REPUBLIC OF KENYA

Transforming Health: Accelerating attainment of Health Goals

HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN (KHSSP) JULY 2013-JUNE 2017

THE SECOND MEDIUM TERM PLAN FOR HEALTH

KHSSP PERFORMANCE MONITORING INDICATORS AND TARGETS

Policy Objective	Indicator	Targeted trend's Baseline (2013)	Mid Term (2015)	Target (2017)
Eliminate Communicable Conditions	% Fully immunized children	79	90	90
	% of target population receiving MDA for schistosomiasis	50	95	95
	% of TB patients completing treatment	85	90	90
	% HIV + pregnant mothers receiving preventive ARV's	63	90	90
	% of eligible HIV clients on ARV's	60	90	90
	% of targeted under 1's provided with LLITN's	44	85	85
	% of targeted pregnant women provided with LLITN's	30	70	85
	% of under 5's treated for h diarrhea	40	10	5
	% School age children dewormed	49	85	90
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	50	40	35
	% Women of Reproductive age screened for Cervical cancers	50	70	75
	% of new outpatients with mental health conditions	<1	2	1
	% of new outpatients cases with high blood pressure	1	5	3
	% of patients admitted with cancer	1	2	2
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender based violence	<1	3	2
	% new outpatient cases attributed to Road traffic Injuries	4	2	2
	% new outpatient cases attributed to other injuries	<1	0.5	0.5
	% of deaths due to injuries	10	5	3
Provide essential health services	% deliveries conducted by skilled attendant	44	60	65
	% of women of Reproductive age receiving family planning	45	80	80
	% of facility based maternal deaths	400	100	100
	% of facility based under five deaths	60	20	15
	% of newborns with low birth weight	10	6	5
	% of facility based fresh still births	30	10	5
	Surgical rate for cold cases	0.40	0.85	0.90
	% of pregnant women attending 4 ANC visits	36	80	80
Minimize exposure to health risk factors	% population who smoke	18		
	% population consuming alcohol regularly	35		
	% infants under 6 months on exclusive breastfeeding	32		
	% of Population aware of risk factors to health	30		
	% of salt brands adequately iodized	85		
	Couple year protection due to condom use			
Strengthen collaboration with health related sectors	% population with access to safe water	60		85
	% under 5's stunted	35		15
	% under 5 underweight	17		5
	School enrollment rate	60	80	80
	% of households with latrines	34		70
	% of houses with adequate ventilation	65		80
	% of classified road network in good condition	30		50
	% Schools providing complete school health package	15		50
INVESTMENT OUTPUTS				
Improving access to services	Per capita Outpatient utilization rate (M/F)	2	3	4
	% of population living within 5km of a facility	80	90	90
	% of facilities providing BEOC	65	80	90
	% of facilities providing CEOC			
	Bed Occupancy Rate	85	95	95
	% of facilities providing Immunisation	80	100	100
Improving quality of care	TB Cure rate	83	88	90
	% of fevers tested positive for malaria	45		20
	% maternal audits/deaths audits	10	70	85
	Malaria inpatient case fatality	15	8	5
	Average length of stay (ALOS)	5.6	4.5	4

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***Accelerating attainment of Health Goals:* The KENYA HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN – KHSSP July 2012 – June 2017**

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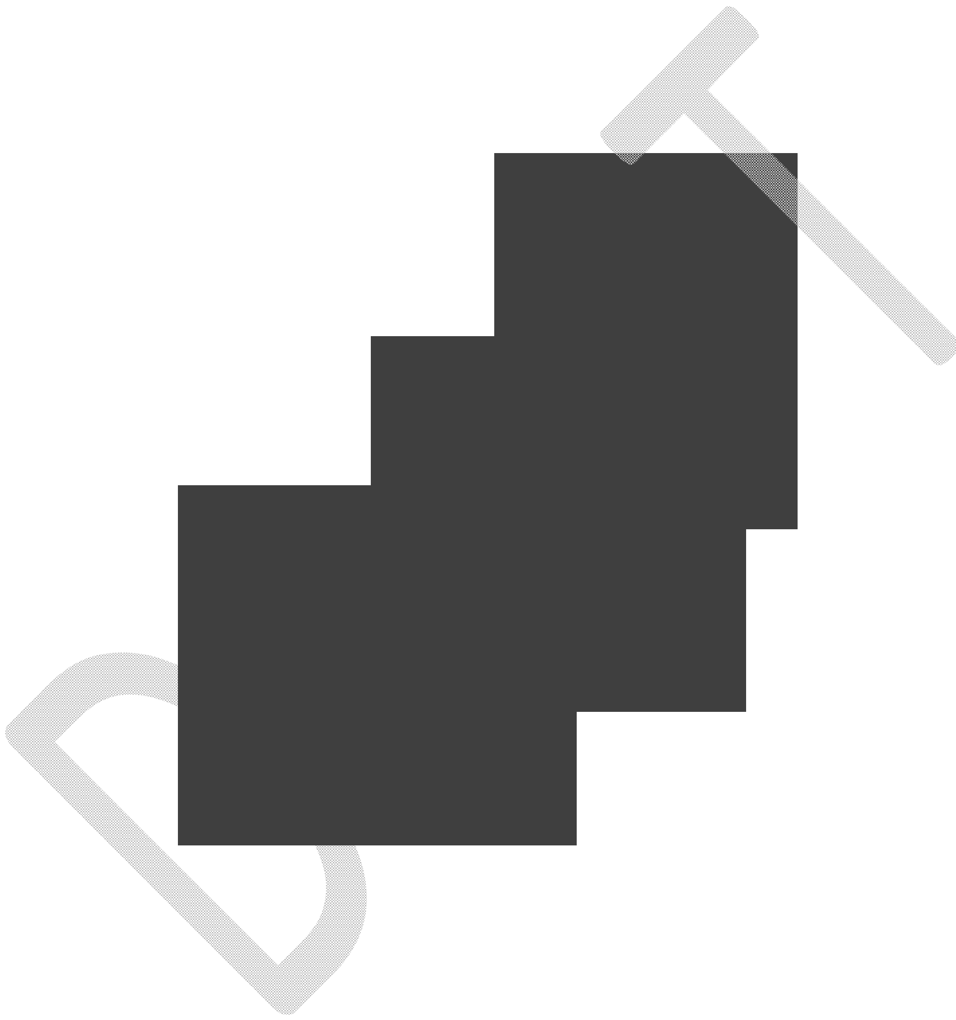
ABBREVIATIONS

Abbreviation	Meaning
AIDS	Acquired Immuno deficiency syndrome
ALOS	Average length of stay
AMR	Adult Mortality Rate
ANC	Antenatal
AOP	Annual Operational Plan
ARV	Anti Retro-Viral
AWP	Annual Work Plan
BEOC	Basic Emergency Obstetric care
BMI	Body Mass Index
BOM	Board of management
CDF	Constituency Development Fund
CFMT	County Health facility management teams
CHC	Community Health Committee
CHMT	County health management teams
CMA	Common Management Arrangements
CoC	Code of Conduct
CPD	Ccontinous proffessional development
CSO	Civil Society Organizations
CT Scan	Computerized Tomography
DAC	Development Assistance Committee
DALYs	Disability Adjusted Life Years
DfID	Department for International Development
DHIS	District Health Information System
DHS	Demographic and Health Survey
DHSF	District Health Stakeholders Forum
DNA	Deoxyribonucleic Acid
DPHK	Development Partners for Health in Kenya
DQA	Data Quality Assessment
DSRS	Department of Standards and Regulatory Services
EHPT	Essential health products and technologies
EML	Essential Medicinces List
EMMS	Essential Medicines and Medical Supplies
EMR	Electronic Medical Records
FBOs	Faith Based organizations
FTP	File Transfer Protocol
GAVI	Global Alliance for Vaccines and Immunization
GDP	Good Dispensing Practices
GFATM	Global Fund for AIDS TB and Malaria
GIZ	sand t
GoK	Government of Kenya
GPP	Good Prescribing Practices
HFC	Health Facility Committee
HIS	Health Information System
HIV	Human Immunology Virus
HMIS	Health Management and Information System
HRD	Human Resource Development
HRH	Human Resources for Health
HSCC	Health Sector Coordinating Committee
HSS	Health System Strengthening
HSSC	Health Sector Steering Committee
HSSF	Health Sector Service Fund
HTC	HIV Testing and Counseling
HW	Health Workforce
ICC	Inter Agency Coordinating Committee
ICT	Information Communication Technology
ICU	Intensive Care Unit
IDP	Internally displace persons
IDSR	Disease Surveillance and Reporting
IMR	Infant Mortality Rate
JAR	Joint Annual Review
JICA	Japan International Cooperation Agency
JICC	Joint Inter Agency Coordinating Committee
JPWF	Joint program of Work and Funding
JRM	Joint Review Mission
KAIS	Kenya AIDS Indicator Survey
KEMRI	Kenya Medical Research Institution
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KHP	Kenya Health Policy
KHSSP	Kenya Heath Sector Strategic and Investment Plan
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
KQM	Kenya Quality Model
LLITN's	Long Lasting Insecticides Treated Nets
M/F	Male/Female
MCH	Maternal Child Health
MDA	Multi Drug Administration
MDG	Millenium Development Goal
MDR/TB	Multiple Drug Resistant Tuberculosis
MHC	Health Centres
MIS	Malaria Indicator Survey
MMR	Maternal Mortality ratio
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MOT	Ministry of Transport
MRI	Magnetic Ressonance Imaging
MTC	Medicines and Therapeutics Committee

MTEF	Medium Term Expenditure Framework
MTPP	Medium Term Procurement Plan
MTRH	Moi Teaching and Referral Hospital
MUAC	Mid Upper Arm Circumference
NACC	National AIDS Coordinating Council
NCD's	Non Communicable Diseases
NGOs	Non Govermental Oraganization
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan
NMR	Neonatal Mortality rate
NQCL	National Quality Control Laboratory
OBA	Output Based approach
OCPD	Oversight Continous Proffessional Deevelopment
OECD	Organization for Economic Cooperation and Development
OOP	Out of pocket
OPD	Outpatient
PAS	Performance Appraisal System
PHSF	Provincial Health Stakeholders Forum
PPB	Pharmacy and Poisons Board
PPPH	Public Private Partnership for Health
RAC	Resource Allocation Creteria
RBM	Result-based management
RFW	Result Framework
SAGA	Semi Autonomous Government Agency
SARS	Severe acute respiratory syndrome
SWGs	Sector Working Groups
TB	Tuberculosis
THE	Total health expenditure
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
UNDAF	United Nations Development Assistance Fund
UNFPA	United Nations Population Agency
UNICEF	United Nations Emergency Childrens Fund
WB	World Bank
WHO	World Health Organization
XDR/TB	Extreme Drug Resistant Tuberculosis

Foreword



EXECUTIVE SUMMARY

Introduction

The Health Sector Strategic focus in Kenya is guided by the overall Vision 2030that aims to transform Kenya into a globally competitive and prosperous country with a high quality of life by 2030" through transforming the country from a third world country into an industrialized, middle income country. Its actions are grounded in the principles of the 2010 constitution, specifically aiming to attain the right to health, and to decentralize health services management through a devolved system of Governance. This strategic focus has been defined in the Kenya Health Policy, which has elaborated the long term policy directions the Country intends to achieve in pursuit of the imperatives of the Vision 2030, and the 2010 constitution.

The Kenya Health Policy 2012 – 2030 has, as a goal, **'attaining the highest possible health standards in a manner responsive to the population needs'**. The policy aims to achieve this goal through supporting provision of *equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans.* It targets to attain a level and distribution of health at a level commensurate with that of a middle income country, through attainment of specific health impact targets. The policy directions in the Kenya Health Policy are structured around Six Service Delivery outcomes, and Seven System investment orientations.

This strategic plan provides the Health Sector Medium Term focus, objectives and priorities to enable it move towards attainment of the Kenya Health Policy Directions. The Health Sector refers to all the Health and related sector actions needed to attain the Health Goals in Kenya. It is not restricted to the actions of the Health Ministry, but includes all actions in other related sectors that have an impact on health. It will guide both County and National Governments on the operational priorities they need to focus on in Health.

This Strategic Plan follows on the 2nd National Health Sector Strategic Plan (NHSSP II), who's overall goal wasto reduce inequalities in health care services and reverse the downward trend in health-related outcome indicators. Recommendations from implementation of the 5 Strategic Objectives of the NHSSP II have guided prioritization of interventions for implementation during this strategic plan. These recommendations include the call for the sector to:

- Improve evidence based decision making and resource allocation.
- Review and re-align the essential package for health.
- Review, and realign community based services around expectations.
- Focus on strengthening of the referral system.
- Improve planning , and monitoring of quality of care, and service delivery.
- Operationalize the planning and review cycles and frameworks at all levels.
- Align Health Sector operations and services with 2010 constitution expectations.
- Strengthen the Health Information System to act as a resource for the sector.
- Update sector norms and standards.
- Establish systems to coordinate sector investments.
- Continue to strengthen Procurement and Supply Management systems
- Re-invigorate the sector partnership and coordination framework.
- Start to pro-actively, and regularly monitor technical and allocative efficiency in resource use by the Health Sector.
- Accelerate push towards systems to attain universal access to defined health service package.

KHSSP Strategic direction

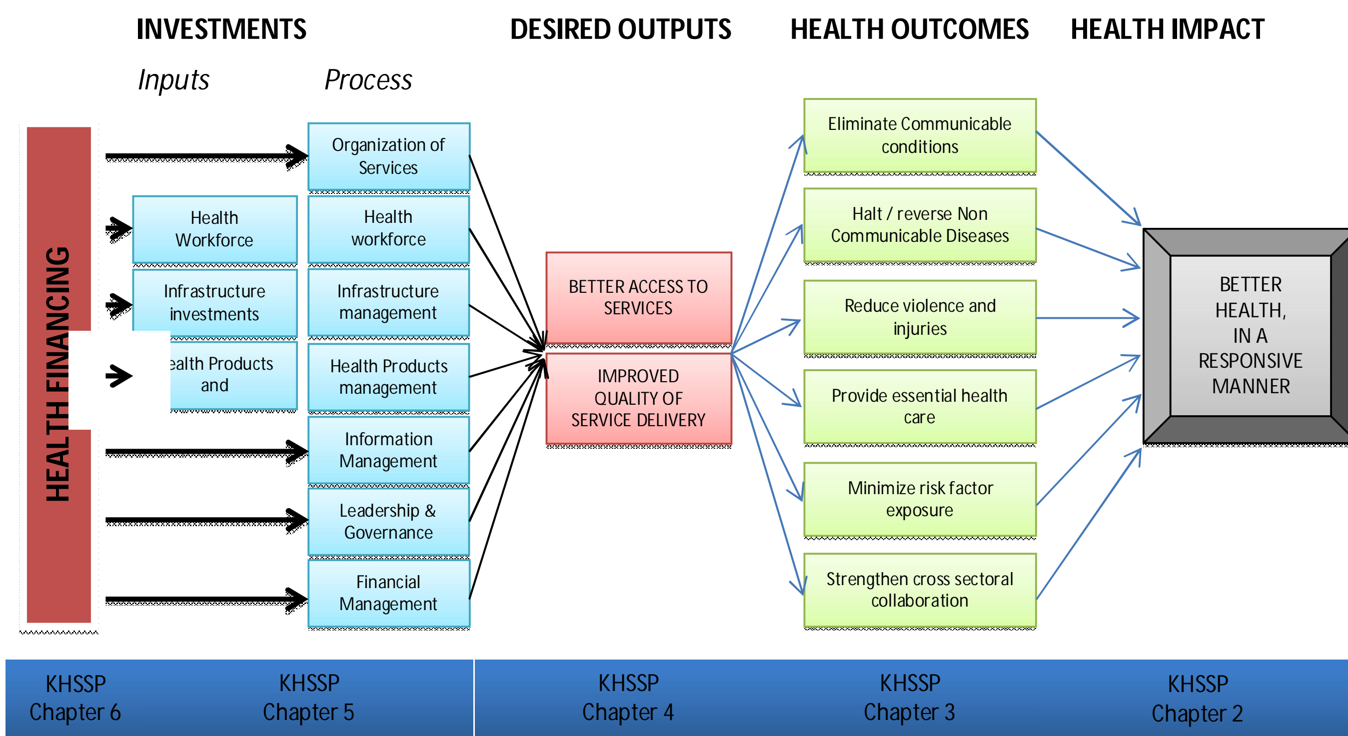
This strategic plan has, as its vision, having **a globally competitive, healthy and productive nation.**

The plan has, as its goal, **'accelerating attainment of health impact goals'** as defined in the Health Policy. The mission of this strategic plan is **"To deliberately build progressive, responsive and sustainable technologically-driven, evidence-based and client-centred health system for accelerated attainment of highest standard of health to all Kenyans"**. This the sector aims to attain through focusing on implementation of a broad base of health and related services that will impact on health of persons in Kenya. It places main emphasis on implementing interventions, and prioritizing investments relating to maternal and newborn health, as it is the major impact area for which progress was not attained in the previous strategic plan. It is designed to provide information on:

a) The scope of Health and related services the sector intends to focus on ensuring are provided for persons in Kenya – outlined in the Kenya Essential Package for Health, KEPH
b) The investments required to provide the above-mentioned services – outlined across the 7 investment areas for health – and
c) How the sector will monitor and guide attainment of the above

A series of priorities shall be focused on during the KHSSP period for attainment. These are defined at the impact, outcome, output and input levels to assure a logical link across sector actions. This is drawn from the KHP framework, and is highlighted below.

KHSSP Framework for Implementation



As outlined in Chapter 2 of the KHSSP, the sector will focus on the following impact priority targets in an equitable and effective manner, to attain the sector goal.

- Reduce, by at least half, the neonatal and maternal deaths
- Reduce, by at least 25%, the time spent by persons in ill health
- Improve, by at least 50%, the levels of client satisfaction with services

Chapter 3 of the plan outlines the service delivery focus and targets that will be implemented to attain the above-mentioned impact targets. Priority will be on

- Eradication of polio, Guinea Worm, and emerging / re-emerging health threats occurring during the KHSSP period such as hemorrhagic fevers.
- Elimination of Malaria, Mother to Child HIV transmission, and Neglected Tropical Conditions
- Containment of conditions causing major disease burden, with efforts focusing on the top 10 causes of morbidity / mortality. These are (1) HIV/AIDS, (2) perinatal conditions, (3) Lower Respiratory infections, (4) Tuberculosis, (5) diarrhoeal diseases, (6) cerebrovascular diseases, (7) Ishaemic heart disease, (8) road traffic accidents, (9) violence, (10) congenital anomalies, and (11) unipolar depressive disorders.
- Contain the main risk factors to health, focusing on the top 10 risk factors to health. These are (1) unsafe sex, (2) unsafe water, sanitation and hygiene, (3) suboptimal breastfeeding, (4) childhood and maternal underweight, (5) indoor air pollution, (6) alcohol use, (7) Vitamin A deficiency, (8) high blood glucose, (9) high blood pressure, (10) zinc deficiency, (11) iron deficiency, and (12) lack of contraception.

The Kenya Essential Package for Health, KEPH, has been updated to reflect this focus. It now defines health services and interventions to be provided for each Policy Objective, by level of care (community, primary care, County and National) and cohort (Pregnancy / newborn, childhood, children / youth, adults, elderly) where applicable. Specific interventions have been defined in each policy objective for attainment, and services around which the interventions are clustered to guide the implementation level and communities on what needs to be provided.

Summary of KEPH for the Strategic Plan 2012 - 2017

Policy Objective	Services		Policy Objective	Services
Eliminate Communicable Conditions	Immunization		**Provide essential health services**	General Outpatient
	Child Health			Integrated MCH / Family Planning services
	Screening for communicable conditions			Accident and Emergency
	Antenatal Care			Emergency life support
	Prevention of Mother to Child HIV Transmission			Maternity
	Integrated Vector Management			Newborn services
	Good hygiene practices			Reproductive health
	HIV and STI prevention			In Patient
	Port health			Clinical Laboratory
	Control and prevention neglected tropical diseases			Specialized laboratory
				Imaging
Halt, and reverse the rising burden of non communicable conditions	Health Promotion &Education for NCD's			Pharmaceutical
	Institutional Screening for NCD's			Blood safety
	Rehabilitation			Rehabilitation
	Workplace Health & Safety			Palliative care
	Food quality & Safety			Specialized clinics
				Comprehensive youth friendly services
Reduce the	Health Promotion and education on violence /			Operative surgical services

Policy Objective	Services		Policy Objective	Services
burden of violence and injuries	injuries			
	Pre hospital Care			Specialized Therapies
	OPD/Accident and Emergency			
	Management for injuries		Strengthen collaboration with health related sectors	Safe water
	Rehabilitation			Sanitation and hygiene
				Nutrition services
Minimize exposure to health risk factors	Health Promotion including health Education			Pollution control
	Sexual education			Housing
	Substance abuse			School health
	Micronutrient deficiency control			Water and Sanitation Hygeine
	Physical activity			Food fortification
				Population management
				Road infrastructure and Transport

These Service Delivery outcomes will be attained through focusing on the following service outputs, as elaborated in Chapter 4 of the KHSSP

- Ensure 100% of KEPH services are being provided in special settings. These special settings in KHSSP are:
  - Congregate settings – prisons, IDP camps, schools, refugee camps, army barracks
  - At risk populations – HealthWorkers, , Commercial Sex Workers, women, persons with disability, elderly, children, youth, marginalized, religious/cultural communities
  - Hard to reach areas – Northern Kenya, focusing on the Counties of Isiolo, Turkana, Mandera, West Pokot, Marsabit, Samburu, Wajir, and Garissa, and
  - Informal settlements – focusing on urban and peri urban areas
- Improve access to KEPH to at least 90% by focusing on
  - Upgrading 40% of dispensaries to full primary care units
  - Operationalize 100% of model Health Centres to fully functional primary care facilities
  - Put in place fully functional referral system in at least 80% of Counties
  - Further reduction of the burden of pre-payment for health services
- Improve by 50% the quality of service delivery at all levels of the system through innovative mechanisms, such as performance based financing and improved availability of health investments

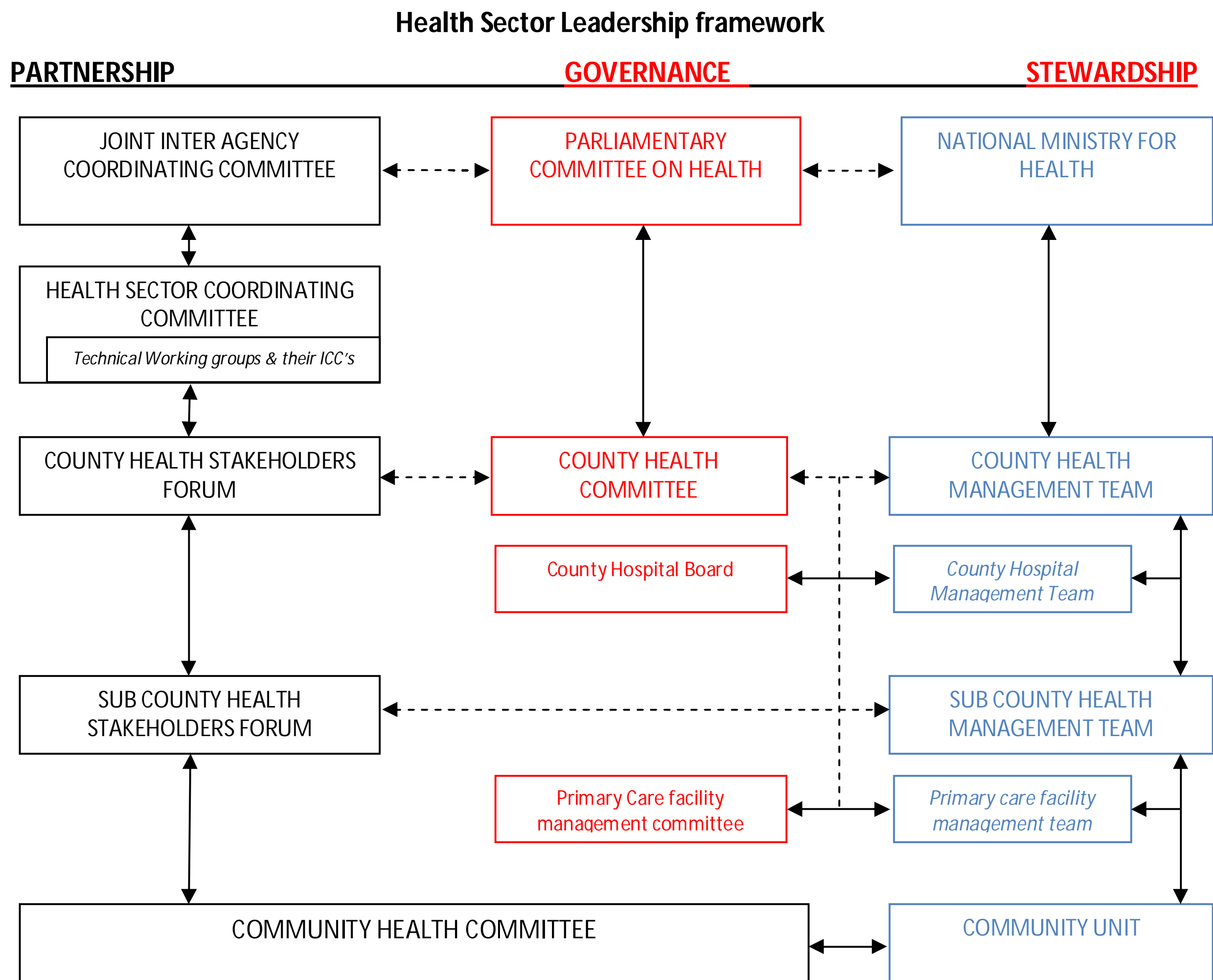
Attainment of these outcomes will be through investing in the Health System. The Health System comprises those investments that are primarily made to support attainment of Health Goals. Investments made that have another primary purpose (improvement in health being a secondary goal) are not included as part of health goals – for example investments to improve access to safe water, or housing. Priority investments are defined in Chapter 5 of the KHSSP, and focus on attaining the following priorities

- Implement County Health System in all Counties
- Recruit additional 50,000 Health Workers, to assure all functional facilities have minimum HR according to norms
- Procure infrastructure and equipment for 2,000 dispensaries, 500 health centres, and 200 hospitals to build them up to required minimum norms

- Establish demand driven procurement system in all Counties
- Automate holistic Health Information System
- Initiate and implement process of Universal Coverage attainment through Social Health Insurance
- Establish mechanisms for collaboration with all health related sectors

Implementation framework for the KHSSP

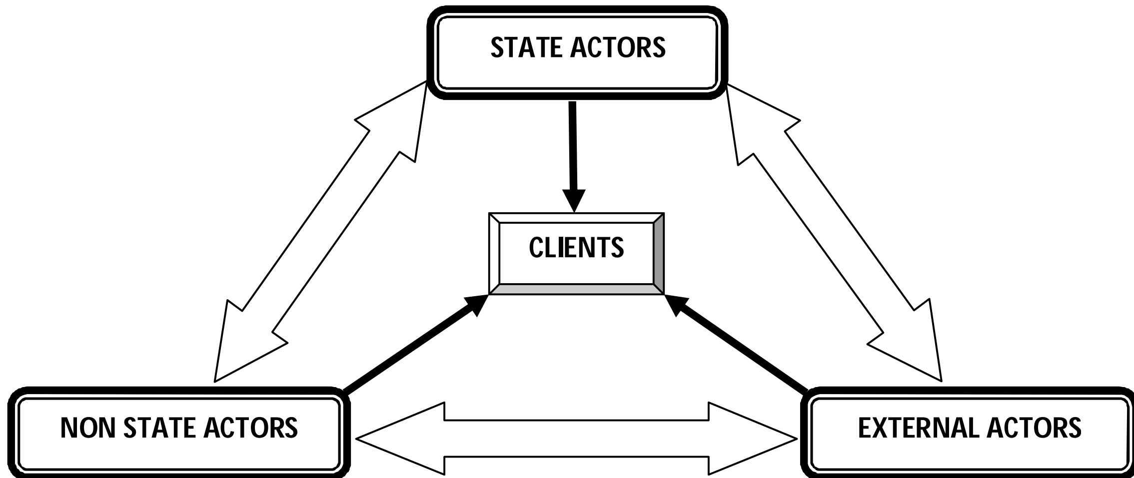
The leadership framework to guide implementation of the KHSSP within the Health Sector is shown below.



The sector partnership, governance, and stewardship processes together work to provide overall leadership in addressing the health agenda in the Country.

The partnership process defines how different actors in health will work together to contribute towards the health agenda. Sector partners are classified as the Clients, State Actors, non State actors, and external actors, each with clear defined responsibilities in implementing the KHSSP. These shall be defined, and their implementation monitored through a partnership instrument – the Sector Code of Conduct

Health Sector Actors



The Stewardship process defines how the Government shall provide overall guidance and support to taking forward the health agenda. The stewardship shall be effected through the National Ministry for Health, and the office of the County Director for Health at the County level.

The governance process defines how the application of the rule of law shall be monitored in the sector. This shall be effected through the County Executive Committee at the County level, and the National Health Ministry and its related regulatory bodies at the National level.

A communication framework is defined, whose main purpose is to build greater support and buy in of the KHSSP among key stakeholders and the public. The strategy will aim to reach to a greater audience than traditionally sort and demonstrate relevance and key benefits to target audiences.

A Monitoring and Evaluation framework is also defined, to improve on the technical accountability of the Health Sector. This shall be achieved through a focus on strengthening of the Country capacity for information generation, validation, analysis, dissemination and use through addressing the priorities as outlined in the Health Information System investment section of this document. It is built around three stewardship objectives:

a) Supporting the establishment of a common data architecture: This shall be to ensure coordinated information generation, comparable analytical methods are applied, and efficiencies are maximized in information dissemination. Information from different sources – routine sources, vital registration, surveys, research shall be used to guide decision making
b) Enhancing sharing of data and statistics: Various methods to share data and statistics shall be used, depending on the audiences targeted.
c) Improving the performance monitoring and review processes: Regular and systematic monitoring of planned progress shall be institutionalized, in line with the wider Government review processes.

Comprehensive KHSSP Indicators and targets

Policy Objective	Indicator	Targeted trend's		
		Baseline (2012)	Mid Term (2015)	Target (2017)
5 YEAR KHSSP IMPACT TARGETS				
Level of Health	Life Expectancy at birth	52	56	65
	Total annual number of deaths (per 100,000 population)	106	95	80
	Maternal deaths per 100,000 live births	*400*	*300*	*150*
	Neonatal deaths per 1,000 live births	*31*	*25*	*15*
	Under five deaths per 1000	*74*	*50*	*35*
	Youth and Adolescent deaths per 1000	*45*	*30*	*20*
	Adult deaths per 1000	*30*	*20*	*10*
	Elderly deaths per 1000	*80*	*80*	*80*
	Years of Life lived with illness / disability	12	10	8
	Due to communicable conditions	*6*	*5*	*4*
	Due to non-communicable conditions	*4*	*4*	*3*
	Due to violence / injuries	*2*	*1*	*1*
Distribution of health	% range of Health Services Outcome Index	45	30	20
Services Responsiveness	Client satisfaction index	65	78	85
PERFORMANCE MONITORING INDICATORS AND TARGETS				
Eliminate Communicable Conditions	% Fully immunized children	79	90	90
	% of target population receiving MDA for schistosomiasis	50	95	95
	% of TB patients completing treatment	85	90	90
	% HIV + pregnant mothers receiving preventive ARV's	63	90	90
	% of eligible HIV clients on ARV's	60	90	90
	% of targeted under 1's provided with LLITN's	44	85	85
	% of targeted pregnant women provided with LLITN's	30	70	85
	% of under 5's treated for h diarrhea	40	10	5
	% School age children dewormed	49	85	90
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	50	40	35
	% Women of Reproductive age screened for Cervical cancers	50	70	75
	% of new outpatients with mental health conditions	<1	2	1
	% of new outpatients cases with high blood pressure	1	5	3
	% of patients admitted with cancer	1	2	2
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender based violence	<1	3	2
	% new outpatient cases attributed to Road traffic Injuries	4	2	2
	% new outpatient cases attributed to other injuries	<1	0.5	0.5
	% of deaths due to injuries	10	5	3
Provide essential health services	% deliveries conducted by skilled attendant	44	60	65
	% of women of Reproductive age receiving family planning	45	80	80
	% of facility based maternal deaths	400	100	100
	% of facility based under five deaths	60	20	15
	% of newborns with low birth weight	10	6	5
	% of facility based fresh still births	30	10	5
	Surgical rate for cold cases	0.40	0.85	0.90
	% of pregnant women attending 4 ANC visits	36	80	80
Minimize exposure to health risk factors	% population who smoke	18		
	% population consuming alcohol regularly	35		
	% infants under 6 months on exclusive breastfeeding	32		
	% of Population aware of risk factors to health	30		
	% of salt brands adequately iodized	85		
	Couple year protection due to condom use			
Strengthen collaboration with health related sectors	% population with access to safe water	60		85
	% under 5's stunted	35		15
	% under 5 underweight	17		5
	School enrollment rate	60	80	80
	% of households with latrines	34		70
	% of houses with adequate ventilation	65		80
	% of classified road network in good condition	30		50
	% Schools providing complete school health package	15		50

Policy Objective	Indicator	Targeted trend's		
		Baseline (2012)	Mid Term (2015)	Target (2017)
INVESTMENT OUTPUTS				
Improving access to services	Per capita Outpatient utilization rate (M/F)	2	3	4
	% of population living within 5km of a facility	80	90	90
	% of facilities providing BEOC	65	80	90
	% of facilities providing CEOC			
	Bed Occupancy Rate	85	95	95
	% of facilities providing Immunisation	80	100	100
Improving quality of care	TB Cure rate	83	88	90
	% of fevers tested positive for malaria	45		20
	% maternal audits/deaths audits	10	70	85
	Malaria inpatient case fatality	15	8	5
	Average length of stay (ALOS)	5.6	4.5	4
FLAGSHIP PROGRAMS INVESTMENT INDICATORS AND TARGETS				
Service delivery systems	% of functional community units	20	30	45
	% outbreaks investigated within 48 hours	90	100	100
	% of hospitals offering emergency trauma services	35	65	80
	% hospitals offering Caesarean services	45	85	95
	% of referred clients reaching referral unit	25	70	85
Health Workforce	# of Medical health workers per 10,000 population	5	7	7
	% staff who have undergone CPD	40	65	70
	Staff attrition rate	10	5	2
	% Public Health Expenditures (Govt and donor) spent on Human Resources	55	45	40
Health Infrastructure	# of facilities per 10,000 population	1.5	2.5	2.5
	% of facilities equipped as per norms	25	60	70
	# of hospital beds per 10,000 population	50	150	150
	% Public Health Expenditures (Govt and donor) spent on Infrastructure	30	25	25
Health Products	% of time out of stock for Essential Medicines and Medical Supplies (EMMS) – days per month	8	2	2
	% Public Health Expenditures (Govt and donor) spent on Health Products	10	15	15
Health Financing	General Government expenditure on health as % of the total government Expenditure	4.5	8	12
	Total Health expenditure as a percentage of GDP	1.5	2	2.5
	Off budget resources for health as % of total public sector resources	60	25	5
	% of health expenditure reaching the end users	65	80	80
	% of Total Health Expenditure from out of pocket	33	25	15
Health Leadership	% of health facilities inspected annually	15	80	85
	% of health facilities with functional committees	70	100	100
	% of Counties with functional County Health Management Teams	0	100	100
	% of Health sector Steering Committee meetings held at National level	50	100	100
	% of Health sector steering committees meeting held at county level	0	100	100
	% of facilities supervised	40	100	100
	Number of counties with functional anti-corruption committees	0	47	47
	% of facilities with functional anti-corruption committees	0	80	100
	% of policies/document using evidence as per guidelines	30	100	100
	% of planning units submitting complete plans	65	95	95
	# of Health research publications shared with decision makers	3	20	20
	% of planning units with Performance Contracts	70	100	100
Health Information	% of quarters for which analysed health information is shared with the sector	50	100	100
	% of planning units submitting timely, complete and accurate information	25	70	85
	% of facilities with submitting timely, complete and accurate information	25	70	85
	% of health facilities with DQA	0	45	50
	% Public Health Expenditures (Govt and donor) spent on Health Information	3	5	5

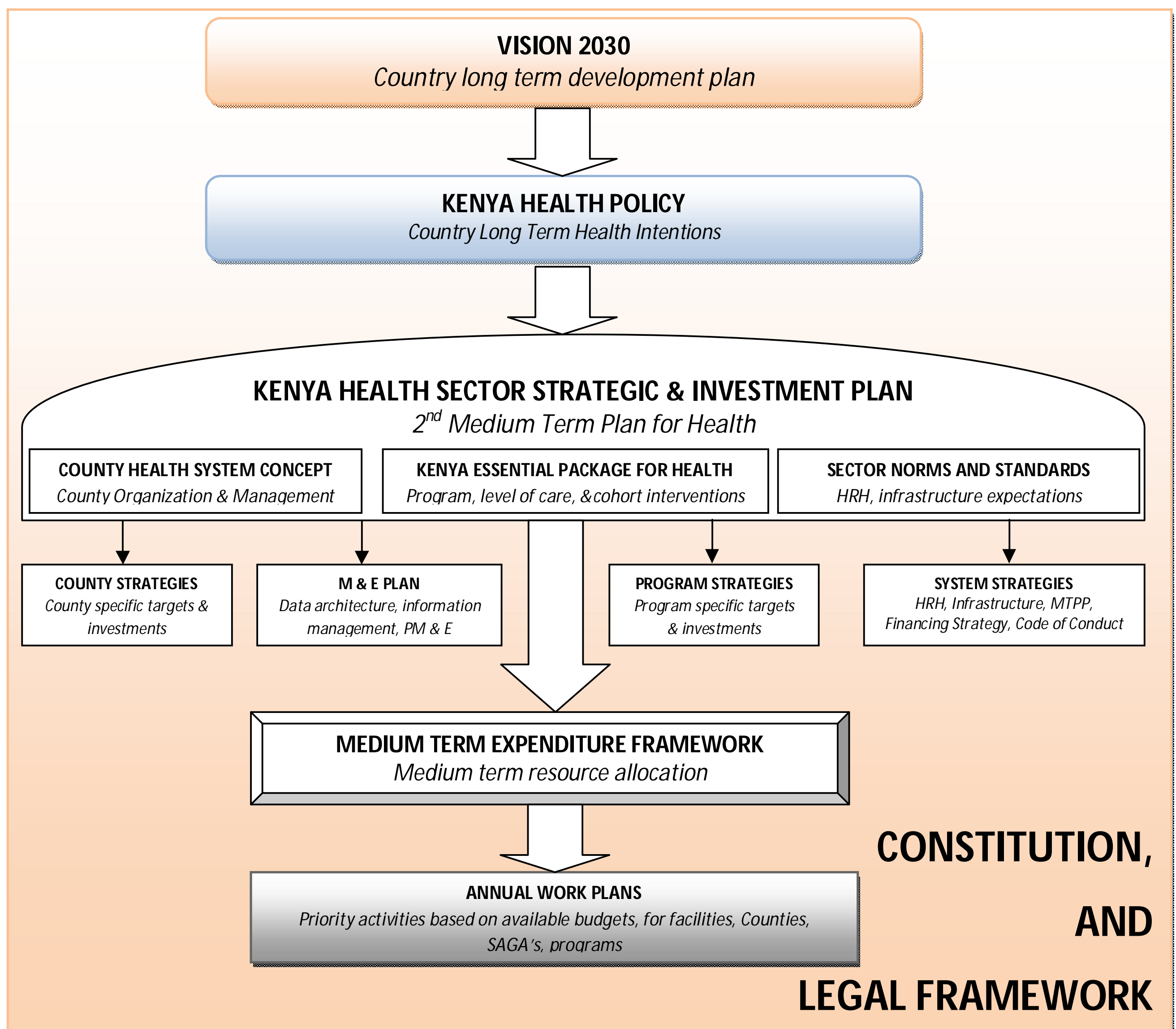
CHAPTER ONE: INTRODUCTION

1.1 Background

The Government of Kenya developed Vision 2030[1] as its new long-term development plan for the country. The aim of the Kenya Vision 2030 is to create "a globally competitive and prosperous country with a high quality of life by 2030" through transforming the country from a third world country into an industrialized, middle income country. Following the launch of the Vision 2030 and the promulgation of the Kenya 2010 Constitution, the Health sector has developed a health policy[2] in line with the two key government policy and legal frameworks and also the recommendations arising from the end term review of the KHPF 1994-2010[3].

The related planning documents and processes relating to this KHSSP are shown in the table below.

Planning framework for health



This strategic plan is the 2nd Medium Term Plan for Health in Kenya. It provides the Health Sector Medium Term focus, objectives and priorities to enable it move towards attainment of the Kenya Health Policy Directions, and therefore the sector obligations in the Constitution[4], and Vision 2030. The Health Sector in this strategic plan refers to all the Health and related sector actions needed to attain the Health Goals in Kenya. It is not restricted to the actions of the Health Ministry, but includes all actions in other related sectors that have an impact on health. It will guide both County and National Governments on the operational priorities they need to focus on in Health.

The Strategic Plan brings together information on the Health and related outcomes to be sought across the sector, Priority Health Investments and flagship programs to attain the above-mentioned health and related outcomes, Resource implications, and Financing Strategy to ensure availability of required investments, andOrganization and management of the sector to enable it efficiently and effectively attain its objectives.

This KHSSP provides the overall framework for sector guidance in the Medium Term. As not all information can be elaborated in one plan, a series of related documents that provide more detail on the milestones and targets in this plan are also in place. In addition to these related documents, operational documents will be developed, to guide planning for different sector constituents. These additional related, and operational documents are shown in the table below.

