020.

The proportion of social protection spending on the NHIF would remain fairly constant over the next ten years, rising only marginally from 12.26 per cent to 12.54 per cent of total social protection expenditure in the next five years, and then rising to 15.26 per cent of total social protection expenditure by 2020.

Further, although the proportion of spending on social assistance nearly doubles, rising from 4.90 per cent in 2010 to 9.26 per cent by 2020, its share in overall expenditures remains modest. One reason for this is that we expect much of the need for social assistance will be provided by the universal pension scheme.

Given the substantial increase in population coverage assumed in major branches of social security, the numbers are still within international standards, although the share of social protection expenditure in per cent of GDP more than triples.

6.3.2 Maximizing fiscal space

Developing fiscal space involves raising money from various sources, but it also entails considering the consequences of doing so. Issues for consideration include, but are not limited to:

- Receiving donor grants for health spending may create concerns about sustainability and could have effects on inflation of health-care prices;
- Increasing taxes may jeopardize economic performance. In some cases, people may also object to increases in insurance contributions.

Thus, there are limits to the fiscal space that can be created. The range of benefits that can be provided under a social protection scheme depends primarily on the available fiscal space and on the needs, which is what makes it such an important topic of discussion in this context. It is apparent that Kenya currently is not exhausting the available fiscal space;

- Social protection spending as a share of GDP is very low, especially by international standards. An increase to 8 to 10 per cent of public budget per year would be feasible here, and would help to overcome many poverty challenges.
- The current schemes largely do not make the best out of the funds available, and this is exacerbated by the fact that administrative costs are high, and that benefits are not supportive enough.
- The collection of revenue is not optimal. For example, as of yet there is no pension funding from civil servants, which would substantially boost social protection revenue.

If the government is able to realize the available options for fiscal space, then we estimate that social protection spending could be doubled without creating a large additional burden for the economy. In order to maximize its fiscal space, Kenya should focus on sustaining economic growth, setting priorities and undertaking measures to ensure efficiency of schemes.

Sustaining Economic Growth

Fiscal space is determined largely by the economic performance of a country. Fiscal space increases as the GDP grows per capita. In terms of overall economic growth, Kenya's current and predicted levels are promising.

If, as predicted, Kenya is able to achieve and sustain a growth rate of 7 per cent – a rate which is the minimum recommended growth level for countries to meet the MDGs – the country will be able to achieve coverage of those most in need at a quicker pace.

Another positive indicator is that the promulgation of the new Constitution signalled political and economic stability in Kenya, increasing investor confidence in the region, a shift which should have positive impacts on investment and growth.

To sustain economic growth, the government might consider the implementation of related macroeconomic policies and adopt effective strategies for eradication of poverty and increase the health status of the population.

The government of Kenya is putting in place a macroeconomic policy framework that is supportive to growth and poverty alleviation. Such policies call for monetary and fiscal policies that ensure low and stable inflation levels; improvements in governance – particularly accountability, transparency and monitoring of administrations and resources; efficient and effective debt management; enforcement of legislation and taxes; and the broadening of tax bases.

Setting Priorities

As the GOK has set ambitious development targets in many varied public policy domains, the government must set priorities in terms of:

- Specific population groups on which to focus,
- Related schemes and their financing mechanisms.

This choice of population groups should be guided by needs. Those most in need include the poor, particularly women, informal economy workers, people living with HIV/AIDS, and migrant workers. These groups should be considered as a priority for the extension of social protection, while simultaneously ensuring that stigma is not attached to the receipt of benefits through the targeting mechanisms.

In order to ensure that priorities are set in accordance with needs, and to ensure the sustainability of all schemes involved, decision-making must be informed by civil society and active social dialogue.

Against this background, entitlement conditions and benefit provisions should be gender-fair and avoid any form of discrimination of the poor. The mainstreaming of gender issues and the reduction in institutional discrimination can be simultaneously achieved through the careful design of social security schemes, benefits packages and coverage patterns. Developing benefits that target women can have strong positive effects on empowerment. International experience from countries with targeted social assistance schemes shows, for example, increased inclusion and heightened status in the beneficiary's community, which has in turn been manifested in being more creditworthy among local lenders. Social transfers can have equally important effects on women, including increased self-confidence, awareness, and control over household resources.⁹⁶

The ILO has also found that "social pensions, in addition to improving income security, have contributed to raising the social status of the elderly;"⁹⁷ when the elderly are perceived as an economic value to a family, rather than as a drain, they are able to move towards restored dignity, which is one of the main aims of the social protection floor initiative and of the Decent Work Agenda.

