

**REPUBLIC OF KENYA**



## **MINISTRY OF HEALTH**



### **MINISTERIAL STRATEGIC & INVESTMENT PLAN JULY 2014– JUNE 2018**

*Accelerating the attainment of equitable, accessible and quality health care for all*

**Principal Secretary, Ministry of Health, Kenya 2014**

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## **FOREWORD**

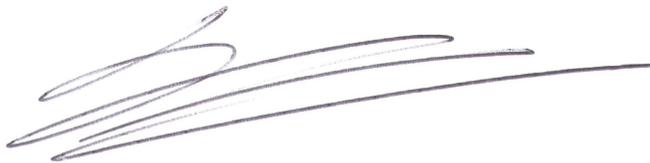
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The development of the Ministerial Strategic Plan 2014-2018 has been guided by the Kenya Constitution, Vision 2030, Kenya Health Policy 2014-2030, Kenya Health Sector Strategic and Investment Plan 2014-2018, Medium Term Plan II 2013-2017 and other health sector policy and strategic documents. The plan aims to support the achievement of the objectives of the Vision 2030 of transforming the country into a globally competitive and prosperous middle income nation with a high quality of life by 2030. It also endeavours to align the ministry's strategic approach towards the aspirations of the Constitution that guarantees the highest attainable standards of health as a right within a devolved system of governance. The ministerial plan aims at ensuring improved service delivery, greater accountability and equity in access and citizens' participation in the management of services as well as resources.

The plan is the first in a series of other five-year strategic plans that will facilitate the implementation of the Kenya Health Policy 2014-2030. The health policy sets to attain a level of distribution of health services commensurate with those of a middle income country through attainment of specific health impact targets. The strategic plan has been developed through a consultative approach involving all key stakeholders in the health sector, while taking cognisance of all new actors under the devolved system of governance.

Further, this plan provides the Ministry of Health with medium term focus, objectives and priorities to enable it move towards attainment of the health goals described in the constitutional and strategic imperatives outlined in the Kenya Health Policy 2014-2030. It provides a detailed description of health outcomes to be sought, priority health investments necessary to achieve the desired outcomes, resource implications and financing strategy and the organisational frameworks required to implement it. It further takes into account and establishes a coordination mechanism to systemise the interactions with county governments and other health actors. The plan also contains a robust monitoring framework that will track achievements in a way that is responsive and accountable to the health needs of Kenyans.

The Ministry of Health is grateful to its staff, partners and other stakeholders who contributed to the development of this ministerial strategic plan. We look forward to working collaboratively across the national and county governments; with our partners and all stakeholders to ensure its successful implementation.



**James W. Macharia**

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## ACKNOWLEDGEMENT

The development process of this strategic plan was done through extensive consultations.

The process was organised through clearly defined working groups reflecting the six broad thematic areas namely: Curative and Rehabilitative Services; Preventive and Promotive Health; Policy, Planning and Health Financing; Standards, Quality Assurance and Regulations; Health Sector Coordination and Inter-Governmental Affairs and Administrative Services.

The appointed senior Ministry of Health staff provided the required leadership to these groups, under the direct supervision of the Director of Medical Services, Dr Nicholas Muraguri. The outputs from the groups were harmonised and summarised before being consolidated to produce the first draft. This draft was shared internally and externally with stakeholders who provided invaluable inputs which have been duly incorporated into this final document.

Undoubtedly, the task would not have been accomplished without the support from the Cabinet Secretary. The effective stewardship by the Director of Medical Services and the Head of the Department of Health Sector Policy Planning and Health Financing, Dr. Peter Kimuu is laudable. I wish to thank all the members of the technical working group for the development of this plan led by Mr. Elkana Ong'uti, Dr. Ruth Kitetu, Dr. Abel Nyakiongora and Mr. Robinson Kahuthu (HPP) for the good job. Indeed, I cannot underplay the significant contribution by the entire staff of the Department of Health Sector Policy Planning and Health Financing for providing all the necessary technical and logistical support to ensure that the plan is completed on time. I commend them for the manner in which they guided the process and the facilitation of the various working groups.

Inputs and contributions from all departments of the ministry, parastatal heads and their officers, development partners and other stakeholders were commendable. To each of the team members and the thematic team leaders, I express gratitude for your dedication towards the development of this important document.