Related and operational documentsemanating from the KHSSP

Related documents	Operational documents
The Kenya Essential Package for Health	County Health business plans
Costing of the KHSSP	SAGA Health business plans
County Health System Concept	Program business plans
Health Sector Norms & Standards (HR, Infrastructure)	HRH strategic plan
Monitoring and Evaluation plan	Health Infrastructure investment plan
Health Partnership Code of Conduct, 2013 – 2017	Medium Term Procurement Plans
	Medium Term Expenditure Framework
	Health Information System business plan, 2013 – 2017
	Health Financing Strategy

1.2 Alignment to Government agenda: Vision 2030, , and the Constitution

1.2.1 Health Sector and the Constitution

The promulgation of the constitution of Kenya on 27th August, 2010 was a major milestone towards the **improvement of health standards**. Citizen's high expectations are grounded on the fact that the new Constitution states that every citizen has right to life, right to the highest attainable standard of health including reproductive health and emergency treatment, right to be free from hunger and to have food of acceptable quality, right to clean, safe and adequate water and reasonable standards of sanitation and the right to a clean healthy environment.

The constitution of 2010 provides an overarching conducive legal framework for ensuring a more comprehensive and people driven health services, and a rights – based approach to health is adopted, and applied in the country[5]. All the provisions of the constitution will affect the health of the people in Kenya in one way or another. However, two critical chapters introduce new ways of addressing health

[4] Government of Kenya, 2010. The Constitution of Kenya
[5] *United Nations, 1948. Universal Declaration of Human rights, Article 25*

problems, and have direct implications to the health sector focus, priorities and functioning: The Bill of Rights, and the devolved Government.

Main constitutional articles that have implications on health

ARTICLE	CONTENT
20	20a) Responsibility of State to show resources are not available 20 b) In allocating resources State will give priority to ensuring widest possible enjoyment of the right
43	(1) Every person has the right— (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; (b) to accessible to reasonable standards of sanitation; (c) to be free from hunger and have adequate food of acceptable quality; (d) to clean and safe water in adequate quantities; (2) A person shall not be denied emergency medical treatment
26	Right to life - Life begins at conception - No person deprived of life intentionally - Abortion is not permitted unless for emergency treatment by trained professional
32	Freedom of conscience, religion, belief and opinion
53-57	Rights of special groups: -Children have right to basic nutrition and health care. -People with disability have right to reasonable access to health facilities, access to materials and devises -Youth have right to relevant education and protection to harmful cultural practices and exploitation -Minority and marginalized groups have right to reasonable health services
174	Objectives of devolution Vs fourth schedule on roles; **National**: Health policy; National referral facilities; Capacity building and technical assistance to counties **County health services**: County health facilities and pharmacies; Ambulance services; Promotion of primary health care; Licensing and control selling of food in public places; Veterinary services; Cemeteries, funeral parlours and crematorium; Refusal removal, refuse dumps and solid waste **Staffing of county governments**: Within frame work of uniform norms and standards prescribed by Act of Parliament establish and abolish offices, appointment, confirmation and disciplining staff except for teachers
176	County Governments will decentralize its functions and its provision of services to the extent that it is efficient and practicable
183	Functions of County Executive Committee's
235	Transfer of functions and powers between levels of Government

1.2.2 Health Sector and the Vision 2030

The Government of Kenya developed Vision 2030 as its new long-term development plan for the country. The aim of the Kenya Vision 2030 is to create "a globally competitive and prosperous country with a high quality of life by 2030" through transforming the country from a third world country into an industrialized, middle income country. To improve the overall livelihoods of Kenyans, the country aims to provide an efficient integrated and high quality affordable health care system. Priority will be given to prevented care at community and household level, through a decentralized national health-care system. With devolution of funds and decision-making to county level, the Ministry headquarters will then concentrate on policy and research issues. With the support of the private sector, Kenya also intends to become the regional provider of choice for highly-specialized health care, thus opening Kenya to "health tourism". Improved access to health care for all will come through: (i) provision of a robust health infrastructure network countrywide; (ii) improving the quality of health service delivery to the highest standards (iii) promotion of partnerships with the private sector; ((iv)providing access to those excluded from health care for financial or other reasons.

The country recognizes that achieving the development goals outlined in Vision 2030 will require increasing productivity. The health sector is expected to play a critical supportive role in maintaining a healthy workforce which is necessary for the increased labour production that Kenya requires in order

to match its global competitors. Health is, therefore, one of the key components in delivering the social pillar 'Investing in the People of Kenya' for the Vision 2030.

1.2.3 The Health Sector and global health commitments

The KHSSP is aligned to support the Country Health Sector implement the various global commitments it has entered into. These include (but are not limited to):

- Implementation of the International Health Regulations – to guide the Country on key actions needed to assure adherence to international health regulations
- Implementation of the Global Framework Convention for Tobacco Control – to guide the country on tobacco control activities
- Ouagadougou declaration on Primary Health Care and Health Systems – to guide the overall strategic focus for the health sector
- Achieving the Millennium Development Declaration(MDGs) by 2015-to guide the country national targets towards international development initiatives.
- International Health Partnerships(IHP+) on Aid Effectiveness
- UN Secretary Generals' Global Strategy 'Every women, every child'.
- Abuja Declaration – to support the improvements of health systems in the country by domesticating the provisions through national legislation, the country committedin theAbujaDeclarationtoallocate15%ofgovernment expenditurebudgettohealth
- Kenya ratified International Human Right agreements as among others; International Declaration for Human Rights, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Child Rights Convention (CRC), the International Conference on Population and Development programme of action (ICPD) and the Beijing Declaration and Platform of Action (BPFA).

Implementation of these international commitments is well integrated into the strategic focus of the health sector – and not being carried out as vertical programs. Regular monitoring and reporting on progress will be carried out

1.3 Methodology for Developing the KHSSP

The development of this Strategic Plan followed comprehensive consultative processes. Six thematic working groups (Leadership & Governance, Service Delivery, Health Workforce, Medical Products and technologies, Health Financing and Health Information/M&E) consisting of members from both Health Ministries (*Ministr*y of Medical Services and Ministry of Public Health & Sanitation), Development and implementing Partners wereconstituted with specific terms of reference. The working groups conducted literature review on the existing policy documents such as the Kenya Constitution 2010, Kenya vision 2030, Kenya Health Policy 2012- 2030, Acts of Parliament, Position paper on constitution implementation in health Sector 2012, Kenya Health Bill 2012, Ministerial strategic plans 2008-2012, KHPF 1994-2010 ETR report, NHSSP II, JPWF, NHSSP II ETR report, Norms and standards, Roadmap of acceleration of implementation of interventions to achieve the objectives of NHSSP II, and other relevant ministerial documents and generated group reports. Representatives from all working groups held a 14 day workshop to consolidate reports and come up with priorities, strategies, outputs and implementation matrix of the plan. The draft plan was circulated internally and to the health sector stakeholders for comments which were incorporated to develop the revised draft plan.

Finally, the revised draft strategy was presented to and discussed with the 2 Ministries of health, selected county representatives, Development Partners (donors, and cooperating partners), and implementing partners (private for profit, and not for profit service providers, and Health NGO's / CSO's through the Health Network for NGO's and various constitutional commissions for consensus building.

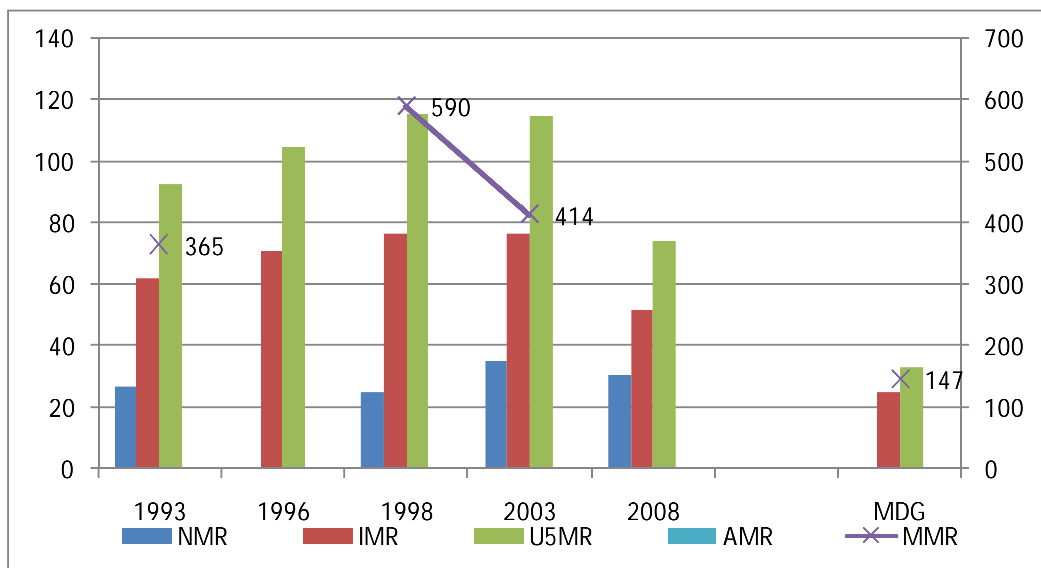
1.4 Health Situation Analysis

The Health Sector undertook recently several detailed and exhaustive studiesthat aimed (i) to provide evidence what had been done and with what result over the period of the previous KHP 1994-2010 and (ii) to identify the direction and priorities for the next Strategic Plan, the Kenya Health Sector Strategic & Investment Plan (KHSSP, July 2012 - June 2017) . A variety of quantitative and qualitative studies were undertaken. The most important studies are:

- The 2010 Health situation trends and distribution 1994-2010 and projections for 2011-2030;
- The 2009 Kenya Demographic and Health Survey (KDHS);
- The 2009 and 2010 client satisfaction surveys;
- The October 2010 Review of the Kenya Health Policy Framework 1994-2010;
- The March 2012 End Term Review of the NHSSP II (2005-2010)

By the end of the NHSSP II, the sector was beginning to see improvements in some health impact targets, in particular adult mortality, Infant mortality and Child mortality (see below). Evidence of improvements in Neonatal and Maternal mortality was not yet seen. Geographical and gender differences in age specific cohorts persists all through the policy period.

Trends in Health Impact indicators during the period of the policy review



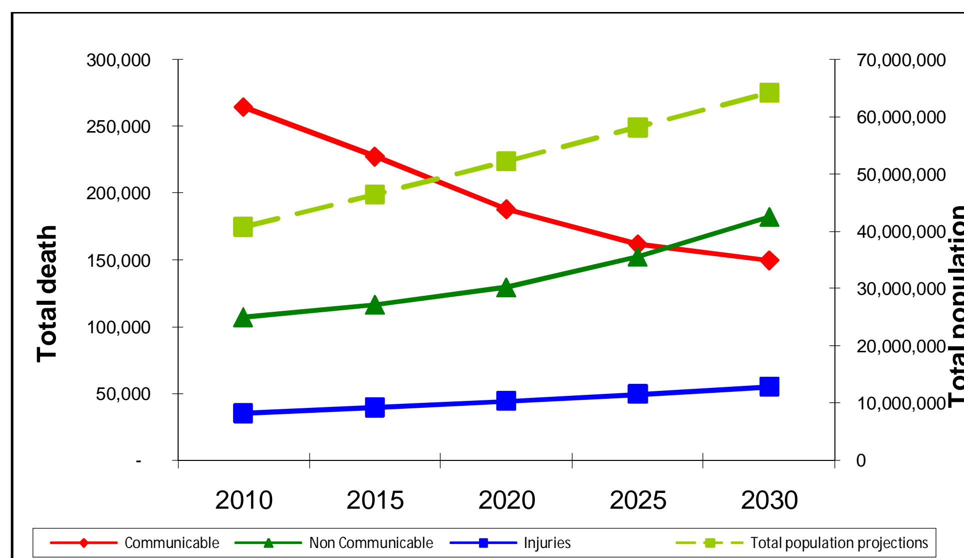
All three disease domains (communicable diseases, non communicable conditions, and violence / injuries) are contributing to the high disease burden in the country. Current trends suggest Non Communicable conditions will continue to increase over time, if not checked at present.

Leading causes of deaths and DALY's in Kenya

Causes of death				*Causes of DALY's*		
Rank	**Disease or injury**	***% total deaths***		**Rank**	**Disease or injury**	***% total DALYs***
1	HIV/AIDS	29.3		1	HIV/AIDS	24.2
2	Conditions arising during the peri-natal period	9.0		2	Conditions arising during the peri-natal period	10.7
3	Lower respiratory infections	8.1		3	Malaria	7.2
4	Tuberculosis	6.3		4	Lower respiratory infections	7.1
5	Diarrheal diseases	6.0		5	Diarrheal diseases	6.0
6	Malaria	5.8		6	Tuberculosis	4.8
7	Cerebral-vascular disease	3.3		7	Road traffic accidents	2.0
8	Ischemic heart disease	2.8		8	Congenital anomalies	1.7
9	Road traffic accidents	1.9		9	Violence	1.6
10	Violence	1.6		10	Uni-polar depressive disorders	1.5

DALY's = Disability Adjusted Life Years.

Projections of Disease Burden 2011 - 2030



In the coming years, HIV/AIDS is still estimated to be the leading cause of death accounting for about 30% of all deaths. The Infectious diseases including HIV/AIDS, Lower Respiratory Tract Infections, TB, diarrheal diseases and malaria accounted for over 50% of all deaths in Kenya. HIV/AIDS together with other infectious diseases such as Malaria, Lower respiratory infections and TB, also accounts for almost half of all DALYs in Kenya.

Overall, malaria has accounted for the highest proportion of mortality, consistently over 12% throughout this period. Lower Respiratory Tract Infections (LRTI) and HIV/AIDS are the next two leading causes of in-patient mortality and this trend has remained largely unchanged during the reporting period.

Looking at specific outcomes, there appears to be stagnation of Maternal and Neonatal health impact. At the output level, such as Ante Natal Coverage (AC down from 95% to 92%) and Skilled Birth Attendance (SBA down from 45% to 42%) show a similar pattern. Child health on the other hand shows improvements in the right track, though ill-health among children remains high (e.g. children reporting diarrhea still around 49%, up from 41% in 1993).

HIV/AIDS control showed progress with the prevalence reducing, though the rate of reduction has slowed. Coverage with critical HIV interventions such as use of ART, PMTCT and condom use has significantly improved.TB control is also showing improvements, since the negative impact the HIV situation was having on the program. Critical indicators such as Case Notification, Case Detection and Treatment Success rate show upward trends.

The Malaria burden remained high, but there are indications that effective interventions such as ITN, IPT and IRS have shown improvements in the targeted areas. The malaria epidemiological map in the country has significantly improved, with most areas that were endemic are no longer so. Currently, the potential of the use of Natural Products that could partly replace buying expensive drugs at the international market is not yet explored.

Neglected Tropical Diseases (NTD)includes a variety of diseases that exist in specific populations, Most interventions addressing the NTDs show a decline in prevalence. However elimination of their occurrence has not yet been achieved.

The Non Communicable Diseases (NCDs) represent a significant (and increasing) burden of ill health and death in the country, the most important being cardiovascular disease, cancers, respiratory and digestive diseases, Diabetes and psychiatric conditions. Together they represent 50%-70% of all hospital admissions during the policy period and up to half of all inpatient mortality. There is no evidence of reductions in these trends. Injuries and violence also feature among the top 10 causes of morbidity and mortality in the country, increasing incrementally over the years (esp. in young and unemployed people).

While various specific health determinants (such as implementation of programs, the coverage of health facilities, the referral system and the available and quality of the health workforce) all contribute to the impact and disability mentioned above, various contextual factors also have a significant impact on the health of the population. Some of the most important ones are:

- The high population growth rate (3% annually) with a young and dependent population;
- While some improvements have been made to reduce (absolute) poverty and improve income (improved GDP), this feature is mainly confined to urban areas (while 80% of the population lives in rural areas)and has not yet reached 'hard to reach' areas, the slums (where 70% of the urban population lives) or various 'at risk' population groups. Absolute poverty still remains very high (46%);
- Literacy levels in Kenya are generally high (around 78%), but inequalities persist in females and in several poor regions of the country (ranging from Nairobi with 87% to Marsabit with only 4%);
- Gender disparities too remained significant, with the Gender Development Index (GDI) ranging from 0.628 (Central) to 0,401 in North East (the higher the value, the better);

The figures point clearly to the need for (i) more attention to the contextual determinants of health and (ii) a stronger equity focus and 'right to health' approach in the next Strategic Plan.

From the ETR of the NHSSP II, the following were the key lessons learnt against implementation of the respective Strategic Objectives

What has worked and what has not worked during 7 years of NHSSP II implementation

NHSSP II objectives	What worked during NHSSP II	What has NOT worked during NHSSP II
1. Equitable access	- CHS developed and implemented; - Health infrastructure L2+3 expanded; - Resource allocation criteria exist; - Service Charter addresses right to health issues.	- Issue of remuneration of CHW not solved, CHW demotivated; - Part of health facilities not functional (no staff, water, drugs); - Inequitable distribution of resources remained paramount; - Right to health approach not operationalised; - Contextual health determinants not given adequate attention.
2. Quality of care & Responsiveness of service delivery	- Infant and Child Mortality improved; - HIV/AIDS prevalence reduced - Malaria/TB control show progress; - Norms and Standards developed; - DSRS formally established	- Neonatal and Maternal Mortality stagnant since 1993; - Funding for disease programs could be reduced (austerity); - Insufficient attention for the rising NCD; - With the expansion of HF, norms were not adhered to; - Limited attention for accreditation issues (left to NHIF).
3. Efficiency & Effectiveness (Systems)	-	-
Planning & budgeting	- Well developed (2 Summits), bottom-up and aligned to GOK process; - HENNET established and involved.	- Annual AOP and APR process not standardized, making assessment of progress difficult; - Private-for-Profit sector not involved / absence of KHP;
Monitoring & Evaluation	- Routine reporting system much improved only for public sector; - Much good research is going on.	- M&E strategy not yet available; no unified comprehensive information system that includes all service providers; - There is no focal point on health research within MOH.
Human Resource Mgmt ***Human Resource Devt***	- MOH initiated RBM (performance contracts); salaries much improved; - Number of HW in the sector increased in absolute terms;	- HR Strategic Plan outdated; - Redeployment of HR never materialized; - No comprehensive Training Needs Assessment available; - Coordination among all HRD actors insufficient.
Procurement & SCM	- MTPP developed and linked to budget; - Pull system expanded nationwide; - Nat Pharmaceutical Policy in place.	- This annual process not anymore in place; - MOH role in oversight of KEMSA limited; - Disconnect between Policy and Pharmacy and Poisons Act.
Investment & Maintenance	- Number of HF expanded substantially; - Rehabilitation (HF) and maintenance (equipment) included in the budget.	- Functionality of many these facilities not known; new inventory with updated norms and standards required for the 47 County Health Departments (CHD).
Communication & ICT	- Communication network (ICT) within MOH and with Districts is in place.	- ICT has been poorly resourced and is not able to expand or play its important role.
4. Financing	- THE increased substantially from $ 17 to $50 per capita; - OOP expenditure has been reduced; - Several funding mechanisms created; - Contribution from DPs almost doubled.	- As a proportion of GOK ,expenditure figures remain stagnant; Inequalities are marked with most resources going to curative / hospital care rather than prevention or rural / hard to reach areas. Equity related 'fairness' in financing remained skewed; - There is no recent Health Financing Strategy available
5. Governance	- Creation of Committees and Boards; - Service Charter defined client's rights;	- Absence of accountability mechanisms for Ctees / Boards; - Limited implementation of the Charter's rights based approach - Bottom-up planning has been eroded.
Partnership & leadership	- Structures are in place but have limited functionality.	- HSCC is not on top of the planning and budgeting process; - There are too many ICCs (> 20); Programs are not part of the HSSP II planning and monitoring process; - Most DPs do not adhere to the Paris principles; - HENNET has lost its strong presence; - KHF(private-for-profit sector) would like to play an active role.
SWAP & Code of Conduct	- COC signed by 20 DPs; - It was reviewed annually during APRs.	- No mutual accountability between stakeholders defined (COC has no 'muscle'); - SWAp has been seriously eroded, project mode is on the rise.

Based on the reviews, the recommendations for the KHSSP to consider were as follows:

1. Implement a comprehensive approach to address health that includes not only the sector itself but also the various contextual factors around health. Focus not just on services but on ALL determinants and risk factors affecting health impact.
2. Develop a clear service delivery strategy to attain Universal Coverage of Interventions (UCI) for health services. Together, - the interventions for health services, the other contextual health determinants and the risk factors - are likely to move more rapidly towards the attainment of health impact. This could make the difference with the previous strategic plan!
3. Institute mechanisms for regular monitoring of impact of the various contextual factors on health outcomes. Priorities should be determined in terms of overall plus equity disaggregated coverage.
4. Given the persistent causes of the high Maternal Mortality Ratios over the last 20 years (since 1993), include reduction of MMR as a Flagship Program in the MTP / KHSSP 2012-2017.
5. The development of'National Products' in the KHSSP will involve (i) developing a customized regulatory framework to assure acceptable standards of product quality, safety and efficacy, (ii) make provision for natural product procurement through KEMSA. This could become the second Flagship Program of the sector.
6. Balance the relative contribution of the various service delivery programs on the basis of the findings of this situational analysis (e.g. HIV/AIDS);
7. In terms of resource allocation, ensure that priorities for preventive and promotional health will match the resources allocated to curative and hospital care. In terms of equity, resources should be preferentially allocated to hard-to-reach areas and vulnerable populations.
8. Revitalize the Community Health Strategy (CHS), providing guidelines to the County Health Departments on how to realize its implementation with regard to the remuneration of CHW.
9. Include a specific objective on the Non-Communicable Diseases (NCD) in the KHSSP; Include interventions related to violence and injuries in the NCDs.
10. Undertake a tertiary Hospital Strategy / feasibility study that will ensure a coordinated distribution of specializations and quality and efficient care at the highest referral levels.

Specific recommendations and priorities for different system areas are as follows;

Planning

1. Ensure one Planning Summit each year (May-June), resulting in one comprehensive Health Plan and Budget at national level, bringing together all County plans, targets and budgets (top-down and bottom-up). Harmonize planning and budgeting cycles at national and county level;
2. Ensure one Review Summit each year (October-November), resulting in one comprehensive health sector performance report, bringing together all County annual performance reports;
3. Review and update current planning tools in line with the provisions of the devolution law to ensure One sector plan and One sector budget;
4. Ensure firm leadership by the Sector Planning and Monitoring Department (SPMD) of the MOH to guide this planning, budgeting and review process;
5. Strengthen policy dialogue structures at national and county levels, engaging DPs, civil society and the for-profit sector in planning and sector review processes at both levels;

Monitoring and Evaluation

1. Develop / update the National Information Policy and adjust existing guidelines;

2. Include the HIS Division in the SPMD at national and county levels to provide technical advice / oversight and ensure implementation of the M&E strategic framework at both levels;
3. Strengthen HMIS institutional capacity, linking the various information units at national level to develop an 'information observatory', where health related data are shared and analyzed.
4. Draft a Capacity Development Plan for national and county HMIS staff;
5. Develop a Five Year Operations Research Agenda, aiming to provide feedback to policy makers on the progress in the devolution process (both achievements and constraints);
6. Establish a focal point on health research within MOH as a first step to build the capacity and ensure effective coordination and priority setting among research institutions.

Human Resource Management and HR Development

1. Develop a new HR Policy and update the current HRH Strategy for the period 2012-2017. Address both HRM and HRD issues in the context of the upcoming devolution;
2. Update norms and standards of all staff by category and level for each of the health facilities;
3. Review and revise existing procedures for result-based management / finance and performance appraisal systems based on targets and on funding levels at county level;
4. The Office of CPD and HRD to strengthen IST, PST and CPD, including selection criteria for staff to be eligible for CPD; develop and expand e-Learning for peripheral staff;
5. Revise criteria for accreditation of Training Institutions at county and national levels, including the standardization and quality of curriculums.

Quality assurance and standards

1. DSRS to draft a five year strategic plan as part of KHSSP with details of outputs to be achieved in the public and private sectors at both levels; Initiate the accreditation of public and private facilities;
2. MOH to review the effectiveness its health facility charters under the new county health departments;
3. Develop a comprehensive set of regulations and tools that will define the various dimensions of quality of careat all levels and in the health systems (planning, HRH, HMIS / M&E, procurement etc);
4. Establish an independent Health Inspectorate body, responsible for overseeing the performance of the health sector at national and county levels.

Procurement and Commodity Supply Management

1. Revise the Pharmacy and Poisons Act (2009) in the light of the upcoming devolution.
2. Re-define the role of KEMSA as the central procurement agency vis a vis the procurement authority of the County Health Departments. Similarly, synchronize procurement cycles and budgets between national and county levels.
3. Develop a resource strategy to reduce the large funding gap in the GOK allocation for Essential Medicines and Medical Supplies, taking the expected reduction in international funding into account.

Investment and Maintenance (infrastructure, equipment and transport)

1. Ask all County Health Departments to make an inventory of available infrastructure (with catchment areas and coverage figures), equipment and transport for the public, FBO/NGO and private sectors. Based on this inventory, counties should make their five year investment and maintenance plans.
2. Update the 2006 "Norms and Standards for service delivery", using new guidelines for infrastructure, equipment, transport, taking the devoluted responsibilities into account.
3. Open specific budget lines for maintenance of infrastructure, equipment and transport at national and county levels. Invest in the establishment of maintenance units at county level.
4. Develop a capacity building program for each of these specific areas for national and county staff.
5. Develop a transport policy / strategy to guide investment and priority setting at national level.

Communication and ICT systems

1. Develop a comprehensive data handling, data storage and data ownership policy together with all national parties involved in data collection (e.g. Kenya National Bureau of Statistics and others); undertake a realistic costing of this ICT policy over a five year period;
2. Develop a functional, reliable and up-to-date vital registration system, recording births and deaths in the country. Make this vital registration compulsory by law, while taking privacy protection into account.

Governance, Partnership and SWAp

1. Strengthen the performance of the HSCC by introducing two co-chairs to assist the PS when he is unable to attend HSCC meetings, one from the DPH-K and the other from civil society
2. Reduce the number of ICC through a process of restructuring that aims to bring their strategic priority setting back to the mandate of the HSCC and in line with the new KHSSP.
3. Ensure that the various program related strategies are fully aligned with the KHSSP (timeline, priorities, baseline and target indicators, financing etc)
4. Bring HENNET and the Private-for-Profit sector (KHF) into the governance of the sector
5. Update the COC in anticipation of the introduction of two levels of government, (national and county), reinforcing the commitment of all parties to comply and respect the various articles. Ensure that adequate representation and mutual accountability is being addressed at both levels.

CHAPTER TWO: HEALTH STRATEGIC DIRECTIONS

1.1 Overview of the Kenya Health Policy

The Health Sector has elaborated its Kenya Health Policy (KHP to guide attainment of the long term Health goals sought by the Country, outlined in the Vision 2030 and the 2010 constitution.

The policy framework has, as an overarching goal, **'attaining the highest possible health standards in a manner responsive to the population needs'**. The policy will **aim** to achieve this goal through supporting provision of *equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans.*

The **target** of the policy is to attain a level and distribution of health at a level commensurate with that of a middle income country, through attainment of the following targets.

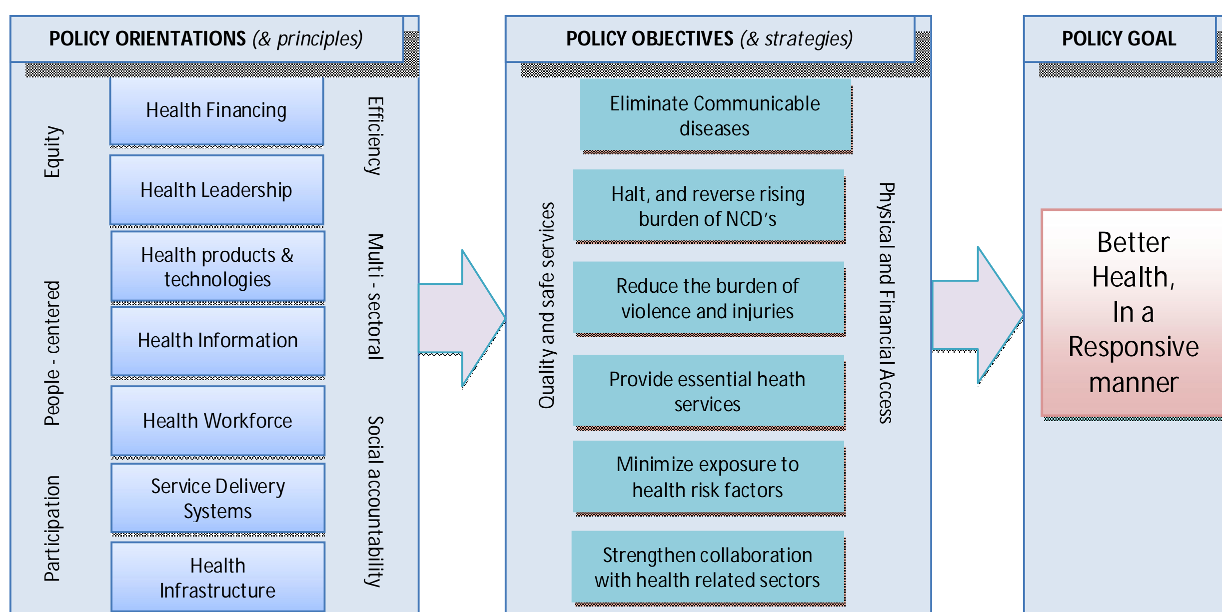
Kenya Health Policy targets

Target	Baseline status (2010)	Policy target (2030)	% change
Life Expectancy at birth (years)	60	72	16% improvement
Annual deaths (per 1,000 persons)	10.6	5.4	50% reduction
Years Lived with Disability	12	8	25% improvement

The Kenya Health Policy is guided by both the Constitution, and the Country's Vision 2030 by focusing on Implementing a Human rights based approach, and maximizing Health contribution to overall Country development

Policy Directions to guide the attainment of this policy intent are defined in terms of six policy objectives (relating to Health and Related services), and seven policy orientations (relating to investments needed). These are interlinked as shown in the figure below.

Framework for Policy directions



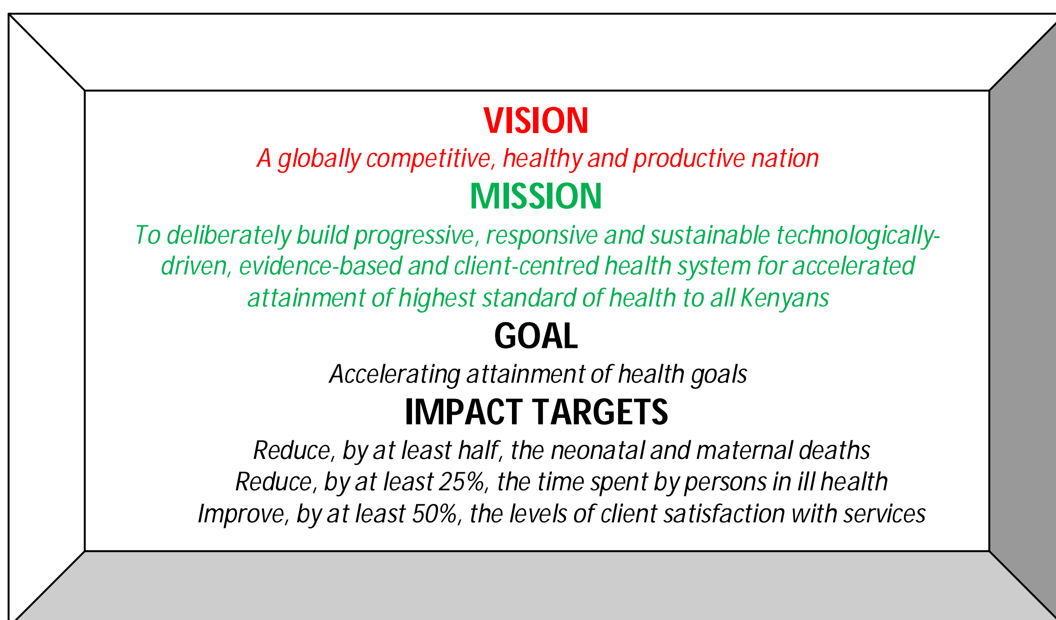
The Health Services objective for the Kenya Health Policy is to **attain universal coverage with critical services that positively contribute to the realization of the overall policy goal.** Six policy objectives, therefore, are defined, which address the current situation – each with specific strategies for focus to enable attaining of the policy objective.

1. **Eliminate communicable conditions:** This it aims to achieve by forcing down the burden of communicable diseases, till they are not of major public health concern.
2. **Halt, and reverse the rising burden of non communicable conditions.** This it aims to achieve by ensuring clear strategies for implementation to address all the identified non communicable conditions in the country.
3. **Reduce the burden of violence and injuries.** This it aims to achieve by directly putting in place strategies that address each of the causes of injuries and violence at the time.
4. **Provide essential health care.** These shall be medical services that are affordable, equitable, accessible and responsive to client needs.
5. **Minimize exposure to health risk factors.** This it aims to achieve by strengthening the health promoting interventions, which address risk factors to health, plus facilitating use of products and services that lead to healthy behaviors in the population.
6. **Strengthen collaboration with health related sectors.** This it aims to achieve by adopting a 'Health in all Policies' approach, which ensures the Health Sector interacts with and influences design implementation and monitoring processes in all health related sector actions.

The policy framework outlines the need for medium term (5 year) strategic plans that will elaborate, in a comprehensive manner, the medium term strategic and investment focus the sector will apply every 5 years, as it moves towards attaining the overall policy directions. The 5 year plans are aligned to the Government Medium Term Plan to ensure they are well integrated into the overall Government agenda (Kenya Vision 2030).

2.1 Overall Vision, goal and focus of the KHSSP

This strategic plan represents the 2nd Medium Term Plan of the Health Sector to support attainment of the Vision 2030. It is designed to provide an overall framework into which sector priorities and actions are derived. Its strategic focus is as follows:



This KHSSP places emphasis on implementing interventions, and prioritizing investments relating to maternal and newborn health, as it is the major impact area for which progress was not attained in the previous strategic plan. It is designed to provide information on:

- The scope of Health and related services the sector intends to focus on ensuring are provided for persons in Kenya – outlined in the Kenya Essential Package for Health, KEPH
- The investments required to provide the above-mentioned services – outlined across the 7 investment areas for health – and
- How the sector will monitor and guide attainment of the above

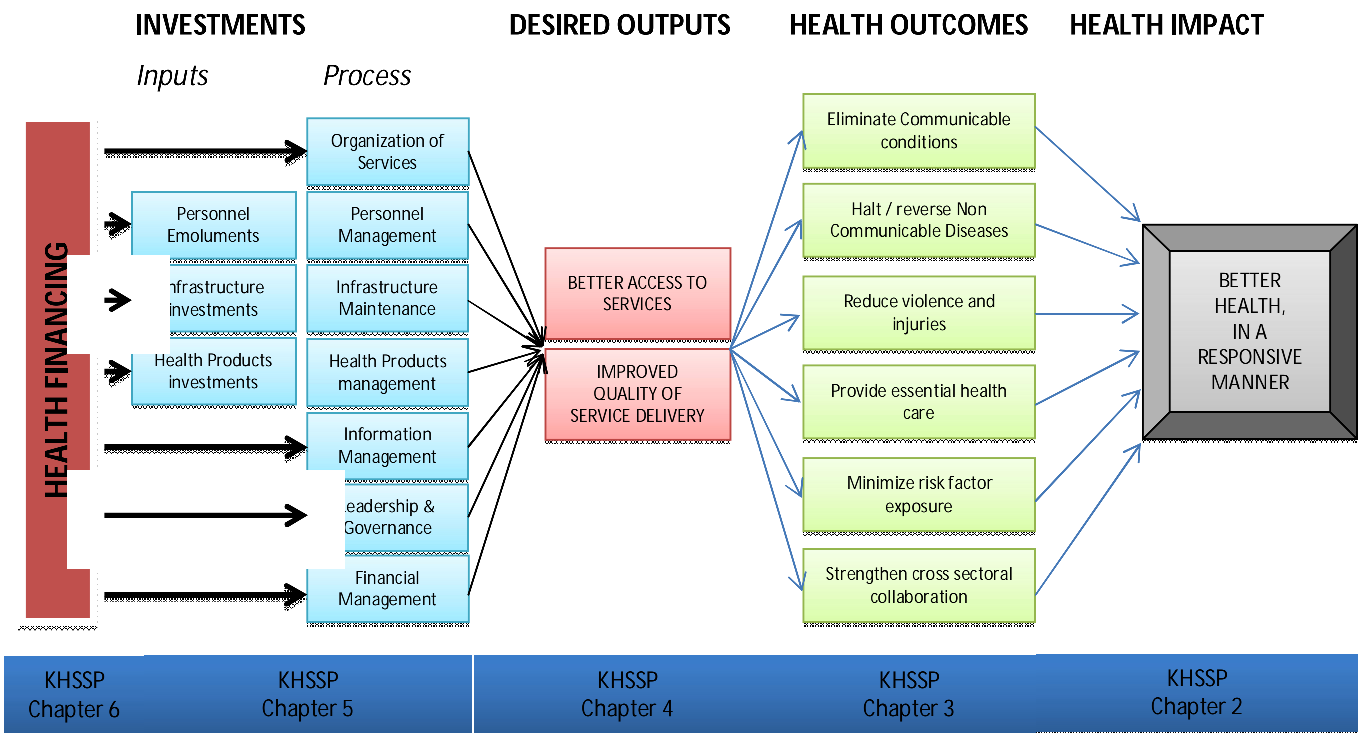
The innovations to facilitate attainment of the KHSSP objectives that this plan introduces include the following:

- Ensuring a comprehensive plan that which brings together all the health and relates services by all actors. The KHSSP, as opposed to the NHSSP II, focuses on giving guidance not only for priorities, but on all health and related actions needed to attain health objectives
- Consolidation of all Sector Medium Term Plans into one plan. In the past, the health sector medium term focus was guided by the NHSSP II, Joint Program of Work, MTP 1, Ministry Strategies, and specific program strategic plans that were not necessarily all aligned to each other. This KHSSP now defines clearly the role of each planning tool, and how it contributes to the KHSSP objectives
- Redefinition of the service package (KEPH), to ensure it provides appropriate guidance to health investments and targeting of services
- Incorporation of the environment within which the plan is being developed in the process of defining targets and interventions. As such, efforts towards implementing devolution, and the right to health are an integral part of the plan implementation process, as opposed to the NHSSP II when the environmental issues were not adequately integrated into the plan
- An M&E plan is being developed to guide follow up of implementation of the strategic objectives

2.2 KHSSP framework, targets and flagship programs

A series of priorities shall be focused on during the KHSSP period for attainment. These are defined at the impact, outcome, output and input levels to assure a logical link across sector actions. This is drawn from the KHP framework, and is highlighted below.

KHSSP Framework for Implementation



To attain the defined impact targets, the KHSSP prioritizes attainment of the Health Outcomes that target specific strategies for different conditions. These will be eradication (completely remove the condition from the Country), elimination (reduce the burden till it is not of a public health concern), control / containment (halt, and/or reverse the rising burden of the condition)

Focus of different Health Outcomes in KHSSP

CONDITIONS TARGETED FOR ERADICATION	CONDITIONS TARGETER FOR ELIMINATION
1. Polio 2. Guinea Worm Infestation 3. Maternal and Neonatal Tetanus 4. Leprosy **5.** New / re-emerging infections	1. Malaria 2. Mother to Child HIV transmission, 3. Measles, 4. Neglected Tropical Conditions
CONDITIONS TARGETED FOR CONTROL	**RISK FACTORS TARGETED FOR CONTAINMENT**
1. HIV / AIDS 2. Conditions in the perinatal period 3. Lower Respiratory infections, 4. Tuberculosis 5. Diarrhoeal diseases in children, 6. Cerebrovascular diseases, 7. Ischaemic Health disease, 8. Road traffic accidents, 9. Violence including Gender Based Violence 10. Unipolar depressive disorders	1. Unsafe Sex 2. Unsafe water, sanitation & hygiene 3. Suboptimal breastfeeding 4. Childhood and maternal underweight, 5. Indoor air pollution, 6. Alcohol use, 7. Vitamin A deficiency, 8. High blood glucose, 9. High blood pressure, 10. Zinc deficiency, 11. Iron deficiency, 12. Lack of contraception

These Service Delivery outcomes will be attained through focusing on the following service outputs

- Ensure 100% of KEPH services are being provided in special settings. These special settings in KHSSP are:
    - Congregate settings – prisons, IDP camps, schools, refugee camps, army barracks
    - At risk populations – HealthWorkers, , Commercial Sex Workers, women, persons with disability, elderly, children, youth, marginalized, religious/cultural communities
    - Hard to reach areas – Northern Kenya, and informal settlements
- Improve physical access to KEPH services to at least 90% by focusing on
    - Upgrading 40% of dispensaries to full primary care units
    - Operationalize 100% of model Health Centres to fully functional primary care facilities
    - Construction of new facilities in priority underserved areas and establishment of mobile health services in nomadic settings
    - Put in place fully functional referral system in at least 80% of Counties
    - Further reduction of the burden of pre-payment for health services
- Improve the quality of care provided in health facilities, through introducing innovative mechanisms to improve patient experiences during utilization of health services

These outputs will be attained through investing in priorities across the 7 policy orientations. Flagship programs to catalyze attainment of the policy orientation targets. Investments in these flagships shall be prioritized by all sector programs, and sources of financing. They are shown below.

KHSSP Flagship Programs

Policy Orientation	Sector Flagship Programs (for prioritization by National and County Governments)
Service delivery systems	Establish fully functional **referral system**
Health Workforce	Put in place minimum **staffing norms** in ALL health facilities
Health Infrastructure	Put in place minimum **infrastructure and equipment norms** in ALL health facilities
Health Products	Establish a comprehensive **supply chain system** – from warehouse to patient
Health Financing	Implement **innovativehealth financinginstitutional arrangements**, focusing on Social Health Insurance and Performance Based Financing mechanisms
Health Leadership	Implement **devolution** in Health, ensuring the County Health system is fully functional
Health Information	Establish a comprehensive **IT based HIS** within, and across health facilities

CHAPTER THREE: HEALTH OUTCOMES – THEKENYA ESSENTIAL PACKAGE FOR HEALTH (KEPH)

As highlighted in the NHSSP II, the Essential Health Services targeted by the sector were defined in the Kenya Essential Package for Health (KEPH). This was focused on integration of all health programs into a single package that focuses its interventions towards the improvement of health at different phases of the human development cycle, at the different levels of the health care delivery system.