As regards priority setting for schemes and financing mechanisms, it is important to focus on high-impact approaches, for example, in terms of revenue generation for social protection schemes. In general the Kenyan tax and contribution burden is still very low at about KSH 550 billion or about 25 per cent of GDP. Here, there might be room for a substantial increase in measures to protect people against impacts of risks.

A shift from a budget-financed to a contribution-financed pension scheme for public servants will free resources, which should be used to improve social protection, especially for the poor. In any case, it is evident that additional fiscal space is available, given the low levels of spending in Kenya. This refers to both contribution and tax funding.

Concerning the willingness to pay contributions, this will depend on the credibility and effectiveness of a proposed scheme. Employers have already signalled that they would be willing to support the improvement of social protection. Workers would also support an increase in benefits and financing if the parameters are appropriate; that is, if schemes are efficient and effective, if benefits are adequate, if the sharing of burden between employers and workers is just, and if contributions are equitable and established according to ability-to-pay.

In the long-term, if Kenya aims to aligning its social protection system with that envisaged in Convention No. 102, substantial change and implementation of protection for contingencies is required (refer to Annex B). Most notably, the development of protection against loss of income in the case of unemployment should be extended to Kenyans. Mass and chronic unemployment in Kenya is a key issue for the country.

Ensuring Efficiency

Fiscal space may also be generated through reduction of costs, synergy effects and improvement in efficiency that increases cost-effectiveness. This includes measures such as reducing administration costs, introducing contributions for the public servants pension

⁹⁶ ILO. 2010. *Extending Social Security to all: A Guide through challenges and options* (Geneva).

⁹⁷ ILO. 2010. *Extending Social Security to all: A Guide through challenges and options* (Geneva).

scheme, introducing effective primary care, focusing on generic drugs, negotiating prices and quality with providers, using economies of scale, getting discounts for bundling orders and so on. Each of these measures can free fiscal space, which can be used to extend coverage and subsidize payments for those who have very limited financial means.

In Kenya, social protection schemes are burdened with high administrative expenses. Before additional sources are tapped, it is recommended to address these issues. Therefore, any improvement in existing schemes must include reducing administration costs. In NSSF and NHIF the share spent for administration is far too high. There are two options to reduce this share: to make an in-depth assessment to identify areas of saving and/or to expand membership without increasing administrative expenses.

It would be possible to create synergies and to free capacities for better services through the improvement of scattered structures and through effective coordination. For example, there is no need to have so many institutions collecting contributions. There are opportunities to further improve the management of services, so that they might be coordinated better.

Additionally, there exists a lot of scope to extend social protection to the workers in the informal economy. This can be done through a variety of actions:

- Inclusion into existing social insurance programmes (NHIF, NSSF).
- Inclusion into existing and newly developed micro-insurance programmes and community based organizations.
- Cash transfer programmes for those below the poverty line.
- There is a lot of scope for intensifying health programmes for the informal economy.

Ensuring efficiency at all levels related to social protection is vital to the efficiency and sustainability of social security schemes individually and overall, both institutionally and administratively. Overlapping responsibilities and duplication of work – such as developing and implementing contribution collection mechanisms and means tests – can be avoided by closely coordinating all institutions involved in social protection.

In this context, it is essential that there is close coordination between the various schemes, both public and private and that – not least for coordination and planning purposes – the revenues and expenditure accounts of all the schemes can be analyzed in a national social protection budget. This will ensure that future expenditure and financing of the schemes comprising the social security system are planned in an integrated way.

Further, it is suggested to achieve these efficiency gains through leadership, transparency and economic responsibility. There are a series of steps that can be undertaken to promote efficiency:

- Ensure good governance based on efficient management, transparency and accountability.
- Design insurance schemes based on tripartite governance of independent, quasi-autonomous funds ruled by public law and involvement of civil society at the regional, national, district and/or local levels in decision-making processes.
- Minimize administrative costs e.g. by using incentives.

- Development of data bases and monitoring.
- Following the implementation of an integrated approach to social protection, decentralize organizational structures with a view to reducing the burden of the government and improving responsiveness.
- Ensure that regulations are enforced.