The development of the plan was made possible through the technical and financial assistance from USAID (Health Policy Project). Other development partners who provided technical assistance to the process included DANIDA and the WHO, to whom we are very grateful.



**Dr. Khadijah Kassachoon**

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## *Acronyms and Abbreviations*

AIDS	Acquired Immune Deficiency Syndrome
CSO	Civil Society Organisations
EHPT	Essential Health Products and Technologies
EMMS	Essential Medicines and Medical Supplies
EMR	Electronic Medical Records
FBO	Faith Based Organisation
GDP	Gross Domestic Product
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
HMIS	Health Management and Information System
HRD	Human Resource Development
HRH	Human Resources for Health
HSCC	Health Sector Coordinating Committee
HSSC	Health Sector Steering Committee
ICC	Inter-agency Coordinating Committee
ICT	Information Communication Technology
IMR	Infant Mortality Rate
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KHP	Kenya Health Policy
KHSSP	Kenya Health Sector Strategic Plan
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
KQMH	Kenya Quality Model for Health
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTRH	Moi Teaching and Referral Hospital
NCD's	Non Communicable Diseases
NGOs	Non-Governmental Organisations
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan
NMR	Neonatal Mortality Rate
PPP	Public Private Partnership
SAGA	Semi-Autonomous Government Agency
SWAp	Sector Wide Approaches
SWG	Sector Working Group
TB	Tuberculosis
WHO	World Health Organization



## EXECUTIVE SUMMARY

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This Ministerial Strategic and Investment Plan (MSP) constitutes the statement of intentions and actions of the Ministry of Health over the period July 2014 to June 2018 based on the assigned functions and responsibilities. The plan's development involved in-depth analyses and stakeholder consultations.

The MSP is an integral component in the overall national planning arrangements. It foundationally emanates from the Constitution and the Kenya Vision 2030 through the Kenya Health Policy 2014-2030 and the second Medium Term Plan 2013-2017 and cascaded through the Kenya Health Sector Strategic and Investment Plan 2014-2018. This plan will guide the MTEF planning and budgeting and will form the basis for annual planning and performance contracting.

Despite immense investments in health sector, global, regional and local challenges still present obstacles to health and human capital development. Globalisation, political instability in the region, global economic downturn and climatic change continue to adversely impact on health while increased cross-border movement of people and goods place considerable influence on national health risks and priorities. The country is also striving to meet global commitments including the Millennium Development Goals, reorientation towards Universal Health Coverage and commitment to global partnerships frameworks.

Challenges in the health environment includes high maternal, neonatal and child mortalities from preventable conditions, emerging and re-emerging diseases, increasing numbers of persons newly infected with HIV, threats from fevers such as Ebola and Marbug and the increasing cases of injuries and non-communicable diseases. Poverty still remains a major challenge affecting peoples' ability to maintain health and seek health when needed. Limited resources, inefficiencies in utilization of available resources and weak regulatory systems have greatly constrained the sector from effectively responding to these challenges.

This plan conforms to Kenya's social and economic development agenda as given below;

- Recognizes and adheres to the Constitution of Kenya requirement that attainment of the highest attainable standard of health is a Right, among other constitutional provisions related to health,
- Recognizes and appropriately integrates all the international commitments related to health including International Health Regulations, Aid Effectiveness, MDGs among others,
- Institutes measures to contribute to the Kenya Vision 2030's aim of providing an efficient, integrated, high quality and affordable health care system,
- Is guided by the Kenya Health Policy 2014-2030 and Kenya Health Sector Strategic and Investment Plan 2014-2018 and has focused in putting up measures to achieve the six policy objectives,
- Integrates interventions that will contribute to realization of Medium Term Plan (MTP II) targets through participating in delivery of national flagship programmes.

The primary role of the Ministry of Health is to provide the policy framework that will facilitate the attainment of highest possible standard of health, and in a manner responsive to the needs of the population. This is done through the constitutionally assigned functions of; health policy, health regulation, national and referral facilities and capacity building and technical assistance to counties. Further, elaboration of these mandates is outlined in the presidential Executive Order No. 2 of May 2013. The Ministry has adopted specific core values to govern its operations while delivering on these mandates.