The KEPH approach offered a number of important lessons to do with integrated health services delivery in NHSSP II, which are built on in this strategic plan. Some changes are made that have informed the adaptation of the KEPH in this strategic plan:

- Adaption by the Country of a new constitution in 2010, which introduces a rights based approach to provision of services, a legal framework for clarity on a service package, plus redefinition of governance levels
- Definition of a new National Health Policy, which elaborates a comprehensive set of Health Services to be provided across six Policy Objectives
- Increasing evidence of an increasing burden of Non Communicable Diseases and Violence / injuries affecting persons in Kenya

In addition, the NHSSP II review highlighted the following issues that related to the design and operationalization of the KEPH during NHSSP II.

1) A difficulty in aligning and planning for cross cutting health services within specific cohorts
2) Absence of specific services for some cohorts, such as elderly persons
3) Paucity of information to plan and monitor services in some cohorts, such as adolescents
4) Disjoint between planning guided by cohorts, operations guided by programs, and budgeting / financing guided by budget areas
5) Limitation of a basic package description, which doesn't fit with reality of actual provision of comprehensive services irrespective of the limited services defined in the KEPH
6) Integration of interventions was not appropriately guided by the KEPH, and it didn't define the service areas around which KEPH interventions would be provided (and integration practiced)

As a result of these changes, the shifts in the Essential Package are highlighted in the table below.

Key shifts in the Kenya Essential Package for Health

New alignments	Rationale
Comprehensive description of the service package	As per constitution requirements, a clear definition of services and interventions to be provided to persons in Kenya
	Addressing the increasing burden on Non Communicable Conditions and Violence / Injuries
	Need for an inclusive package, with rationalization done by expected access / coverage's to be achieved as opposed to limitation of interventions
Elaboration of both interventions (what clients receive) and services (how interventions will be	Need for clear description of what clients receive
	Ability to link with investments, and budgeting processes through clear

New alignments	Rationale
organized – the new basis for integration)	description of services
Alignment of services and interventions to overall Health Sector Policy Objectives	Need to align to overall National Health Policy Objectives
Specification of cohort – specific services and interventions where applicable, not for all services	Highlighting of priorities for specific cohorts
Re-alignment of levels of care, and cohorts	Alignment of levels of care to new devolved system
	Updating cohorts based on experiences gained in implementation
Description of KEPH implementation arrangements	Guide the sector on how the KEPH needs to be applied during implementation

The Kenya Essential Package for Health in this strategic plan, therefore, defines health services and interventions to be provided for each Policy Objective, by level of care and cohort (where applicable). The tiers in the KEPH are the levels of care as defined in the Kenya Health Policy.

1. **Community level**: The foundation of the service delivery system, with both demand creation (health promotion services), and specified supply services that are most effectively delivered at the community. In the essential package, all non facility based health and related services are classified as community services – not only the interventions provided through the Community Health Strategy as defined in NHSSP II.
2. **Primary care level**: The first physical level of the health system, comprising all dispensaries, health centres, maternity / nursing homes in the country. This is the 1st level care level, where most clients health needs should be addressed
3. **County level**: The first level hospitals, whose services complement the primary care level to allow for a more comprehensive package of close to client services
4. **National level**: The tertiary level hospitals, whose services are highly specialized and complete the set of care available to persons in Kenya.

The KEPH interventions by cohorts are defined only for those specific to a given cohort, not for all KEPH interventions. The cross cutting interventions are not aligned to any cohort. Specific KEPH cohorts are:

1. **Pregnancy and the newborn (up to 28 days):** The health services specific to this age-cohort across all the Policy Objectives
2. **Childhood (29 days – 59 months):** The health services specific to the early childhood period
3. **Children and Youth (5 – 19 years):** The time of life between childhood, and maturity.
4. **Adulthood (20 – 59 years):** The economically productive period of life
5. **Elderly (60 years and above):** The post – economically productive period of life

The updated KEPH is summarized in the table below.

Summary of KEPH for the Strategic Plan 2012 - 2017

Policy Objective	Services	Policy Objective	Services
Eliminate Communicable Conditions	Immunization	**Provide essential health services**	General Outpatient
	Child Health		Integrated MCH / Family Planning services
	Screening for communicable conditions		Accident and Emergency
	Antenatal Care		Emergency life support
	Prevention of Mother to Child HIV Transmission		Maternity
	Integrated Vector Management		Newborn services
	Good hygiene practices		Reproductive health
	HIV and STI prevention		In Patient
	Port health		Clinical Laboratory
	Control and prevention neglected tropical diseases		Specialized laboratory
			Imaging
Halt, and reverse the rising burden of non communicable conditions	Health Promotion &Education for NCD's		Pharmaceutical
	Institutional Screening for NCD's		Blood safety
	Rehabilitation		Rehabilitation
	Workplace Health & Safety		Palliative care
	Food quality & Safety		Specialized clinics
			Comprehensive youth friendly services
Reduce the burden of violence and injuries	Health Promotion and education on violence / injuries		Operative surgical services
	Pre hospital Care		Specialized Therapies
	OPD/Accident and Emergency		
	Management for injuries	**Strengthen collaboration with health related sectors**	Safe water
	Rehabilitation		Sanitation and hygiene
			Nutrition services
Minimize exposure to health risk factors	Health Promotion including health Education		Pollution control
	Sexual education		Housing
	Substance abuse		School health
	Micronutrient deficiency control		Water and Sanitation Hygeine
	Physical activity		Food fortification
			Population management
			Road infrastructure and Transport

The sector targets towards progressive attainment of services are shown in the table below.

Sector 5 year targets for indicators against Health Policy Objectives

Policy Objective	Indicator	ANNUAL TARGETS FOR ATTAINMENT					
		2012/13	*2013/14*	*2014/15*	*2015/16*	*2016/17*	
Eliminate Communicable Conditions	% Fully immunized children	79	85	88	90	90	
	% of target population receiving MDA for schistosomiasis	50	70	95	95	95	
	% of TB patients completing treatment	85	85	90	90	90	
	% HIV + pregnant mothers receiving preventive ARV's	63	80	90	90	90	
	% of eligible HIV clients on ARV's	60	70	80	90	90	
	% of targeted under 1's provided with LLITN's	44	60	85	85	85	
	% of targeted pregnant women provided with LLITN's	30	45	58	70	85	
	% of under 5's treated for h diarrhea	40	20	10	10	5	
	% School age children dewormed	49	60	85	85	90	
Halt, and reverse the rising burden of non communicable conditions	% of adult population with BMI over 25	50	50	45	40	35	
	% Women of Reproductive age screened for Cervical cancers	50	50	60	70	75	
	% of new outpatients with mental health conditions	<1	3	3	2	1	
	% of new outpatients cases with high blood pressure	1	3	5	5	3	

Policy Objective	Indicator	ANNUAL TARGETS FOR ATTAINMENT					
		2012/13	2013/14	2014/15	2015/16	2016/17	
	% of patients admitted with cancer	1	3	3	2	2	
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender based violence	<1	2	3	3	2	
	% new outpatient cases attributed to Road traffic Accidents	4	4	3	2	2	
	% new outpatient cases attributed to other injuries	<1	1	1	0.5	0.5	
	% of deaths due to injuries	10	8	6	5	3	
Provide essential health services	% deliveries conducted by skilled attendant	44	46	50	60	65	
	% of women of Reproductive age receiving family planning	45	65	75	80	80	
	% of facility based maternal deaths (per 100,000 live births)	400	350	150	100	100	
	% of facility based under five deaths (per 1,000 under 5 outpatients)	60	50	35	20	15	
	% of newborns with low birth weight	10	10	8	6	5	
	% of facility based fresh still births (per 1,000 live births)	30	25	20	10	5	
	Surgical rate for cold cases	0.40	0.60	0.70	0.85	0.90	
	% of pregnant women attending 4 ANC visits	36	50	70	80	80	
Minimize exposure to health risk factors	% population who smoke	18		15		6	
	% population consuming alcohol regularly	35		25		10	
	% infants under 6 months on exclusive breastfeeding	32		50		70	
	% of Population aware of risk factors to health	30		60		80	
	% of salt brands adequately iodised	85		100		100	
	Couple year protection due to condom use						
Strengthen collaboration with health related sectors	% population with access to safe water	60		70		85	
	% under 5's stunted	35		30		15	
	% under 5 underweight	17		10		5	
	School enrollment rate	60	70	75	80	80	
	% women with secondary education	34		45		70	
	% of households with latrines	65		75		80	
	% of houses with adequate ventilation	30		40		50	
	% of classified road network in good condition	15		35		50	
	% Schools providing complete school health package	34	50	55	70	85	

3.1 Strategic Objective 1: Eliminate Communicable Conditions

Through this first strategic objective, the sector aims to force down -the burden of communicable diseases, to a level that they are not of major public health concern. In the medium term, the priority strategies include:

- Increase access of the population to key interventions addressing communicable conditions causing the highest burden of ill health and death
- Ensure communicable disease prevention interventions directly addressing marginalized and indigent populations
- Enhance comprehensive control of communicable diseases by designing and applying integrated health service provision tools, mechanisms and processes

Efforts at addressing communicable conditions will focus on three strategies: Eradication; elimination, or containment of the diseases.

- Eradication efforts will focus on diseases for which the country will work towards complete removal in Kenya during the KHSSP period. Polio, Guinea Worm infestation, leprosy, and new / re-emerging diseases will all be targeted for eradication
- Elimination efforts will focus on diseases for which the sector will work towards reducing the burden to levels not of a public health concern. Malaria, Mother to Child HIV transmission, Maternal and Neonatal Tetanus, Measles, and Neglected Tropical Conditions (including infestations) will be targeted for elimination
- Containment efforts will focus on diseases for which the sector will work towards managing their burden to avoid unnecessary ill health and death. Current investments are not at a level to allow elimination / eradication – this will be the focus for these in subsequent strategic plans as investments, and / or strategies to allow this are attained. These include HIV, Tuberculosis, diarrheal diseases, measles and other immunizable conditions, respiratory diseases, and other diseases of public health concern.

The service package to be provided at each tier of care, based on these services, is highlighted in the table below.

KEPH Service Package for eliminating communicable conditions, by level of care

Service area	Interventions	Minimum Tier	Cohort
Immunization	BCG vaccination	2	1
	Oral Polio Vaccination	2	2
	Pentavalent vaccination	2	2
	Rotavirus vaccination	2	2
	PCV – 10 vaccination	2	2
	Measles vaccination	2	2
	Typhoid vaccination	2	All
	Yellow fever vaccination	2	All
	HPV vaccination	2	All
Child Health	Deworming	1	2
	Management of pneumonia	2	2
	Management of malaria	1	2
	Management of diarrhea	1	2
Screening for communicable conditions	HIV Testing and Counseling (HTC)	2	All
	Active case search for TB	1	All
	Diagnostic Testing for Malaria	2	All
	Screening for drug resistant TB	3	All
	Screening for Animal Transmitted Conditions		
Antenatal Care	Physical examination of pregnant mother	2	1
	Tetanus Vaccination	2	1

Service area	Interventions	Minimum Tier	Cohort
	Supplementation (*Folic acid, multivitamins, calcium, ferrous sulphate)*	2	1
	Intermittent Presumptive Treatment for Malaria in endemic areas	2	1
	Antenatal profiling	2	1
	Delivery planning	2	1
	Hypertensive disease case management	3	1
	Syphilis detection and management	2	1
Prevention of Mother to Child HIV Transmission	HIV Testing and Counseling	2	1
	ARV prophylaxis for children born of HIV+ mothers	3	1
	Highly Active Anti retroviral Therapy	3	1
	Cotrimoxazole prophylaxis	3	1
	Counseling on best breastfeeding and complementary feeding practices in HIV	2	1
Integrated Vector Management	Indoor Residual Spraying of malaria	1	All
	ITN distribution	1	All
	Destruction of malaria breeding sites	1	All
	Household vector control (cockroaches, fleas, rodents)	1	All
Good hygiene practices	Appropriate Hand washing with soap	1	All
	Appropriate latrine use	1	All
	Food outlet inspections	1	All
	Meat inspections (abbartoirs, butcheries)	1	All
	Household water treatment	1	All
HIV and STI prevention	Male Circumcision	3	All
	Management of Sexually transmitted Infections	2	All
	Pelvic Inflammatory Disease management	3	All
	Post Exposure Prophylaxis	3	All
	Condom distribution/ provision	2	All
	HIV Testing and Counselling (HTC)	2	All
Port health	Monitoring of imported and exported commodities affecting public health	4	All
	Monitoring of people movement in relation to International Health Regulations	4	All
	Cholera vaccination	4	All
	Meningococcal vaccination	4	All
	Yellow fever vaccination	4	All
Control and prevention neglected tropical diseases	Mass education on prevention of NTDs (*Kalar Azar, Schistosomiasis, Drucunculosis, Leishmaniasis)*	1	All
	Mass deworming for schistosomiasis control	2	All
	Mass screening of NTDS (*Kalar Azar, Schistosomiasis, Drucunculosis, Leishmaniasis)*	2	All

Table Key

	Tiers		Cohorts
1	*Community*	**1**	*Pregnancy and the new born (up to 28 days)*
2	*Primary Care*	**2**	*Early childhood (29 days – 59 months)*
3	*County*	**3**	*Childhood and youth (5 – 19 years)*
4	*National*	**4**	*Adulthood (20 – 59 years)*
		5	*Elderly (60 years and over)*
		All	*Cross cutting interventions*

3.2 Strategic Objective 2: Halt, and Reverse rising burden on Non Communicable Conditions

This second strategic objective will focus on ensuring efforts are initiated to prevent a rise in the burden of key non communicable conditions affecting persons in the country. In the medium term, the sector will focus on:

- Providing prevention activities addressing the major non communicable conditions
- Put in place interventions directly addressing marginalized and indigent populations affected by non-communicable conditions
- Integrating health service provision tools, mechanisms and processes for NCD's
- Establish screening programs in health facilities for major non communicable conditions

The NCD's targeted for control during the strategic planning period shall include Mental health, Diabetes Mellitus, Cardiovascular Diseases, Chronic Obstructive Airway Conditions, Blood disorders focusing on Sickle cell conditions, and Cancers. These represent the NCD's contributing to the highest NCD burden. The Service package that shall be provided under this strategic area focusing on non communicable conditions is shown in the table below.

KEPH Service Package for reversing rising burden of non communicable conditions, by level of care

Service area	Interventions	Minimum Tier	Cohort
Health Promotion and education for NCD's	Public information on NCD's prevention, screening and early treatment	1	All
	Community detection and diagnosis for NCD's	1	All
	Education on Referral/evacuation of persons with NCD's	1	All
Institutional Screening for NCD's	Routine Blood Sugar testing	3	3,4
	Routine Blood Pressure measurement at OPD	2	3,4
	Routine Body Mass Index (weight and height) measurement for all outpatients	2	3,4
	Cervical cancer screening	3	3,4
	Fecal Occult Blood testing for bowel cancers	3	3,4,5
	Breat cancer screening	3	3,4,5
	Lung Function Testing	3	3,4,5
	Lipid profiling	3	3,4,5
	Annual prostate examination for all men over 50 years	3	4,5
Community screening for NCD's	Routine Blood Pressure measurement in the community	1	3,4,5
	Adult Mid Upper Arm Circumference measurement	1	3,4,5
Rehabilitation	Home based care clients with NCD's	1	All
	Physio therapy for persons with physical disabilities	3	All
	Occupational therapy for persons with disabilities	3	All
	Psychosocial therapy for persons with disabilities	3	All
	Provision of rehabilitative appliances	3	All
Workplace health and safety	Workplace wellness programs	1	All
	Inspection and certification	1	All
	Safety education	1	All
Food quality and safety	Food demonstrations (at community and facilities)	1	All
	Food quality testing	1	All
	Consumer Education on food quality and safety	1	All

Table Key

	Tiers		Cohorts
1	*Community*	**1**	*Pregnancy and the new born (up to 28 days)*
2	*Primary Care*	**2**	*Early childhood (29 days – 59 months)*
3	*County*	**3**	*Childhood and youth (5 – 19 years)*
4	*National*	**4**	*Adulthood (20 – 59 years)*
		5	*Elderly (60 years and over)*
		All	*Cross cutting interventions*

3.3 Strategic Objective 3: Reduce the burden of violence and injuries

The third strategic objective will focus on managing the burden due to violence and injuries affecting persons in the country. In the medium term, the sector will focus on:

- Make available corrective and intersectoral preventive interventions to address causes of injuries and violence
- Scaling up access to quality emergency care (curative and rehabilitative) that mitigates effects of injuries and violence
- Put in place interventions directly addressing marginalized and indigent populations affected by injuries and violence
- Scale up physical, and psychosocial rehabilitation services to address long term effects of violence and injuries

The major violence and injuries targeted during KHSSP areprimary prevention of Gender Based violence (including sexual violence), Female Genital mutilation, Road Traffic Injuries, Burns/Fires, Occupational injuries, Poisoning including snake bites, Drowning ,Conflict/war, and Child maltreatment.The service package that shall be provided under this strategic area focusing on managing the rising burden on violence and injuries is shown below.

KEPH Service Package for managing the rising burden of violence and injuries, by level of care

Service area	Interventions	Minimum Tier	Cohort
Health Promotion and education	Awareness creation on violence and injuries (including Sexual and Gender Based Violence)	1	All
	Public education on prevention of violence and injuries	1	All
Pre hospital Care	Basic First Aid	1	All
	Evacuation Services for Injuries	1	All
OPD/Accident and Emergency	Basic Emergency Trauma care	2	All
	Advanced Emergency Trauma care	3	All
Management for injuries	Basic imaging for violence and injuries	2	All
	Advanced imaging for Violence and Injuries (*CT Scan, MRI)*	3	All
	Basic Lab services for violence and Injuries (*Blood transfusions, vaginal swabs, HIV serology)*	2	All
	Advanced Lab services for violence and Injuries (*DNA testing)*	3	All
Rehabilitation	Physiotherapy following recovery from violence and Injuries	3	All
	Occupational Therapy following recovery from violence and Injuries	3	All
	Psychosocial therapy for violence and Injuries	3	All
	Rehabilitative appliances following violence and injuries	3	All

Table Key

	Tiers		Cohorts
1	*Community*	**1**	*Pregnancy and the new born (up to 28 days)*
2	*Primary Care*	**2**	*Early childhood (29 days – 59 months)*
3	*County*	**3**	*Childhood and youth (5 – 19 years)*
4	*National*	**4**	*Adulthood (20 – 59 years)*
		5	*Elderly (60 years and over)*
		All	*Cross cutting interventions*

3.4 Strategic Objective 4: Provide essential health services

These shall be affordable, equitable, accessible and responsive to client needs. This will be achieved by strengthening the planning and monitoring processes relating to health care provision, to ensure demand driven priorities are efficiently and effectively provided to the populations, based on their expressed needs. The priority policy strategies to achieve this are:

- Scale up physical access to person centered health care, with local solutions designed to fore hard to reach, or vulnerable populations
- Ensure provision of quality health care, as defined technically, and by users
- Avail free access to trauma care, critical care, and emergency care and disaster care services.
- Initiate efforts to promote medical tourism as a means to ensure high quality care availability in the Country

The service package that shall be provided under this strategic area focusing on providing essential health services is shown in the table below.

KEPH Service Package for providing essential health services, by level of care

Service area	Interventions	*Minimum Tier*	*Cohort*
General Outpatient	Management of ENT conditions (*Pharyngitis, Tonsillitis, sinusitis)*	2	All
	Management of Eye conditions (*Allergies, Bacterial Keratitis, Conjunctivitis (Pink Eye), Dry Eye, Low Vision, Myopia (Nearsightedness), Stye)*	2	All
	Management of Oral conditions (dental carried, *dental extraction, halitosis,)*	2	All
	Management of Respiratory conditions (*Croup, Asthma, bronchitis, bronchiolitis)*	2	All
	Management of Cardiovascular conditions (e.g. *Ischaemic heart disease, stroke, peripheral vascular diseases, RHD, congential heart disease)*	2	All
	Management of Gastrointestinal conditions (*Hepatitis)*	2	All
	Management of Genito-urinary conditions (e.g. *Lower UTI's, genital tract infections)*	2	All
	Management of Muscular skeletal conditions (*Juvenile rheumatoid arthritis, fructures)*	2	All
	Management of Skin conditions (*Impetigo, dermatitis / eczema, scabies, fungal skin infections)*	2	All
	Management of Neurological conditions	2	All
	Management of mental disorders	2	All
	Management of Sexual and Gender Based Violence	2	All
	Idnetification and management of disabilities	2	All
	Management of Endocrine and metabolic conditions (*Diabetes Mellitus, Hypothyroidism, hyperthyroidism)*	2	All
	Management of Haematology conditions (*Anaemia, Leukaemia, Lymphoma)*	2	All
	Management of birth defects (*Downs syndrome, Edwards syndrome)*	2	All
	Management of nutritional disorders (micronutrient deficincies, *Kwashiorkor, Marasmus, Obesity, Iodine and Vitamin A deficiency)*	2	All
	Management of other infectious conditions *(Malaria, typhoid, amoebiasis, HIV,)*	2	All
	Vaccination services *(Yellow fever, rabies, Tetanus toxoid)*	2	All
	Management of minor injuries	2	All
	Management of cancers	2	All
	Client registration and management	2	All
	Evacuation / transfer to other service areas / facilities	2	All
Integrated MCH / Family Planning services	Vitamin A supplementation	2	2
	Micronutrient supplementation	2	2
	Iron and folic Acid supplementation	2	2
	Weight monitoring	2	2
	Height measurement		
	Mid Upper Arm Circumference measurement	2	2
	Counseling: On infant feeding: Exclusive Breastfeeding, and complementary feeding	2	2
	Counseling: On maternal nutrition		
	Screening: for malnutrition, skin diseases, anemia	2	2
	FP Barrier methods (*Condoms, diaphragm, caps, vaginal ring and sponge)*	2	
	FP Hormonal methods (*Oral, injectable, sub dermal implants)*	2	
	FP Surgical methods (*Tubal ligation, vasectomy)*	3	
	FP Natural methods	2	
	FP Intra Uterine Contraceptive Devices	3	
Accident and Emergency	Management of ENT conditions (*Pharyngitis, Tonsillitis, sinusitis)*	3	All
	Management of Eye conditions (*Allergies, Bacterial Keratitis, Cataracts, Detached and Torn Retina, Glaucoma)*	3	All
	Management of Oral conditions (*Oral Infections, maxillofacial trauma, oral cancers)*	3	All
	Management of Respiratory conditions (*Croup, Asthma, bronchitis, bronchiolitis)*	3	All
	Management of Cardiovascular conditions (*Infective endocarditis, Rheumatic heart disease, Congestive heart failure, Shock, hypertension)*	3	All

Service area	Interventions	*Minimum Tier*	*Cohort*
	Management of Gastrointestinal conditions (*Hepatitis, Liver failure, Ascitis, Malabsorption, GI bleeding, Acute abdomen)*	3	All
	Management of Genito-urinary conditions (*Nephritis, nephrotic syndrome, renal failure, lower UTI's, pyelonephritis)*	3	All
	Muscular skeletal conditions (*Pyomyoscitis, septic arthritis, osteoarthritis, Juvenile rheumatoid arthritis, fructures)*	3	All
	Management of Skin conditions (*Dermatitis, fungal skin infections)*	3	All
	Management of neurological conditions (*Meningitis, encephalitis, seizure disorders, cerebral palsy, tumours, raised intracranial pressure, coma)*	3	All
	Management of Endocrine and metabolic conditions (*Diabetes Mellitus, Hypothyroidism, hyperthyroidism)*	3	All
	Management of Haematology conditions (*Anaemia, Septicemia, Hemophilia, Idiopathic Thrombocytopenic Purpura, Leukaemia, Lymphoma)*	3	All
	Management of other infectious conditions *(complicated Malaria, severe diarrhoea, typhoid, amoebiasis, HIV,)*	3	All
	Management of injuries	3	All
	Management of birth defects	3	All
	Client registration and management	3	All
	Evacuation / transfer to other service areas / facilities	3	All
Emergency life support	Triage for emergency cases	1	All
	Basic life support	2	All
	Mass casualty and trauma management care	3	All
	Advanced life support	4	All
Maternity	Pre-term labour management (*Corticosteroids, antibiotics for pPROM, tocolytics)*	3	1
	Complications during pregnancy (*Pre eclampsia, fever (due to infections)*	3	1
	Abnormal pregnancy management (*Ectopic pregnancy, molar pregnancy, spontaneous abortion)*	3	1
	Labour induction	3	1
	Labour monitoring		
	Normal Vaginal Delivery	2	1
	Assisted Vaginal Delivery (vacuum extraction)	2	1
	Caesarian section	3	1
	Obstetric emergencies (*Eclampsia, Shock, Post Partum Hemorrhage, Premature Rupture of Membranes)*	3	1
	Active management of 3rd stage of labour	2	1
	Feeding of mothers post labour		
	Post partum care	2	1
	Post operative care for mother and child	2	1
	Client registration and management	2	1
	Referral of clients	2	1
Newborn services	Neonatal resuscitation	2	1
	Treatment of newborns with sepsis	2	1
	Early initiation of breastfeeding	2	1
	Kangaroo mother care	2	1
	Management of newborn conditions *(Asphyxia, jaundice, birth trauma)*	2	1
	Client registration and management	2	1
	Care for premature babies (*Warmth, feeding)*	3	1
Reproductive health	Breast examination by palpation	3	All
	Management of reproductive health cancers e.g. *Breast cancer, cervical cancer, prostate cancer*	3	All
	Management of abnormal uterine bleeding	3	All
	Management of other gynaecological conditions	3	All
	High Vaginal Swab	3	All
	Obstetric fistula management	4	All
	Management of Infertility	3	All
In Patient	Management of Cardiovascular conditions (*Congenital Heart Disease, Infective endocarditis, Rheumatic heart disease, Congestive heart failure, hypertension)*	3	All
	Management of Respiratory conditions (Croup, Asthma, bronchitis, bronchiolitis)		
	Management of Gastrointestinal conditions (*Hepatitis, Ascitis, Malabsorption, GI bleeding)*	3	All
	Management of Genito-urinary conditions (*Haemolytic uraemic syndrome, nephritis, nephrotic syndrome, lower UTI's, bilharzia, Wilms tumour, ambiguous genitalia)*	3	All
	Management of gynaecological conditions *(abnormal uterine bleeding, fibroids, endometriosis, ovarian cysts, ovarian cancer, pelvic floor disorders)*		
	Management of Muscular skeletal conditions (*Pyomyoscitis, septic arthritis, osteoarthritis, Juvenile rheumatoid arthritis, fractures)*	3	All
	Management of Skin conditions (*Impetigo, dermatitis / eczema, fungal skin infections)*	3	All
	Management of neurological conditions (*Seizure disorders, cerebral palsy, tumours)*	3	All
	Management of Endocrine and metabolic conditions (*Diabetes Mellitus, Hypothyroidism, hyperthyroidism)*	3	All
	Management of Haematology conditions (*Anaemia, Haemophilia, Idiopathic Thrombocytopenic Purpura, Leukaemia, Lymphoma)*	3	All
	Management of birth defects (*Downs syndrome, Edwards syndrome)*	3	All
	Management of nutritional disorders (*Kwashiorkor, Marasmus, vitamin and mineral deficiencies)*	3	All
	Management of various infections conditions *(complicated malaria, diarrhoea)*	3	All
	Specialized cancer therapy (surgery, *Radiotherapy and brachytherapy, Co-60, LINAC, Chemotherapy)*	4	All
	Management of mental disorders	3	All
	Client registration and management	3	All
Clinical Laboratory	Haematology *(Hb, RBC/WBC counts, hematocrit, peripheral film)*	2	All
	Pregnancy test	2	All
	Bleeding and coagulation time	2	All

Service area	Interventions	*Minimum Tier*	*Cohort*
	Blood grouping with Rh factors	2	All
	Parasitology *(RDT)*	1	All
	Hepatitis B and C tests	3	All
	Bacteriology *(ZN staining, Alberts staining, Gram Staining)* microscopy	2	All
	ELISA tests	3	All
	Widal tests	3	All
	CD 4 count	3	All
	PCR tests	4	All
	Viral culture	4	All
	Agglutination tests	3	All
	Urinalysis	2	All
	Liver Function Tests	3	All
	Renal Function Tests	3	All
	Blood gases	4	All
	Cardiac enzymes	4	All
	Cholesterol tests (Total / Differential)	3	All
	Blood culture	4	All
	Blood sugar	2	All
	Semen analysis	3	All
	Fecal Occult Blood testing	3	All
	Tumour markers *(PSA, Bence Jones protein, CA125, cytology, biopsy examinations)*	3	All
	Histopathology (FNA, Tru cut, Incision or excision) and cytology	3	All
	Micro nutrient test	3	All
	Cerebro Spinal Fluid analysis *(culture, biochemistry, cytology)*		All
	Client registration and management	3	All
Specialized laboratory	DNA testing	4	All
	Food analysis	4	All
	Water analysis	4	All
	Blood analysis *(alcohol, drug)*	4	All
	Stool testing *(e.g. polio)*	4	All
Imaging	Ultra sound scan	3	All
	X – ray	3	All
	Endoscopopy	3	All
	Laparascopy	3	All
	Computerized Tomography Scan	4	All
	Magnetic Resonance Imaging	4	All
	Radio-isotope scanning	4	All
	Angiography	4	All
	AVU / AVP	4	All
	Electro Encephalogram (EEG)	4	All
Pharmaceutical	Medical Therapy Management	3	All
	Medicines dispensing	3	All
Blood safety	Blood donation and storage	1	All
	Blood screening (*Hepatitis B and C, Syphilis, Malaria, blood grouping)*	4	All
	Blood product preparation	4	All
	Blood transfusion	3	All
Rehabilitation	Physiotherapy	3	All
	Speech and hearing therapy	3	All
	Orthopedic technology (appliances)	3	All
	Occupational therapy	3	All
	Client registration and management	3	All
Palliative care	Pain management	3	All
	Counseling services	3	All
	Psychosocial support	3	All
	Client registration and management	3	All
Specialized clinics	HIV clinic (*ART provision (1st and 2nd line), AT's for TB patients, Opportunistic infection management, nutrition care and support, Cotrimoxazole prophylaxis for children and TB patients, TB screening)*	3	All
	TB clinic (*TB treatment (1st and 2nd line), MDR and XDR TB management, Treatment follow up)*	3	All
	Pediatric clinic (*Nutrition, neurological conditions, birth defects, chronic pediatric conditions, post admission follow up)*	3	All
	ENT clinic (*Sinusitis)*	3	All
	Eye clinic (*Bacterial Keratitis, Cataracts, Detached and Torn Retina, Diabetic Retinopathy, Glaucoma)*	3	All
	Dental clinic (*Oral Infections, maxillofacial trauma, oral cancers, major oral surgery)*	3	All
	Chest clinic (*Croup, Asthma, bronchitis, bronchiolitis, uncomplicated TB, drug resistant TB)*	3	All
	Cardiac clinic (*Congenital Health Disease, Infective endocarditis, Rheumatic heart disease, Congestive heart failure, Shock, hypertension)*	3	All
	Gastro Intestinal clinic (*Hepatitis, Liver failure, Ascitis, GI bleeding, Acute abdomen)*	3	All
	Genito-urinary clinic (*Haemolytic uraemic syndrome, nephritis, nephrotic syndrome, renal failure, pyelonephritis, Wilms tumour, ambiguous genitalia)*	3	All
	Mental health clinic (*Substance abuse, Neurotic conditions, psychosis)*	3	All
	Oncology clinic	3	All

Service area	Interventions	*Minimum Tier*	*Cohort*
	Surgical clinic (*Pyomyoscitis, septic arthritis, osteoarthritis, Juvenile rheumatoid arthritis, fractures)*	3	All
	Orthopedic clinic	3	All
	Skin clinic (*Impetigo, dermatitis)*	3	All
	Neurological clinic (*Meningitis, encephalitis, seizure disorders, raised intracranial pressure, coma)*	3	All
	Endocrine and metabolic clinic (*Diabetes Mellitus, Hypothyroidism, hyperthyroidism)*	3	All
	Haematology clinic (*Anaemia, Septicaemia, Haemophilia, Idiopathic Thrombocytopenic Purpura, Leukaemia, Lymphoma)*	3	All
Comprehensive youth friendly services	Provision of life skills	2	All
	Information on healthy lifestyle	2	All
Operative surgical services	Outpatient operations	2	All
	Emergency operations	3	All
	General operations	3	All
	Specialized operations	4	All
	Client registration and management	3	All
Specialized Therapies	Radiotherapy	4	All
	Chemotherapy	4	All
	Interventional Radiology	4	All
	Dialysis	4	All
	Organ transplants *(kidney, liver, bone marrow)*	4	All
	Bypass surgeries	4	All
	Reconstructive surgery	4	All
	Assisted Reproduction *(IVF)*	4	All
	Client registration and management	4	All

Table Key

	Tiers		Cohorts
1	*Community*	**1**	*Pregnancy and the new born (up to 28 days)*
2	*Primary Care*	**2**	*Early childhood (29 days – 59 months)*
3	*County*	**3**	*Childhood and youth (5 – 19 years)*
4	*National*	**4**	*Adulthood (20 – 59 years)*
		5	*Elderly (60 years and over)*
		All	*Cross cutting interventions*

3.5 Strategic Objective 5: Minimize exposure to health risk factors

The objective is focused on putting in place appropriate Health Promotion interventions that will address risk factors to health. These include:

- Reduction in unsafe sexual practices, particularly amongst targeted groups
- Mitigate the negative health, social and economic impact resulting from the excessive consumption and adulteration of alcoholic products
- Reduce the prevalence of tobacco use and exposure to tobacco smoke and other harmful addictive substances
- Institute population-based, multi sectoral, multidisciplinary, and culturally relevant approaches to promoting physical activity and healthy diets
- Strengthen mechanisms for screening and management of conditions arising from health risk factors at all levels.
- Increase collaboration with research based organizations and institutions

The key service areas areHealth Education, Growth monitoring, Sexual education, Substance abuse, and Physical activity and healthy diets. The service package for addressing risk factors is shown below.

KEPH service package for addressing health risk factors

Service area	Interventions	Minimum Tier	Cohort
Health Promotion including health Education	Health promotion on violence and injury prevention (*Road Traffic, Burns/Fires, Occupational , Poisoning, Falls , Sports , Drowning ,Conflict/war, Female Genital mutilation, Self-inflicted , Interpersonal injuries ,Gender Based violence, Child maltreatment.*)	1	All
	Health promotion on prevention of communicable conditions (Environmental sanitation and hygiene, infection prevention practices, safe dwellings and habitant, safe sex practices, safe food handling, safe water, blood safety practices, immunization*)*	1	All
	Health promotion on prevention of Non Communicable conditions (tobacco control, control of harmful use of alcohol, prevention of drug and substance abuse, health diets and physical activities, control of indoor polution, control of environmental polution and contamination, radiation protection, safe sex practices, work place safety, personal hygiene)	1	All
Sexual education	Sensitization of the community on safe sex practices	1	All
	Incorporation of sex education in education curricular		
	Targeted education methods for high risk groups (MARPS) (*commercialsex workers, uncircumcised men, Men Having Sex with men, intravenous drug users,Adolescents)*and negative cultural practices	1	All
Substance abuse	Communication on harmful effects of Tobacco use	1	All
	Communication on harmful effects of Alcohol abuse	1	All
	Communication on harmful effects of Substance abuse (*Cocaine, Heroine, glue, khat, and others)*	1	All
	Communication on harmful effects of Prescription drug abuse	1	All
	Counseling		
Micronutrient deficiency control	Advocate for food fortification		
	Advocacy for consumption of fortified foods		
	promotion of dietary diversification		
	Food supplementation		

Table Key

	Tiers		Cohorts
1	*Community*	**1**	*Pregnancy and the new born (up to 28 days)*
2	*Primary Care*	**2**	*Early childhood (29 days – 59 months)*
3	*County*	**3**	*Childhood and youth (5 – 19 years)*
4	*National*	**4**	*Adulthood (20 – 59 years)*
		5	*Elderly (60 years and over)*
		All	*Cross cutting interventions*

3.6 Strategic Objective 6: Strengthen Collaboration with health related sectors

As highlighted in the National Health Policy, this strategic objective highlights the key services and interventions that have a secondary effect on health. These health related interventions are in the following sectors (but not limited to).

- Economy and employment: Ensure work and stable employment and entrepreneur opportunities for all people across different socio economic groups
- Security and justice: Have fair justice systems, particularly in managing access to food, water & sanitation, housing, work opportunities, and other determinants of wellbeing
- Education and early life: Support education attainment of both women and men to promote abilities to address challenges relating to health
- Agriculture and food: Incorporation of considerations of health in safe food production systems, manufacturing, marketing and distribution
- Nutrition: Ensure adequate nutrition for the whole population, through avoiding and managing over, or under nutrition
- Infrastructure, planning and transport: Optimal planning of health impacts for roads, transport and housing investments, to facilitate efficient movements of people, goods and services relating to health
- Environments and sustainability: Influence population consumption patterns of natural resources in a manner that minimizes their impact on health
- Housing: Promote housing designs and infrastructure planning that take into account health and wellbeing
- Land and culture: Strengthening access to land, and other culturally important resources by particularly women
- Population: Manage population growth and urbanization implications
- Gender and vulnerable populations: Strengthen identification of special groups and their needs so as to increase equitable access to health care services

The priority interventions during the strategic plan period are shown in the service package below. The sector will focus on the following priority actions:

- Information generation on activities, and their impact on Health
- Advocacy for required investments with related sector, donors, and Ministry of Finance, based on evidence

KEPH service package for collaboration with health related sectors

Service area	Interventions	Minimum Tier	Cohort
Safe water	Provision of safe water sources	1	All
	Health Impact Assessment	1	All
	Community sensitization on safe water	1	All
	Water quality testing	1	All
	Water purification / treatment at point of use	1	All
	Water source protection	1	All
Sanitation and hygiene	Monitoring human excreta disposal practices	1	All
	Hand washing facilities	1	All
	Hygiene promotion	1	All

Service area	Interventions	Minimum Tier	Cohort
	Home inspections for sanitation adequacy	1	All
	Health Impact Assessment	1	All
	Promotion of safe food handling	1	All
	Sanitation surveillance and audits	1	All
Nutrition services	Nutrition education and counseling	1	All
	Community based growth monitoring and promotion	1	All
	Micronutrient supplementation (e.g vitamin A, IFA)	1	All
	Management of acute malnutrition	1	All
	Health Impact Assessment	1	All
	Health education on appropriate infant and young child feeding	1	All
Pollution control	Indoor pollution management	1	All
	Liquid, solid and gaseous waste management	1	All
	Health Impact Assessment	1	All
	Control of Water body, soil and air pollution	1	All
Housing	Approval of building plans	1	All
	Health and environmental impact assessment		
	Advocacy for enforcement of standards on housing	1	All
	Physical planning and housing environment to promote healthy living including prevention of rickets	1	All
School health	School feeding and nutrition	1	All
	School Health promotion		
	School based disease prevention programme		
	School water sanitation and hygiene		
	Health Impact Assessment	1	All
	Children with special needs		
Food fortification	Salt fortification with Iodine	1	All
	Toothpaste fortification with fluoride	1	All
	Health Impact Assessment	1	All
	Micronutrient fortification of food products (*flour, cooking oil, sugar, etc)*	1	All
Population management	Information on child spacing benefits	1	All
	Awareness creation on the impact of population growth	1	All
	Health Impact Assessment	1	All
	Management of population movement particularly to informal settlements	1	All
Road infrastructure and Transport	Improve road infrastructure to health facilities	1	All
	Road safety/Injury prevention	1	All
	Health Impact Assessment	1	All

Table Key

	Tiers		Cohorts
1	*Community*	**1**	*Pregnancy and the new born (up to 28 days)*
2	*Primary Care*	**2**	*Early childhood (29 days – 59 months)*
3	*County*	**3**	*Childhood and youth (5 – 19 years)*
4	*National*	**4**	*Adulthood (20 – 59 years)*
		5	*Elderly (60 years and over)*
		All	*Cross cutting interventions*

CHAPTER FOUR: HEALTH OUTPUTS –ACCESS AND QUALITY OF CARE

Improvements in access and quality of care remain the major focus for the sector investment efforts.

4.1 Improving access to KEPH

Access isameasureoftheabilityofaperson/community to receive available services. It is a pre- requisite to high utilization of health services as it bringsservicesclosertothepeopleaswellasmakes themcheaper.Additionally,accessisinfluencedby geographic,economicandsocio-culturalfactors as barriers to care.Poordistribution of facilities, poor public transport, weakreferralsystems,insufficientcommunityhealth services and weak collaborations with other service providershaveperpetuatedpoorgeographicalaccess to health services.

There are imbalances in geographical distribution of health facilities in terms of the numbers and types of facilities available. Some areas have disproportionately more facilities than others. Consequently, while the average distance covered to reach the nearest health facility is reasonable (within 5 km for medical services, and 2.5km for public health services as recommended by WHO), there are under-served areas in the Country, particularly in the Northern Counties of Isiolo, Turkana, Mandera, West Pokot, Marsabit, Samburu, Wajir, and Garissa.