Some of these improvements will require capacity building where the priority should be given to actors who will be involved in decision making and implementation of related activities.

6.4 Improving social dialogue

Making decisions about the design and implementation of social protection strategies is just one aspect of introducing reforms. Another key aspect is consensus-building through social dialogue. In free and participative societies there is no alternative to this. This process must occur partly during the planning and design process and partly once a proposal has been made.

There is wide recognition of the role that social dialogue plays in advancing and sustaining reform processes in many areas of social protection in order to improve coverage and mitigate negative impacts on households. To ensure better protection, the institutions and capacity for social dialogue need to be strengthened.

Social dialogue and consensus-building are needed because:

- social partners and stakeholders will eventually have to work with the new scheme and thus should understand it and support it;
- governments and planners cannot anticipate all of the unique concerns and problems of stakeholders without consulting them;
- the Constitution of many countries foresees a social dialogue before decisions are taken, and decision-makers depend on voters and interest groups acceptance of decisions;
- social dialogue facilitates smooth implementation.

There are formal tools for social dialogue such as official parliamentary or government hearings and non-formal types of dialogue such as exchange of information, conferences, and working groups.

Social dialogue can rely on direct dialogue or on indirect tools and methods. Direct dialogue includes all types of negotiation and consultation, starting with the exchange of information (between representatives of governments, employers, employees and other stakeholders) on issues of common interest relating to economic and social policy. These elements of social dialogue are crucial to the outcome sought by the social partners and their choice depends on the outcome desired. A common understanding has to be reached on the purpose of social dialogue. Therefore, at the start of a process of social dialogue, the social partners should have a clear idea of the elements of social dialogue to be included and who will decide on their inclusion.

Indirect tools are technical tools such as surveys, discussion groups, workshops, focus groups, and interviews with selected representatives of social groups. The purpose of all

these instruments is to obtain information and quantitative and qualitative data about the problems, concerns and desires of the people involved. In the end, it is those who are affected by the system who will make the system succeed. If the ideas and needs of these groups remain unknown to decision makers, the decisions rendered cannot be considered representative or valid.

As regards social protection, the partners in social and national dialogue are – in principle – all people concerned. People are usually represented through authorities and interest groups including public authorities (as regulators and as employers), private employers' and workers' organizations, and various stakeholders in the sector. Given the large financial implications of the sector for other government structures and for employers and workers, other stakeholders beyond the sector may also be involved in policy development (except on matters that are exclusively the concern of parties that conduct negotiations and collective bargaining). The organizations or institutions that represent the groups in the sector have changed over the past two decades. There is also greater variety in the levels of government levels now involved. New private employers have entered the social protection sector and related services. Key partners and stakeholders are:

- central government (e.g. ministries and agencies such as the Ministries of Health, Finance, Labour, Gender, Children and Social Protection, Commerce, Agriculture, Economic Affairs, and the Planning Commission);
- local government (provincial and district governments, communities, selected villages, and mayors);
- employers' organizations and individual large, medium and small employers (through interviews, workshops and site visits);
- employees (either through trade unions or through focus group discussions, surveys and individual interviews);
- health care providers (through their respective organizations and or through site visits, surveys and individual meetings);
- existing schemes like NSSF, NHIF, occupational schemes;
- civil society organizations and NGOs;
- community-based schemes;
- retirees, patients (through surveys and focus group discussions).

Many of these groups of partners have their own organizations or representatives that are the counterparts in the dialogue. However, in many countries, patients, community-based health insurance schemes and some types of health care providers do not have representatives. In order to get their opinions and ideas, specific methods of dialogue must be used, as discussed above.

In Kenya, the focus for the coming years must be on the process. All stakeholders should agree on the basic objectives to be achieved. A comprehensive social dialogue should follow at the end of which concrete proposals should be agreed upon. The Government has already taken steps to moderate such a process, including:

- Technical support and elaboration of proposals for the discussion.
- Capacity building, best practices and forums.

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- Legislative inputs and promotion of reform measures through draft laws and technical assistance to Government, Parliamentarians and other policy makers.

Additionally, in order to fulfil the mandate of the EAC on the issue of cooperation in the domain of social protection, it is suggested that Kenya align its social security policies with those of Uganda, Tanzania, Rwanda and Burundi. This could be achieved within and outside the forum of the EAC through discussions with relevant ministries and other stakeholders in these neighbouring countries. Such dialogue needs to be undertaken during and following Kenya's reform, and should centre on issues such as portability and coordination.