Despite considerable health status improvements over the previous medium term period, there are still some diseases and conditions that continue to exert burden on the health

system. Infant and child mortality rates are still high 39 and 14 per 1000 live births in 2014 , while infectious disease like HIV/AIDS, TB, Malaria, respiratory infections and diarrhoeal disease contribute to over 50 percent of disability adjusted life years. Non-communicable conditions like cardiovascular diseases, cancers, diabetes and mental disorders are contributing to 50 percent of all hospital deaths. Maternal deaths remain high although facility utilization is showing an upward trend with introduction of free maternity services. Use of modern contraceptive increased to 58 percent, and fertility .3.9 per WRA and population growth rates (2.7%) remains high.

In order to discharge its mandate and contribute to the national and health development agenda, the Ministry has adopted the vision, mission, goal and the strategic objectives from the Kenya Health Policy 2014-2030, incorporated selected programmes from the MTP II and prioritized on essential national health strategic programmes (Child Health, HIV Prevention and Control, TB Control, NTD and NCDs and Disease Outbreak Response). The appropriate organization structure has been laid out for this purpose and is constituted by six departments, each assigned specific outcomes as presented below;

Department	Outcomes	Outcome Indicators
<b>Health Sector Coordination and Intergovernmental Affairs</b>	-A well-coordinated and synchronized national and county health system	-A health sector intergovernmental framework -Policies/strategies/Plans for specific technical areas -Percent compliance with coordination framework
<b>Policy, Planning and Health Financing</b>	-Responsive, appropriate, efficient and cost-effective health care system	-Percent of subsector strategies aligned to health policy -Percent of health sub-sectors with policy development capacities -Percent of Annual MoH Work Plan funded
<b>Health Standards, Quality Assurance and Regulations</b>	-Strengthened systems for management of health care quality and safety	-Percent of county health facilities complying with current health norms and standards -Percent of health institutions complying with new or reviewed health laws and regulations
<b>Preventive and Promotive Health</b>	-Reduced burden of preventive conditions and events -Improved health awareness and practice of positive health behaviours	-Prevalence and incidence of preventable conditions -Level of public awareness and of practice of positive health behaviours
<b>Curative and Rehabilitative Health</b>	-Improved access to quality and rehabilitative health services	-Increased access to quality clinical care in slum areas -Increased access to emergency medical care and disaster management -Increased access to quality national forensic and pathology services
<b>Administrative Services</b>	-Efficient and responsive administrative support services	-Composite score for ministerial performance contract improved -Percent of staff scoring 100 and above in performance appraisal system -Operational units functionally linked to MoH Wide Area Network increased

The plan's strategic model elaborates those departmental outcomes to the specific outputs that Divisions and other operational units will deliver, with indicators and the annual targets to be achieved. Specific interventions and activities and their linkages to the KHP and KHSSP priority interventions areas is presented as appendage to the main document.

The Health Intergovernmental Consultative Forum will be the formal coordination platform, between the MoH and county governments. The plan will further apply the SWAp approach and enhance coordination and synergies with health actors to optimize on their roles in health sector advancement. These actors include clients, state, non-state, external actors and professional bodies and associations. A clear partnership and coordination framework has been established.

The Ministry of Health is administratively organized into six (6) departments and responsible for 8 semi-autonomous government agencies and 8 regulatory bodies. The organization structure with a staff complement of 2,602 is deemed more than adequate for implementation of this plan. However, skills for the human resource pool in specific technical areas need to be enhanced and additional financial resources, estimated at Ksh. 152 billion, mobilized for successful implementation of this Plan.

Financial resources in the sector will be targeted towards realization of Universal Health Coverage, whose concept involves optimizing equity to make even the poor have access to care, protection from catastrophic health spending and to ensure that resources are utilized in the most efficient and cost-effective way. During this plan period, the financial resources required by the Ministry, GOK funds available and the financing gap is shown below (excludes transfers to Mathari and Spinal Injury hospitals);