Economic access constraints – the affordability of health services – also hinder access to services. These includelowhouse- holdincome,lowprioritizationofhealthathousehold levelandlowallocationofresourcesbythestateto thehealthsector.BecauseofthehighlevelofpovertyinKenya,mosthouseholdscannotaffordtopay forhealthservices. Wherethereissomehousehold income, health is not given priority. On its part, the governmentisrequiredtoachievethecommitmentin theAbujaDeclarationtoallocate15%ofgovernment expenditurebudgettohealth.Themeasuresinclude introductionoftheNationalHealthInsuranceFund, review of the cost sharing strategy, promotion of communitypre-paymentschemesanddevelopment of criteria for allocating public funds.

Socio-cultural barriersassociatedwithlowliteracy levels,religiousbeliefsandgenderbiashinderaccess to health services, especially by women, children, adolescents, the disabled and other vulnerable groups.Recognizingthisproblem,thegovernment has to make the provision of health services more humane,compassionateanddignified.Targetedmeasuresincludeensuring privacy in the course of service delivery, especially for women.

The sector, therefore, will prioritize addressing these barriers to access, for it to attain its KHSSP service outcomes as outlined in the KEPH. Priority actions during the KHSSP to improve access include:

- Ensure 100% of KEPH services are being provided in special settings. These special settings in KHSSP are:
    - Congregate settings – prisons, IDP camps, schools, refugee camps, army barracks
    - At risk populations – HealthWorkers, , Commercial Sex Workers, women, persons with disability, elderly, children, youth, marginalized, religious/cultural communities
    - Hard to reach areas – Northern Kenya, and informal settlements
- Improve geographical access of the population to the KEPH to at least 90% of the population through
    - Upgrading 40% of dispensaries to full primary care units

- Operationalize 100% of model Health Centres to fully functional primary care facilities
- Put in place fully functional referral system in at least 80% of Counties

- Further reduction of the burden of pre-payment for health services to improve financial access

4.2 Improving quality of care

Thequalityofcare isinfluenced bythe capacity to use available inputs to deliver desired outcomes[6]. A focus on quality of care ensures the sector is able to respond to the legitimate needs of the clients receiving services. It is affected by the 'soft inputs' needed to deliver care – Health Worker attitudes, motivation, equipment management, leadership skills, amongst others.

Variables of interest in quality of care relate to service relevance and acceptability, continuity of care, integration, holistic / comprehensive approach to services. Currently, most sector efforts are aimed at improving access to services, with disjointed approaches to ensuring client experience when accessing these services is enriching. The sector therefore aims to ensure significant improvements in quality of care are attained during the KHSSP period. This, together with investments to improve access to care (availability of inputs) should facilitate attainment of desired health outcomes. Priority actions to improve quality of care during KHSSP period include:

- Improving services relevance and acceptability by use of regular service charters by all service delivery points, Conducting regular client satisfaction surveys to continually ensure clients expectations are informing intervention provision, and ensuring patient safety is ensured in provision of services
- Improving continuity of care through Strengthening of referral services, and improving within facility management of patient experiences
- Integration of services by linking provision of similar interventions together, through the KEPH defined service groupings
- Ensuring a comprehensive approach to services is applied and used, not focusing only on programs.

4.3 KHSSP targets for Access and Quality of Care improvements

The KHSSP output targets for access and quality improvements are shown in the table below.

KHSSP Output targets

Policy Objective	Indicator	Targeted trend's					
		2012/13	2013/14	2014/15	2015/16	2016/17	
Improving access to services	Per capita Outpatient utilization rate (M/F)	2	2.5	3	3	3.5	
	% of population living within 5km of a facility	80			90		
	% of facilities providing BEOC	65	75	80	80	90	
	Bed Occupancy Rate	85	90	90	95	95	
	% of facilities providing Immunisation	80	85	95	100	100	
Improving quality of care	TB Cure rate	83	85	85	88	90	
	% of fevers tested positive for malaria	45		30			
	% maternal audits/deaths audits	10	35	50	70	85	
	Malaria inpatient case fatality	15	13	10	8	7	
	Average length of stay (ALOS)	5.6	5.1	5	4.5	4	

[6] As opposed to Quality of Service Delivery, which focuses on availability of inputs in delivery of health outcomes.

CHAPTER 5: HEALTH INVESTMENTS

This sectionoutlines the investments required to deliver on the Health Services outlined in the previous chapter. Investment areas relate to the different policy orientations in the Kenya Health Policy, which will lead to the attainment of the defined health services. Health Investments are defined as those investments that are primarily made to support attainment of Health Goals. Investments made that have another primary purpose (improvement in health being a secondary goal) are not included as part of health goals – for example investments to improve access to safe water, or housing.

Investments have been defined across the seven Policy Orientations. The Principles to guide prioritization within each of the seven investment areas are outlined in the Kenya Health Policy. These principles are:

- Equity: This is to ensure all services provided avoid exclusion and social disparities. Investments are defined to ensure access to services is equitable, irrespective of persons gender, age, caste, color, geographical location and social class.
- People-centred: To ensure that health, and health interventions are organized around people's legitimate needs and expectations. Interventions prioritizing community involvement and participation are prioritized
- Participation: Involvement of different actors to attain interventions is a factor in prioritization. Interventions involving different actors are prioritized, as they allow more scope for financing, and attainment.
- Multi sectoral approach: This is based on the recognition that health cannot be improved by interventions relating to health services alone, with a focus of 'Health in all Sectors' required. Interventions implemented by health related sectors are also prioritized, as their attainment doesn't require significant health investments, but can lead to high health outcomes.
- Efficiency: To maximize the use of existing resources. Interventions that show high levels of cost efficiency are prioritized, as the potential benefits from these are high.
- Social accountability: To improve on the public perception of health services, interventions that involve performance reporting, public awareness, transparency and public participations in decision making on health related matters are prioritized.

The investment targets are shown in the table below.

Investment targets during the KHSSP period

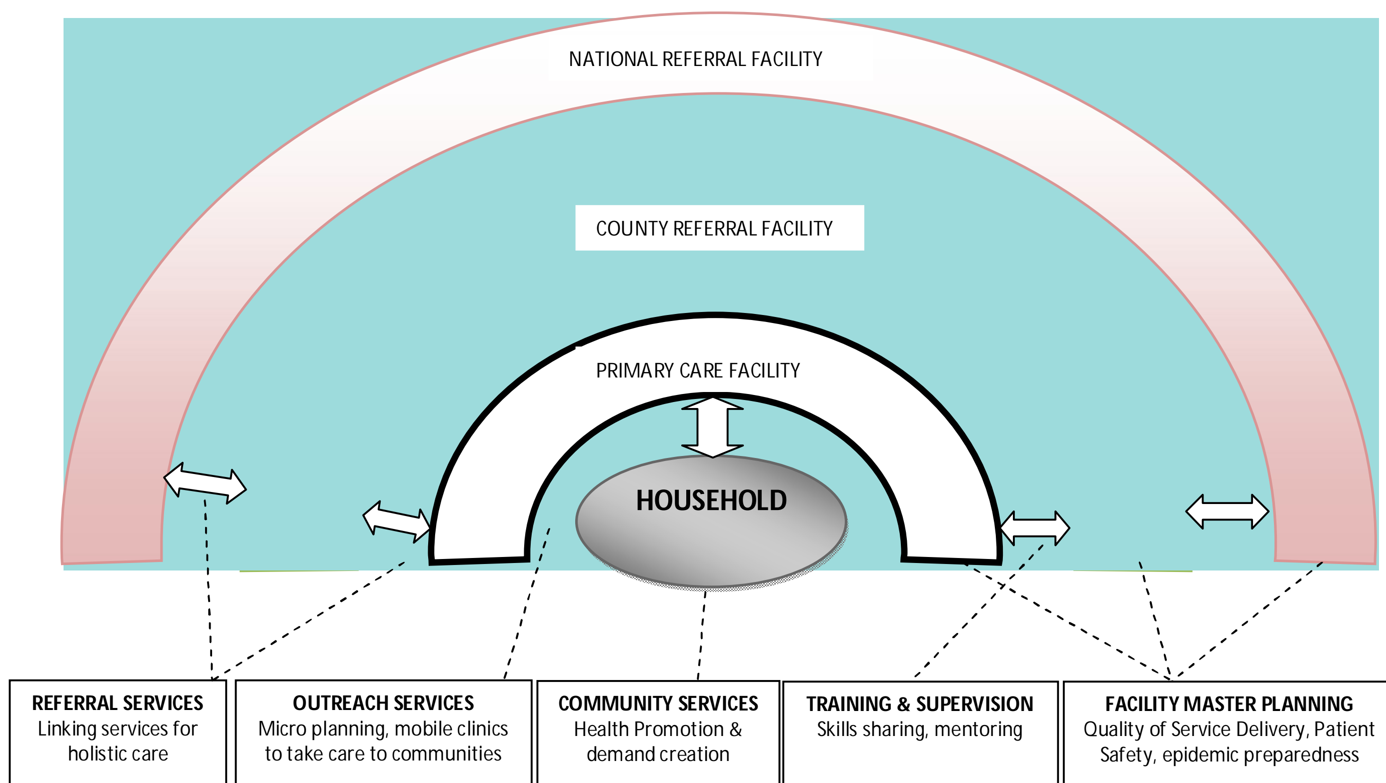
Policy Orientation	Indicator	Targeted trend's					
		2012/13	2013/14	2014/15	2015/16	2016/17	
Service delivery systems	% of functional community units	20	23	26	30	40	
	% outbreaks investigated within 48 hours	90	100	100	100	100	
	% of hospitals offering emergency trauma services	35	40	50	65	75	
	% hospitals offering Caesarean services	45	60	70	85	90	
	% of referred clients reaching referral unit	25	35	50	70	80	
Health Workforce	# of Medical health workers per 10,000 population	5	5.5	6	7	7	
	% staff who have undergone CPD	40	50	50	65	70	
	Staff attrition rate	10	8	5	5	4	
	% Public Health Expenditures (Govt and donor) spent on Human Resources	55	50	45	45	40	
Health Infrastructure	# of facilities per 10,000 population	1.5	1.6	2	2.5	2.5	
	% of facilities equipped as per norms	25	35	50	60	65	
	# of hospital beds per 10,000 population	50	60	100	150	150	
	% Public Health Expenditures (Govt and donor) spent on Infrastructure	30	30	25	25	25	
Health Products	% of time out of stock for Essential Medicines and Medical Supplies	8	5	4	2	2	

Policy Orientation	Indicator	Targeted trend's					
		2012/13	2013/14	2014/15	2015/16	2016/17	
	(EMMS) – days per month						
	% Public Health Expenditures (Govt and donor) spent on Health Products	10	10	15	15	15	
Health Financing	General Government expenditure on health as % of the total government Expenditure	4.5	5.5	6	8	10	
	Total Health expenditure as a percentage of GDP	1.5	1.6	1.8	2	2.2	
	Off budget resources for health as % of total public sector resources	60	40	35	25	15	
	% of health expenditure reaching the end users	65	75	80	80	80	
	% of Total Health Expenditure from out of pocket	33			25		
Health Leadership	% of health facilities inspected annually	15	40	70	80	80	
	% of health facilities with functional committees	70	85	100	100	100	
	% of Counties with functional County Health Management Teams	0	75	100	100	100	
	% of Health sector Coordinating Committee meetings held at National level	50	100	100	100	100	
	% of County Health Stakeholders fora held at county level	0	50	100	100	100	
	% of facilities supervised	40	60	80	100	100	
	Number of counties with functional anti-corruption committees	0	24	47	47	47	
	% of facilities with functional anti-corruption committees	0	20	50	80	100	
	% of policies/document using evidence as per guidelines	30	90	100	100	100	
	% of planning units submitting complete plans	65	80	95	95	95	
	# of Health research publications shared with decision makers	3	10	10	20	20	
	% of planning units with Performance Contracts	70	100	100	100	100	
Health Information	% of quarters for which analyzed health information is shared with the sector	50	100	100	100	100	
	% of planning units submitting timely, complete and accurate information	25	40	55	70	85	
	% of facilities with submitting timely, complete and accurate information	25	40	55	70	85	
	% of health facilities with DQA	0	10	30	45	45	
	% Public Health Expenditures (Govt and donor) spent on Health Information	3	5	5	5	5	

5.1 Investment area 1: Organization of Service Delivery

These are the investments that relate to organization and management of health services. They Health Service Delivery System, and related services to operationalize this are shown below.

Health Service Delivery System



For each service area, the key strategies for implementation are shown in the table below.

Strategies against each Service Area

Service Area	Description and scope	Strategies
Referral Services	How services are planned, and delivered across different types of facilities. The focus is on ensuring holistic delivery of services.	Physical client Movement (physical referral)
		Patient Parameters movement (e-health)
		Specimen movement (reverse cold chain, and reference laboratory system)
		Expertise movement (reverse referral)
Outreach services	How services are supplied to communities, as per their needs.	Micro planning to Reach Every Person
		Mobile clinics in hard to reach areas
Community services	How community capacity to demand for services is built, and supported.	Comprehensive community strategy
		Program targeted community services
Training and Supervision	How skills and expertise are provided to health workers.	Program training programs
		Systems and Services trainings

Service Area	Description and scope	Strategies
		Supervision and mentoring
Facility Master Planning	How the facility organizes itself internally, to provide and manage care delivery.	Patient Safety
		Epidemic preparedness planning & response
		Quality of Service Delivery Improvement

5.1.1 Current status of investments

Referral Services: The referral system as defined in the National Referral Strategy aims at facilitating movement of clients, specimens, client parameters, or skills (downward referral) across different tiers of health service delivery units. At present, capacity improvements are not coordinated, leading to different facilities having different capacities to manage different elements of the referral system. In addition, the referral between communities and facilities is still weak.

Outreach services: Theseare the main method applied to take care into the communities. In hard to reach areas, these outreaches are in the form of mobile clinics. The application of outreach services at present is not uniform. Some facilities, particularly hospitals, are not carrying out any outreaches. The facilities carrying these out are not all planning these as integrated outreaches, with focus on some, not all services and interventions. Plus, the outreaches are not well coordinated to ensure adequate coverage of the whole population with planned services due to limited use of micro planning approaches. Some programs, such as Immunization, have clear guidelines on how these micro planning should be carried out (Reach Every Child approach).

Community Services: The approach that aims to ensure households are practicing healthy behaviours, and are knowledgeable about health threats has been addressed in a disjointed manner. On one hand, there is the Comprehensive Community Strategy that is a key Government program aimed at organizing communities to take care of their health, with services by community health extension workers and community health workers (439 units established). On the other hand, some direct health promotion activities are carried out, particularly from well resourced programs to improve community awareness about the programs and available services. So far, national coverage of health promotion services is difficult to ascertain, through that for community units is still low. In addition, the service package for community health services is not adequately funded, leading to a mix in scope and quality of activities the existing community units are carrying out. Not all non facility based KEPH interventions are, or should be provided through the community units – some are more effectively delivered through other health related sector actions

Training and Supervision: At present, different programs are providing various forms of technical support to improve in Service skills. This support is coordinated at the program level, with little coordination of efforts. In addition, continuous in service support through supervision is not well applied. Tools for supervision for all levels exist, but the process is not applied consistently and comprehensively. This is primarily due to lack of support to operations and logistics for the supervision process, plus lack of agreement on how the outputs are incorporated into, and affect decision making at all levels. As the Counties become operational, supervision focus will need to shift, from National level to County level as the primary coordinating unit for supervision.

Facility Master Planning: At present, there is little guidance on how facilities can manage and coordinate care being provided. Some facilities have put in place local solutions to manage clients within facilities, with positive results seen in some areas (e.g. Nakuru, Khilifi hositals). Facilities are carrying out regular management committee meetings. These have, however, increasingly focused on administration, as opposed to management of service delivery. Facility performance achievements and

challenges are not well planned and monitored. Standardized clinical guidelines (SCGs) and a national Essential Medicines List (EML) were reviewed and updated in 2009 to guide management and referral of common conditions at all levels of care, in line with the KEPH. These tools are at the core of an evidence-based approach to clinical management, and they were distributed to health facilities countrywide. However, their application is not fully integrated into health facility management systems, and mechanisms are not in place to monitor their relevance and impact on clinical practice. The process of reviewing and updating these tools is also irregular and not institutionalized, often lagging behind key developments in disease control interventions.The health sector has in place a national coordination mechanism to prepare and respond to disasters. Health Services delivery system is an integral part of this coordination mechanism, to ensure response capacity is adequate to respond to anticipated disasters. In addition, capacities in facilities in disaster prone areas, such as Road Traffic Accident hot spots, has been strengthened to improve their response capacity. Preparedness planning is however not yet institutionalized in all facilities in the country.

5.1.2 Required investments and flagship program

The sector requires establishment of an effective organization and management system to deliver on the KEPH as outlined in the previous chapter. The Kenya Health Policy defines the expected organization structure for health services delivery, across four tiers of care (Community, Primary Care, County Services, and National Services). Based on current populations, the following are the required units at each level:

- The sector is targeting to have a community unit for every 5,000 persons, giving an overall target of having 8,000 functional Community Units.
- At the primary care level, there are 7,568 units that qualify to function as such primary care units – 2,526 dispensaries, 3,929 private clinics, 935 health centres, and 178 maternity homes.
- For the County level, there are 489 hospitals, representing public and non public level hospitals at district / sub district levels.
- Finally, the National referral hospitals are 12 – Kenyatta National Hospital, Moi Teaching and Referral Hospital, Spinal Injury hospital, Pumwani hospital, Mathari hospital, plus the 7 Provincial General Hospitals.

Sub County management units are 360, while Counties are 47 in total. National Management Units are 5, and include Ministry of Health Headquarters, Kenya Medical Research Institute, Pharmacy and Poisons Board, National Quality Control Laboratories, National Public Health Laboratories, Government Chemist, National Blood Transfusion Services, and Radiation Protection Board.

Key investment and milestone targets for Organization of Service Delivery are shown in the table below.

Priority processes to invest in Organization of Service Delivery

Area	Priorities	Milestones	Base line	Mid Term	Target
Referral Services	Update referral tools and guidelines for all levels	Updated referral tools and guidelines		1	
	Orientation of all management teams on referral roles and functioning	County Health Management teams oriented on referral roles and functioning	0	47	47
	Develop and disseminate Tools for referral **Support establishment of referral services**[7]	Counties establishing comprehensive referral system	0	21	47
Outreach Services	Tools and guidelines for conducting micro-planning and outreaches	Updated tools and guidelines for conducting outreaches	1		
	Orientation of facilities on process and focus of	Counties with monthly Outreaches from at least 80%	0	25	47

[7] Flagship program

Area	Priorities	Milestones	Base line	Mid Term	Target
	outreaches Establishment of mobile clinics in all hard to reach areas Support micro planning, to reach every targeted person	of their facilities			
		Counties in hard to reach areas with monthly mobile clinics	2	5	8
		Counties developing micro plans for at least 80% of their facilities	0	10	40
Community Services	Update Community Strategy, and information system Scale up comprehensive community strategy	Community units established and functional	439	3,500	5,000
Training and Supervision	Update Supervision tools and guidelines, to focus on County level supervision Improve County capacity for supervision Develop annual training plans for in service training skills Support Counties to develop on job training plan	Counties carrying out quarterly supportive supervision	0	47	47
		Counties with on the job training plans			
		Annual national training plan with identified skills building priorities	1	1	1
Facility Master Planning	Develop facility master plans Support facilities actively plan for patient safety Update standard clinical guidelines and EML Update guidelines and tools for establishing MTC's Establish innovative IT based systems to manage and support patient flow / experience Support facilities develop disaster preparedness plans Update health facility management team guidelines	Counties with updated Standard Clinical guidelines and EML available in all facilities	47	47	47
		Counties with at least 80% of facilities having master plans	0	47	47
		Counties with at least 50% of facilities using innovative IT based systems for management (EMR's)	0	6	30
		Counties with at least 80% of hospitals practicing disaster preparedness planning	0	20	47

5.2 Investment area 2: Human Resources for Health

5.2.1 Current status of investments

The health sector still faces significant HR shortages, in spite of the investments made during the NHSSP II. This is because of the increase in expected services provided, coupled with the freeze in recruitment that existed during the 1st half of the NHSSP II. HR investments need to be designed to address:

- Availability of appropriate and equitably distributed health workers
- Attraction and retention of required health workers
- Improving of institutional and health worker performance, and
- Training capacity building and development of the Health Workforce

The current challenges with these areas of HR is shown in the table below.

Status of Human Resources processes

HRH Area	Current Status
Appropriate and equitably distributed health workers	▪ Inadequate numbers of health workers in-post ▪ Lack of skills inventory ▪ Skewed distribution of HW, with significant gaps in North eastern and Northern rift provinces ▪ Lack of budgetary support to enhance recruitment
Attraction and retention of HW	▪ High level of attrition ▪ Unfavorable terms and conditions of work ▪ Lack of incentives for hard-to-reach areas ▪ Improved but disharmonized remuneration. ▪ Lack of equity in remuneration of HW ▪ Low employee satisfaction level ▪ Stagnation due to unfavorable career guidelines
Institutional and HW performance	▪ Lack of adequate functional structures to support performance ▪ Weak staff performance appraisal ▪ Leadership and management capacities not institutionalized in all service delivery posts ▪ Lack of functional PMS for recruited staff ▪ Weak regulatory framework
Training capacity building and development of HW	**<u>Pre-service training</u>** ▪ Lack of mechanism to link training institutions with service need in the sector ▪ Skills inventory lacking ▪ Training policy for health sector not developed ▪ Inadequate facilities
	<u>In-service Training</u> ▪ Lack of policy guideline on competencies and skills required for specific cadres ▪ Skills inventory of HW not available ▪ Inadequate CPD guidelines ▪ Inadequate facilities for training ▪ Lack of internship policy ▪ Lack of training funds ▪ Skewed allocation of training funds among different cadres

Relating to input investments, the existing staff numbers at different levels of care and ownership are shown in the table below.

Numbers, by level of care

	Staff cadres	**Numbers by level of care**				**Numbers by owner**		**Total**	**Total/ 10,000 population**
		Community	*Primary Care*	*County Hospital*	*National Hospitals*	*Public*	*Faith Based*		

	Staff cadres	Numbers by level of care				Numbers by owner		Total	Total/ 10,000 population
		Community	*Primary Care*	*County Hospital*	*National Hospitals*	*Public*	*Faith Based*		
1	Specialists (Medical / Public Health)	-	1	149	327	477	251	**728**	0.18
2	Medical Officers	-	55	342	206	603	402	**1,005**	0.25
3	Dentists	-	7	79	68	154	61	**215**	0.05
4	Dental Technologists	-	1	50	49	100	34	**134**	0.03
5	Community Oral Health Officers	-	13	86	16	115	19	**134**	0.03
6	Clinical Officer (Spec)	-	65	583	273	921	165	**1,086**	0.27
7	Clinical Officers (Gen.)	-	332	770	144	1,246	389	**1,635**	0.41
8	BSN Nursing officers	1	58	323	1,689	2,071	1,273	**3,344**	0.84
9	Registered Nurses	5	1,192	2,122	1,779	5,098	2,162	**7,260**	1.82
10	Enrolled Nurses	18	4,840	3,797	1,251	9,906	2,397	**12,303**	3.08
11	Public Health Officers	149	930	384	83	1,546	172	**1,718**	0.43
12	Public Health Technicians	289	1,255	180	34	1,758	59	**1,817**	0.45
13	Pharmacists	-	27	170	80	277	52	**329**	0.08
14	Pharm. Technologist	-	49	154	108	311	194	**505**	0.13
15	Lab. Technologist	-	292	567	380	1,239	407	**1,646**	0.41
16	Lab. Technician	-	354	273	106	733	412	**1,145**	0.29
17	Orthopaedic technologists	-	8	72	48	128	40	**168**	0.04
18	Nutritionists	-	106	217	130	453	110	**563**	0.14
19	Radiographers	1	29	194	153	377	97	**474**	0.12
20	Physiotherapists	-	55	268	189	512	111	**623**	0.16
21	Occupational Therapists	-	20	149	110	279	52	**331**	0.08
22	Plaster Technicians	-	10	112	70	192	28	**220**	0.06
23	Health Record & Information Officers	-	110	164	135	409	91	**500**	0.13
24	Health Record & Information Technicians	-	63	175	105	343	104	**447**	0.11
25	Trained Community Health Workers	12,949	3,096	570	34	16,649	1,389	**18,038**	4.51
26	Social health workers	300	16	56	77	449	55	**504**	0.13
27	community health extension workers	483	512	107	10	1,112	53	**1,165**	0.29
28	Medical engineering technologist	12	10	113	67	202	37	**239**	0.06
29	Medical engineering technicians	-	49	135	51	235	21	**256**	0.06
30	Mortuary attendants		-		-	258		**258**	0.06
31	Patient attendants		-		-	1,902		**1,902**	0.48
32	Drivers		-		-	2,158		**2,158**	0.54
33	Clerks		-		-	671		**671**	0.17
34	Cleaners		-		-	511		**511**	0.13
35	Security		-		-	365		**365**	0.09
36	Accountants		-		-	271		**271**	0.07
37	Administrators		-		-	513		**513**	0.13
38	Cooks		-		-	535		**535**	0.13
39	Secretaries		-		-	1,796		**1,796**	0.45
40	Casuals		-		-	673		**673**	0.17
	TOTAL	**14,207**	**13,555**	**12,361**	**7,772**	**57,548**	**10,637**	**68,185**	17.05

Information on staff numbers in the private for profit facilities are not known, though the numbers are not expected to be higher than those in the Faith based facilities (plus, the double counting for health workers operating in both public, and private facilities). However, the public sector has more than 6 times the staff numbers in the Faith based providers. Community Health Workers and enrolled nurses (focused on community based health services) account for over half of the existing staff numbers.

Total health workers are just over 17 per 10,000 population. Medical staff represent over 5 per 10,000 population. Their distribution however, is not equitable with many areas of the county having significant Health Workforce gaps.

5.2.2 Required investments

The Human Resource distribution remains skewed overall, with some areas of the County facing significant gaps while others have optimum / surplus numbers.

With establishment of Counties, the National level prioritize establishment of a minimum number of health workers in each facility, based on the expected services as defined in the KEPH.

A staffing norm has been defined for each level, to outline the minimum health workers, by cadre, needed to assure provision of the KEPH. It should be emphasized that this only defines the minimum that the sector will work towards ensuring equitable distribution of human resources for health. The optimum staffing shall be defined for each facility, based on its actual workload. During the period of the KHSSP, the sector efforts shall be geared towards assuring this minimum number of staff. Once this is assured, additional funds would be used to provide additional human resources to attain optimum norms that facilities and Counties will have elaborated.

These minimum norms, by tier of the health system, plus their implications for overall human resource numbers, are shown overleaf.

Required numbers, by level of services

Staff Cadre	Required numbers per facility						Total requirements						
	Community	*Primary Care facilities*	*County hospitals*	*County management*	*National hospitals*	*National Management*	*Community*	*Primary Care facilities*	*County hospitals*	*County management*	*National hospitals*	*National Management*	***Total***
No of units	***8,000***	***4,000***	***489***	***47***	***12***	***6***							
Specialists (Medical / Public Health)	-	-	4	4	30	30	-	-	1,956	188	360	180	**2,684**
Medical Officers	-	-	4	2	60	10	-	-	1,956	94	720	60	**2,830**
Dentists	-	-	1		3	2	-	-	489	-	36	12	**537**
Dental Technologists	-	-	1		6		-	-	489	-	72	-	**561**
Community Oral Health Officers	-	-	1		-		-	-	489	-	-	-	**489**
Clinical Officer (Spec)	-	-	2	1	15	4	-	-	978	47	180	24	**1,229**
Clinical Officers (Gen.)	-	2	3		30		-	8,000	1,467	-	360	-	**9,827**
BSN Nursing officers	-	1	1	2	15	5	-	4,000	489	94	180	30	**4,793**
Registered Nurses	-	1	6		60		-	4,000	2,934	-	720	-	**7,654**
Enrolled Nurses	0	5	12		120		2,667	20,000	5,868	-	1,440	-	**29,975**
Public Health Officers	0	2	2		10		2,667	8,000	978	-	120	-	**11,765**
Public Health Technicians	0	2	2		10		2,667	8,000	978	-	120	-	**11,765**
Pharmacists	-	-	1		5	2	-	-	489	-	60	12	**561**
Pharm. Technologist	-	1	2		10		-	4,000	978	-	120	-	**5,098**
Lab. Technologist	-	1	1		5		-	4,000	489	-	60	-	**4,549**
Lab. Technician	-	-	4		3		-	-	1,956	-	36	-	**1,992**
Orthopaedic technologists	-	-	1		4		-	-	489	-	48	-	**537**
Nutritionists	-	-	1		8	2	-	-	489	-	96	12	**597**
Radiographers	-	-	2		4		-	-	978	-	48	-	**1,026**
Physiotherapists	-	-	2		4		-	-	978	-	48	-	**1,026**
Occupational Therapists	-	-	1		2		-	-	489	-	24	-	**513**
Plaster Technicians	-	-	1		3		-	-	489	-	36	-	**525**
Health Record & Information Officers	-	-	1	3	4	5	-	-	489	141	48	30	**708**
Health Record & Information Technicians	-	-	2	2	5		-	-	978	94	60	-	**1,132**
Trained Community Health Workers	20	20	20		20		160,000	80,000	9,780	-	240	-	**250,020**
Social health workers	-	-	2		4		-	-	978	-	48	-	**1,026**
Medical engineering technologist	-	-	1		4		-	-	489	-	48	-	**537**
Medical engineering technicians	-	-	1		2		-	-	489	-	24	-	**513**
Mortuary attendants	-	-	1		4		-	-	489	-	48	-	**537**
Patient attendants	-	2	4		10		-	8,000	1,956	-	120	-	**10,076**
Drivers	-	1	3	2	10	20	-	4,000	1,467	94	120	120	**5,801**
Clerks	-	-	4	3	5	30	-	-	1,956	141	60	180	**2,337**
Cleaners	-	-	2	2	10	10	-	-	978	94	120	60	**1,252**
Security	-	1	2		10	10	-	4,000	978	-	120	60	**5,158**
Accountants	-	-	1	1	5	5	-	-	489	47	60	30	**626**
Administrators	-	-	1	1	8	20	-	-	489	47	96	120	**752**
Cooks	-	-	3		5		-	-	1,467	-	60	-	**1,527**
Secretaries	-	-	3	2	5	20	-	-	1,467	94	60	120	**1,741**
Casuals	-	-	2	2	10		-	-	978	94	120	-	**1,192**
TOTALS	**8,021**	**4,040**	**596**	**74**	**540**	**181**	**168,000**	**160,000**	**52,323**	**1,269**	**6,336**	**1,050**	**385,467**

5.2.3 Investment priorities

The resultant HR gaps to attain the minimum norms are shown in the table below.

Numbers of HR Investment targets

Staff Cadre	Total requirements	Total existing numbers	HR Gap	% of gap
Specialists (Medical / Public Health)	2,684	728	1,956	0.27
Medical Officers	2,830	1005	1,825	0.36
Dentists	537	215	322	0.40
Dental Technologists	561	134	427	0.24
Community Oral Health Officers	489	134	355	0.27
Clinical Officer (Spec)	1,229	1086	143	0.88
Clinical Officers (Gen.)	9,827	1635	8,192	0.17
BSN Nursing officers	4,793	3344	1,449	0.70
Registered Nurses	7,654	7260	394	0.95
Enrolled Nurses	29,975	12303	17,672	0.41
Public Health Officers	11,765	1718	10,047	0.15
Public Health Technicians	11,765	1817	9,948	0.15
Pharmacists	561	329	232	0.59
Pharm. Technologist	5,098	505	4,593	0.10
Lab. Technologist	4,549	1646	2,903	0.36
Lab. Technician	1,992	1145	847	0.57
Orthopaedic technologists	537	168	369	0.31
Nutritionists	597	563	34	0.94
Radiographers	1,026	474	552	0.46
Physiotherapists	1,026	623	403	0.61
Occupational Therapists	513	331	182	0.65
Plaster Technicians	525	220	305	0.42
Health Record & Information Officers	708	500	208	0.71
Health Record & Information Technicians	1,132	447	685	0.39
Social health workers	1,026	504	522	0.49
Medical engineering technologist	537	239	298	0.45
Medical engineering technicians	513	256	257	0.50
Mortuary attendants	537	258	279	0.48
Patient attendants	10,076	1902	8,174	0.19
Drivers	5,801	2158	3,643	0.37
Clerks	2,337	671	1,666	0.29
Cleaners	1,252	511	741	0.41
Security	5,158	365	4,793	0.07
Accountants	626	271	355	0.43
Administrators	752	513	239	0.68
Cooks	1,527	535	992	0.35
Secretaries	1,741	1796	(55)	1.03
Casuals	1,192	673	519	0.56
TOTAL	**135,448**	**48,982**	**86,466**	**0.36**
Trained Community Health Workers	*250,020*	*18038*	*231,982*	*0.07*
TOTAL (with trained CHW's)	**385,467**	**67,020**	**318,447**	**0.17**

Existing staff represent only 36% of the total requirements, if the minimum staffing requirements are to be attained. Most acute gaps based on numbers required, and proportional gaps are for;

- General Clinical Officers
- Public Health Officers
- Public Health technicians
- Enrolled nurses
- Pharmaceutical technologists
- Patient Attendents

Human Resource Management priority investments to support addressing the HR gaps are highlighted in the table below.

Human Resource Management priority investments

HRH Area	Priority areas for investment	Measure of success	ANNUAL TARGETS					
			2012/13	*2013/14*	*2014/15*	*2015/16*	*2016/17*	*2017/18*
Appropriate and equitably distributed health workers	Undertake HR Mapping to establish available skills and gaps	HR mapping done		1				
	Develop comprehensive county HW plans based on approved norms and standards	Counties with HR plans part of their County Health Strategies	6	47				
	Government/DP to provide funds for recruitment of additional staff.	Targeted posts with funding secured	100%	100%	100%	100%	100%	100%
	Deploy staff to Counties on basis of approved norms and standards.	Existing staff deployed	100%					
Attraction and retention of HW	Finalize preparation and implementation of all Schemes of Service.	% staff with updated schemes of service for all staff	70%	100%				
	Fast track promotions for all cadres	% pending promotions completed	100%					
	Scale up Output Based Aid mechanisms as a HW motivation strategy	Counties applying OBA	1	10	25	30	30	30
	Develop change management strategies , including sensitizing staff on the implications of devolution.	Change management strategy in place	1					
Institutional and HW performance	Establish health management positions based on functional structures	% of Health Management positions established	80%	100%				
	Develop leadership and management capacity at all levels	County Management teams oriented on Health Leadership & management	6	20	35	47		
		County Management teams oriented on Health Systems and Services management	47					
	Review performance appraisal tools	Updated performance appraisal tools		1		1		1
	Strengthening of regulatory bodies	% HR regulatory bodies strengthened		40%		80%		100%
Training capacity building and development of HW	MOH to take lead in curriculum development for training institutions.	Updated curriculum for training institutions			1			
	Develop Pre-Service investment plan based on emerging health needs of the country.	Pre service investment plan		1				
	Involve DPs in implementing training programs based on the TNA	Training Needs Assessment for in service HW	1		1		1	
	Finalize and implement the NHTP	National Health Training Plan for in service HW		1				

5.3 Investment area 3: Health Infrastructure

5.3.1 Current status of investments

Infrastructure in this strategic plan covers all investments relating to

- Physical infrastructure
- Medical equipment
- Communication and ICT
- Transport

Kenya has a wide range of health facilities distributed all over the country and provided by the Government, Faith-based Organizations (FBOs), Non-Governmental Organizations(NGOs) and private institutions as shown in the table below.

Distribution of Health Facilities, by ownership and level of care

Key Health Infrastructure	*Community*	*Primary Care facilities*					*County hospitals*	*National hospitals*	*Total*
		Dispensaries	*Health Centres*	*Medical Clinics*	*Maternity homes*	*Nursing homes*			
Government		2954	682	35	1	0	268	16	3956
Faith Based		561	166	61	3	11	79		881
NGO's		200	24	73	4	5			306
Private		196	60	2,098	32	150	116		2652
Total		3911	932	2267	40	166	463	16	7795

No infrastructure is planned for at the community level. Current primary care facilities are of varied forms, a reflection of the different forms of facilities that have existed. Most public facilities are dispensaries and health centres, while most private facilities are medical clinics, maternity homes and nursing homes – a reflection of their focus on outpatient / maternity care.

Over half of these facilities have old and dilapidated infrastructure and its worse for hospitals some of which were constructed in the 1920s. Given these different forms of infrastructure, most of the existing facilities do not conform to current norms and standards with respect to expected staffing, infrastructure and equipment.

At the beginning of this strategic plan, infrastructure investment focus has been on establishment of 201 model health centres under the economic stimulus package while more than 80 hospital projects are at various stages of completion. There are, however, significant challenges particularly in relation to equity in distribution of infrastructure, as shown in the table below.

Current status of health infrastructure

Area	Current Status
Physical infrastructure	▪ Significant ongoing projects, focusing on establishment of 201 model health centres, and expansion of hospital infrastructure in 80 hospitals ▪ Many primary care facilities not offering comprehensive package of primary care services ▪ Facility investments not matched with other investments (HRH, commodities, etc), leading affecting functionality after completion of investments ▪ Limited investment in maintenance of physical infrastructure – ongoing supervision

Area	Current Status
	process monitoring maintenance of physical infrastructure in hospitals
Communication and ICT equipment	▪ ICT equipment supplied to all public / FBO facilities ▪ Communication equipment (telephones) available in all hospitals ▪ Radio equipment provided to all facilities in Arid / Semi Arid areas of the Country ▪ Limited investment in maintenance of communication equipment
Medical equipment	▪ Investments in medical equipment ongoing in selected hospitals ▪ Lack of comprehensive, coordinated investment, with gaps in some facilities still existent ▪ Limited investment in maintenance of medical equipment
Transport	▪ Purchase of ambulances ongoing, at hospitals, and model Health Centres ▪ Still significant gaps in utility vehicle availability (some ambulances also used as utility vehicles as a result) ▪ MoH undertaking some measures to enhance transport possibilities in the sector such as: outsourcing of certain activities to the private sector, e.g. courier companies to collect/deliver stocks/specimens, taxi companies for referral in very rural areas with appropriate reimbursement and ambulances for bigger hospitals ▪ Limited maintenance investment

Proposals for investment in infrastructure should be geared towards addressing and achieving equitable geographical access to health care. However, a number of facilities are yet to be built to improve access to health services. It is imperative that these health facilities are constructed to significantly improve access to each level healthcare.

Availability and functionality of diagnostic and medical equipment is critical in treatment. Most of medical equipment used in public health facilities is more than 20 years old (some double their lifespan) and therefore characterized by frequent breakdowns. Furthermore, most public facilities do not have modern equipment such as dialysis machines, radiology equipment, laundry machines and theatre equipment. It is noteworthy that, the available equipment falls far short of the required numbers, Of those available, about 50% of the equipment is too old to pass required standards and that maintenance of equipment has been inadequate.

Distribution of Health Infrastructure across tiers of care and by ownership

Type of Infrastructure	Existing infrastructure					
	Community	*Primary Care facilities*	*County hospitals*	*County Health management*	*National hospitals*	*National Management*
PHYSICAL INFRASTRUCTURE						
OPD block		932	466		12	
Casualty block			466		12	
MCH/FP		932	466		12	
Maternity		932	466		12	
Inpatient wards		932	466		12	
Pharmacy & Medicinesstore		440	250		12	
Laboratory		932	473		12	
Radiology		20	112		12	
Maintenance workshop			466		12	
Rehabilitation			466		12	
Mortuary			466		12	
Intensive Care Unit			-		3	
High Dependency Unit			-		12	
Main theatre			466		36	

Type of Infrastructure	Existing infrastructure					
	Community	*Primary Care facilities*	*County hospitals*	*County Health management*	*National hospitals*	*National Management*
Minor theatre		932	466		48	
Maternity theatre			466		24	
Orthopedic workshop			466		12	
Specialized units			1,864		240	
Stance pit latrine		932	466		12	
Water catchment		932	466		12	
Protected placenta pit		932	466		12	
Protected diesel incinerator		932	466		36	
Power supply		932	466		12	
Kitchen			466		12	
Laundry			466		12	
Administration			466	47	12	6
Staff housing		932	466		600	
COMMUNICATION						
2 way radio		932	466		60	5
Phone		932	466		60	5
Internet		932	466		60	5
TRANSPORT						
Utility vehicle			68	285	120	20
4 wheel ambulance		43	168		30	
Motor cycles		932				
Bicycles	50,000					
EQUIPMENT FOR UNITS						
OPD block	-	932	466	-	12	-
Casualty block	-	-	466	-	12	-
MCH/FP	-	932	466	-	12	-
Maternity	-	932	466	-	12	-
Inpatient wards	-	932	466	-	12	-
Pharmacy	-	440	250	-	12	-
Laboratory	-	932	473	-	12	-
Radiology	-	20	112	-	12	-
Maintenance workshop	-	-	466	-	12	-
Rehabilitation	-	-	466	-	12	-
Mortuary	-	-	466	-	12	-
Intensive Care Unit	-	-	-	-	3	-
High Dependency Unit	-	-	-	-	12	-
Main theatre	-	-	466	-	36	-
Minor theatre	-	932	466	-	48	-
Maternity theatre	-	-	466	-	24	-
Orthopedic workshop	-	-	466	-	12	-
Specialized units	-	-	1,864	-	240	-

5.3.2 Required investments in Health Infrastructure

The Health Infrastructure distribution remains skewed overall, with some areas of the County facing significant gaps while others have optimum / surplus numbers. With establishment of Counties, the National level prioritize establishment of a minimum number of health facilities, based on the expected services as defined in the KEPH.

An infrastructure norm has been defined for each level, to outline the minimum expectations for physical infrastructure, communication and ICT, transport, and equipment. It should be emphasized that this only defines the minimum that the sector will work towards ensuring equitable availability of health infrastructure, based on its actual workload. During the period of the KHSSP, the sector efforts shall be geared towards assuring this minimum health infrastructure. Once this is assured, additional funds would be used to provide additional health infrastructure to attain optimum norms that facilities and Counties will have elaborated.These minimum norms, by tier of the health system, plus their implications are shown overleaf.