7. Laying the groundwork for universal coverage: Suggestions for technical cooperation

In the past, Kenya had developed a social protection system that covers already some parts of the population and provides benefits, e.g., in the area of old age and health .

In the coming years it will be critical to achieve the objectives of i) raising the social protection floor by providing effective access to adequate income support and health services to all those in need and ii) meeting the standards of ILO Convention No. 102 through higher coverage levels, better risk protection mechanisms and improved benefits.

This report, in line with ILO Convention No. 102 and the Social Protection Floor Initiative suggests a holistic approach towards social protection. Key measures to undertake include:

- Extension of legal coverage in all social protection branches.
- Development of adequate and affordable benefits.
- Improving the cost-benefit ratio in all existing branches.
- Realizing the potentials that exist in the form of fiscal space.
- Closing the gaps in the existing landscape of schemes and benefits, e.g., with regard to unemployment.

Success will rely on the efficient and effective implementation of the reforms. This includes the development of technical and administrative capacity and increased understanding of the reform processes in all groups of the population through awareness-raising.

Against this background, it is suggested to follow-up on this report. ILO stands ready to support the implementation of a possible project should funds be made available. The objective of the project would be to strengthen administrative efficiency and effectiveness of social protection institutions, to build capacity and to raise awareness and support consensus building among government, labour unions, employers and other stakeholders on key aspects of social protection reforms e.g. in pension, health and social assistance. The project would consist of two parts:

1. Strengthening capacity for the development, implementation and management of reforms
2. Facilitating national and social dialogue on the reform process and awareness raising.

7.1 Strengthening capacity for the development, implementation and management

Strengthening capacity for the development, implementation, and management of reforms should take place at various levels. At the administrative and managerial level, for example, knowledge and competencies can be enhanced in the following areas: the use of funds, efficiency, managerial capacity, legislation, enforcement, decision-making processes and monitoring as regards all branches of social protection. Target groups for capacity building vary greatly and should include administrators, managers from different departments and technical staff (pension schemes, social health insurance, micro

insurances), government policymakers, employers, employees, trade unions, health providers, and academic, research or training institutions.

Capacity building is an essential component that aims at complementing the development of the national social protection framework and strategic plan. Building administrative and technical capabilities, through training and the establishment of efficient structures and procedures is one of the key preparatory activities for sustainable social protection schemes.

Two interrelated projects in this area are suggested:

1. The first project will **support the Government in creating capacity** in the following areas: Social protection planning, project management, data analysis. Further, the participants will be trained to:
 - understand and appreciate the socio-economic and policy environment affecting the social protection schemes;
 - analyze country specific issues and policy options for expanding coverage specifically for the informal economy (tax based financing, social insurance, community and micro-insurance schemes, vouchers, cash transfers); and
 - gain an understanding of the key principles in the financing, management and governance of social protection schemes including data development and monitoring.

The capacity strengthening will be tailored depending on the current skills and capacities of each participant and related to their respective mandates in social protection.

This form of capacity building requires the development of country specific approaches involving local expertise and can be organized either through sending officials abroad - e.g. to special training centres such as the International Training Centre of the ILO in Turin or through in-country seminars.

2. The second part of the project will **support specific reform approaches for NSSF and NHIF**: It is suggested to carry out specific studies that allow an efficient and effective development, implementation and monitoring of these schemes.

With relation to the **NSSF** it is suggested to carry out

- an actuarial study to identify space to increase interest to member accounts;
- an in-depth administrative review; and
- a technical assistance project to develop a universal pension scheme or alternatively a fully-fledged contribution based pension scheme.

With relation to the **NHIF** this would consist of:

- a study to assess returns of investments in the NHIF and to assess and develop possibilities for efficient use;

- a study developing options for systematic inclusion of the informal economy workers and their families; and
- an in-depth administrative review.

In addition, it would be useful to undertake a series of studies on specific schemes and social security institutions to better inform policy and procedures. This would include an in-depth administrative review of each major scheme.

7.2 Facilitation of national and social dialogue and awareness raising

It is suggested to support a broad national stakeholder dialogue through:

- The organization of a **nationwide conference** in which key elements of the results of part of the studies would be presented and discussed. The objective would be to create awareness among stakeholders and to create consensus. It should facilitate dialogue among main stakeholders through the facilitation of information sharing, gathering of stakeholder positions through interviews and meetings in small groups and the elaboration of a stakeholder mapping.
- Supporting the development of a **consensus-based national action/coverage plan** outlining suggestions for improving health financing mechanisms, building linkages between subsystems, designing adequate benefit packages and creating institutional and administrative efficiency.
- **The creation of a consultative body of stakeholders and a framework for national dialogue** to form agreement on key administrative, legislative and regulatory policies that impact on the extension of coverage, e.g. subsidies, benefit packages, fee schedules, auditing etc.
- **The development and launch of a broad awareness raising campaign led by the Ministry of Labour.** It is suggested that this be done perhaps in the context of the above conference. Raising public awareness and understanding of social protection schemes is crucial for the development of an integrated, effective social protection system and for continued support and compliance of all stakeholders. A symbolic forging of commitments by relevant stakeholders (e.g. insurers, trade unions, and employers, policymakers, health providers and decision makers) may be done to signify consensus, support and intent to pursue the coverage of the population. The campaign and the conference may also be used to institutionalize the social dialogue and consensus building as a mechanism to achieve national and local level plans and reforms. This activity would involve the development of the communication plan and strategy, forming a consensus on key messages, identifying the type of medium used to deliver the messages, for which sector of the population, for how long and agency/ person responsible.

The quality of Kenya's social protection system will be a decisive factor in its success in poverty reduction. As international experience has demonstrated, economic growth is important to reduce poverty and to create fiscal space for social protection; however, growth alone is not enough to protect people that are vulnerable. Markets fail in protecting people. The predicted redistributive effects of globalization and economic growth do not exist to the degree required. This is why wealthy countries, regardless of economic success, have large, well-developed social protection schemes.

Accordingly, without the implementation of effective and adequate social protection systems, Kenya will not be able to reduce its poverty levels significantly. This report has outlined a series of recommended measures to strengthen social protection in Kenya and the ILO is prepared to support Kenya on its way.

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Annexes

A. Operational Definition of Social Security

- (1-2) protection in sickness, including:
 - (1) medical care, as defined in Part II of Convention No. 102 and by Convention No.130;
 - (2) income support in the form of cash sickness benefits, as defined in Part III of Convention No. 102 and by Convention No. 130;
- (3) protection in disability, including income support but also medical care, rehabilitation and long-term care – income support invalidity benefit as defined in Part IX of Convention No. 102 and by Convention No. 128;
- (4) protection in old age, including income support and long-term care – income support old-age benefit as defined in Part V of Convention No. 102 and by Convention No. 128;
- (5) protection of survivors in case of death of a family member (“breadwinner”) – income support benefit, as defined in Part X of Convention No. 102 and by Convention No. 128;
- (6) protection in maternity, including medical care and income support maternity benefit, as defined in Part VIII of Convention No. 102 and by Convention No. 183;
- (7) protection in “responsibility for the maintenance of children”, including the provision in kind to, or in respect of, children, of “food, clothing, housing, holidays or domestic help” and of cash income support family benefits as defined in Part VII of Convention No. 102;
- (8) protection in unemployment, including income support in the form of unemployment benefits, and also other labour market policies promoting employment – income support benefits as defined in Part IV of Convention No. 102, and income support and other labour market policies as defined by Convention No. 168;
- (9) protection in case of employment injury: medical care, rehabilitation and income support in the form of sickness, invalidity or survivors’ benefit as defined in Part VI of Convention No. 102 and by Convention No. 121;
- (10) general protection against poverty and social exclusion in through social assistance that provides protection to all residents without sufficient other means of income from work and not covered (or not covered sufficiently) by social security branches listed above.

Source: International Labour Office (ILO). 2010. World Social Security Report 2010–11: Providing coverage in times of crisis and beyond (Geneva).