Required numbers, by level of services

Type of Infrustructure	Required infrastructure per facility type						Total Country requirements					
	Community	*Primary Care facilities*	*County hospitals*	*County Health management*	*National hospitals*	*National Management*	*Community*	*Primary Care facilities*	*County hospitals*	*County Health management*	*National hospitals*	*National Management*
PHYSICAL INFRASTRUCTURE	*8,000*	*4,000*	*489*	*47*	*12*	*6*						
OPD block		1	1		1		-	4,000	489	-	12	-
Casualty block			1		1		-	-	489	-	12	-
MCH/FP		1	1		1		-	4,000	489	-	12	-
Maternity		1	1		1		-	4,000	489	-	12	-
Inpatient wards		1	1		1		-	4,000	489	-	12	-
Pharmacy &Medicine store		1	1		1		-	4,000	489	-	12	-
Laboratory		1	1		1		-	4,000	489	-	12	-
Radiology			1		1		-	-	489	-	12	-
Maintenance workshop			1		1		-	-	489	-	12	-
Rehabilitation			1		1		-	-	489	-	12	-
Mortuary			1		1		-	-	489	-	12	-
Intensive Care Unit					1		-	-	-	-	12	-
High Dependency Unit					1		-	-	-	-	12	-
Main theatre			1		3		-	-	489	-	36	-
Minor theatre		1	1		4		-	4,000	489	-	48	-
Maternity theatre			1		2		-	-	489	-	24	-
Orthopedic workshop			1		1		-	-	489	-	12	-
Specialized units			4		20		-	-	1,956	-	240	-
Stance pit latrine		1	1		1		-	4,000	489	-	12	-
Water catchment		1	1		1		-	4,000	489	-	12	-
Protected placenta pit		1	1		1		-	4,000	489	-	12	-
Protected diesel incinerator		1	1		3		-	4,000	489	-	36	-
Power supply		1	1		1		-	4,000	489	-	12	-
Kitchen			1		1		-	-4,000	489	-	12	-
Laundry			1		1		-	4,000-	489	-	12	-
Administration			1	1	1		-	-	489	47	12	-
Staff housing		2	5		200		-	8,000	2,445	-	2,400	-
COMMUNICATION												
2 way radio		1	1	1	5	5	-	4,000	489	47	60	30
Phone		1	1	1	5	5	-	4,000	489	47	60	30
Internet		1	1	1	5	5	-	4,000	489	47	60	30
TRANSPORT												
Utility vehicle		1	2	4	20	20	-	4,000	978	188	240	120
4 wheel ambulance			1		10		-	-	489	-	120	-
Motor cycles	1	1					8,000	4,000	-	-	-	-
Bicycles	20						160,000	-	-	-	-	-
EQUIPMENT FOR UNITS												
OPD block	-	1	1	-	1	-	-	4,000	489	-	12	-
Casualty block	-	-	1	-	1	-	-	-	489	-	12	-
MCH/FP	-	1	1	-	1	-	-	4,000	489	-	12	-
Maternity	-	1	1	-	1	-	-	4,000	489	-	12	-
Inpatient wards	-	1	1	-	1	-	-	4,000	489	-	12	-

Type of Infrustructure	Required infrastructure per facility type						Total Country requirements					
	Community	*Primary Care facilities*	*County hospitals*	*County Health management*	*National hospitals*	*National Management*	*Community*	*Primary Care facilities*	*County hospitals*	*County Health management*	*National hospitals*	*National Management*
Pharmacy	-	1	1	-	1	-	-	4,000	489	-	12	-
Laboratory	-	1	1	-	1	-	-	4,000	489	-	12	-
Radiology	-	-	1	-	1	-	-	-	489	-	12	-
Maintenance workshop	-	-	1	-	1	-	-	-	489	-	12	-
Rehabilitation	-	-	1	-	1	-	-	-	489	-	12	-
Mortuary	-	-	1	-	1	-	-	-	489	-	12	-
Intensive Care Unit	-	-	-	-	1	-	-	-	-	-	12	-
High Dependency Unit	-	-	-	-	1	-	-	-	-	-	12	-
Main theatre	-	-	1	-	3	-	-	-	489	-	36	-
Minor theatre	-	1	1	-	4	-	-	4,000	489	-	48	-
Maternity theatre	-	-	1	-	2	-	-	-	489	-	24	-
Orthopedic workshop	-	-	1	-	1	-	-	-	489	-	12	-
Specialized units	-	-	4	-	20	-	-	-	1,956	-	240	-

5.3.3 Investment priorities

The resultant health infrastructure gaps to attain the minimum norms are shown in the table below.

Numbers of Health Infrastructure Investment targets

Staff Cadre	Total requirements	Total existing numbers	Gap	% of gap
PHYSICAL INFRASTRUCTURE				
OPD block	4,501	1,410	3,091	0.31
Casualty block	501	478	23	0.95
MCH/FP	4,501	1,410	3,091	0.31
Maternity	4,501	1,410	3,091	0.31
Inpatient wards	4,501	1,410	3,091	0.31
Pharmacy &Medicine store	4,501	702	3,799	0.16
Laboratory	4,501	1,417	3,084	0.31
Radiology	501	144	357	0.29
Maintenance workshop	501	478	23	0.95
Rehabilitation	501	478	23	0.95
Mortuary	501	478	23	0.95
Intensive Care Unit	12	3	9	0.25
High Dependency Unit	12	12	-	1.00
Main theatre	525	502	23	0.96
Minor theatre	4,537	1,446	3,091	0.32
Maternity theatre	513	490	23	0.96
Orthopedic workshop	501	478	23	0.95
Specialized units	2,196	2,104	92	0.96
Stance pit latrine	4,501	1,410	3,091	0.31
Water catchment	4,501	1,410	3,091	0.31
Protected placenta pit	4,501	1,410	3,091	0.31
Protected diesel incinerator	4,525	1,434	3,091	0.32
Power supply	4,501	1,410	3,091	0.31
Kitchen	501	478	23	0.95
Laundry	501	478	23	0.95
Administration	548	531	17	0.97
Staff housing	12,845	1,998	10,847	0.16
COMMUNICATION				
2 way radio	4,626	1,463	3,163	0.32
Phone	4,626	1,463	3,163	0.32
Internet	4,626	1,463	3,163	0.32
TRANSPORT				
Utility vehicle	5,526	493	5,033	0.09
4 wheel ambulance	609	241	368	0.40
Motor cycles	12,000	932	11,068	0.08
Bicycles	160,000	50,000	110,000	0.31
EQUIPMENT FOR UNITS				
OPD block	4,501	1,410	3,091	0.31
Casualty block	501	478	23	0.95
MCH/FP	4,501	1,410	3,091	0.31
Maternity	4,501	1,410	3,091	0.31
Inpatient wards	4,501	1,410	3,091	0.31
Pharmacy	4,501	702	3,799	0.16
Laboratory	4,501	1,417	3,084	0.31
Radiology	501	144	357	0.29
Maintenance workshop	501	478	23	0.95
Rehabilitation	501	478	23	0.95
Mortuary	501	478	23	0.95
Intensive Care Unit	12	3	9	0.25
High Dependency Unit	12	12	-	1.00
Main theatre	525	502	23	0.96
Minor theatre	4,537	1,446	3,091	0.32
Maternity theatre	513	490	23	0.96
Orthopedic workshop	501	478	23	0.95
Specialized units	2,196	2,104	92	0.96

Overall, the upgrading of dispensaries to full primary care facilities is a critical priority for the sector. For specific infrastructure areas, the priority investments based on areas with largest gaps relate to;

- Pharmacy and drug stores in facilities
- Establishment of Intensive Care Units
- Staff housing
- Utility vehicles
- Motor cycles
- Equipment for pharmacies, radiology units, and ICU's

Regarding health infrastructure maintenance / processes, the following priority investments are required.

Health infrastructure priority investments

Infrastructure Area	Priority areas for investment	Measure of success	ANNUAL TARGETS					
			2012/13	*2013/14*	*2014/15*	*2015/16*	*2016/17*	*2017/18*
Utilization of norms and standards for health infrastructure	Finalize Health Infrastructure norms and standards	Health Infrastructure norms	1					
	Undertake audit of health infrastructure, to facilitate asset sharing	Completed mapping of health infrastructure	1					
	Update and maintain health infrastructure information at County, and National level	Updated Master Facility List and DHIS	1	1	1	1	1	1
Health Infrastructure and maintenance planning	Develop County specific infrastructure investment plans as part of County Health Strategies	County infrastructure investment plans	47					
	Develop facility master plan for long term infrastructure development and maintenance	% facilities with master plans	5%	20%	50%	80%	100%	100%
	Develop guidelines for donations of vehicles, medical equipment	Guidelines for donations of vehicles, medical equipment		1				
	Develop guidelines for disposal of assets	Guideline's for disposal of assets		1				
Management of health infrastructure	Develop guidelines on medical devices	Guidelines on medical devices	1					

5.4 Investment area 4: Health Products and Technologies

5.4.1 Current status of investments

Health Products and Technologies (HPT)[8] are a vital component of health care. As a critical area for health investment, the strategic outcome envisaged is *universal access to essential health products and technologies*; i.e. these should be **available**, **affordable**, **safe**, **efficacious** and of **good quality** and **appropriately used**;thus contributing to optimal healthcare. The sector will adopt a comprehensive approach to investment in all aspects of HPTs[9], so as to maintain a reliable supply of these inputs (availability), as well as the requisite management systems for ensuring that they are affordable, effective, of good quality and appropriately utilized.

Investment in HPT will aim to advance progress across the seven parameters of access. Based on available evidence from national data[10], the following summary highlights the status of each parameter; at the current level of investment.

Access Parameter		Goal	Highlights of Current Status
1)	**Availability**	Households should regularly access the medicines they need at a facility close enough to where they live	a) Basic medicines are highly available in public, private & FBHS facilities; but the broader range of essential medicines is less available (66% in public & FBHS). b) Less than half (47%) of patients treated in public facilities report receiving all the medicines prescribed, compared to 71% of patients in FBHS. c) Two thirds of households are dissatisfied with the level of medicines availability in the public facility nearest to them.
2)	**Affordability**	The products should be affordable at the point of care. Preferably no out-of-pocket payment should be required for essential HPTs	a) Patients accessing medicines from public facilities face low or no financial barriers. About 89% of basic medicines are issued for free in public facilities; 15% in FBHS facilities. b) However for priced medicines in both public and FBHS facilities, patient prices are generally 4 times higher than the central procurement prices. c) Patients often pay out-of-pocket for other health technologies (e.g. diagnostics, devices, etc) and the associated procedures; often these are more expensive than the medicines.
3)	**Efficacy, Effectiveness, Quality & Safety**	**When accessing medicines from any approved provider, households should have the assurance (from a competent National Regulatory Authority) that:**	
		a) **Efficacy:** the medicines availed to them are efficacious when used as intended	Medicines registered by the PPB are deemed to be efficacious. In collaboration with disease programs, there is some efficacy monitoring of anti-microbials, but this does not cover all products. There is widespread,

[8]This term encompasses a wide range of products that are used in healthcare delivery, or those whose utilization impacts on the health of the population.
[9]The scope of national investment in HPT is very broad and includes research & innovation, regulation, production & trade, procurement & supply, and utilisation of these products in the healthcare setting and the community
[10] Access to Essential Medicines Surveys (Health facility & household); post-market surveillancedata; Health Sector Customer Satisfaction Survey

Access Parameter		Goal	Highlights of Current Status
			prescribing, sale and use of antimicrobials within the population, posing risks of antimicrobial resistance.
		b) **Effectiveness:** medical devices and other health products are effective in performing their intended function; and new technologies are objectively assessed before introduction into the healthcare system	a) Systems for assessing effectiveness of medical devices & diagnostics are weak and fragmented. b) The Health Policy provides for a comprehensive regulatory system, which is being implemented by the PPB to address this gap. c) There is no mechanism to objectively assess new technologies against health system needs and priorities; with the attendant risk of irrational investment in new technologies
		c) **Quality:** The HPTs meet international standards of quality, as established and enforced by the Authority	Post-market surveillance studies for ARVs, antimalarial and anti-TB products indicate that the majority meet quality specifications. More investment is required in market surveillance, inspection and quality control to continuously enforce compliance.
		d) **Safety:** The benefit of using the medicines outweigh any potential harm to the patient; patients and health workers are adequately advised on health products' safety	A pharmacovigilance system is in place to monitor the safety of medicines and medical products. Appropriate regulatory actions are taken for products that do not comply with safety and quality standards. Autonomy of the PPB is critical for independence in enforcement.
4)	**Cost-effectiveness**	Within the context of the national healthcare system, costs of accessing the medicines should be reasonable (to the patient & the system)	Centralized bulk procurement by KEMSA & MEDS is price-efficient. They procure almost exclusively generics; at prices 44% and 61% below international reference prices (IRPs) respectively. However, poor patients spend more time travelling and queuing to access affordable medicines from public facilities

Sources[11]*: Access to Essential Medicines in Kenya: A Health Facility Survey (2010); Access to Essential Medicines in Kenya: A Health HouseholdSurvey (2010);Post-market surveillancedata (various, PPB); Health Sector Customer Satisfaction Survey (2012)*

The summary above highlights current gaps in access to EHPT. These gaps arise from multiple factors: insufficient budget allocationfor the essential package of EHPTs; weak institutional systems for ensuring access e.g. inefficient supply chain, weak regulatory structures and inadequate HR.

This makes the health facilities undertake their own purchases using user fees revenues, which is not sustainable. Patients are also forced to make private out of pocket purchases, resulting in poor patient outcomes and inappropriate medicine use, e.g. under-dosage which may result in drug resistance.

Currently, EHPTs are critically underfunded, and this is a major hindrance to access. According to the National Health Accounts, total pharmaceutical expenditure in Kenya is about 20% of total health expenditure (THE). Of this, about 80% is from private sources, while public pharmaceutical expenditure (PPE) has remained at about 15-20% of TPE.Government allocation towards Essential Medicines and

[11] *The current data primarily relates to essential medicines. A major focus during the KHSSP period will be to strengthen the M&E system to generate similar data on allessential HPTs.*

Medical Supplies (EMMS) has been increasing steadily over the years, from Ksh 260 million in the financial year 1993/94 to an estimated Ksh 7.3 billion in 2009/10. However, as a proportion of the overall government recurrent allocation to health, the budgetary allocation for pharmaceuticals has decreased from 15.2% in the financial year 2000/01 to 12.9% in 2009/2010.

The Ministries of Health currently receive about 50 per cent of the required funds for Health Products and Technologies, with the balance provided by development partners, which is not a sustainable arrangement. Based on WHO estimates, about US$ 1.5-2 per capita is required to provide essential medicines in a basic health care package. Furthermore, to provide a more comprehensive package which includes essential health technologies (as in KEPH), the allocation required would be higher. Currently the MOH allocation stands at US$ 1.1 per capita (or 2 billion annually) which is not sufficient. There is need to meet the Abuja Declaration target of 15% in health care financing.

HPT also entail significant investment by non-state actors (private, FBO, NGO), especially in the areas of manufacturing and distribution (import, export, wholesale & retail distribution). There is need to encourage this investment as a means of attaining self-sufficiency and contributing to growth in industrialization. This requires strong government stewardship for proper regulation and multi-sector collaboration; to optimize strategic actions and investments by all actors towards stated health goals and targets; while ensuring that public health considerations are addressed in all aspects of HPT.

It is estimated that 3% of Health Products are consumed at the community level, 60% at the primary care facilities, 30% at County hospitals, and 7% at National hospitals. The overall distributions of Health Products across these levels are shown in the table below.

Current Distribution of Health Products investments across tiers of care

Key Health Products	Existing levels of investments (mio of kshs)						
	Community	*Primary Care facilities*	*County hospitals*	*County Health management*	*National hospitals*	*National Management*	*Total*
	3%	60%	30%		7%		100%
Vaccines	22.3	445.5	222.8	-	52.0	-	742.5
Family Planning commodities	52.2	1,044.3	522.2	-	121.8	-	1,740.6
Essential Medicines & Medical Supplies	208.4	4,167.5	2,083.7	-	486.2	-	6,945.8
Anti Retrovirals	129.0	2,580.2	1,290.1	-	301.0	-	4,300.3
TB and Leprosy drugs	6.1	121.5	60.8	-	14.2	-	202.5
ACT medicines	67.1	1,342.5	671.2	-	156.6	-	2,237.5
X – ray commodities	3.5	69.7	34.8	-	8.1	-	116.1
Laboratory Commodities	72.6	1,451.9	725.9	-	169.4	-	2,419.8
Essential Transaction Documents[1]	0.9	17.0	8.5	-	2.0	-	28.4
Nutrition commodities	19.3	386.6	193.3	-	45.1	-	644.3
TOTAL	**581.3**	**11,626.6**	**5,813.3**	**-**	**1,356.4**	**-**	**19,377.6**

[1] *– Prescription pads, Treatment Sheet, MR reporting forms, ME forms, EDR forms etc*

Just over 19 billion kshs is currently spent on Health Products annually, with approximately 11.5 billion kshs spent at the primary care level, and 1.3 billion kshs at the National hospitals.

The sector estimates that 74% of all these Health Products are consumed through the Public Sector, 19% through the Faith Based / NGO sub sector, and 7% through the private sub sector (see below).

Current Investments in Health Products, by sub sector

Key Health Products		Ownership		
	Total	*Public*	*FBO*	*Private*
Vaccines	742.5	550.0	137.5	55.0
Family Planning commodities	1,740.6	1,289.3	322.3	128.9
Essential Medicines & Medical Supplies	6,945.8	5,145.0	1,286.3	514.5

Anti Retrovirals	4,300.3	3,185.4	796.4	318.5
TB and Leprosy drugs	202.5	150.0	37.5	15.0
ACT medicines	2,237.5	1,657.4	414.3	165.7
X – ray commodities	116.1	86.0	21.5	8.6
Laboratory Commodities	2,419.8	1,792.4	448.1	179.2
Essential Transaction Documents	28.4	21.0	5.3	2.1
Nutrition commodities	644.3	477.2	119.3	47.7
TOTAL	**19,377.6**	**14,353.8**	**3,588.4**	**1,435.4**

5.4.2 Required investments in Health Products

The current levels of investments in Health Products & Technologies represent a major under-investment in the Health Sector. Frequent stock outs, inappropriate prescribing, dispensing and use; the risk of substandard and counterfeit products; and the high out-of-pocket expenditures on medical products all contribute to a major quality gap in service provision.

The current sector estimates for requirements (procurement & supply) across the different categories of HPT are shown in the table below.

Required investments in Health Products

Key Health Products	**Required levels of investments (mio of kshs)**					*% of needs currently addressed*
	Community	*Primary Care facilities*	*County hospitals*	*National hospitals*	*Total*	
Vaccines	105.1	2,102.4	1,051.2	245.3	3,504.03	21.2%
Family Planning commodities	225.5	4,510.8	2,255.4	526.3	7,517.92	23.2%
Essential Medicines & Medical Supplies	1,007.9	20,157.2	10,078.6	2,351.7	33,595.3	20.7%
Anti Retrovirals	628.6	12,572.2	6,286.1	1,466.8	20,953.62	20.5%
TB and Leprosy drugs	132.8	2,655.8	1,327.9	309.8	4,426.36	4.6%
ACT medicines	170.0	3,399.6	1,699.8	396.6	5,666.07	39.5%
X – ray commodities	23.9	477.8	238.9	55.7	796.37	14.6%
Laboratory Commodities	299.8	5,995.1	2,997.6	699.4	9,991.9	24.2%
Essential Transaction Documents	3.5	70.2	35.1	8.2	117.07	24.2%
Nutrition commodities	79.8	1,596.1	798.1	186.2	2,660.2	24.2%
TOTAL	**2,676.9**	**53,537.3**	**26,768.7**	**6,246.0**	**89,228.8**	21.7%

The required budget to deliver the essential package of EHPTs is just under 90 billion kshs. The major cost driver is Essential Medicines & Medical Supplies (EMMS), plus the ARV's. The current investments in HPT represent about 22% of the required investments. The financing gaps are highest for TB / leprosy drugs, ARVs and vaccines. The gap in TB / leprosy drugs is primarily due to the high costs of MDR / XDR TB, the burden of which is increasing; the gap for ARVs is due to projected changes in treatment regimens to cater for anticipated changes in drug efficacy, resistance or safety; and the gap for vaccines is primarily driven by the costs of the new vaccines intended to be introduced in the Health Sector during the period of this Strategic plan.

Besides the cost of procurement and supply of these EHPTs, investments are required in strengthening **three critical functions** of the health system concerned with access to these products, i.e.:

a) **Regulation of HPTs**: ensuring that all HPTs meet the established standards of quality, safety and efficacy/performance. Investments will primarily focus on the ongoing restructuring of the medicines regulatory system - comprising the Pharmacy & Poisons Board (PPB) and the National Quality Control Laboratory (NQCL) - into a full-fledged Food and Drugs Authority (FDA).

b) **Assessment of HPTs**: assessment of clinical effectiveness in the context of the national healthcare system, including cultural and ethical considerations. HTA assessment provides evidence-based guidance (guidelines, protocols, lists, etc) on appropriate technologies for specific levels of care and clinical settings. Investments will focus on strengthening the development of the EML and Clinical Guidelines; and establishing an assessment system for medical devices (i.e. medical supplies, diagnostics, etc).

c) **Management of HPTs**: procurement & supply (at all levels of the system); prescribing and dispensing of the products in accordance with established guidelines and protocols; monitoring and educating consumers on appropriate use. Investments will primarily target the ongoing reform of KEMSA, and mechanisms to create linkages to the supply systems of non-state actors (FBO, NGO & private) through accreditation and effective monitoring.

Source: Health Technology Assessment of Medical Devices (WHO Technical Series, 2011)

The specific investment priorities and gaps relating to these health systems domains are captured in the respective strategic plans of KEMSA, PPB and NQCL.

5.4.3 Investment priorities

The sector will focus on assuring up to 80% of the Health Product supply needs are addressed, by the end of this Strategic Plan. Priorities that will call for 100% of needs being addressed include:

- Vaccines and supplies – low relative cost, and are very critical in attaining medium term objectives
- TB . leprosy drugs – low relative cost, and high direct implications of MDR/XDR spread
- ACT drugs – high priority of Malaria for elimination during the strategic plan
- X Ray commodities – low relative cost
- Nutrition commodities – low relative cost, and high impact on Sector goals

Targets for Health Commodities

Key Health Products	*% of needs currently addressed*	Annual increases in Health Products investments (?KSh)						*% of needs addressed*
		2012/13	*2013/14*	*2014/15*	*2015/16*	*2016/17*	*2017/18*	
Vaccines	21.2%	742.5	1,294.81	1,847.11	2,399.42	2,951.72	3,504.03	100%
Family Planning commodities	23.2%	1,740.6	2,745.68	3,750.79	4,755.90	5,761.02	6,766.13	90%
Essential Medicines & Medical Supplies	20.7%	6,945.8	10,259.94	13,574.13	16,888.33	20,202.52	23,516.71	70.0%
Anti Retrovirals	20.5%	4,300.3	6,583.31	8,866.28	11,149.26	13,432.24	15,715.22	75.0%
TB and Leprosy drugs	4.6%	202.5	1,047.27	1,892.04	2,736.82	3,581.59	4,426.36	100.0%
ACT medicines	39.5%	2,237.5	2,923.20	3,608.92	4,294.64	4,980.35	5,666.07	100.0%
X – ray commodities	14.6%	116.1	252.15	388.21	524.26	660.32	796.37	100.0%
Laboratory Commodities	24.2%	2,419.8	3,334.67	4,249.59	5,164.50	6,079.42	6,994.33	70.0%
Essential Transaction	24.2%	28.4	46.09	63.84	81.58	99.33	117.07	100.0%

Documents								
Nutrition commodities	24.2%	644.3	1,047.44	1,450.63	1,853.82	2,257.01	2,660.20	100.0%
TOTAL	21.7%	19,377.6	**29,534.57**	**39,691.55**	**49,848.53**	**60,005.51**	**70,162.48**	**78.6%**

The capacity for attainment of these targets should be enhanced by the anticipated reductions in costs of many of the products, particularly ACTs, vaccines, and ARVs.

In addition, the priority processes and interventions for strengthening investment in Health Products and Technologies are summarized in the table below.

Health Products and Technologies priority actions

Health Products area	Priority areas for investment	Measure of success	ANNUAL TARGETS					
			2012 /13	*2013 /14*	*2014 /15*	*2015 /16*	*2016 /17*	*2017 /18*
Defining and applying an evidence-based essential package of health products and technologies.								
	Restructure the National Medicines and Therapeutics Committee (NMTC) into a statutory committee	NMTC in place	1					
	Mandate the establishment of Medicines and Therapeutic Committees in Hospitals	% Hospitals with functional MTCs	15	30	55	70	90	100
	Develop comprehensive guidelines on the establishment of MTCs and management of formulary systems in health facilities & counties	Comprehensive Guidelines on MTCs and formulary system	0	1				
	Review and update of the Clinical Guidelines	Updated Guidelines in place			1			
	Review and update the essential medicines List	Updated EML			1			
	Develop a national formulary to guide decision-making on the medicines package within healthcare financing	National Formulary in place		1				
Establishing a national appraisal mechanism for health products and technologies.	Institutionalize Heath Technology Assessment (HTA) to guide evidence-based use of medical devices, diagnostics & health technologies	HTA established	1					
	Develop a national list of essential medical devices	List of Essential Medical Devices			1			
	Develop a national list of essential diagnostics	List of Essential Diagnostics			1			
Strengthen the operationalization of a harmonized national regulatory framework for health products and technologies	Restructure the PPB into a Food & Drug Authority (FDA)	Functional FDA		1				
	Develop a specific law on health products and technologies (harmonize and update Cap 244 and related laws)	Health Products law in place	1					
	Expand the mandate and capacity of the NQCL to include testing of all products that are under the harmonised regulatory scope.	NQCL with expanded mandate		1				
Rational investment in and efficient management of health products and technologies	Restructure the national and county management of Health Products and Technologies in line with policy provisions	Restructurednational management of HPTs	1					
	Facilitate implementation of the Kenya National Pharmaceutical Policy (KNPP 2012)	Progress of KNPP Implementation	20%	40%	60%	80%	100%	100 %
	Develop specific policy & strategic guidelines to guide comprehensive investment and actions on HPTs	Policy & specific guidelines on HPTs	0	2	5	7	9	10
	Promote appropriate prescribing and dispensing that contributes to optimal therapy, i.e. through the principles of Good Prescribing Practices (GPP) and Good Dispensing Practices (GDP)	Annual reports on GPP and DGP		1	1	1	1	1
	Institutionalise medium term procurement planning (MTPP) for HPT.	Mid Term Procurement Plan updated annually	1	1	1	1	1	1
	Establish County systems for coordinating and managing investments in HPT	Counties with functional Systems for Coordinating Health Products	0	30	47	47	47	47
	Enhance and integrate the M&E system for HPTs to comprehensively capture key elements of Access	Comprehensive M&E system for HPTs linked to County & National HIS			1			
Have in place effective	Establish a national mechanism for accreditation of	National supplier	1					

Health Products area	Priority areas for investment	Measure of success	ANNUAL TARGETS					
			2012 /13	*2013 /14*	*2014 /15*	*2015 /16*	*2016 /17*	*2017 /18*
and reliable procurement and supply systems.	suppliers of medical products and technologies (based on principles of GPP) to provide alternatives for counties in case of supply disruptions in KEMSA	accreditation mechanism in place						
	Operationalize the routine accreditation of HPT suppliers	% HPT suppliers accredited		50%	100%			
	Finalize the legal structure and strengthen the institutional framework to enable KEMSA fully play its role	Updated KEMSA legal framework			1			
	Strengthen inventory management system at facilities and county level to improve supply chain efficiency	Counties with IT based inventory management systems	0	6	15	30	47	47
	Institutionalize the demand driven pull system and establish a National HPT supplies chain audit mechanism.	Counties with all facilities using pull system	10	30	47	47	47	47
	Integrate the commodity monitoring system linked into the DHIS	Commodity monitoring system in DHIS		1				
	Develop an effective system for management of HPT during disasters and emergencies	HPT system in disasters & emergencies	1					
Promoting local production, research and innovations of essential health products and technologies	Facilitate the development and implementation of strategies to promote local production of HPTs	Plan for facilitation of local production of HPTs	1					
	Propose and mobilise resources for priority research for HPTs outlined in the National Research agenda	% of HPTs research funded	0	40	80	80	80	80
	Develop a comprehensive strategy to facilitate research and innovation of products for health conditions of priority national importance (e.g. NTDs)	Strategy on Public Health, Innovation & Intellectual Property (PHI)		1				
Ensuring availability of affordable, good quality health products and technologies.	Promote joint initiatives on full exploitation of TRIPS provisions and safeguards in securing access to HPTs.	Report on TRIPS utilization	1	1	1	1	1	1
	Promote use of generics through the necessary legal and administrative interventions	% of products prescribed by generic name						
	EstablishaHPT indicator price guide	Price guide for HPTs		1	1	1	1	1
	Mobilize, rationalizeand allocateresources for the provision of essential HPTacross all sectors.	Financing strategy for HPTs(within the health financing strategy)		1				

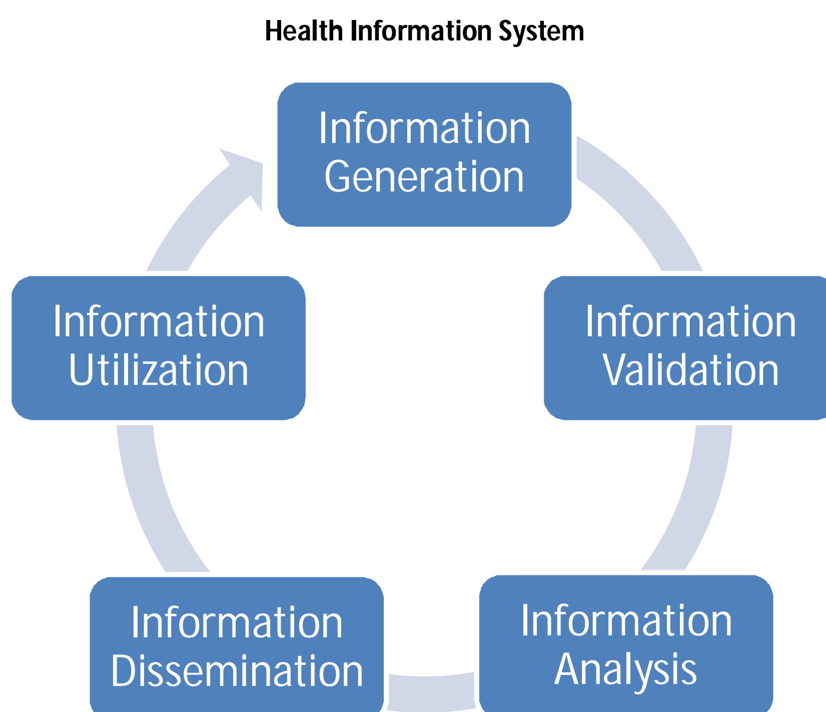
5.5 Investment area 5: Health Information

The Health Information System in Kenya covers five key areas:

1. Information generation – the different forms of information and how they are collected, and stored
2. Information validation – the process of reviewing the information to improve its accuracy and representativeness
3. Information analysis – the process of understanding what the information is saying
4. Information dissemination – the process of sharing the emerging information from the analysis with relevant stakeholders, and
5. Information utilization – the process of ensuring information available is informing the decision making process

These areas are all interlinked, and together form the continuum of the Health Information System in Kenya.

Health Information System



The information sources for the Health Sector are:

- **Facility generated information:** Information on Health target and management activities occurring in health facilities, and is collected through the routine HMIS
- **Vital events information:** Information on vital events occurring in the communities that is collected routinely. These are information on births, deaths and Causes of Death in the community

- **Disease surveillance information:** the information fast track system for critical health events / notifiable conditions occurring in the community
- **Regular surveys:** Service delivery, or investment information on health and related activities occurring in the communities that is collected on a regular basis. These include the Demographic and Health Surveys, AIDS and Malaria Indicator Surveys, Service Provision Assessments, Availability and Readiness assessments
- **Research:** Scientific biomedical, and systems researches coordinated through the Kenya Medical Research Institute, but carried out by many different academic institutions

5.5.1 Current status of Health Information Systems processes

The current status of the different elements in the Health Information System are shown in the table below.

Current Status of Health Information System processes

Health Information area	Current Status
Information generation and warehousing	▪ HMIS Technical Working Group formed, bringing together different sources of information for Health in one forum ▪ Weak legal framework to coordinate and manage Health Related Information generation across sectors, and different actors ▪ Data for the health sector is held in different databases such as HRH, Commodity and logistics supply systems,DHIS2, financial systems, MFL, surveillance systems, community health information systems, vital registration system, KNBS,EMRs e.t.c. The systems currently are not interoperable. This creates a situation where we have a lot of data redundancy and time wastage in data collection. **Routine HMIS** ▪ Electronic District Health Information System has been launched and rolled out nationally ▪ At facility level, Routine healthData are collected manually using registers and other paper based tools. Other data are collected through mobile technologies (m-Health) and Electronic health records(EHRs)/Electronic Medical Records(EMRs). The number of EMRs in the country is however still minimal and not well coordinated. ▪ Weak health information system from non-state facilities (NGO/FBOs and private sector) ▪ Is regular updating / changing of indicators by programs, leading to varying capacities for data collection ▪ Adequate data storage capacity has been established, to facilitate National and County data storage of HMIS information ▪ Many partners supporting generation of routine HMIS information – who are not well coordinated leading to duplication of efforts (e.g. purchases of hardware) ▪ Limited capacity of primary care facilities to utilize electronic based system **Vital events** ▪ Still paper based, with significant delays in registration of vital events ▪ Ongoing pilot to develop IT based Monitoring of Vital Events in the Country ▪ Still in the process of linking Vital Events information with HMIS **Disease Surveillance**

Health Information area	Current Status
	▪ Capacity built across the country for collection of information on notifiable conditions ▪ Application of 2005 International Health Regulations (IHR) is ongoing **Surveys** ▪ DHS, KAIS, MIS carried out regularly due to availability of funding for these ▪ Other surveys not regularly carried out, due to inappropriate planning for financing ▪ No / limited regular information on different investment areas – Service Availability and / or readiness information not collected **Research** ▪ Significant amount of research carried out in the country, by a number of research institutions ▪ Limited linkages of research generated information, with decision making processes
Information Validation	**Routine HMIS** ▪ No data validation / audit processes regularly carried out. One exercise of verification was conducted (2010) ▪ Eye ball validation checks are done and outliers are isolated. EMRs and DHIS2 have inbuilt validation checks. **Vital events** ▪ Data verification occurs late, due to delays in data entry and processing of the manual systems **Surveys** ▪ Extensive data verification and validation, through established mechanisms for the respective surveys ▪ Process delays data analysis and sharing of information **Disease surveillance** ▪ Information regularly followed up, by phone or email, to validate information. Field visits further validate emerging information **Research** ▪ Comprehensive data verification as part of the established research protocols ▪ National Scientific Committee carrying out ethical approvals for most biomedical and systems research carried out. Assessment includes comprehensive methodology assessments, to ensure emergent information is representative and addressing research objectives ▪ Limited capacity of the scientific committee to comprehensively assess research protocols
Information analysis	▪ No comprehensive information analysis systems in place ▪ Attempt at establishment of Health Observatory to facilitate comprehensive Health Information analysis ongoing, but not yet in place **Routine HMIS** ▪ No information analysis regularly carried out. Information is presented as reported **Vital events** ▪ No analysis is carried out on information on vital events **Disease surveillance** ▪ Information analysis is immediate on receipt **Surveys** ▪ Limited analysis of information is carried out on survey information – most information is presented as produced **Research**

Health Information area	Current Status
	▪ Little systematic review of existing research ▪ Analysis is done for specific research carried out
Information dissemination	▪ Annual Health Summits planned, to disseminate sector information **Routine HMIS** ▪ Some facilities are disseminating Health Information at source, through Health Stakeholder For a, or Community dialogue days ▪ Limited comprehensive dissemination outside of the Health System is carried out. Clients to aware of progress made **Vital events** ▪ No information dissemination currently ongoing **Disease surveillance** ▪ Weekly IDSR reports are produced on notifiable conditions, though are not always complete **Surveys** ▪ Dissemination through public events carried out on completion of surveys **Research** ▪ Annual research / policy meetings held, coordinated by KEMRI and some programs (e.g. Reproductive Health) ▪ Information regularly published in peer reviewed scientific journals
Information utilization	▪ No comprehensive systems in place for ensuring and monitoring evidence based policy making being practiced ▪ Absence of systems to generate data demand, and knowledge management **Routine HMIS** ▪ Information use primarily at source, to guide planning for activities **Vital events** ▪ Limited use of information on vital events to guide decision making **Disease surveillance** ▪ Information guides surveillance response actions directly **Surveys** ▪ Strategic focus guided by trends from surveys, particularly DHS. Current reproductive health focus guided by evidence of lack of progress in this area, for example **Research** ▪ Limited understanding of how it is informing decision making processes

5.5.2 Key focus investments to strengthen Health Information Systems

Given the above-mentioned status and issues in Health Information, a number of innovative approaches need to be put in place and implemented, to assure a comprehensive, effective Health Information System that is guiding decision making. The priority areas for investment, together with their measures of success and annual targets are shown in the table below.

Health Information Systems investments

Health Information	Priority areas for investment	Measure of success	ANNUAL TARGETS

Systems area			2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18
Information generation and warehousing	Ensure fully functional coordination framework for HIS	Regular HIS Working Group meetings	4	4	4	4	4	4
	Develop updated Health Information System legal framework aligned to the Health Policy and general health law	HIS Law			1			
	Establish virtual system interlinking different databases of Health Information Systems to ensure information all inter-connected	Interlinked HIS databases		1				
	Ensure national application of DHIS 2, generating complete timely and accurate information	Counties with accurate DHIS information produced in a timely and complete manner	0	20	40	47	47	47
	Supply registers to all facilities – public and non public – for information collation (paper based, or electronic)	% facilities provided with registers	30	70	90	100	100	100
	Establish coordinated system for Electronic Medical Records management in facilities	% Hospitals with coordinated EMR system	5	15	45	70	100	100
	Assure data storage capacity for national and County HIS (physical or virtual storage capacity)	Counties with adequate storage capacity	0	30	47	47	47	47
	Establish IT based system for collecting information on Vital Events	Counties using IT based system for Vital Events information collection	0	6	20	47	47	47
	Strengthening capacity for IDSR	Counties with adequate IDSR capacity	0	20	35	47	47	47
	Carry out comprehensive Demographic and Health Survey	DHS report				1		
	Carry out Service Availability and Readiness Assessment (SARA)	SARA report	1					1
	Carry out service provision assessment	KSPA report			1			
	Set up health research agenda for the medium term	Country Health Research agenda	1					1
Information validation	Carry out regular Data Quality Audits for DHIS information	Data Quality Audit	1		1		1	
	Carry out regular data verification assessments on DHIS data	Reports on data verification included in AWP reports	1	1	1	1	1	1
	Assure ethical approval process is adapted (including rapid approval where applicable) for all research carried out in Kenya, which includes clear methodologies	% research for which ethical approval got	40	70	100	100	100	100
Information analysis	Establish Country Health Observatory for assuring comprehensive analysis of Health Information linked with other key research institutions eg. Kemri, universities etc	Number of Health Observatory meetings	0	2	2	2	2	2
	Carry out systematic reviews on priority health topics that have been identified by policy makers	Number of systematic reviews	0	4	10	10	15	15
Information dissemination	Carry out annual Health Information Dissemination forums – as part of Annual Health Summits/ stakeholders fora	Annual HIS dissemination forum	0	1	1	1	1	1
	Publish annual Health Statistical Abstracts	Health Statistics abstract	1	1	1	1	1	1
	Annual publication on 'the state of Health in Kenya', based on analysis of Health Information by Health Observatory	The state of Health in Kenya report	1	1	1	1	1	1
	Develop quarterly publications on Health Outcome trends	Quarterly Health trends newsletters	1	4	4	4	4	4
Information utilization	Establish Policy Analysis team, to monitor use of evidence in policy making	Meetings of Policy Analysis team	0	2	4	4	4	4
	Establish process to monitor data utilization by decision makers	Report of data utilization by decision makers	1	1	1	1	1	1
	Put in place disaster response team to assure response to disasters and epidemics in a timely manner	% disasters responded to within 48 hours	80	100	100	100	100	100

5.6 Investment area 6: Health Financing

5.6.1 Current status of processes

Increasing demand for health care along with inadequate funding for existing needs support the need for continued increases in financing for health. According to the most recent National Health Accounts (2009/10), the country was spending approximately 5.4% of its GDP on health (equivalent to 42.2 US$ per capita), with Government Health Expenditure equivalent to only 4.6 of General Government Expenditures.The Government Health Expenditures have been between 4 - 7 percent of total Government expenditures, which is under half of the Abuja declaration target of 15% and the Economic Recovery Strategy (ERS) target of 12% of total Government allocations. 63.3% of total health expenditure is funded publicly, including external (donor) support and health insurance, the latter being responsible for 11% of total health expenditure. The remaining 36.7% is funded privately, with OOP at the point of service being predominant. Private health insurance is limited.

Investment in the health sector has steadily increased over the years. Total health expenditure increased from US$33.5 per capita in 2001/02 to US$42.2 in 2009/10. However, these increases are characterized by the following:

- Flat (slightly declining) share of government health expenditure of the total health expenditure
- Increasing share of donors out of total health expenditure,
- Declining share of households out---of---pocket expenditure as a proportion of total health expenditure,

Kenya's health sector identifies several modes of financing health services:

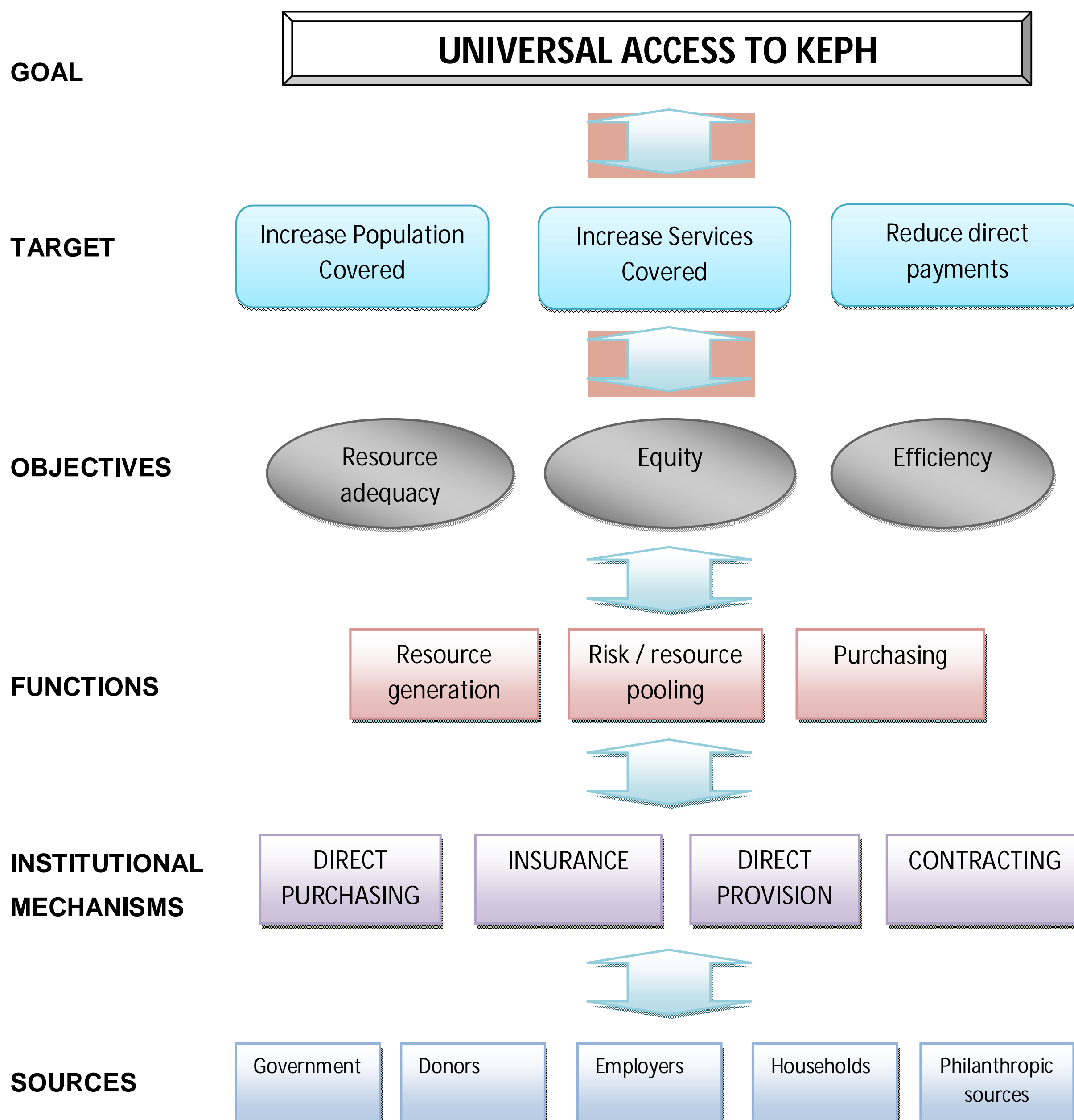
- Government funding through taxation.
- User fees, through Out of Pocket payments directly by clients
- External sources from bilateral, multilateral, or philanthropic sources
- Health insurance – either social or private insurance mechanisms.

Each of these modes of financing has certain characteristics that affect the attainment of the overall financing objectives of resource adequacy, efficiency and equity.

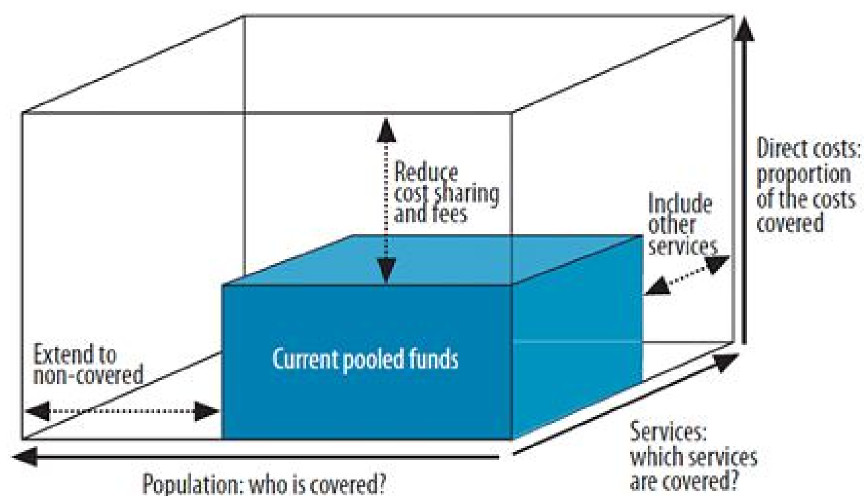
Kenya has made several attempts to introduce healthcare financing reforms to eliminate chronic under-funding of the sector, minimize out-of-pocket expenditures and ensure universal access to quality healthcare and therefore achieve the Vision 2030 goals on health. In 2005 attempts to implement Social Health insurance were unsuccessful largely as a result of pressures from interest groups. Following on the SWAP process and the stakeholder workshop held on December 6, 2006, the MOH established a task Force comprising of representatives of stakeholders to develop strategies on health financing.

The overall goal for Health Financing efforts is to assure Universal access of the population to the defined KEPH. This is to be attained through a focus on objectives, relating to resource adequacy, efficiency, and equity. To achieve these objectives, the sector needs to put in place adequate means to assure effectiveness in functions of resource generation, risk / resource pooling, and purchasing of services. These functions are carried out through four main institutional mechanisms for managing health resources: direct purchasing of services, insurance (social, or private), direct [provision of services, and contracting of care. These apply to the different sources of financing. This is captured in the conceptual framework below.

Conceptual framework: Towards a comprehensive Health Financing Strategy



The Health Financing overall goal is on assuring Universal access to the KEPH. This it aims to attain through a focus on three areas: increasing population covered, increasing services covered, and reducing direct payments for health care (see figure below)



Three dimensions to consider when moving towards universal coverage

The current status of different Health Financing Objectives in the country are shown in the table below

Current status of Health Financing Objectives

Health Financing Objective	Current Status
Assuring resource adequacy	▪ No sector wide mechanism to provide comprehensive financing information on Health Funding. A lot of resources, particularly donor resources and private expenditures are not known ▪ Absence of a strategic approach to guide Resource Mobilization efforts has been a major hindrance. The efforts to develop a Social Protection Strategy that focuses health financing on pre-payment mechanisms (taxation, insurance) is ongoing, though consensus building is still ongoing. ▪ There has been no costing information to guide resource mobilization efforts
Assuring equity in resource use	▪ Resource Allocation Criteria exist for allocating resources. However, these are limited in impact as they are o Limited to only financing for operations, with allocations of other resources are primarily based on historical patterns o Limited primarily to on budget resources, with off budget resources not subject to a similar rational RAC ▪ Regular monitoring of effects of Health Financing particularly on the vulnerable populations is not ongoing. Household expenditure survey was last carried out in 2007, with no follow up. Benefit incidence analysis is not regularly done for different financing
Assuring efficiency in resource use	▪ Health Sector Services Fund has been rolled out to all primary care facilities (Hospital Medical Services Fund for hospitals) to make available direct financing from the national level ▪ Available direct financing allocations not adequate to facilitate management functions, particularly at district level. How this is aligned to County functions is not yet clear ▪ There are no value for money assessments carried out for health programs ▪ Expenditure Tracking to follow management and use of funds not regularly carried out ▪ Annual Public Expenditure Reviews are carried out, though these are primarily focused on

Health Financing Objective	Current Status
	public (and on budget donor) resource's, as opposed to all sector resources ▪ Innovative financing techniques linked to performance, such as Output Based Financing are being piloted in some regions, with need for scale up ▪ No sector wide efficiency assessments are carried out to provide regular information on allocative and technical efficiency in resource utilization

4.3.1 Key focus investments to improve Health Financing

The emergent Health Financing Strategy will look into all aspects of this framework – that is:

- Scope of different sources of financing
- Proposed mix and form of institutional arrangements to manage resources from the different sources
- Expected functions to be carried out, and roles of the different institutional mechanisms
- Quantify the expected objectives to be attained, and
- Characterise the overall goal to be attained.

The different performance measures that need to be defined, to review / target the attainment of the objectives are:

- Level of funding
- Fairness in financing mechanism
- Level of financial risk protection
- Level of solidarity
- Population coverage
- Value for money
- Services coverage, and
- Sustainability

The key strategies required to improve on health financing across the objectives are shown in the table below.

Focus investments for strengthening Health Financing

Health Information Systems area	Priority areas for investment	Measure of success	ANNUAL TARGETS					
			2012 /13	*2013 /14*	*2014 /15*	*2015 /16*	*2016 /17*	*2017 /18*
Assuring resource adequacy	Institutionalize System for Health Accounts, to provide annual information on Health budgets and expenditures nationally, and by County	Annual System for Health Accounts	0	1	1	1	1	1
	Finalize Health Financing and Social Protection Strategy	Health Financing Strategy	1					
	Institutionalize costing approach as a method for guiding Health Financing information use	Institutionalized costing approach			1			
	Promotion of Community Based pre-financing mechanisms	% Community Units with pre-financing mechanisms	0	5	20	30	40	40

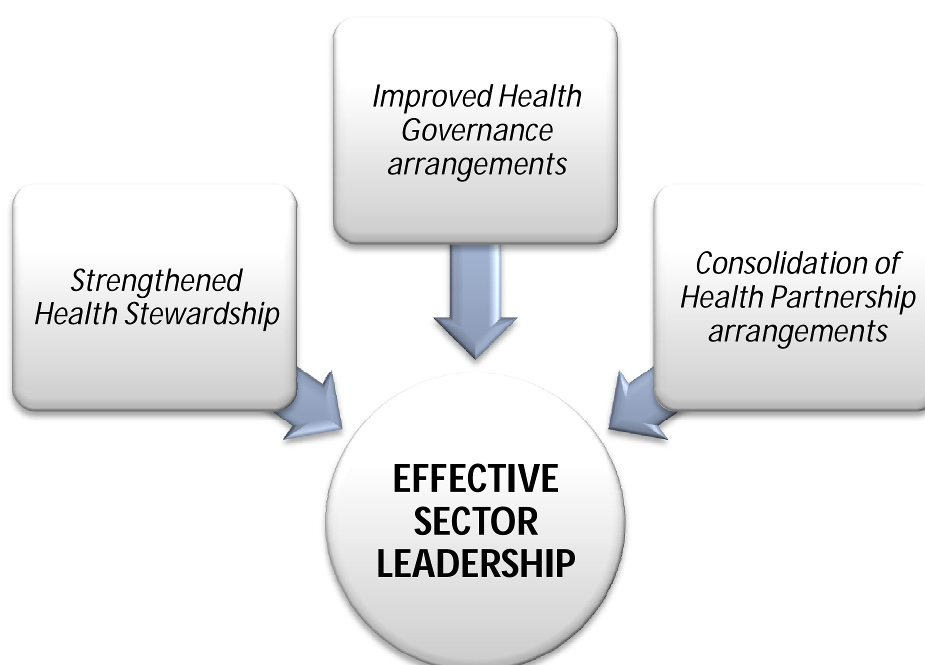
Health Information Systems area	Priority areas for investment	Measure of success	ANNUAL TARGETS					
			2012/13	*2013/14*	*2014/15*	*2015/16*	*2016/17*	*2017/18*
	Advocacy for increasing financing for Health in line with commitments	Meetings with MPs on Health Financing	0	2	4	4	4	4
Assuring equity in resource utilization	Update Resource Allocation Criteria (RAC), to include all resources available and for all sources	Updated RAC	1			1		1
	Carry out regular Benefit Incidence Analysis (BIA) for Health Expenditures in the Country	BIA report	1	1	1	1	1	1
	Regular monitoring of presence, and effects of financial barriers in seeking care affecting the poor and vulnerable populations	Report on assessments	1			1		1
Assuring efficiency in resource utilization	Carry out Household Expenditure Survey	Household expenditure Survey		1		1		1
	Restructure direct Financing mechanisms in line with County functions, and restructured to address management needs	Restructured direct financing mechanisms	1					
	Carry out value for money assessments for all new programs of support, and within expenditure reviews	Value for money assessment as part of Expenditure Reviews						
	Carry out National, and County level Expenditure Tracking Surveys	Expenditure Tracking Survey	1		1		1	
	Carry out expenditure reviews for all sector resources	Expenditure Review	1	1	1	1	1	1
	Scale up Output Based Financing mechanisms linked to the service package, particularly in hard to reach areas of the Country as a means for Health Worker motivation and retention	Counties applying OBA	1	10	25	30	30	30
	Sector wide efficiency assessments are carried out to provide regular information on allocative and technical efficiency in resource utilization	Efficiency assessments	1	1	1	1	1	1

5.7 Investment area 7: Health Leadership and Governance

Health Sector Leadership and Governance addresses three key objectives:

- Improved **Health Stewardship** by Government of the Health agenda.Stewardship relates to the management function of the Government, through the Ministry of Health and is built around implementation of the mandate of the Ministry responsible for health.
- Implementation of appropriate systems for **Health Governance**.Governance relatesto the functioning of the institutions by which the authority of the State of Kenya is exercised. These address the regulatory and legal functions that all actors in the sector have to adhere to, and are built around the sector legal and regulatory framework.
- Consolidating **Health Partnership** arrangements. Partnership relates to the inter-relations and coordination of different actors working towards the same goals, and is built around the adherence to the sector partnership Code of Conduct.

Effective Health Sector Leadership requirements



5.7.1 Current status of investments to improve Health Leadership

The current status of the Health Sector leadership objectives is shown in the table below.

Health Leadership Objective	Current Status
Strengthened Health Stewardship	▪ The Kenya Health Policy 2012 – 2030 has been developed, in line with the Health Sector obligations as outlined in the 2010 constitution and the Vision 2030 ▪ Separate Ministries focusing on Public Health / Sanitation, and Medical Services exist allowing for adequate focus and stewardship. Some areas of overlap have at times led to unnecessary conflict in the execution of the stewardship function. ▪ Some critical primary functions for a Health Ministry lie outside the current mandate of the two health Ministries, making a coordinated stewardship of the health agenda difficult. These include nutrition, and coordination of the HIV agenda

Health Leadership Objective	Current Status
	▪ Comprehensive Planning, and Monitoring framework is in place at all sector levels ▪ Capacity building program for Mid Level Managers in Health Systems and Services management is ongoing ▪ Leadership and Management strengthening programs are being supported for District and Provincial Health Managers ▪ Establishment of management structures in line with the new constitution has not yet occurred. County and Sub County health management teams need to be put in place
Improved Health Governance	▪ 2010 constitution implementation is ongoing, with various bills being developed by Ministries of Finance and Local Government to guide the process ▪ A draft Kenya Health Law developed ▪ Multiple Health Legislations in existence, relating to different Health functions ▪ Many National referral institutions are still not operating autonomously. They are under direct management of the National Ministry, in contravention of the mandate as outlined in the 2010 constitution ▪ Guidelines for Health Governance structures at all implementation levels have been developed, and structures established – Community Health Committee's, Health Facility Committee's, District and Hospital Boards
Consolidated Health Partnership arrangements	▪ Health Sector partnership is in place, the Code of Conduct ▪ A Joint Financing Agreement is in place to facilitate joint funding arrangements ▪ Guidelines for establishment, and functioning of Sector coordination structures at all levels have been put in place. These include Community dialogue days, District, and Provincial Health Stakeholders fora, Health Sector Coordinating Committee ▪ Adherence to the sector partnership obligations is monitored annually by all sector actors ▪ Many key stakeholders are still outside of the Code of Conduct, by design or default. Some key funders see no need / have no capacity to engage at this depth with other health actors, and prefer to play a peripheral role ▪ The engagement of the private sector in the sector coordination process is still weak. In spite of the presence of the Sector Code of Conduct, there are efforts to define a parallel PPPH instrument that is not in line with CoC ▪ Inter Agency Coordinating Committees are too many, and not aligned to the sector policy / strategic direction. Their inter-linkages, and linkages with the HSCC are weak and not adhered to ▪ There are no reward / punishment mechanisms to influence behavior of different actors towards desired actions ▪ There is still limited movement away from a project mode of operation in the sector. Many partners still fund through a project mode, even though common plans, budgets and monitoring processes have been put in place. Multiple Project Implementation Units still exist, some of which are embedded too deeply in the Ministry and are affecting duties of Ministry staff ▪ There is still overlap of coordination bodies and initiatives. Non State Actors were represented by coordination bodies that overlapped in membership and mandate. In addition, the role of the emerging Public Private Partnership for Health process within the overall sector coordination process was not clear. ▪ Level of engagement of different actors was also varied. Some actors, though formally signatory to the partnership Code of Conduct, were not actively engaged in sector processes.

5.7.2 Key focus investments to improve Health Leadership

For the Health Sector to carry out the functions as outlined in the 2010 constitution and translated into the Kenya Health Policy, the following priority Health Leadership actions are needed

Priority Health Leadership actions

Health Information Systems area	Priority areas for investment	Measure of success	ANNUAL TARGETS					
			2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18
Strengthened Health Stewardship	Facilitate restructuring of the Ministry of Health, in line with the functional organogram	Restructured Ministry for Health		1				
	Carry out Annual Work Planning to guide priority operations at all levels of the sector	Annual WorkPlan	1	1	1	1	1	1
	Coordinate Annual performance Monitoring of Health operations	AWP report	1	1	1	1	1	1
	Build capacity for recruited County and sub County managers in Strategic Leadership, health systems and services management, and Governance	Counties with managers oriented	6	47		47		47
Improved Health Governance	Finalize general Health Law	General Health Law	1					
	Develop specific laws addressing HRH, Health Information, Health Financing, Health Products	Specific health laws developed	0	1	2	1		
	Establish the legal framework to grant semi autonomy for all National Referral services to assure separation of Service Delivery and Sector Stewardship	% National Referrals that are Semi Autonomous	30	40	60	80	100	100
	Set up an office for a Health Ombudsman	Ombudsman in place		1				
	Carry out annual monitoring of client perspectives to	Client satisfaction survey report	1	1	1	1	1	1
Consolidated Health Partnership arrangements	Update Sector Code of Conduct, incorporating PPPH principles and obligations, plus adjusting it to County realities	Updated Code of Conduct	1					
	Assure regular Health Sector Coordinating Committee meetings	HSCC regular meetings	4	4	4	4	4	4
	Constitute County Health Stakeholders fora	Counties holding annual Health Stakeholders fora	0	30	47	47	47	47
	Reconstitute the ICC's in a rational manner, aligned and linking appropriately with HSCC	Reconstituted ICC's	1					
	Assure Joint Inter Agency Coordinating Committee meetings	JICC regular meetings	0	1	1	1	1	1
	Constitute Sub County Health Stakeholders for a	% of Sub Counties holding annual Health Stakeholders for a	0	30	60	95	95	95
	Ensure Community dialogue days are being held in all functional community units (CU's)	% of functional CU's holding quarterly dialogue days	0	30	60	95	95	95
	Annual monitoring of sector partnership adherence to Code of Conduct	AWP reports with partnership monitoring	1	1	1	1	1	1

CHAPTER SIX: RESOURCE IMPLICATIONS

6.1 Resource requirements for KHSSP implementation

To provide sustainable health care services for Kenyans, an adequate and sustained flow of resources is required. The Comprehensive National Health Policy Framework of 2011-2030, identifies several modes of financing health services that include public sector provision through taxation, as well as user fees, donor funds, and health insurance targeting both public and private sectors. These modes of financing have become increasingly important for funding health services in the country, but they should reflect both the cost of service provision and the population's ability to pay. By and large, health care financing in Kenya is dependent on the government's budget provision, which in turn depends on the performance of the economy.

Information on cost of providing health care services is becoming increasing important, especially in the context of the new constitution that provides health care as a right to all Kenyans. Thischapterpresents cost estimates of providing health care services under the KHSSP-III, by health programmes and investment areas, as well as by the well-known WHO health system building blocks. Thecostsarebasedon data derived from program-specific strategic targets, published documents on unit costs, and interviews with key experts in related health fields. The data was processed in the One Health Model to generate the overall costing estimates.

The technical process of generating the cost estimates using the One Health Model is introducedin this first section, with detailed methodology discussed in Annexxx,which also provides tables with detailed cost estimates. Further in this first section, cost estimates are tabulated, given different views on the health sector and its components. Inthesecond section,theavailableresources are tabulated and discussed.Finally, in the third section,the resourcegaps for the plan period are provided by comparing resources required (cost estimates) with the resources available, focusing on the seven health sector investment areas. Overall, thisinformationoncosts, resources available,andthe financinggapshould assiststakeholders todevelop realisticannualhealthbudgetswithoutwhichannualoperationalplanscannotbedesignedorimplemented in a more effective way.

6.1.1 Costing methodology

The Kenya Health Sector Strategic Plan (KHSSP) III was costed using the One Health model. The One Health Model is a tool for medium term for the medium term to long term (3-10 years) strategic planning in the health sector at national level. It estimates the **costs** of health service delivery and health systems as related to the **public sector**. It computes the cost implications of achieving the targets set under the disease programs and for the health system. It also estimates **health impact** (not shown in this chapter)achieved by using internationally-approved epidemiological and impact models. The OneHealth model is therefore a unified tool in two ways: enabling joint planning, costing, budgeting, impact, and financial space analysis, and in combining disease programmes and health systems. The model provides health sector planners with a single framework. The multilateral development of the OneHealth model has leveraged the best components of different prior costing tools and is also designed in a modular fashion to allow for program-specific costing, as well as sector-wide costing as was conducted here.

6.1.2 Cost estimates for the KHSSP-III by strategic objectives

The new Kenyan Health Policy informed by the new Constitution and the Country's development blue print, the Vision 2030, has the objective of ensuring **attainment of universal health coverage for all Kenyans.** Six policy objectives in the KHSSP-III were formulated to address the current situation, so as to enable the overall policy objective. The One Health model was adjusted to provide cost estimates by these objectives. Table xx1 below therefore provides costs estimates by strategic objectives and the health system areas for the public sector.

Table xx1: Total costs by strategic objectives and investment areas (KSh Millions)

	2012-13	2013-14	2014-15	2015-16	2016-17	Total
Strategic Objective (SO)						
SO 1: Eliminate Communicable Conditions	92,668	95,344	101,200	106,408	114,298	**509,918**
SO 2: Halt and Reverse Rising Burden of NCD	6,757	9,737	12,830	16,034	19,350	**64,707**
SO 3: Reduce the Burden of Violence and Injuries	3,177	2,248	3,578	4,669	6,087	**19,759**
SO 4: Provide Essential Health Services	51,410	57,813	65,922	74,444	83,382	**332,971**
SO 5: Minimize Exposure to Health Risk Factors	326	391	458	530	604	**2,309**
SO 6: Strengthen Collaboration with Health Related Sectors	7,231	7,844	8,550	9,236	9,881	**42,742**
Health System Investment Areas						
Human Resources	25,828	30,608	35,794	41,413	47,112	**180,756**
Logistics, Safety Stock, Wastage	2,998	26,162	8,840	9,523	10,103	**57,627**
Infrastructure and Equipment	47,421	55,906	54,964	43,546	43,741	**245,578**
Health Financing	1,890	335	335	335	335	**3,228**
Health Information Systems	2,231	2,382	1,971	1,971	1,971	**10,525**
Leadership & Governance	*TBD*	*TBD*	*TBD*	*TBD*	*TBD*	*TBD*
Total	**241,937**	**283,349**	**289,020**	**302,687**	**331,443**	**1,448,436**

TBD: To be decided. Source: One Health Model

6.1.3 Cost estimates for the KHSSP-III by levels of care

Kenya's health system is broadly categorized into six levels of care, namely, Level 1 comprising of the community and outreach level of care, Level 2 representing the dispensaries, Level 3 of health centers and clinics, Level 4 of the district hospitals, Level 5 of the provincial hospitals, and Level 6 of tertiary referral hospitals. However, the OneHealth model is designed to generate estimates for Levels 1 and 2 combined, Level 3, and Levels 4, 5 and 6 combined.

Table xx2 below shows the cost of providing health care by the different levels of the health care system, the national programme management costs, and the cross-cutting health system areas.

Table xx2: Total costs by levels of care & cross-cutting investment areas (KSh Millions)

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	TOTAL
Levels 1 & 2	42,886	46,129	49,813	54,000	58,551	**251,378**
Level 3	42,303	49,320	57,651	65,713	75,842	**290,830**
Levels 4, 5, and 6	86,734	93,124	100,064	96,532	102,786	**479,239**
National programme	37,067	35,289	34,552	33,202	34,744	**174,854**
Health System Investment Areas (cross-cutting)						
Logistics, Safety Stocks, Wastage	2,998	26,162	8,840	9,523	10,103	**57,627**
Human Resources	25,828	30,608	35,794	41,413	47,112	**180,756**
Health Financing	1,890	335	335	335	335	**3,228**

Health Information Systems	2,231	2,382	1,971	1,971	1,971	**10,525**
Total	**241,937**	**283,349**	**289,020**	**302,687**	**331,443**	**1,448,436**

Source: One Health model

6.1.4 Cost estimates for the KHSSP-III by health program areas

The One Health model, implemented with technical support from the USAID-funded Health Policy Project, generated the cost analysis of implementing KHSSP III by health programme areas Maternal, Neonatal and Reproductive Health; Child Health; Kenya Expanded Programme on Immunization (KEPI); HIV/AIDS; Tuberculosis and Leprosy; Control of Malaria; Water, Sanitation and Hygiene (WASH), Non Communicable Disease (NCD), and the Basic and Emergency Health. In addition, the six health system investment areas are health infrastructure, health financing, human resources for health, logistics and supply chain management, health information systems, and health leadership and governance.

Table xx3 below shows the cost of implementing the KHSSP-III by its disease programmes and the health system investment areas.

Table xx3: Total costs of the KHSSP-III by disease programmes and health system investment areas (KSh Millions)

Disease Program Areas (all costs of service delivery except human resources)	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Total**
Maternal/newborn & reproductive health	12,571	14,005	15,531	17,015	18,428	**77,550**
Child health	6,746	7,237	7,720	8,238	8,651	**38,592**
Immunization	5,723	5,045	5,913	5,016	6,281	**27,978**
Malaria	33,561	34,355	37,047	40,374	44,524	**189,861**
TB	17,170	17,233	17,106	17,043	17,035	**85,588**
HIV/AIDS	54,049	57,616	62,651	68,028	73,817	**316,160**
Nutrition	4,217	4,386	4,607	4,849	5,070	**23,129**
WASH	13,002	13,100	13,158	13,521	13,548	**66,329**
Non-communicable diseases	6,770	9,750	12,843	16,048	19,363	**64,773**
Basic services, emergency, trauma care	7,761	10,650	15,962	21,190	26,885	**82,447**
Sub-Total, Disease Program Areas	*161,569*	*173,376*	*192,538*	*211,321*	*233,603*	***972,407***
Health Systems Investment Areas						
Human Resources	25,828	30,608	35,794	41,413	47,112	**180,756**
Infrastructure and Equipment	47,421	50,485	49,543	38,125	38,320	**223,894**
Logistics, Safety stocks, Wastage	2,998	26,162	8,840	9,523	10,103	**57,627**
Health Financing	1,890	335	335	335	335	**3,228**
Health Information Systems	2,231	2,382	1,971	1,971	1,971	**10,525**
Leadership & Governance	*TBD*	*TBD*	*TBD*	*TBD*	*TBD*	**TBD**
Sub-Total, Health Systems Areas	*80,368*	*109,973*	*96,482*	*91,366*	*97,840*	**476,029**
Total	**241,937**	**283,349**	**289,020**	**302,687**	**331,443**	**1,448,436**

TBD: To be decided. Source: One Health model

6.2. Available resources

A combination of secondary data sources were used to establish the available financial resources for the Kenya National Health Sector Strategic Plan III, 2012/13 – 2016/2017.The shadow budget provided comprehensive available donor resources for the first two years and extrapolation was done for the remaining three years to cover the plan period. Government financial commitments were obtained from the Health Sector Report and Medium Term Expenditure Framework 2012, and calibrated with the BOPA (2012/13-2014/2015) to establish available funding for the first three years. Probable levels of funding for the remaining two years were estimated based on the growth over the last two years.

The 2009/10 National Health Accounts (NHA) report provided expenditure estimates for households and private firms which, were adjusted for inflation and population growth to provide estimates from these sources for the plan period.

6.2.1. Available resources by year and source

Tables xx4 and xx5 below shows the total available resources by year and source to support the implementation of the KHSSP-III over the short-term.

Table xx4: Estimated and projected financial resources from the Government of Kenya for the health sector (KSh Millions)

Government of Kenya		**Estimates**		**Projected**	
Programme	Sub-Programme	**2011-12**	**2012-13**	**2013-14**	**2014-15**
Preventive and Promotive Health	General administration and planning	10,712	16,791	19,310	22,206
	Preventive medicine and promotive health	13,216	29,941	34,432	39,597
	Disease prevention and control	243	4,925	5,664	6,513
	Primary Health Services	8,650	18,856	21,684	24,937
	Technical Services	144	426	490	563
Sub-Total, Preventive and Promotive Health		32,965	70,939	75,916	93,816
Curative Health	General Admin. and Planning	2,591	3,463	3,982	4,580
	Curative Health	14,744	43,138	49,609	57,050
	Health Training and Research	2,006	2,682	3,084	3,547
	Medical Supplies Coordinating Unit	467	6,281	7,223	8,305
	SAGAs	8,883	12,180	13,997	16,086
Sub-Total, Curative Health		28,690	67,744	77,895	89,568
Total Preventive, Promotive, and Curative Health		**61,655**	**138,683**	**153,811**	**183,384**
Research and Development	Research and Development	45	2,237	2,684	2,953
	Capacity building and training	23	140	168	185
	Products and services	33	89	106	117
	Management and Administration	1,231	2,279	2,924	3,210
Sub-Total, Research and Development		1,332	4,745	5,882	6,465
Total Health Sector		**62,987**	**143,428**	**159,693**	**189,849**

Source: Health Sector Report and Medium-Term Expenditure Framework, 2012

Table xx5: Projected financial resources from development partners* for the health sector (KSh Millions)

Investment areas	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Total**
Service Delivery, Health Products & Logistics	42,833	44,027	42,499	42,089	42,089	**213,537**
Human Resources for Health	2,094	1,798	1,790	1,790	1,790	**9,261**
Health Infrastructure	1,701	1,701	1,563	1,563	1,563	**8,090**
Health Information	2,070	1,790	1,790	1,790	1,790	**9,228**

Health Financing	138	138	0	0	0	**277**
Health Leadership & Governance	5,073	5,774	5,373	5,373	5,373	**26,964**
Development Partners Total	**53,909**	**55,228**	**53,014**	**52,603**	**52,603**	**267,356**

* Note: Excludes World Bank and DANIDA (on-budget support included in table xx4). These resources support both the public and FBO/NGO sector. Exact breakdown of support across these sectors was not available
Source: DPHK Secretariat

6.3. Financial gap analysis

6.3.1. Financing gap by year

Table xx6 below summarizes the available resources by year from the tables xx4 and xx5 above, and the required resources per year as prescribed by the KHSSP-III from section 6.1. Probable levels of Government of Kenya resources for 2015-16 and 2016-17 were estimated based on the growth over the previous two years. Since we did not estimate Research and Development funding requirements, they have been excluded from the financial gap analysis.

Table xx6: Financial gap analysis for the health sector (KSh Millions)

	2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Total**
Government of Kenya						
Total Preventive, Promotive and Curative Health	138,683	153,811	183,384	210,878	242,493	929,249
Development Partners						
Total for Six Investment Areas*	53,909	55,228	53,014	52,603	52,603	267,356
Total Resources Available	**192,592**	**209,039**	**236,398**	**263,481**	**295,096**	**1,196,605**
Total Resource Requirements for the Public Health Sector	**241,937**	**283,349**	**289,020**	**302,687**	**331,443**	**1,448,436**
Total Financial Gap	**49,346**	**74,310**	**52,622**	**39,206**	**36,347**	**251,831**

** These resources support both the public and FBO/NGO sector. Exact breakdown of support across these sectors was not available*

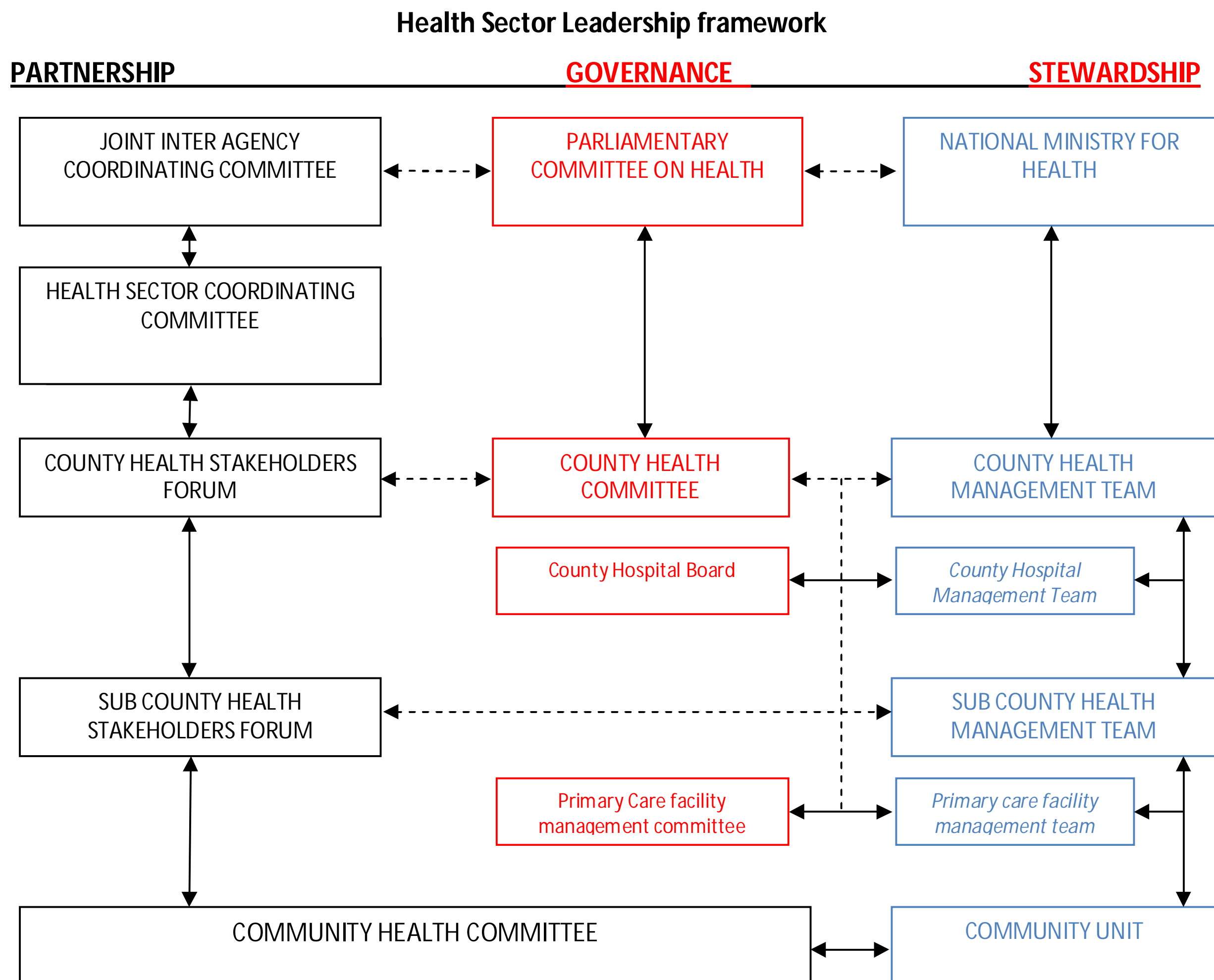
Thefinancing gap was estimated by generating the differencebetweentheavailable resourcesandthecostofimplementingthe KHSSP-III for the five years as estimated by the OneHealth Model.The resources available increase by 53% from their base of 192.6 KSh billion in 2012-13, to 295.1 KSh billion in 2016-17. In terms of resources available for the public sector specifically, the estimate will be lower, given that many development partners provide integrated support to both the public as well as the faith-based/NGO health sector. The breakdown of development partner support across sectors was not available. In addition, the overhead and headquarters personnel costs for most of the development partners could not be excluded in this analysis due to a lack of data. Therefore, the financial gap in table xx6 is likely an underestimate of the true financing gap for the public health sector per year and over the period.

The financing gap can be bridged through additional allocations from theTreasury and/or donor contributions. Alternatively, the gaps for each fiscal year can be reduced by scaling down the targets of thepopulationtobeserved for each programme area.

CHAPTER SEVEN: IMPLEMENTATION FRAMEWORK FOR THE KHSSP

The overall framework for sector leadership that will be applied is shown in the figure below.

Health Sector Leadership framework



The sector partnership, governance, and stewardship processes together work to provide overall leadership in addressing the health agenda in the Country. The partnership process defines how different actors in health will work together to contribute towards the health agenda. The Stewardship process on the other hand defines how the Ministry for Health shall provide overall guidance and support to taking forward the health agenda. The governance process, on the other hand, defines how the application of the rule of law shall be monitored in the sector.

7.1 Health Sector Devolution Implementation

7.1.1 Key milestones and targets

At the commencement of this plan, the health sector had put in place the basic tools and framework to support effective devolution of health services. Key actions included:

- Extensive discussions with stakeholders, on the devolution related Acts and their implications for Health
- Elaboration of the Kenya Health Policy, to define the long term focus and intent for health in the Country
- Drafting of the General Health Act, to provide a legal framework that facilitates implementation of health services, within the devolved system of Governance
- Development of a comprehensive mapping of health investments and services being provided across Counties, to facilitate hand over and planning by Counties
- Elaboration of a County Health System, which highlights the key actions, roles and responsibilities in implementing health services at the County level, for attainment of the health sector goals

During the implementation of this KHSSP, the Health Sector will focus on establishing the required capacity to manage devolved health services in all the Counties in Kenya. The critical milestones the sector will work towards attaining during the KHSSP period are shown in the table below.

Key devolution milestones during KHSSP implementation

Milestone	**Timeline**			
	Year 1 (2013/14)	*Year 2 (2014/15)*	*Year 3 (2015/16)*	*Year 4 (2016/17)*
PREPARATORY MILESTONES (PRIOR TO KHSSP)				
Completion of Kenya Health Policy				
Agree guidelines for County Health Strategic Planning				
Mapping of Health Services and Investments				
Definition of County Health System structure and functioning				
Update of required Health Legislation				
Agree with CIC and transition authority on plan for handover of services and assets to Counties				
KHSSP IMPLEMENTATION MILESTONES (DURING KHSSP)				
Development of County Health Strategies in all 47 Counties	✓			
Hand over of agreed Health Services to ready Counties	✓	✓	✓	✓
Discussion with Counties on Health Services and expectations	✓			

7.1.2 Functions of different levels of Government

The KHSSP has defined, in Chapter 5, the different strategies for implementation during the KHSSP. The National Government, and the Counties each have defined functions in supporting attainment of these strategies, as is highlighted in the table below.