B. Minimum requirements for coverage and minimum rates of cash benefits under Convention No. 102

Branches	Coverage	Benefit (per cent)
Sickness benefit	At least 50 per cent of all employees; or Economically active population constituting at least 20 per cent of all residents; or All residents with means below certain limit.	45 ¹
Unemployment benefit	At least 50 per cent of all employees; or All residents with means below certain limit.	45
Old-age benefit	At least 50 per cent of all employees; or Economically active population constituting at least 20 per cent of all residents; or All residents with means below certain limit.	40
Employment injury benefits	At least 50 per cent of all employees	
Short term		50
Disability		50
Survivors		45
Family benefit	At least 50 per cent of all employees; or At least 20 per cent of all residents; or All residents with means below certain limit.	3 (or 1.5) ²
Maternity benefit	All women in prescribed classes, constituting at least 50 per cent of all employees; or All women in prescribed classes of the economically active population, constituting at least 20 per cent of all residents.	45
Invalidity benefit	At least 50 per cent of all employees; or Economically active population constituting at least 20 per cent of all residents; or All residents with means below certain limit.	40
Survivors' benefit	Wives and children of at least 50 per cent of all employees; or Wives and children of breadwinners of classes of economically active population, constituting at least 20 per cent of all residents; or All resident widows or resident children with means below certain limit.	40

¹ Percentage of reference wage corresponding either to former earnings (earnings-related benefits) or to the wage of an unskilled male labourer (flat-rate benefits).

² Percentage of reference wage multiplied by total number of children of persons protected (or of all residents).

Source: ILO. (2008) Setting Social Security Standards in a Global Society: An analysis of present state and practice and of future options for global social security standard setting in the International Labour Organization. Social Security Policy Briefings, Paper 2 (Geneva).

C. MDG Progress in Kenya

Goal 1- Eradicate Extreme Poverty & Hunger	Base Level (1990)	MDG Target (2015)	1996/97	2000/01	2004/05	2008/09(or most recent)
Population living below the poverty line (%)	56	28	57	52	52	46
Poverty Gap Ratio	N/A	N/A	18.7	13	N/A	N/A
Stunting: % of Children below weight-for-age	N/A	N/A	N/A	N/A	N/A	16.1
Children Underweight (%)	N/A	N/A	N/A	21.2	N/A	6.7
Goal 2- Achieve Universal Primary Education	Base Level (1990)	MDG Target (2015)	1995/96	2001/02	2004/05	2008/09(or most recent)
Primary Gross Enrollment Ratio (Grade 1-8) (%)	N/A	N/A	93	93	104.8	107.6
Primary Completion Rate %	N/A	100		62.8	76.9	79.5
Literacy Rate (%)	N/A	N/A	N/A	N/A	N/A	61.5
Goal 3- Promote Gender Equality and Women Empowerment	Base Level (1990)	MDG Target (2015)	1995/96	2000/01	2004/05	2008/09(or most recent)
Ratio of Girls to Boys in: Primary education	N/A	N/A	N/A	77.3	83.5	92.5
Secondary education	N/A	N/A	N/A	29.7	29.3	42.5
Higher education	N/A	N/A	N/A	44.2	N/A	N/A
Number of Women in Parliament (HoPR)	N/A	N/A	4.1	4.1	N/A	22 (10.47%)
Goal 4- Reduce Child Mortality	Base Level (1990)	MDG Target (2015)	1995/96	2000/01	2004/05	2008/09 (or most recent)
Under-5 Mortality Rate (per 1,000)	90	33	112	112	115	74
Infant Mortality (per 1000)	60	20	74	74	77	52
Immunization -Measles (%)	78	90	76	75	73	85
Immunization- DPT3 (%)	84	95	80	75	72	86
Goal 5- Improve Maternal Health	Base Level (1990)	MDG Target (2015)	1995/96	2000/01	2004/05	2008/09 (or most recent)
Maternal Mortality Ratio (per 100,000)	670	174	590	590	414	414
Contraceptive Prevalence Rate (%)	27		39	39	41	46
Proportion of Births Attended by Skilled personnel (%)	45 (1993)		49	49	42	40
Ante-Natal Coverage					90	88
Goal 6- Combat the Spread and Impacts of HIV/AIDS, Malaria and other Diseases	Base Level (1990)	MDG Target (2015)	1995/96	2000/01	2004/05	2008/09 (or most recent)
Overall HIV/AIDS prevalence rate (%)	5.1		11	13	6.7	7.4
HIV/AIDS prevalence among 15-24 old pregnant women (%)	6.8	N/A	11.3 (1996)	13	6.5	6.3
% of HIV/AIDS receiving Anti-retroviral Treatment (%)	N/A	N/A	N/A	N/A	40.5	54.4
% population W/Treated Bed nets (%)	N/A	N/A	N/A	N/A	N/A	54
TB Prevention & control (% cases successfully treated with DOTS)	N/A	N/A		75	80	N/A
Goal 7- Ensure Environmental Sustainability	Base Level (1990)	MDG Target (2015)	1995/96	2000/01	2004/05	2008/09 (or most recent)
Population without access to safe water	40			52		43
Goal 8-Develop a Global Partnership 4 Dev	2001/02	2002/03	2003/4	2004/05	2005/06	2008/09
ODA per Capita (USD \$) Significantly less compared to very low income countries						

Source: UNDP MDGs Report Kenya. http://www.ke.undp.org/download.php?f=571__UNDPKE-MDGs%20report%20Kenya.pdf.

D. Income Statement NHIF, 2006-2008

National Hospital Insurance Fund Income Statement For Year Ending Ended 30th June 2008				
		2007/2008 Kshs	2006/2007 Kshs	
Revenue	Notes			
Contribution	11	4,546,199,354	3,954,939,675	
Other Incomes	12	265,146,634	340,665,322	
Total Revenue		4,811,345,988	4,295,604,997	
Expenses				
Benefit Expenses	13	2,054,179,529	1,414,859,280	
Personnel Costs	14	1,353,896,888	1,096,044,560	
Administration Expenses	15	577,577,336	563,017,620	
Depreciation		254,894,779	243,444,785	
Total Expenditure		4,240,548,532	3,317,366,245	
Surplus (Deficit) for the year		570,797,456	978,238,752	
Less Withholding Tax	1 (h)	(32,455,658)	(44,059,805)	
Net surplus after Tax		538,341,798	934,178,947	

Source: NHIF 2009.

E. Financial Statements NSSF 1. 2008-2009

<u>DESCRIPTION</u>	<u>Note</u>	<u>JUNE</u> <u>2009</u> <u>KSHS. '000</u>	<u>JUNE</u> <u>2008</u> <u>KSHS. '000</u>
DEALINGS WITH MEMBERS			
Contributions Receivable	1	6,317,984	5,670,353
Benefits Payable	2	<u>2,552,455</u>	<u>2,375,353</u>
Net additions from dealings with members		<u>3,765,529</u>	<u>3,295,000</u>
RETURN ON INVESTMENTS			
Investments Income	3	4,566,502	5,035,684
Change in Market Value of Investments	4	<u>(10,846,853)</u>	<u>4,328,855</u>
Total Return on Investments		<u>(6,280,352)</u>	<u>9,364,539</u>
TOTAL REVENUE		(2,514,822)	12,659,539
Administration Expenses	5	4,897,950	3,648,219
NET INCREASE/(DECREASE) IN SCHEME FUNDS DURING THE PERIOD		<u>(7,412,772)</u>	<u>9,011,320</u>

Source: NSSF. 2009. NSSF Financial Statements for the Year ended 30 June 2009 (Nairobi).

F. Financial Statements NSSF 2, 2008-2009

1. CONTRIBUTIONS RECEIVABLE

	JUNE 2009	JUNE 2008
<u>Particulars</u>	<u>KSHS. '000</u>	<u>KSHS. '000</u>
Contributions Receivable -Employer	3,482,431	3,125,461
Contributions Receivable -Employee	<u>2,835,553</u>	<u>2,544,892</u>
Total Contributions Receivable	<u>6,317,984</u>	<u>5,670,353</u>

2. BENEFITS PAYABLE

	JUNE 2009	JUNE 2008
<u>Particulars</u>	<u>KSHS. '000</u>	<u>KSHS. '000</u>
Age Benefit Payments	1,060,390	1,001,797
Survivors Benefit	303,432	265,502
Invalidity Benefit	31,024	26,222
Withdrawal Benefit	1,137,604	1,057,928
Emigration Grant	12,818	16,506
Refunds	3,893	4,003
Funeral Grant	<u>3,295</u>	<u>3,395</u>
Total Benefit Payable	<u>2,552,455</u>	<u>2,375,353</u>

Source: NSSF. 2009. NSSF Financial Statements for the Year ended 30 June 2009 (Nairobi)