Functions of National, and County Governments in implementing KHSSP Strategies

Service Area	Function areas	Role of National Government	Role of County Government
ORGANIZATION OF HEALTH SERVICES			
Referral	Physical client Movement (physical referral)	- Provide guidelines and SOP's for patient movement	- Manage and monitor patient movement referral system
	Patient Parameters movement (e-health)	- Develop overall architecture to facilitate e-health	-
	Specimen movement (reverse cold chain, and reference lab system)	- Provide guidelines and SOP's for specimen movement	- Manage process of specimen movement to reference laboratories
	Expertise movement (reverse referral)	- Provide experts to support Counties with expertise	- Coordinate, manage and monitor process of reverse referral
Outreach	Micro planning to Reach Every Person	- Develop micro planning guidelines	- Develop and implement micro plans for each facility / community
	Mobile clinics in hard to reach areas	-	- Establish and manage mobile clinics in hard to reach areas, when applicable
Community	Comprehensive community strategy	- Provide guidelines and SOP's for implementing the Comprehensive Community Strategy	- Scale up community services through establishment of Comprehensive Community Units
	Program targeted community services	- Facilitate program based services in Communities	-
Training and Supervision	Program training programs	- Develop Annual training plans	- Carry out trainings, as per schedules
	Systems and Services trainings	- Develop Annual training plans	- Carry out trainings, as per schedules
	Supervision and mentoring	- Provide guidelines and SOP's for supervision	- Carry out Supervision and Monitoring
Facility Master Planning	Patient Safety	- Develop guidance and SOP's for assuring patient safety	- Implement and monitor Patient Safety strategies
	Epidemic preparedness planning & response	- Raise funds for facilitating epidemic and disaster response - Provide back up support during epidemics based on County requests	- Develop epidemic preparedness plans - Respond to disasters and epidemics
	Quality of Service Delivery Improvement	- Develop guidance and SOP's for quality improvement strategies	- Implement and monitor quality of service delivery improvement strategies
HEALTH WORKFORCE			
Appropriate and equitably distributed health workers	Recruitment of HW	- Development of required competencies - Provision of overall staffing norms - Guidance on determination of facility based norms	- Prioritization of staff cadres for recruitment - Advertisement, and recruitment of HW
	Skills and expertise inventory	- Guidance on required skills for service provision	-
	Deployment of HW	- Monitoring HW distribution	- Planning, and execution of deployment
Attraction and retention of HW	HW motivation	- Monitoring HW attrition - Provide guidelines and SOP's for HW motivation - Develop career development SOP's	- Provision of incentives for hard to reach areas - Apply non financial incentives to improve HW motivation
	Monitoring Employee satisfaction	- Coordinate annual employee satisfaction surveys	- Participate in annual employee satisfaction surveys - Implement recommendations on employee satisfaction
Institutional and HW performance	Staff performance appraisal	- Develop processes and SOP's for staff performance appraisal	- Apply, and implement recommendations for staff appraisal
	Skills building in Leadership & Management	- Develop curricula and SOP's for leadership & Management trainings	- Train qualifying HW's in Leadership and Management
	Regulatory framework strengthening	- Develop National HW regulatory framework	- Develop County specific by laws for HW regulation

Service Area	Function areas	Role of National Government	Role of County Government
Training capacity building and development of HW	Pre Service training	- Develop training policy guidelines - Curriculum update to align to Service needs - Manage National training facilities	- Train HW's based on training strategy
	In Service training	- Develop guidelines for conducting skills inventories - Develop internship guidelines - Update CPD guidelines	- Conduct skills inventory for HW's - Manage interns - Implement and Monitor CPD
		-	-
HEALTH INFRASTRUCTURE			
Physical infrastructure	Construction of facilities	- Develop physical infrastructure norms and standards	- Construct facilities as per norms and standards
	Upgrading of existing facilities	-	-
	Infrastructure maintenance	- Provide SOP's for physical infrastructure maintenance	-
Communication and ICT	Roll out of ICT backbone	-	-
	Communication equipment	-	-
	Communication equipment maintenance	- Provide SOP's for communication equipment maintenance	-
Medical Equipment	Purchase of medical equipment	- Development of medical equipment norms and standards	- Procurement planning for medical equipment
	Maintenance of medical equipment	- Provide SOP's for medical infrastructure maintenance	-
		-	-
Transport	Purchase of ambulances	- Development of guidelines and SOP's for managing ambulance services	- Forecasting ambulance needs - Purchasing of ambulances - Monitoring use and impact of ambulance services
	Purchase of utility transport	-	- Purchasing of utility vehicles
	Transport Maintenance	- Provide SOP's for transport services maintenance	- Maintaining all transport services as per SOP's
HEALTH PRODUCTS & TECHNOLOGIES			
Health Products Availability	Procurement of Health Products	- Provision of guidelines and SOP's for procurement of Health Products - Facilitate international procurement of Health Products, based on requests from Counties	- Demand forecasting for Health Products - Procurement of Health Products
	Warehousing and distribution of Health products	- Provision of National warehousing facilities	- Distribution of Health Products and Technologies - Provision of appropriate storage facilities for health products at facilities
Health Products Affordability	Ensuring appropriate Pricing of Health Products	- Regular pricing surveys for Health Products and Technologies	- Determining and applying appropriate pricing of Health Products
Health Products effectiveness	Health Products efficacy	- Regular monitoring of quality and efficacy of Health Products (post market surveillance, etc) - Conduct Pharmacovigilance to monitor safety of Health Products - Guidance, and SOP's for good pharmaceutical practices	- Implement strategies to ensure effective Health Products are provided to Clients
	Appropriate Health Products	- Design of regulatory framework for Health Products - Guidance and SOP's on introduction / use	-

Service Area	Function areas	Role of National Government	Role of County Government
		of new Health Products and Technologies	
HEALTH INFORMATION			
Information generation	Routine Health Information	- Guidance and SOP's for collection of routine Health Information - Update legal framework for routine Health Information - Build data storage capacity	- Collection of agreed health information & statistics
	Disease Surveillance and Response	- Guidance and SOP's for collection of information on notofiable conditions	- Collection of agreed information on notifiable conditions
	Health research	- Develop Health Research agenda - Conduct National research	- Carry out County specific research
	Health Surveys	- Carry out required National Surveys (DHS, KAIDS, MIS)	- Carry out County specific surveys
	Monitoring of Vital Events (births, deaths, Cause of deaths)	- Guidance and SOP's for collection of information on vital events	- Collection of information on vital events
Information validation	Data Quality Auditing	- Conduct national data quality audits	- Conduct targeted data quality audits
	Data Quality Surveys	- Guidance and SOP's for conducting data quality surveys	- Conduct regular data quality surveys
Information Analysis	IT based solutions for analysis at point of collection	- Guidance and SOP's for IT based Health systems and records	- Application of available IT solutions based on County needs and expectations
Information dissemination	Annual Performance Monitoring	- Compile annual performance report based on information from ALL Counties	- Compile annual performance report for County
	IDSR reporting	- Regular dissemination of IDSR information	- Weekly sharing of IDSR information with National Level
Information Utilization	Research to policy engagement	- Conducting annual research / policy meetings	-
	Health Observatory	- Establish and facilitate National Health Observatory	- Set up County Health Observatory
HEALTH FINANCING			
Resource mobilization	Government resource mobilization	- Develop National MTEF based on information from Counties	- County MTEF elaboration
	Donor resource mobilization	- Develop proposals for donor resources	- Develop County specific donor proposals
	Household resource mobilization	- Carry out Household expenditure and utilization surveys	-
Institutional arrangements	Direct Purchasing	- Guidance and SOP's for direct purchasing	- Purchasing of services
	Insurance	- Develop legislation, guidance, SOP's, on Social Health Insurance	- Management of Social Health Insurance mechanisms
	Direct Provision	- Guidance and SOP's for direct service provision by the State	- Management and coordination of provision of public services
	Contracting	- Guidance and SOP's for contracting of health and related services	- Contracting of service providers in public facilities - Contracting of non public service providers
Efficiency of resource use	Allocative Efficiency	- Carry out National Expenditure Reviews - Monitor efficiency trends in resource allocation across Counties	-
	Technical efficiency	- Conduct regular expenditure tracking surveys - Carry out technical efficiency analyses across Counties	- Carry out County Expenditure Tracking Surveys
Equity in resource use		- Develop overall equitable Resource	- Application of RAC in resource allocation

Service Area	Function areas	Role of National Government	Role of County Government
		Allocation Criteria - Conduct benefit incidence analyses	
HEALTH LEADERSHIP			
Health Governance	Constitution implementation	- Monitoring and supporting County alignment to constitution	-
	Legislative and regulatory framework	- Guide elaboration of National Health Laws	- Elaborate County specific by laws as required
	Service delivery relations between National and County Governments	- Grant autonomy to National Service Delivery institutions (referral facilities)	- Define working relations with National referral facilities
	Cross County relations	- Guidance and SOP's to guide Counties willing to work together for specific service delivery functions	- Identify areas for cross County service functions
Health Partnership	Sector Wide Approach implementation	- Develop overall sector Code of Conduct for guiding health partnerships - Guidance and SOP's for coordination and partnership arrangements - Carry out Annual Joint Reviews for Country	- Engage partners at different levels - Apply reward / sanction mechanisms for adherence to good partnership principles - Carry out County Annual Joint Reviews with supporting partners
	Public Private Partnerships	- Guidance on alignment of PPP's within SWAp process	- Implement PPP's
Health Stewardship	Comprehensive policy framework	- Define overall policy direction - Elaborate National Health Strategic Directions for programs, and system investments	- Develop County specific Health Strategic direction
	Engagement with health related sectors	- Guidance and SOP's for engagement with health related sectors	- Establish and apply systems of engagement with health related actors
	Comprehensive planning and monitoring	- Guidance and SOP's for Annual planning and reporting - Develop overall sector Annual Work Plans and Reports	- Develop County Annual Work Plans and Reports

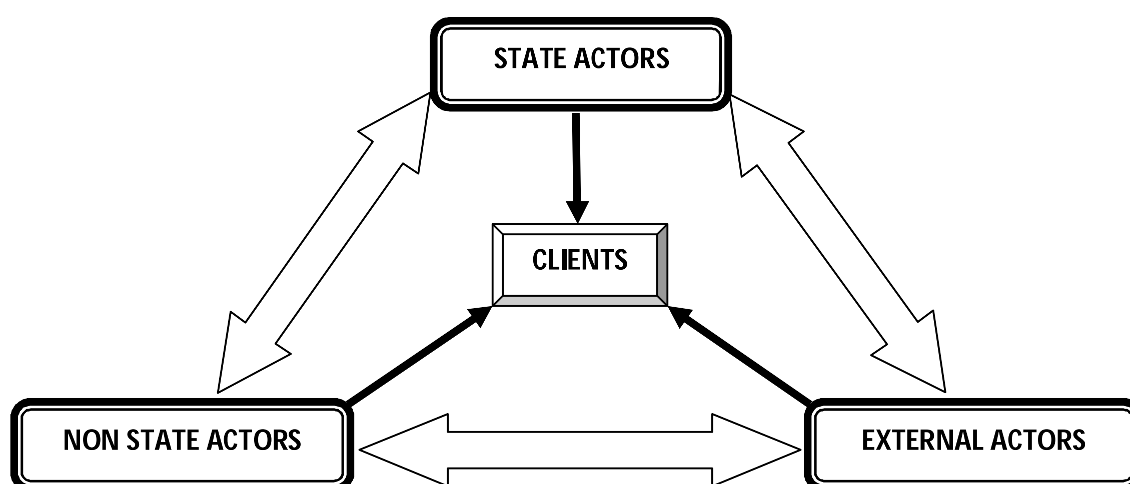
7.2 Roles and responsibilities of health stakeholders at National, and County levels

The full Implementation of this strategic plan will require multi-sectoral effort and approach with various health stakeholders playing different roles which are complimentary and synergistic at all levels of health care service in the devolved government systems. These responsibilities and roles are geared towards the realization of the right to health.

The various stakeholders in the health sector include:

- **Clients:** The individuals, Households, and Communities whose health is the focus of this strategic plan
- **State actors:** The public sector (MoH -National and County, SAGAs, other ministries and the Ministry responsible for devolution), regulatory bodies Regulatory bodies (Boards and Councils) and professional bodies/associations whose mandate is drawn from that of the State, and have an effect on health
- **Non State actors:** The Private sector NGOs, CSOs, FBOs, Traditional Practitioners, media, and all other persons whose actions have an impact on health, but don't draw their mandate from the state
- **External actors:** The bilateral, multilateral, or philanthropic actors that draw their mandate from out of Kenya, but support national programmes

Health Sector Actors



7.2.1 Clients (individuals, Households, Communities)

These represent the core reason for the existence, and activities of the sector. For attainment of the health goals, the Individuals are expected to exercise the appropriate healthy and health care seeking behavior required to maintain their health; seek health care intervention at the earliest possible moment; and take up health care services made available, to maintain their health, particularly disease prevention and control services.

On the other hand, Households are expected to take responsibility for their own health and well being, and participate actively in the management of their local health services

Finally, the communities are expected to exhibit real ownership and commitment to maximizing their health. Communities should define their priorities, with the rest of the health system seen as

supportive. They focus on ensuring individuals, households and communities carry out appropriate healthy behaviors, and recognize signs and symptoms of conditions that need to be managed at other levels of the system; facilitate community based referrals; and mobilize community resources to address their identified priorities.

7.2.2 State actors

State actors are varied, but connected in that they all draw their mandates from the State. They include:

- The National Ministry responsible for Health
- The County department responsible for health
- Semi Autonomous Government Agencies
- Legal and Regulatory bodies primarily relating to health

7.2.2.1 National Ministry responsible for Health

The roles and responsibilities for the national ministry responsible for health are quite a number. The Ministry is ultimately responsible for shaping the nature of health system and delivery of sector wide programme.This responsibility will not be carried out by the ministry but will involve many other players both within and outside the ministry.

The principal mandate of the National ministry as stipulated in the National Health Policy and the constitution shall be:

1) Establishing a National Health Policy and Legislation, Standard Setting, National reporting, supervision, sector coordination and resource mobilization
2) Offering technical support with emphasis on planning, development and monitoring of Health services and delivery standards throughout the country;
3) Monitor quality and standards of performance of the County Governments and community organizations in the provision of Health services;
4) Provide guidelines on tariffs chargeable for the provisions of Health services;
5) Provide National health referral services
6) Conduct studies required for administrative or management purposes;

During this strategic plan, the national government shall directly support establishment of required capacities at the county level

- **Establishing a National Health Policy and Legislation**: This will include: issuing annual strategic direction and planning guidelines for itself, county government and other stakeholders (with budget ceilings based on MTEF) and ensuring that budgeting and resource allocation reflect national priorities. It also involves monitoring of the performance of health care providers in both public (County Health Management Teams, community health services, primary health services, county health services and National referrals) and private sectors. Besides these the National Ministry in collaboration with the county department responsible for health will regulate the providers in the private sector (Private for Profit and private not for profit such as FBOs, NGOs and traditional medicine providers)
- **Ensuring quality of health service**: The National Ministry will set quality standards for all stakeholders and monitor their implementations. The national ministry will also structure and

define mechanisms for regular coordination and collaboration with all health stakeholders through annual work plans and reports

- **Enforce regulation of the health sector**: this will include regular review of the legal framework as need arises and its implementation. Standards and guidelines will be set to ensure quality service delivery and overall performance. It also entails the enforcement of the legal framework, standards and regulations including the provision of relevant information to the public

7.2.2.2 County Department responsible for Health

The Constitution has assigned the larger portion of delivery of health services to the Counties with exception of National Referral Services. Its overall roles and responsibilities shall be:

1) Delivering County Health services:
    - County health facilities and pharmacies
    - Ambulance services
    - Promotion of primary health care
    - Licensing and control of undertakings that sell food to the public
    - Veterinary services (excluding regulation of profession)
    - Cemeteries, funeral parlours crematoria and refuse removal, refuse dumps and solid waste disposal.
2) Licensing and accrediting Non State Health Service Providers (HSPs).
3) Financing of County level Health services
4) Maintain, enhance and regulate (Asset development) and HSPs (operations);
5) Approve County Special Partnership Agreements (SPAs) for County HSPs.
6) In collaboration with national Government, gazette regulations for community managed health supplies to be implemented at county level
7) Planning, investment and asset ownership function of Public Health Facilities
8) Develop an investment plan to enable fulfillment of the highest attainable right to health and document annually progress on fulfillment as required by the Constitution.
9) Asset financing and ownership;
10) channel public and other funds to develop health facilities;
11) Collect and aggregate information at County level on implementation of projects in order to document value for money and progress of the rights.
12) Provide a legal framework for on-lending arrangements to facilitate loan repayments and fees for use of assets by licensed HSPs

Stewardship Responsibilities at the different levels of the Health Sector

Levels	Responsibilities/functions
Senior management at National level (Directorates)	- Formulating policy, developing strategic plans, setting priorities - Budgeting, allocating resources - Regulating, setting standards, formulating guidelines - Monitoring performance and adherence to the planning cycle - Mobilizing resources - Coordinating with all (internal and external) partners - Provision of Technical support to the county level - Capacity building of county level - National health referrals services - Training health staff(both pre and in service), ensuring curricula and training institutions are in place
County health	- Provide leadership and stewardship for overall health management in the County,

management teams(CHMT)	- Provide Strategic and operational planning, Monitoring and Evaluation of health service delivery in the county. - Provide a linkage with the national Ministry responsible for health. - Collaborate with State and Non state Stakeholders at the County and between counties in health services - Mobilize resources for County health services - Establish Mechanisms for the referral function within and between the counties, and between the different levels of the health system in line with the sector referral strategy - Coordinating and collaborating through County Health Stakeholder Forums (CHMB, FBOs, NGOs, CSOs, development partners)
County Health facility management teams(CFMT)	- Delivering services in all health facilities (levels 1–3) - Developing and implementing facility health plans (FHPs) - Supervising and controlling the implementation of FHP (M&E) - Coordinating and collaborating through County Health Stakeholder Forums (FBOs, NGOs, CSOs, development partners) - Training and developing capacity (in-service) - Maintaining quality control and adherence to guidelines

7.2.2.3 Semi Autonomous Government Agencies (SAGAs)

Currently there are six SAGAs under MOH governed by 8-15 members Board of Management composed of senior officers representing the public sector (MOH and other ministries), private sector and other interested parties. A Chief Executive Director (CEO) is responsible for the daily management and implementation of the institutions strategic plans guided by the Sector strategic plan. The Chair of BOM of each of the six SAGAs will sign a contract with GOK, represented by Principal Secretary, MOH. They are financed partly through GOK (Ministry of Finance) and have to raise the other part for themselves through cost sharing or through other sources (development partners, donations, NGOs, their clients/students).

The SAGAs and their key mandates

SAGA	Founded	Corporation status date	Key Mandate
KNH	1901	Legal notice no.109 (April 1987)	Provide specialized care, training and research
MTRH	1917	Legal notice no.78 (June 1998)	Provide specialized care, training and research
KMTC	1927	Legal notice no.14 (1994)	Train middle level health professionals
KEMRI	1979	Science and technology act no.79 (April 1979)	Conduct multi-sector health research
KEMSA	2001	Act of Parliament cap 446 (2000), Legal notice no.17	Procure, warehouse and distribute health commodities in Kenya
NHIF	1966	Act 9 (1998)	Provide quality social health insurance

Key: KNH = Kenyatta National Hospital; MTRH = Moi Teaching and Referral Hospital; KMTC = Kenya Medical Training College; KEMRI =Kenya Medical Research Institute; KEMSA = Kenya Medical Supply Agency; NHIF = National Hospital Insurance Fund.
Source: Strategic plans of the respective SAGAs

The Sector expects the SAGAS to pursue the following outputs to improve their operations, performance and that of the overall health sector:

- Become client centred and responsive to the needs of the population. The two referral hospitals should become centres of excellence in patient care and training of medical professionals. They should become truly referral in their operations. KEMRI should strengthen its operational and health systems research work through a clearly defined research agenda, responding to priorities of the sector and generating evidence for policy and decision making, while KEMSA

and KMTC should re-direct their operations to become demand driven and strengthen their core business towards KEPH implementation (community/ county-related work).

- Become cost-effective, adopting private sector management principles, such as results-based management, with a flexible and lean structure and increasingly trying to de-link their operations and funding from the public sector.
- Search for alternative financial sources and move towards full cost-recovery of their operations in order to become financially self-sustainable.

7.2.2.4 Other Ministries and institutions

Both National ministry responsible for health and County department of health will strengthen their relations with other ministries and institutions, as mentioned earlier in this plan, and in this way strengthen and intensify its inter-sector work. In particular in the water and sanitation sector, fruitful collaboration is expected as part of KEPH implementation (joint hygiene and health promotion messages). In the education sector, special attention will be given to the expansion of school health programmes for primary and secondary schools (health education, de-worming, counseling on reproductive health and substance abuse). Collaboration will be strengthened with relevant research institutions in the country to develop operational research (OR) programmes and health systems research that are relevant to MOH policy development. MOH will therefore review its research agenda and define new research priorities in line with KEPH and the renewed emphasis on health reforms and SWAp. Research should become a regular tool for policy makers' review of MOH achievement of the Kenya Vision 2030 and international commitments.

Ministry responsible for devolution

Local government has been a partner in implementation of health services in municipals councils /cities (MOH has delegated the responsibility). Nairobi Health Board has been established to provide guidance and oversight in a coordinated and it is envisaged that this model will be rolled out to other urban areas. Work relationships between MOH and the council authorities in general have been good and cordial, with regular sharing of information and resources. Over the last three decades, however, local authority revenue collection has progressively diminished, affecting the delivery of social services including health care. The limited resources have resulted in allocations to key priorities that in most cases did not include health, with an almost corresponding deterioration of the quality of health care.

Ministry responsible for devolution will ensure that the urban areas and cities provide quality health care services as agents of county governments

7.2.2.5 Regulatory bodies (Boards and Councils) and professional bodies/associations

Regulatory Bodies (Boards and Councils)

The regulatory bodies (for example the Pharmacy and Poison Board and the Medical Practitioners and Dentists Board) are semi-independent institutions that operate under an Act of Parliament. These bodies perform important service related regulatory functions on behalf of the Ministry of Health: the definition of professional standards; the establishment of codes of conduct; and the licensing of facilities, training institutions and professional workers. From their work, they often generate considerable revenues that finance their operations. However, the legal position of the various boards and councils does not allow them to undertake effective regulatory functions. Under KHSSP, MOH will strengthen the capacity of these regulatory bodies, aiming for outputs like harmonization of the legal framework of the regulatory bodies.

Professional Associations

Various professional associations represent the interests of specific professional groups, including doctors, dentists, nurses, physiotherapists and others. They are independent and are mainly involved in welfare related activities for their members. According to a recent study, the performance and management of professional associations in general is weak. There is

little coordination and sharing of information among them. Through a legal framework, MOH will work with these associations with the aim of strengthening their inputs to and support for the health sector.

7.2.3 Non State Implementing partners

Implementing partners in health have played a significant role in social development in Kenya specifically making significant contribution in making available health services to the community. The implementing partners have also been a critical source of much needed human and monetary resources that will be needed to implement this strategy

The Private Sector (for-Profit and Not-for-Profit)

Whether for-profit or not-for-profit, the private sector is really only partially co-opted for health development.

In the past years, collaboration between MOH and the private sector has been irregular and not fully productive. The KHSSP 2012-2017 has recognized the need to improve collaboration in order to:

- Facilitate regular consultative meetings between MOH and private providers.
- Facilitate acquisition of GOK owned land by private providers to develop health facilities in under-served areas as a step to improve equity.
- Rent out under-utilized facilities to private providers, on the condition that they cushion vulnerable groups from the high cost of health care.
- Facilitate waivers of taxes/duty on drugs and medical supplies

Available information shows that much expertise and many resources are available from the privates Sector at national and county levels. These could provide significant support to National MOH, as well as county health authorities, in expanding quality care to remote and under privileged populations. In particular, the experiences of FBOs, NGOs and CSOs in working with the community are an asset for the implementation of the KEPH at grassroots level. The County stakeholder forums will be the platform where such collaboration should be promoted.MOH will also stimulate other innovative mechanisms for involving the private sector. Finally, by stimulating outsourcing and subcontracting of non-core services (e.g., laundry services, provision of food, laboratory services, etc.) to the private sector, MOH will attempt to improve the efficiency and quality of the services and thus reduce costs. Public–private partnership seems an excellent mechanism to stimulate such collaboration. CSOs and community-based groups are another group of not-for-profit health providers. They often consist of local initiatives that respond to a felt need, being a small maternity or dispensary, the hiring of a night guard or ticket collector, or the arrangement of transport facilities (bicycle or motorbike) in case of emergency situations. Their source of income is most often local contributions among those interested, or money from cost-sharing. As the CSOs are widespread and in addition represent active members of society with proven interest in contributing to the improvement of their health, they will be invited to participate in the implementation of KEPH in their societies.

Traditional Practitioners and Traditional Medicine

The general health law and legislation will ensure quality assurance and standardization, capacity building, protection of intellectual property rights, and the halting of loss of biodiversity. It also recommended the developmentof a national policy on traditional medicine and the exploration of possibilities of initiating commercial production of traditional plants for medical use. The Ministry responsible for Health shall establish and put in place measures to identify and document:

- the extent to which traditional medicine is practiced in Kenya
- the areas of Kenya in which contacts with traditional practitioners comprise a particularly significant proportion of all health consultations
- the conditions for which populations are most prone to seek traditional medical support
- the medical conditions in which such support is conceived to be particularly beneficial
- the practical considerations, financial or otherwise, which are most likely to lead to such consultation
- the characteristics of those members of the population most prone to seek the assistance of traditional practitioners
- the extent to which cross referral between orthodox and traditional practitioners is experienced
- evidence as to the beneficial and adverse consequences of traditional or complementary methods of treatment

This document will form further justifications for enhancing collaboration: discouraging / eliminating harmful practices; encouraging referrals to facilities for medical care; expanding community-based networks for health education by including TPs

The Cabinet Secretary responsible for Health shall, in consultation with the Health Council, on the basis of information generated under measures set out in the above section, and shall make legislative or regulatory proposals accordingly

7.2.4 External Actors

Development partners constitute a rather heterogeneous group with a variety of objectives, interventions, technical and reporting requirements, and funding modalities. Some intend to support the SWAp and participate in funding, whereas others prefer to continue their "off-budget" support for programs in specific areas or targeted to special population groups. In general, coordination between MOH and the development partners is improving because of the established health sector coordination framework. MOH intends to strengthen that

framework and would like to harmonize the different modes of cooperation with its development partners International initiatives, including the March 2005 Paris Declaration14 by the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) provide an important foundation for doing. This role has been structured around principles of aid effectiveness, which places emphasis on government ownership, alignment, harmonization, mutual accountability and managing for results on programmes in the health sector the implementation of this strategy will require the continued support of development health partners from an increasingly strategic and coherent perspective given the devolved government system.

Many development partners and the Kenyan Government through Code of Conduct, have agreed and are committed to:

- Simplifying procedures and systems (like common performance indicators).
- Harmonizing their procedures (make them the same or similar).
- Aligning procedures with national systems and informing the country in a timely way of intended aid flows/contributions.
- Aligning with government budget cycles and disbursements.
- Sharing information and being more transparent.
- Untying aid or at least using a common conditionality framework.
- Strengthening local capacity and supporting government leadership in aid coordination.
- Using existing coordination structures, such as participating in joint annual planning and performance reviews.
- Relying on budget support (sector earmarked or direct budget support).
- Relying on SWAp and engaging in collective and open forms of dialogue between each other and with the national governments.

MOH together with its development partners will pursue the realization of these commitments during the elaboration of the Common Management Arrangements (CMA).

7.3 Governance, legal and regulatory framework at national, and County levels

This Strategic Plan realizes that effective governance and regulatory frameworks are the main vehicles through which targets set for KHSSP can be achieved as it allows all health sector stakeholders to collaborate and coordinate their actions, recognizing each one's specific responsibilities. The Governance obligations are outlined in the Country's legal framework.The governance of the health sector have been guided by several legal frameworks including the 2010 constitution, Public Health Act Cap 242, the Pharmacy and Poisons Act Cap 244, Dangerous Drugs Act Cap 245the Medical and Practitioners and Dentists Act Cap 253 and many others which continue to be enacted. As a result of the expansion of services and growth in the sector the numerous enacted legal frameworks in the sector have increasing led to divergence and negative synergy. It is therefore necessary for these laws to be harmonized and aligned to the current Constitution.

The governance functions shall be coordinated through the National, and County Governments, with their functions as defined in the Constitution.

- The National Government shall operate through the National Ministry responsible for Health. National service provision functions shall be provided through autonomous, or semi-autonomous agencies, defined in this strategic plan, and include specialized clinical support functions (National Referral Services including laboratory; National Blood Transfusion Services, Medical procurement, warehousing and distribution), and regulatory functions, through professional councils and or boards.
- The County Government governance of the health agenda shall be exercised by the County Executive Committee, through its Department responsible for Health. Both levels of government are distinct and are required to work in collaboration, consultation and cooperation

Governance and management structures that define ownership, selection and technical responsibility through boards/committees and the management team, respectively, are defined, strengthened and made functional (as part of devolution, in line with the constitutional 2010). These structures shall focus on attaining the following objectives

- **Improved voice and accountability:** Through ensuring their issues and aspirations are being raised, and incorporated into the priorities for the health sector at the level
- **Political stability and lack of violence:** Through ensuring actions of the health managers are appropriately articulated to the population
- **Government effectiveness:** Through appraising performance of stewardship functions exercised by the management levels by participating in, and approving annual work plans and reports of performance
- **Regulatory quality:** Through ensuring expected regulatory functions are carried out to the benefit of the population
- **Rule of law:** Through ensuring legal framework is adhered to, in all actions of the sector, and
- **Control of corruption:** Through monitoring of implementation of health activities

The functioning of these systems shall be guided by the legal framework to achieve the following key interventions:

i) Have fully functional governance structures at all the Counties. These include

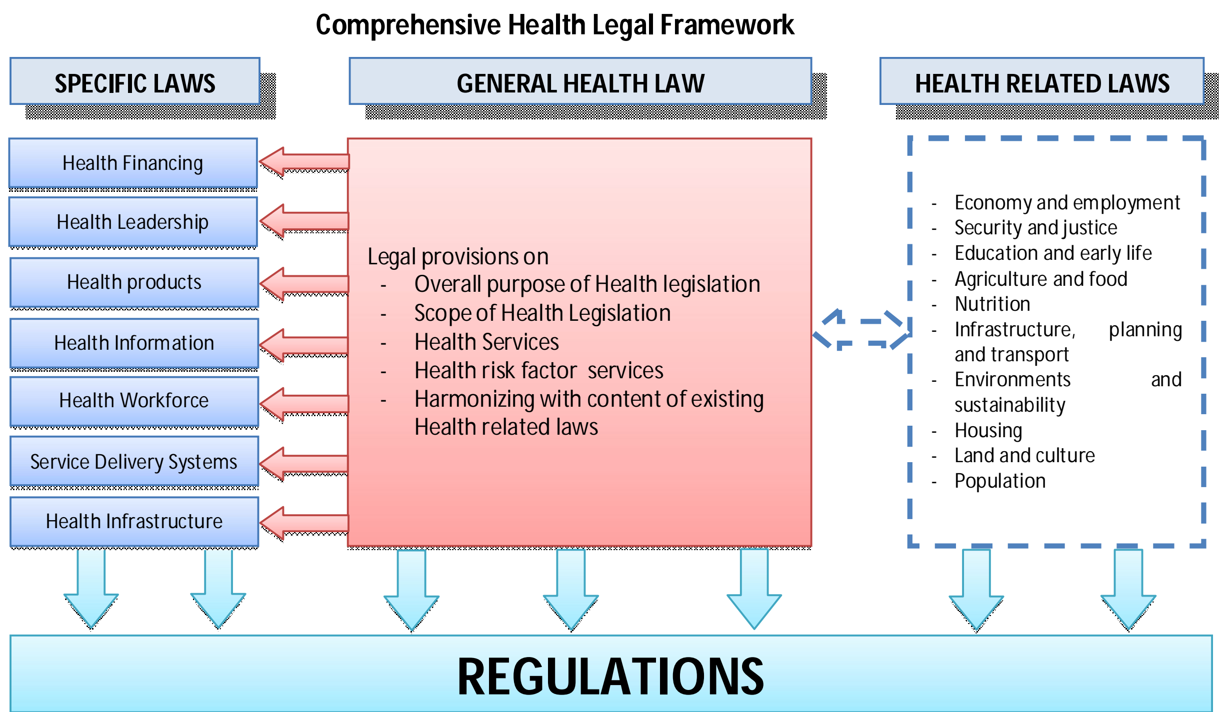
- County Department responsible for Health

- Hospital Boards
- Primary Care Management Committee's
- Community Health Committee's

ii) Update sector guidelines for functioning of these structures, in line with the above-mentioned 6 governance dimensions

iii) Update the health sector legal framework, taking into consideration the current needs and aspirations as outlined in the National Health Policy and the 2010 constitution. The legal and regulatory framework shall bring together, in a comprehensive manner, all the health and health related legislation required to guide the implementation of the policy orientations, using the framework below.

Comprehensive Health Legal Framework



7.4 Stewardship and Management framework at national, and County levels

The sector stewardship and management framework relates to how the Government, through the Ministry for Health, shall organize itself to coordinate and lead the delivery of the defined health package.

The Constitution of Kenya further redefined the new roles and responsibilities of the National and County governments. This redefinition of functions requires reorganization and alignment of the existing stewardship arrangements within the sector.

The restructuring of the sector stewardship is guided by the expectations on health in the 2010 constitution, and the experiences from NHSSP II implementation. Apart from redefining and separating the roles and functions of the National and county governments, the constitution outlines the structural arrangements critical for delivery of the functions at both levels. On one hand the functions of the National government are articulated in section 174 of the Constitution include health policy, national referral facilities, capacity building and technical assistance to County governments. On the other hand, the County functions include county health facilities and pharmacies, ambulance services, promotion of primary health care, licensing and control selling food in public places, veterinary services cemeteries funeral services, funeral palours and crematorium refuse removal refuse dumps and solid waste. The trigger for the restructuring include

- Promulgation of the constitution and the redefinition of the national and county government roles and responsibilities
- The impetus and renewed emphasis to accelerate the provision of services targeting maternal and neonatal health whose performance over the past strategic plan has stagnated while sustaining the gains made in other interventions especially child health and HIV/AIDs control.
- The recognition of the emerging future epidemiological and demographic transition
- The increasing demand for quality health care and health as a right amidst declining national and global economic growth with negative effects on health care financing.
- The need to reorganize implementation arrangements around the policy objectives in response to both the burden of disease and the national approach to budgeting focusing on programmes as opposed to inputs.
- The reorganization of KEPH service delivery levels under the new policy
- The need for change management during the transition period

Based on the constitution the sector will define central tasks and responsibilities of structures at the national and county level. The new organization structure will be informed by:

- Functionality: the structure will allow for clusters of responsibility to permit coordinated and integrated approach to efficient service delivery
- Cooperation: The structures should allow seamless consultation between the National and County Governments under the devolved system.
- Accountability: the new structure should embrace good principles of management by have a hybrid of tall-thin and flat-broad organization structure to minimize bureaucracy and cost.
- Complementarity: the new structure should allow for effective and coordinated implementation of health sector investments.

7.4.1 National Government Stewardship of Health

The National Ministry for Health will be organized in a manner to plan and monitor attainment of the Policy Directions of the sector. To achieve this, the National Ministry will be managed by a Secretary for Health. This shall be a Presidential Appointment, with responsibilities defined by the overall Government. The Cabinet Secretary will have overall responsibility for addressing the health agenda in the Country, and shall

- Guide the organs of the state on the strategic direction of addressing the Health agenda in the Country
- Act as a liaison between the National Government and the County Executive Committee on health matters
- Coordinate mobilization of resources for implementing the Health Policy agenda, by National and County Governments
- Chair the Joint Inter Agency Coordinating Committee, bringing together heads of all signatories of the Sector Code of Conduct

The Secretary for Health shall have a Principle Secretary and a Director General for Health to provide administrative, and technical guidance to the overall Government (through the Cabinet Secretary), and internal to the sector.

As the final accounting officer for the Ministry for both Public, and non public resources, the Principle Secretary shall facilitate implementation of the Health agenda by:

- Coordinating actions of Semi Autonomous Government Agencies in the Health Sector
- Carry out regular expenditure reviews on use of Government, and external resources, including efficiency and value reviews
- Coordination of financial management systems at the national level, and between National and County Governments
- Carry out regular value-for-money audits, sector-wide efficiency assessments and regular updating of costing data of funds supporting health activities in the sector

The Principle Secretary functions shall be executed through the Director General for Health, the SAGA's, and a Directorate for Administration.

On the other hand, the Director General for Health as the final technical officer for the Ministry for both Public and Non Public actions shall:

- Guide the Cabinet Secretary on technical issues in Health, for communication within Government, parliament, and other organs of the state
- Provide the sector with technical direction in all matters relating to the strategic direction of the Health Sector
- Act as a liaison between the National Government and County Directors of Health, to coordinate attainment of Health goals
- Manage a resource centre for health and related information for the County, including library, reports, internet presence, and other information sources
- Coordination of Health responses to disaster management actions
- Chair the Health Sector Coordinating Committee, comprising technical heads for all agencies signatory to the Sector code of conduct

The Director General for Health functions shall be executed through three Directorships:

- Preventive and promotive services: For all public / population health services
- Curative and rehabilitative services: For all individual care services

- Planning and Governance: For sector Leadership coordination

The office of the Director General for Health shall also have two units within it, for management of disasters, and the resource centre.

Each Directorate shall have departments within them, aligned to addressing the Health agenda as outlined in the Kenya Health Policy.

The Sector Top management shall be responsible for long term / policy setting and policy analysis, and shall comprise of:

- The Cabinet Secretary
- The Principle Secretary
- The Director General for Health
- Heads of SAGA's

The Sector senior management shall be responsible for operational priority setting, implementation follow up and monitoring processes and shall comprise of:

- The Director General for Health
- Heads of Directorates (including administration, as representative of the Principle Secretary)
- Heads of all sector departments, including those in SAGA's
- Heads of Units

Each of the technical departments shall have the following as their generic functions:

1. Developing the strategic approach for the area it is responsible for. This includes defining outcome targets, and required investments (across seven orientations) needed to achieve the desired impact
2. Monitor implementation of the Strategic approach by different implementation units - achievement (or lack of it) of agreed targets
3. Mobilize resources for implementation for different implementation units
4. Develop annual targets, based on known resource envelope
5. Develop guidelines to guide service delivery by implementation units
6. Develop, and facilitate implementation of a research agenda to ensure evidence based decision making

7.4.2 County Government stewardship of the Health Agenda

The forth schedule of the constitution assigns the County Government responsibility for developing County Health Services, including the management of health facilities and pharmacies at the County level; ambulance services; promotion of primary health care; licensing and control of undertakings that sell food to the public, cemeteries; funeral parlors and crematoria; and refuse removal; refuse dumps and solid waste disposal.

The health sector has further outlined, through a National Health Policy how these functions will be coordinated and managed, keeping in light the linkages with the National Government functions in relation to health.

The County will be managed by a County Secretary for Health. This shall be an appointment from the County Executive Committee, responsible for:

- A liaison between the County Health Services and the County Executive Committee
- Present, and lead discussion on health services plans and reports
- Mobilizing resources for County Health Services from all sources – donor and Government
- Coordination of audit of funds supporting health activities in the County
- Manage a resource centre for health and related information for the County, including library, reports, internet presence, and other information sources

The County will have a County Director for Health. This shall be recruited through the County Public Service Board, based on Terms of service defined by the National Ministry responsible for Health. the County Director for Health shall be responsible for overall coordination and management of Health activities in the County, focusing on

- Guiding Implementation of health related issues from the County Executive Committee
- Interpreting, and integrating National Government health policy
- Coordinating development, and implementation of County Health Strategies and priorities
- Coordinating disaster preparedness and response in the County
- Management of referral health services, in County, across Counties, and with the national Government

The County will have five (5) directorates in the Health Services, corresponding to the respective functions. The functions and responsibilities of these respective directorates, and their related units are shown in the table below.

Directorate	Sector policy implementation responsibilities	Constitutional responsibilities	Constituent units
Disease prevention and Health Promotion	- Elimination of Communicable Conditions - Minimize exposure to health risk factors	- Promotion of primary health care - licensing and control of undertakings that sell food to the public - Refuse removal; refuse dumps and solid waste disposal	- Child Health - HIV, TB and Malaria - Health Promotion - Neglected Disease management - Hygiene control - Community services
Curative services and rehabilitation	- Halt and reverse the rising burden of Non Communicable Conditions - Provision of essential health services	- Ambulance services - Management of health facilities and pharmacies - Cemeteries; funeral parlors and	- Maternal Health - Blood Safety - Laboratory services - Pharmaceutical services

Directorate	Sector policy implementation responsibilities	Constitutional responsibilities	Constituent units
	- Reducing the burden of violence and injuries	crematoria	- Nursing services
Planning and monitoring	- Organization and management of health service delivery - Strengthening collaboration with health related sectors	-	- Health Planning - Sector Coordination - Health Information
Administration	- Coordination of Human Resources for Health - Coordination of Health infrastructure - Coordination of commodity supply	-	- Human Resources Management - Infrastructure maintenance - Procurement - Financial Management
Sub County Health Management	- Implementation of agreed health services	-	- Sub County Health Management Teams

7.5 Partnership and coordination framework

The health sector partnership in Kenya is guided by the Kenya Health Sector-Wide Approach (KHSWAp) introduced in 2005. The SWAp provides a framework through which all sector actors can engage to improve effectiveness of health actions. The SWAp principles reflect those set out in the Paris Declaration on Aid Effectiveness, built around country ownership, alignment, harmonization, managing for results, and mutual accountability. It is based on having the sector working around:

- One planning framework
- One budgeting framework
- One Monitoring framework

All the sector actors should be working within these 3 one's.

7.5.1 Description of the partnership framework

The sector actors are classified in 3 constituencies, as shown below.