G. Preliminary projections of social protection expenditures, 2010 - 2020

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<i>GDP (billion KSH in constant 2010 prices)</i>	2,250.00	2,362.50	2,527.88	2,704.83	2,894.16	3,096.76	3,313.53	3,545.48	3,793.66	4,059.21	4,343.36
<i>GDP (billion KSH in current prices)</i>	2,250.00	2,622.38	3,068.18	3,559.09	4,092.95	4,706.89	5,412.93	6,224.87	7,158.60	8,232.39	9,467.24
<i>Estimated growth rate</i>	5%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%
<i>Inflation Rate</i>	15%	11%	10%	9%	8%	8%	8%	8%	8%	8%	8%
<i>Public Budget (billion KSH)</i>	524.00	567.00	606.69	676.21	723.54	805.16	861.52	957.28	1,024.29	1,136.58	1,216.14
<i>Public budget in % of real GDP</i>	23%	24%	24%	25%	25%	26%	26%	27%	27%	28%	28%
<i>Social Protection Expenses (billion KSH)</i>											
<i>NSSF</i>	6.30	9.42	13.42	18.50	24.92	33.00	43.09	55.67	71.28	90.59	114.40
<i>Beneficiaries (million)</i>	1.80	2.30	2.80	3.30	3.80	4.30	4.80	5.30	5.80	6.30	6.80
<i>NHIF</i>	5.40	6.71	8.33	10.35	12.85	15.96	19.82	24.62	30.58	37.97	47.16
<i>Beneficiaries (million)</i>	10.00	11.50	13.23	15.21	17.49	20.11	23.13	26.60	30.59	35.18	40.46
<i>Social Assistance</i>	2.16	2.70	3.51	4.56	5.93	7.71	10.02	13.03	16.94	22.02	28.63
<i>Beneficiaries (million)</i>	0.12	0.15	0.20	0.25	0.33	0.43	0.56	0.72	0.94	1.22	1.59
<i>Public Pension</i>	25.20	28.31	31.81	35.74	40.15	45.11	50.68	56.94	63.97	71.87	80.75
<i>Beneficiaries (million)</i>	0.20	0.21	0.22	0.23	0.24	0.26	0.27	0.28	0.30	0.31	0.33
<i>% contribution financed</i>	-	-	10%	15%	20%	25%	30%	35%	40%	45%	50%
<i>Social pension</i>	-	4.80	12.84	14.38	15.92	17.46	19.00	20.54	22.08	23.63	25.17
<i>Beneficiaries (million)</i>	-	0.20	0.50	0.56	0.62	0.68	0.74	0.80	0.86	0.92	0.98
<i>Other (estimates)</i>	5.00	5.50	6.05	6.66	7.32	8.05	8.86	9.74	10.72	11.79	12.97
<i>Total</i>	44.06	57.44	75.95	90.18	107.10	127.29	151.48	180.55	215.57	257.88	309.08
<i>Contribution financed</i>	11.70	16.13	24.93	34.20	45.80	60.23	78.12	100.22	127.45	122.93	201.94
<i>Financed from public budget</i>	32.36	41.31	51.03	55.98	61.29	67.06	73.36	80.33	88.13	96.97	107.14
<i>In % of public budget</i>	6.18%	7.29%	8.41%	8.28%	8.47%	8.33%	8.52%	8.39%	8.60%	8.53%	8.81%
<i>Total SP in % of real GDP</i>	1.96%	2.43%	3.00%	3.33%	3.70%	4.11%	4.57%	5.09%	5.68%	6.35%	7.12%
<i>% of total SP Expenses</i>											
<i>NSSF</i>	14.30%	16.40%	17.66%	20.51%	23.27%	25.92%	28.45%	30.84%	33.07%	35.13%	37.01%
<i>NHIF</i>	12.26%	11.68%	10.97%	11.47%	12.00%	12.54%	13.08%	13.63%	14.18%	14.73%	15.26%
<i>Social Assistance</i>	4.90%	4.70%	4.62%	5.06%	5.54%	6.06%	6.62%	7.22%	7.86%	8.54%	9.26%
<i>Public Pension</i>	57.19%	49.29%	41.88%	39.63%	37.49%	35.44%	33.46%	31.54%	29.67%	27.87%	26.13%
<i>Social pension</i>	0.00%	8.36%	16.91%	15.95%	14.87%	13.72%	12.54%	11.38%	10.24%	9.16%	8.14%
<i>Other (estimates)</i>	11.35%	9.58%	7.97%	7.38%	6.84%	6.33%	5.85%	5.40%	4.97%	4.57%	4.20%
<i>Total</i>	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Source: Authors' Calculations.