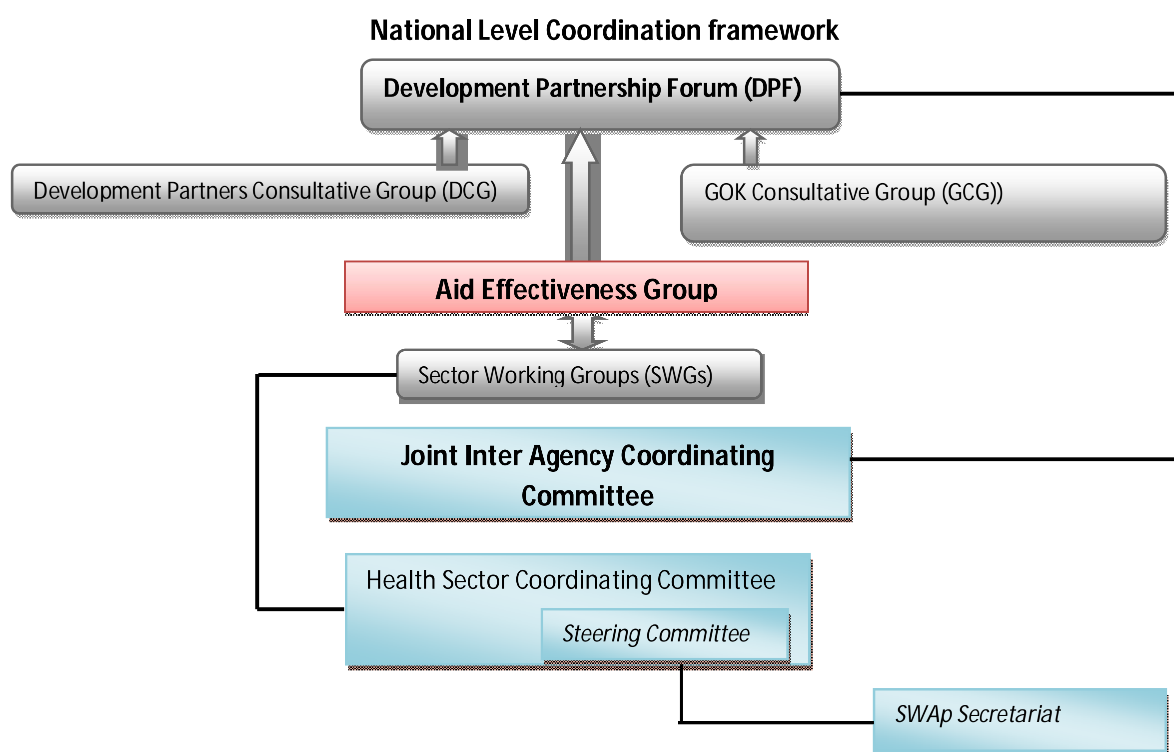
Health Sector Actors

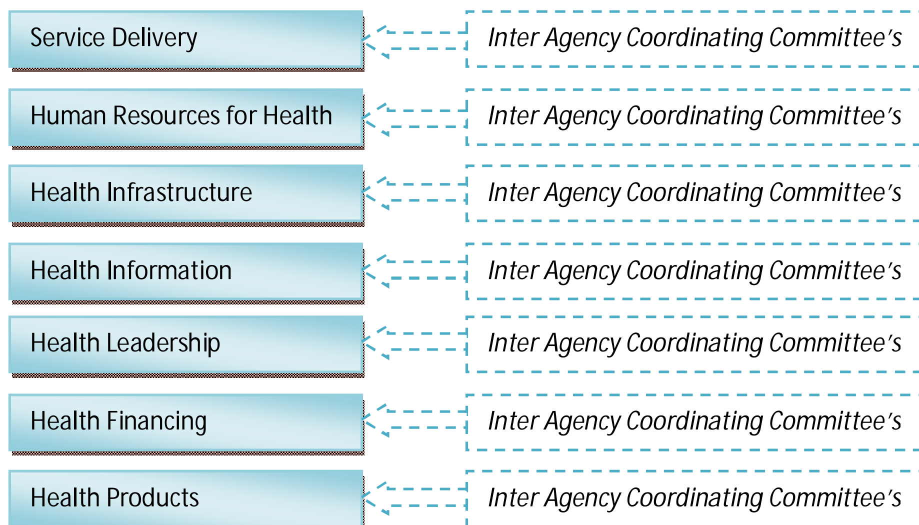
1. **State Actors:** Led by the Ministry for Health at the National Level, and County Executive Committee at the County level. They include
   - Government Health related Ministries, including Ministry of Finance, Ministry of Planning and National Development, Office of the President (DPM) Cabinet Office (Public Service Reform and Development Secretariat), Ministry of Local Government (responsible for City Council health services), Public Service Commission, Ministry of Education;
   - Ministry Semi Autonomous Government Agencies
   - Regulatory bodies (like Pharmacy and Poison Board, the Medical Practitioner and Dentist Board) and various professional associations.
2. **Non State Actors:** Those who include all the actors supporting delivery of health services to Kenyans. These are broadly categorized as
   - Facility based providers: Faith based, and private providers
   - Traditional practitioners
   - Non facility based organizations: Non Governmental Organizations and Civil Society Organizations
3. **External Actors:** All international partners supporting the health sector. These are broadly categorized as:
   - Multilateral partners
   - Bilateral partners
   - Philanthropic partners

The partnership is guided by an overall instrument, the Code of Conduct, which defines roles and obligations of different sector actors towards attaining its overall goal and objectives. The NHSSP II Code of Conduct needs to be updated to reflect

- The Specific roles and obligations of the National, vs County Governments in implementing the obligations of the State
- Definition of the relationship between the County, and National Governments in executing the obligations of the state
- Clarity on the relationships and processes of engagement between
  - The State and the Non State actors (Objectives relating to Public Private Partnerships for Health – PPPH)
  - The State and the External Actors
  - The Non State actors and the external actors

As such, PPP framework shall be an integral part of the Code of Conduct, and not a stand alone element.The partnership structures at the National Level are interlinked as shown below.





7.5.1.1 National Aid Effectiveness Structures

1. Development Partnership Forum (DPF)

The DPF seeks to strengthen mutual accountability between the Government and its Development Partners to accelerate the development of Kenya. It is a multi-sectoral biannual high-level forum to reflect on ongoing cooperation, discuss political and policy developments as they relate to Kenya's economic and social development programme in Vision 2030, and identify joint goals and targets.

2. GOK Coordination Group (GCG)

The GCG provides a high level monthly forum for government to discuss economic, development, and humanitarian issues with a focus on aid effectiveness across ministries, and to increase the effectiveness and efficiency of external assistance to Kenya by exchanging information and experiences on key issues and ensuring that clear guidance is communicated to development partners in a coordinated manner and aligned with shared objectives.

3. Donor Coordination Group (DCG)

The DCG provides a monthly forum for donors to discuss economic and development issues and to increase the effectiveness and efficiency of external assistance to Kenya by exchanging information and experiences on key issues, ensuring that support is provided in a predictable and coordinated manner and aligned with shared objectives.

4. Aid Effectiveness Group (AEG)

The AEG brings GOK and donors together on a monthly basis with an aim to increase the effectiveness and efficiency of development assistance in Kenya by reducing transactions costs to the government, streamlining systems for delivering aid, standardizing procedures, eliminating duplication, managing for development results and upholding mutual accountability

The AEG is supported by the ***Aid Effectiveness Secretariat (AES)*** whose purpose is to promote aid and development effectiveness through improvement in harmonization, alignment and coordination through the provision of support to the AEG, GCG and SWGs.

5. Sector Working Groups (SWGs)

Sector Working Groups seek to ensure that support is provided to the Government of Kenya and non-state actors in the sector in a predictable and coordinated manner and aligned in support of the government's Vision 2030, its medium-term implementation plan and other agreed development priorities

7.5.1.2 Joint Inter-Agency Coordinating Committee (JICC)

The JICC brings together high-level actors in the health sector to provide leadership for overall policy direction. The JICC approves the National Health Policy and Strategic Plans, undertakes advocacy for the sector, and leads resource mobilization efforts for the sector.

The JICC is chaired by the Cabinet Secretary for Health, and meets twice yearly. Members comprise the Principal Secretary for Health who serves as the Secretariat, and the Principal Secretaries for Health Related Ministries; Non-state actors represented by Heads of agencies signatory to the Code of Conduct. Its members sit on the Development Partners Forum.

1. Health Sector Coordinating Committee (HSCC)

The Health Sector Coordinating Committee (HSCC) promotes coordinated technical support and policy dialogue on strategic sector issues with the government, donors and development partners, the private sector, and civil society. It also functions as the Health Sector Working Group in the wider Government coordination process.

The HSCC is chaired by the Principle Secretary Ministry for Health and meets quarterly. HSCC membership comprises MOH Heads of Departments, representatives from health related Ministries, Semi Autonomous Government Agencies and councils, non state and external actors signatory to the Code of Conduct.

The HSCC will operationalize its activities through two organs:

a) A Steering Committee, and

b) HSCC Technical Groups

The Steering Committee that provides technical and administrative support. The Steering Committee is chaired by Director of Health Services and meets at least quarterly. Members comprise MOH heads of departments for non state and external partner agencies signatory to the Code of Conduct. Its functions are to:

- Identify key sector issues and tasks that need to be taken up by the HSCC.
- Recommend and prepare agenda items for HSCC meetings.
- Ensure that action points arising from the HSCC are adequately addressed in a timely manner.
- Identify key action points that need to be addressed by ICCs
- Support the secretariat function for the HSCC.

The HSCC Technical Groups provide a forum for joint planning, coordination and monitoring of specific investments in the sector. Their purpose is to -

- Bring all key sub-sector partners together for joint planning, oversight and decision-making.
- Enable partners to become jointly responsible for planning, monitoring, reviews and reporting.
- Hold all sector partners jointly accountable for achieving results.
- Reduce the number of separate meetings with individual partners.
- Enable harmonization of inputs and better coordination of investments in the sector partnership for more effective use of all available resources - reduce duplication of efforts and critical gaps.
- Provide easy access to coordinated TA and support for priority actions.

The Technical Groups will be re-structured to follow the seven key Policy Orientations set out in the National Health Policy Framework 2011-2030:

1. Leadership and Governance
2. Service Delivery Systems
3. Health Workforce
4. Health Financing
5. Health Products and Technologies
6. Health Information Systems
7. Health Infrastructure

These Technical Groups are chaired by the Director, meet at least quarterly, and report to the HSCC Steering Committee. They will form Inter Agency Coordinating Groups (ICC's) or task forces as needed to address priority issues and areas of focus.

Different actors will set up their own coordination frameworks to guide their engagement and monitor adherence to their obligations. These include:

- State Actors: Head of Departments meetings

- External Actors: Development Partners for Health in Kenya (DPHK)

- Non State Actors:
    - o Non Facility based providers: Health Network for NGO's (HENNET) for NGO's and CSO's
    - o Facility based actors: Christian Health Association of Kenya (CHAK); Kenya Episcopal Conference (KEC); Supreme Council for Kenya (SUPKEM), and the Kenya Private Health Care Providers Consortium for Anglicans, Catholics, Muslim faiths and private facilities respectively

The HSCC will serve as a repository for their respective constitutions, and act as a arbitrator where needed to resolve issues amongst their respective members.

7.5.1.3 County Health Stakeholders fora

Each County shall have a Forum bringing together the above-mentioned actors operating within the County, to coordinate health actions within the County. Membership, and Terms of Reference shall be similar to those of the Health Sector Coordinating Committee. The County Health management team shall operate as its Secretariat.

7.5 Planning and budgeting process

The sector stewardship will focus on assuring overall sector budgeting, operational planning, implementation follow up and performance monitoring and evaluation shall be carried out. The aligned timeline for budgeting, planning and reporting is shown in the figure below.

Aligned annual planning and Monitoring timelines for Health-table to be update on planning and review timelines

Month	National Budget Timeline	National Government timelines	County Government timelines
JULY	Issuance of AIEs to implementing agencies.	Issuance of AIEs to implementing agencies. Q4 reports submitted	
AUGUST	Treasury issues MTF Budget Guidelines	Budget guidelines received from Treasury	Budget guidelines received from Treasury
SEPTEMBER	Undertake Ministerial PERs Launch of Sector Working Groups Budget Review and Outlook Paper (BROP) developed Treasury stakeholders consultations	Undertake PER for health sector Launch of Health Sector Working Group	
OCTOBER	BROP updated, submitted to Cabinet, approved BROP circulated to Accounting Officers	Q1 reports submitted	County budget proposals and Reports developed
NOVEMBER	Ministerial MTEF budget proposals developed Draft Sector Reports developed Sector Reports submitted to Treasury	MOH MTEF budget proposal and Health Sector Report developed, submitted to Treasury	
DECEMBER	Review of Sector Budget Proposals Treasury issues circular on the Revised Budget	Sharing of resource envelope to Counties Development of County Health Services targets	
JANUARY	Submission of Supplementary Budget Proposals Treasury reviews Supplementary Budget Proposals Draft Budget Policy Statement (BPS) Submit BPS to Parliament	Submission of Supplementary Budget Proposals Q2 reports submitted	County mid-term performance reports prepared County and SAGA planning initiated, based on agreed Health Services targets and resource enveloped
FEBRUARY	Approval of BPS by National Assembly Treasury Submits supplementary budget proposals to Cabinet,	Appraisal of County and SAGA priorities	Uploading of County and SAGA plans into DHIS

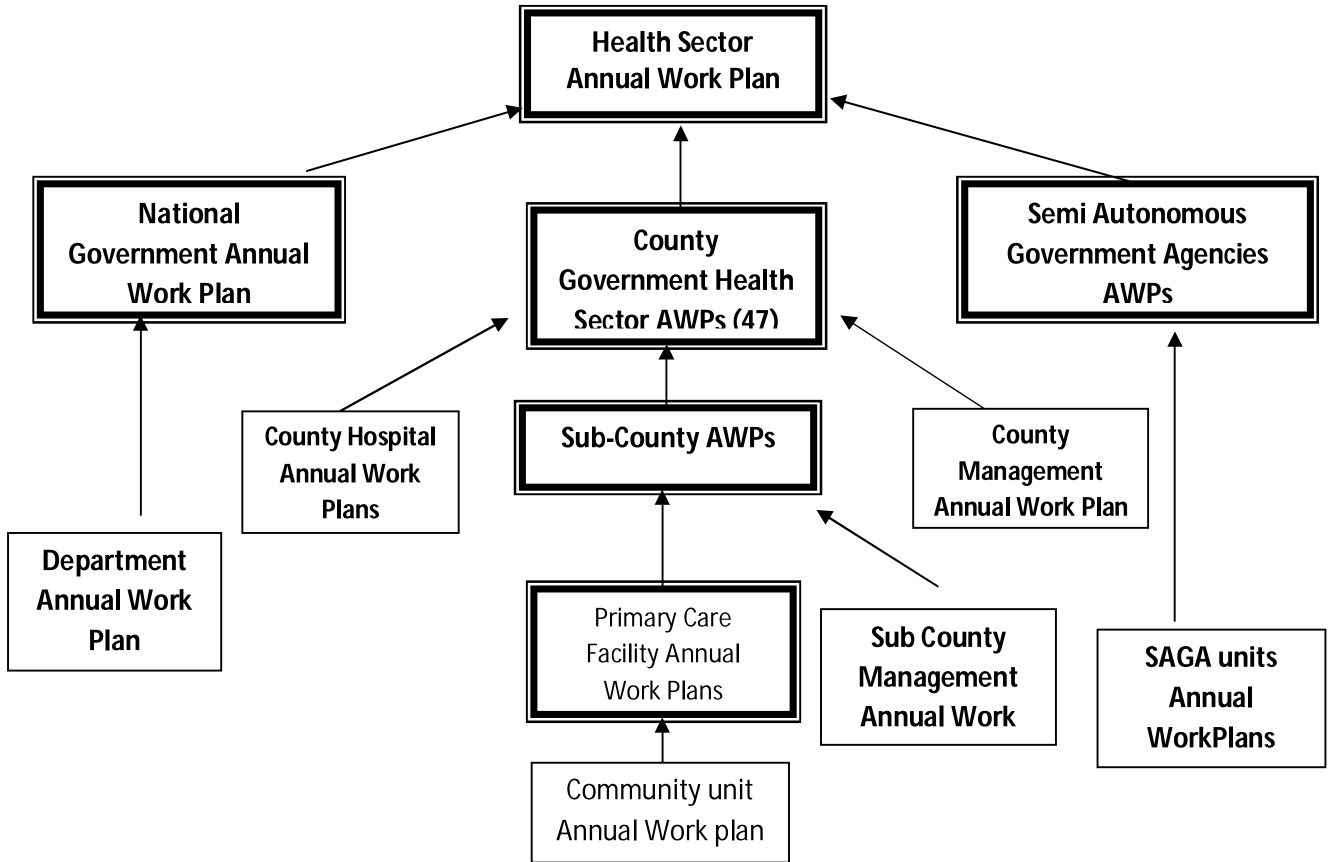
Month	National Budget Timeline	National Government timelines	County Government timelines
	Parliament Issue guidelines on preparation of Ministerial MTEF Budgets		
MARCH		Submission of Budget Proposals to Treasury	
APRIL	Treasury consolidation of Draft Budget Estimates	Q3 reports submitted	
MAY			
JUNE	Budget Speech Treasury consolidation of Final Budget Estimates Parliament Vote on Account Parliament passes Appropriation Bill and Finance Bill		

Based on the defined priorities for investment and the available budget, the management teams need to determine priorities for investment across the 7 different investment areas. Budgeting is for all resources available to the area of responsibility, and not only public resources.

Prioritization of investments for the resource envelope needs to be done basing on a Resource Allocation Criteria that considers the health sector principles: Equity and gender; participation; people centredness; efficiency; social accountability; and multi sectoral focus. The National Ministry for Health shall set out the annual Service delivery targets to be attained by each of the management units. This shall guide their investment prioritization process

With budget information available, each management unit in the sector needs to have Annual Workplans. These outline what activities will be implemented, with the available budgets based on a common framework.

AWP planning linkages



The follow up of the planned activities is a responsibility of the management unit. Weekly management team meetings shall be held, to follow up on activity support. Quarterly management team meetings shall also be held to monitor performance.

7.6 Communication plan for KHSSP

The timely and accurate communication of carefully chosen messages to specific individuals and groups, through appropriate and effective channels, is a key enabling factor for any change process. Getting communication to work well requires analysis and planning.

This guidance focuses on generating a simple guide on developing a communications strategy for the KHSP III.

As with any strategy development and planning exercise, this is not a one-off, static process. The analysis should be regularly revisited, and the plan kept live and updated. The nature of the process is that not all communications needs will be evident at the outset of the programme. The communications plan should be incorporated as an element in the implementation plan of the KHSP III and are subject to planned monitoring and evaluation and review processes.

The understanding and conceptualization of previous national health strategic plans has been the preserve of the health sectors and even this has not been uniform with the national level being more privy to the process and content of these plans. There is a need to not only create a greater connection between the national strategic level and the operational levels, but to also communicate the KHSP III to all stakeholders, including other government sectors.

The Kenya Health Strategic Plan III aims to provide an agreed national framework addressing the health priorities and actions for the next five years. The plan will act as the basis of coordination among all partners and government sectors addressing health in Kenya. This is to be achieved through the common understanding and conceptualization of the plan by all. There is therefore a need to develop a communication strategy to attain, strengthen and preserve a favourable opinion of the KHSP III to ensure buy in from all relevant partners and stakeholders.

The main purpose of the communication strategy is to build greater support and buy in of the KHSP III among key stakeholders and the public. The strategy will aim to reach to a greater audience than traditionally sort and demonstrate relevance and key benefits to target audiences.

The communication strategy will focus on:

1. Ensuring that all stakeholders are fully informed and understand their roles and responsibilities in the implementation of the KHSP III
2. Enhancing consultation with agencies in achieving set outcomes;
3. Ensuring that all stakeholders understand the KHSP III and on-going health reform process;

The main communication focus for each of the stakeholders is outlined in the table below

Communication focus for different stakeholders

Stakeholder		Communication focus
Clients	Individual Households Community	• Role in exercising appropriate healthy and health seeking behaviours • Active participation in the management of their local health services • Ownership and commitment of their health through the implementation of the KHSP III
State actors	MoH -National and County,	• Leadership and stewardship role within the sector and across other sectors and partners
	SAGAs,	• Their role in providing specialized health services
	Other ministries	• Their role in contributing to national health outcomes and need for strengthening the inter-sector work and

		mechanisms
	Ministry responsible for devolution	• Their role in ensuring that quality health care services are provided in all levels including the urban areas and cities as agents of county governments
	Regulatory bodies (Boards and Councils) and professional bodies/associations whose mandate is drawn from that of the State, and have an effect on health	• Their regulatory function in the implementation of the KHSDP III
Non State / external actors		Adherence to the sector partnership Code of Conduct incorporating PPPH principles. Adherence to standardized qualities Ensure harmonized collaboration
		Understanding and adherence of Common Management Arrangements (CMA).

A detailed communications plan with intended communications actions, their timing and responsibility should be completed on the basis of the stakeholder assessment. This will be guided by assessment of stakeholders' perceptions and needs and the environmental (internal and external) implementation of the KHSP.

A communication audit will be used to establish the existing current channels of communication, who they reach, and how effective they are. The plan will also outline the key and secondary target audiences of the KHSP III and clearly spell out the communication goals and objectives for each stakeholder.The plan will among others identify:

- The key messages for communicating to the key stakeholders;
- The method by which the key messages are communicated to key stakeholders;
- The key messages to be communicated to the key stakeholders;
- The actions required for implementation of the strategy and the communication roles;
- Resources needed to undertake the communication tasks;
- Communication risks; and
- Methodology and time-frame for evaluating the effectiveness of communications.

CHAPTER EIGHT: MONITORING AND EVALUATION FRAMEWORK FOR KHSSP

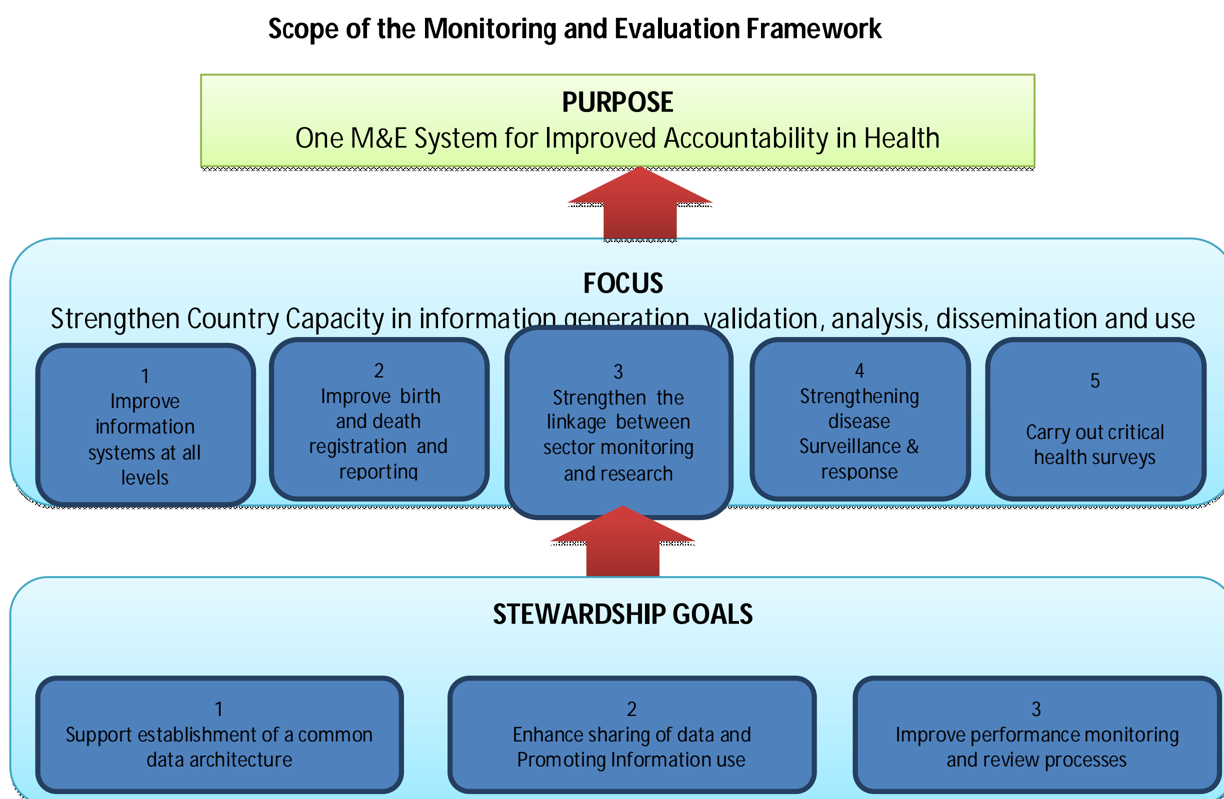
The NHSSP II End Term Review highlighted the absence of a robust Monitoring and Evaluation framework as one of the challenges in assuring adequate follow up of implemented activities. This chapter, therefore, is aimed at addressing this gap. It shall provide direction on Monitoring and Evaluation / Review of the implementation of the KHSSP III.

A comprehensive M&E framework shall be the basis for:

- Guiding decision making in the sector, by characterizing the implications of progress (or lack of it) being made by the sector
- Guiding implementation of services by providing information on the outputs of actions being carried out
- Guide the information dissemination and use by the sector amongst its stakeholders and with the public that it serves.
- Providing a unified approach to monitoring progress by different planning elements that make up the sector – Counties, programs, SAGA's, and others

The overall Monitoring and Evaluation framework being applied in the sector and its linkages with the Health Information System elements is shown below.

Scope of the Monitoring and Evaluation Framework



The overall purpose of the M&E framework is to improve on the accountability of the Health Sector. This shall be achieved through a focus on strengthening of the Country capacity for information generation, validation, analysis, dissemination and use through addressing the priorities as outlined in

the Health Information System investment section of this document. This M&E chapter focuses on how the sector will attain the stewardship goals needed to facilitate achievement of the HIS investment priorities. These stewardship goals are:

d) Supporting the establishment of a common data architecture
e) Enhancing sharing of data and promoting information use
f) Improving the performance monitoring and review processes

8.1 Establishment of a common data architecture

A common data architecture is needed to ensure coordinated information generation, , data and information sharing and efficiencies are maximized in data and information management. The national M and E unit will carry the mandate of establishing and overseeing the common data architecture. The health sector has identified sector indicators for monitoring and evaluating the implementation of KHSSP III. The common data architecture will provide the data sources for these indicators,which have been defined in the 2nd edition health sector indicator manual.The table below details the baseline data, and mid- and end-term targetas well as the sources for these indicators.

Kenya Health Strategic & Investment Plan Targets

Policy Objective	Indicator	Targeted trend's			Source
		Baseline (2012)	Mid Term (2015)	Target (2017)	
IMPACT TARGETS					
Level of Health	Life Expectancy at birth	52	56	65	KNBS
	Total annual number of deaths (per 100,000 population)	106	95	80	
	Maternal deaths per 100,000 live births	*400*	*300*	*150*	*KNBS*
	Neonatal deaths per 1,000 live births	*31*	*25*	*15*	*KNBS*
	Under five deaths per 1000	*74*	*50*	*35*	*KNBS*
	Youth and Adolescent deaths per 1000	*45*	*30*	*20*	*CRD*
	Adult deaths per 1000	*30*	*20*	*10*	*CRD*
	Elderly deaths per 1000	*80*	*80*	*80*	*CRD*
	Years of Life lived with illness / disability	12	10	8	WHO
	Due to communicable conditions	*6*	*5*	*4*	WHO
	Due to non-communicable conditions	*4*	*4*	*3*	WHO
	Due to violence / injuries	*2*	*1*	*1*	WHO
Distribution of health	% range of Health Services Outcome Index	45	30	20	HIS
Services Responsiveness	Client satisfaction index	65	78	85	Policy and planning
HEALTH & RELATED SERVICE OUTCOME TARGETS					
Eliminate Communicable Conditions	% Fully immunized children	79	90	90	HIS
	% of target population receiving MDA for schistosomiasis	50	95	95	HIS
	% of TB patients completing treatment	85	90	90	HIS
	% HIV + pregnant mothers receiving preventive ARV's	63	90	90	HIS
	% of eligible HIV clients on ARV's	60	90	90	HIS
	% of targeted under 1's provided with LLITN's	44	85	85	HIS
	% of targeted pregnant women provided with LLITN's	30	70	85	HIS
	% of under 5's treated for h diarrhea	40	10	5	HIS
	% School age children dewormed	49	85	90	HIS
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	50	40	35	KNBS/HIS
	% Women of Reproductive age screened for Cervical cancers	50	70	75	HIS
	% of new outpatients with mental health conditions	<1	2	1	HIS
	% of new outpatients cases with high blood pressure	1	5	3	KNBS/HIS
	% of patients admitted with cancer	1	2	2	HIS
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender based violence	<1	3	2	HIS
	% new outpatient cases attributed to Road traffic Injuries	4	2	2	HIS

Policy Objective	Indicator	Targeted trend's			Source
		Baseline (2012)	Mid Term (2015)	Target (2017)	
	% new outpatient cases attributed to other injuries	<1	0.5	0.5	HIS
	% of deaths due to injuries	10	5	3	HIS
Provide essential health services	% deliveries conducted by skilled attendant	44	60	65	HIS/KNBS
	% of women of Reproductive age receiving family planning	45	80	80	HIS
	% of facility based maternal deaths	400	100	100	HIS
	% of facility based under five deaths	60	20	15	HIS
	% of newborns with low birth weight	10	6	5	HIS
	% of facility based fresh still births	30	10	5	HIS
	Surgical rate for cold cases	0.40	0.85	0.90	HIS
	% of pregnant women attending 4 ANC visits	36	80	80	HIS
Minimize exposure to health risk factors	% population who smoke	18			KNBS
	% population consuming alcohol regularly	35			KNBS
	% infants under 6 months on exclusive breastfeeding	32			KNBS
	% of Population aware of risk factors to health	30			KNBS
	% of salt brands adequately iodized	85			KEBS
	Couple year protection due to condom use				HIS
Strengthen collaboration with health related sectors	% population with access to safe water	60		85	KNBS
	% under 5's stunted	35		15	KNBS/HIS
	% under 5 underweight	17		5	KNBS/HIS
	School enrollment rate	60	80	80	MOE
	% of households with latrines	34		70	KNBS
	% of houses with adequate ventilation	65		80	KNBS
	% of classified road network in good condition	30		50	MOT
	% Schools providing complete school health package	15		50	MOE/HIS
HEALTH INVESTMENT OUTPUT TARGETS					
Improving access to services	Per capita Outpatient utilization rate (M/F)	2	3	4	HIS
	% of population living within 5km of a facility	80	90	90	KNBS
	% of facilities providing BEOC	65	80	90	HIS/ NCPD
	% of facilities providing CEOC				HIS/ NCPD
	Bed Occupancy Rate	85	95	95	HIS
	% of facilities providing Immunisation	80	100	100	HIS
Improving quality of care	TB Cure rate	83	88	90	HIS
	% of fevers tested positive for malaria	45		20	HIS
	% maternal audits/deaths audits	10	70	85	HIS
	Malaria inpatient case fatality	15	8	5	HIS
	Average length of stay (ALOS)	5.6	4.5	4	HIS
HEALTH INPUT AND PROCESS INVESTMENT TARGETS					
Service delivery systems	% of functional community units	20	30	45	HIS
	% outbreaks investigated within 48 hours	90	100	100	IDSR
	% of hospitals offering emergency trauma services	35	65	80	HIS
	% hospitals offering Caesarean services	45	85	95	HIS
	% of referred clients reaching referral unit	25	70	85	HIS
Health Workforce	# of Medical health workers per 10,000 population	5	7	7	HIS
	% staff who have undergone CPD	40	65	70	HIS
	Staff attrition rate	10	5	2	HIS
	% Public Health Expenditures (Govt and donor) spent on Human Resources	55	45	40	HIS
Health Infrastructure	# of facilities per 10,000 population	1.5	2.5	2.5	HIS
	% of facilities equipped as per norms	25	60	70	HIS
	# of hospital beds per 10,000 population	50	150	150	HIS
	% Public Health Expenditures (Govt and donor) spent on Infrastructure	30	25	25	HIS
Health Products	% of time out of stock for Essential Medicines and Medical Supplies (EMMS) – days per month	8	2	2	HIS
	% Public Health Expenditures (Govt and donor) spent on Health Products	10	15	15	HIS/ NHA

Policy Objective	Indicator	Targeted trend's			Source
		Baseline (2012)	Mid Term (2015)	Target (2017)	
Health Financing	General Government expenditure on health as % of the total government Expenditure	4.5	8	12	NHA/ PETS
	Total Health expenditure as a percentage of GDP	1.5	2	2.5	NHA/ PETS
	Off budget resources for health as % of total public sector resources	60	25	5	NHA/ PETS
	% of health expenditure reaching the end users	65	80	80	NHA/ PETS
	% of Total Health Expenditure from out of pocket	33	25	15	NHA/ PETS
Health Leadership	% of health facilities inspected annually	15	80	85	All Regulato ry bodies and councils
	% of health facilities with functional committees	70	100	100	HIS
	% of Counties with functional County Health Management Teams	0	100	100	HIS
	% of Health sector Steering Committee meetings held at National level	50	100	100	HIS
	% of Health sector steering committees meeting held at county level	0	100	100	HIS
	% of facilities supervised	40	100	100	HIS
	Number of counties with functional anti-corruption committees	0	47	47	HIS
	% of facilities with functional anti-corruption committees	0	80	100	HIS
	% of policies/document using evidence as per guidelines	30	100	100	HIS
	% of planning units submitting complete plans	65	95	95	HIS
	# of Health research publications shared with decision makers	3	20	20	HIS
	% of planning units with Performance Contracts	70	100	100	HIS
Health Information	% of quarters for which analysed health information is shared with the sector	50	100	100	HIS
	% of planning units submitting timely, complete and accurate information	25	70	85	HIS
	% of facilities with submitting timely, complete and accurate information	25	70	85	HIS
	% of health facilities with DQA	0	45	50	HIS
	% Public Health Expenditures (Govt and donor) spent on Health Information	3	5	5	HIS

The information from these different sources shall be brought together to inform the sector on overall trends. A composite of indicators shall be used to calculate the health service index.This index shall be used to compute, and interpret emergent trends to show sector progress (or lack of it).It will summarise the different priority areas of service intervention into a single index, to allow for an overall and fair judgment on the presence, or lack of it on improvement in Health Services. The index is designed, in line with the sector service package, the Kenya Essential Package for Health (KEPH). The indicator number is informed based on the need to balance between ensuring that no single indicator on its own has a significant impact on the overall index and having a manageable number of service coverage indicators for monitoring progress.For details on calculation of the health service index,refer to the health sector M and E framework and guidelines.

The total number of indicators per policy objective is fixed. The focus of the indicators is on implementing the respective policy objective, and are not an end in themselves. In line with this, the indicators used will not be fixed, but may be changed, to limit the vertical focus on improving a single indicator during implementation, and instead focus efforts on improving the targeted result against whose progress the indicator is measuring. Where no data is available for an indicator, its value/achievement shall be taken as zero. This is to ensure the sector takes appropriate steps to improve data collection on all result areas, so that there is adequate planning for activities for all life cohorts.

Basic indicator information shall be the national average achievement. This will be obtained from collating all the available information from all reporting units into the national average figure.

Information on indicators will be analyzed in the following lines

1) Overall national achievement
2) Disaggregation of achievement by;
    - Policy objective
    - Intervention
    - County

At different levels of the health system, sector performance shall be subjected to an equity analysis looking at various dimensions such as gender, aridity, rural/urban residence, literacy levels and poverty

An annual health sector performance report will be developed. The report will be validated by stakeholders to:-

- Obtain stakeholder insight on the information generated;
- Mitigate bias through discussion of the information generated with key M&E actors and beneficiaries;
- Generate consensus on the findings and gaps
- Strengthen ownership and commitment to M&E activities

8.2 Enhancement of sharing of data and promoting information use

The sector recognizes the fact that different data is used by different actors for their decision making processes and investment decisions. For this, data need to be translated into information that is relevant for decision-making. Data will be packaged and disseminated in formats that are determined by the needs of the stakeholders.

8.2.1 Sharing service delivery expectations

In line with the Kenya 2010 constitution, need for sector transparency, information on expected services will be publicly displayed outside each facility unit, based on the package to be delivered there. For example, each maternity will display expected interventions that it needs to deliver as defined in the KEPH, based on the facility tier.

8.2.1.1 Annual state of health in Kenya Report

The health sector shall publish annually a state of health report which will be a compilation of statistical information from different sources presenting a snap shot of performance covering the different strategic objectives articulated in this strategic plan. It will be informed by the county annual M and E report and will be produced by the M and E units at the national and county levels. The use of this report in aiding decision making will be promoted by ensuring that it meets the needs of the target audience. An electronic version of thereport will be availed on the MOH website(s).For details of the structure refer to the M and E framework and guidelines

The annual state of health report will be presented to the Joint review meeting and submitted to the M and E directorate at the ministry of state for planning and Vision 2030.

A popular version of the health report will be developed in form of a fact sheet including the key components of the annual state of health in Kenya report. The target audience for the popular version include all health actors and members of the public.

8.2.1.2 Quarterly Performance Review Reports

At all levels a performance review reports will be produced outlining the performance against the strategic objectives outlined in this plan. The reports will be discussed by the health management teams including all the stakeholders at the quarterly performance review meetings. The discussion will focus on a review of the findings and the agreed action points.The finalised report will be submitted to the next level of reporting.

8.2.1.3 AWP Report

This is the annual report documenting progress against the implementation of the AWP for all planning units at the different levels. The district and county AWP review report will be presented at a County Annual Health Review Summit and be published on the MoH Website. The Sector AWP Performance Review Report will be presented and discussed at the National Annual Sector Review Meeting. This forum will draw attendance from MOH national level, the county health management teams, SAGAs and CSOs,DPs and county implementers and other health related sectors etc.

The M&E unit at the national level will translate data and information according to the target audience and utilize various communication channels e.g. radio, T.V, MOH websites, e-bulletins, newsletters, booklets, etc. to pass the information to all the stakeholders.

8.3 Performance monitoring and review processes

8.3.1. Performance monitoring as a learning process

The performance review process will be one of the learning mechanisms in the sector. For proper follow up and learning:

- All performance reviews and evaluations will contain specific, targeted and actionable recommendations, the process is outlined in the M&E framework and guidelines.
- All target institutions will provide a response to the recommendation(s) within a stipulated timeframe, and outlining a) agreement or disagreement with said recommendation(s), b) proposed action(s) to address said recommendation(s), c) timeframe for implementation of said recommendation(s).
- All the planning units and institutions will be required to maintain a recommendation implementation tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.
- The implementation of the agreed actions will be monitored by the M and E unit at all levels. The CHMT and DHMTs will provide coordination and oversight of performance review at the sub

national levels while the M&E unit at the national level will oversee the recommendations implementation tracking plan of the county units. During the quarterly performance review meetings, the sub national management teams together with all the non-state and external actors in their area will discuss the quarterly performance review report and review the recommendations implementation tracking plan for the quarter and identify performance gaps which will be mitigated and action points minuted and followed up.

8.3.1 Joint assessments of progress

8.3.1.1 Joint Assessments at the Community level

A community units stakeholder forum will be responsible for the joint assesment at the community level. All health actors at community level will be expected to: 1) Strengthen the community health committees 2) The community stakeholder forums for which are the key forums for joint assesment at the community level 3) revitalize the community dialogue and action days.

The meetings above shall in line with the sector planning and performance review cycle. Quarterly meetings will be held to review the performance of the units against the indicators and targets outlined in KHSSP III. The M and E results are expected to be used to sensitise the community and accountability through community barazas and other forums.

8.3.1.2 Joint Assessments at Subnational Level

The NHSSP II Mid-term review recommended strengthening policy dialogue structures at subnational level with the establishment of appropriate structures to improve engagement of civil society and partners in the planning and sector review processes.

During KHSSP III, DHMTs and CHMTs will organize quarterly and annual joint performance reviews.

DHMTs and CHMTs will prepare two sets of quarterly reports: a service delivery report and a report documenting progress in the implementation of the AWP. The latter will be based on observations made during supervision and the actions agreed with the supervised staff. The supervisions will be 'integrated, i.e. they will be conducted by state, non-state and external actors, and be both 'management' and 'technical', the latter ones being conducted by the national referral hospitals. The facilities covered in the assessment will include state and non-state facilities.

Reports of primary care facilities, as well as DHMT reports, will be presented at the district/constituency stakeholders' forum meeting. Similarly, district and CHMT reports will be presented at county stakeholders fora. At these meetings, the findings and the agreed action points will be reviewed and a quarterly action plan formulated to ensure that the decisions taken at the meeting are followed up.

Annual reports will present an assessment of progress on the annual work plans and performance against the sector objectives and targets set in the KHSSP III, using the KHSSP indicators. It will compare current results with results of previous years and formulate challenges and action point. It will use data from different sources, including the routine reporting system, household surveys, administrative data (minutes, supervision reports, financial reports, HRIS reports, etc.) as well as research studies.

Details on the organization of these meetings are provided in the M&E framework and Guidelines

8.3.1.3 Joint Assessments at the National Level

The joint annual review is a national forum for reviewing sector performance. The annual reviews will focus on assessing performance during the previous fiscal year, and determining actions and spending plans for the year ahead (current year+1). The NHSSP II mid-term review recommended redesign and reform the JRM process to become bottom-up not just in terms of information generation, but also in information dissemination and linkage with other processes, particularly the quarterly monitoring review process. In addition, specific technical assessments in problem hot spot areas could be carried out during the year, to feed into the JRM process as opposed to having these all done at the JRM. Annual Sector Reviews should be completed in time to ensure that the findings feed into the planning and budget process of the coming year. The JRM will be organized by MOH in collaboration with the development partners.

8.3.2 KHSSP Evaluations

Evaluations will be used to facilitate assessment of progress, and make attributions and predictions of implications of trends across the different indicator domains – inputs/processes; outputs; outcomes and impact. Two evaluations will be carried out during the KHSSP

- Mid -term review – to review progress with impact attained at the Mid Term of the strategic plan, this will coincide with the End Term of the Millennium Development Goals (2015), so the MTR report shall also serve in the MDG evaluation
- End term review – to review final achievements of the sector, against what had been planned.

KHSSP IMPACT TARGETS

- Reduce, by at least half, the neonatal and maternal deaths
- Reduce, by at least 25%, the time spent by persons in ill health
- Improve, by at least 50%, the levels of client satisfaction with services

KHSSP HEALTH AND RELATED SERVICES OUTCOME TARGETS

- Eradication of polio, Guinea Worm, and emerging / re-emerging health threats occurring during the KHSSP period such as hemorrhagic fevers
- Elimination of Malaria, Mother to Child HIV transmission, and NTD's
- Containment of conditions causing major disease burden, with efforts focusing on the top 10 causes of morbidity / mortality.
- Contain the main risk factors to health, focusing on the top 10 risk factors to health

KHSSP INVESTMENT TARGETS

- Ensure 100% of KEPH services are being provided in special settings (congregate settings, at risk populations, hard to reach areas)
- Improve access to KEPH to at least 90% by upgrading 40% of dispensaries, operationalizing all model health centres, constructing new facilities in hard of reach areas, putting in place fully functional referral system, and reduction of pre-payment for services
- Introduce innovative mechanisms to the quality of care

KHSSP FLAGSHIP PROGRAMS

- Establish fully functional **referral system**
- Put in place minimum **staffing norms** in ALL health facilities
- Put in place minimum **infrastructure and equipment norms** in ALL health facilities
- Establish a comprehensive **supply chain system** – from warehouse to patient
- Implement **innovativehealth financinginstitutional arrangements**, focusing on Social Health Insurance and Performance Based Financing mechanisms
- Implement **devolution** in Health, ensuring the County Health system is fully functional
- Establish a comprehensive **IT based HIS** within, and across health facilities