<b>KES</b>	<b>FY 2014/15</b>	<b>FY 2015/16</b>	<b>FY 2016/17</b>	<b>FY 2017/18</b>	<b>Total</b>
<b><i>Resource required</i></b>	35,105,255,590	37,214,512,369	40,040,035,138	39,545,954,915	151,905,758,012
<b><i>Available Funds</i></b>	19,211,128,555	22,631,520,544	23,659,665,988	24,842,649,288	90,344,964,376
<b><i>Funding Gap</i></b>	15,894,127,035	14,582,991,825	16,380,369,150	14,703,305,626	61,560,793,636

This Plan has integrated the measures to mitigate likely risks that may prevent its successful implementation. The increasing fiscal deficit and rising inflation from adverse weather conditions may shrink the public financial resources available to the sector over time; insecurity may affect the plan implementation in some regions while staff may be challenged by rapid advancement of technology among others. An elaborate programme for mitigation of these risks and monitoring mechanisms is included as part of plan implementation. These measures include initiating innovative resource mobilization strategies and cost-cutting measures, optimizing intersectoral collaborations and restructuring the MoH to be more accountable and efficient.

Finally, implementation of this MSP will be closely monitored by tracking performance of agreed key indicators and annual target that every department, division or unit is expected to achieve. Performance will also be monitored within the sector's overall Monitoring and Evaluation Framework that will combine national and county systems to determine overall health sector performance in terms of outcomes and impact.



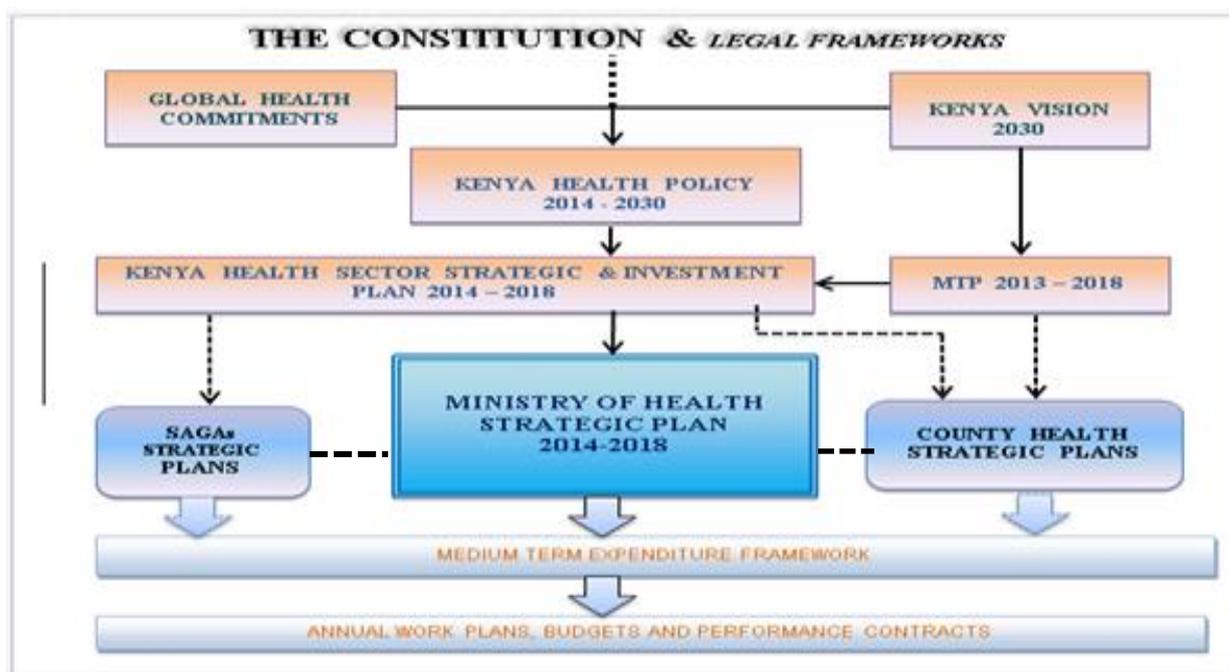
## CHAPTER 1. INTRODUCTION

Strategic planning constitutes a major component of the Government of Kenya's (GoK) ongoing public sector reforms for enhancing efficiency and effectiveness in public service delivery. In addition, strategic planning provides a forum through which the Government can communicate with all its stakeholders the use of public resources for common good. Following the launch of the second Medium Term Plan 2013-2017 of Vision 2030, whose theme is “*Transforming Kenya: Pathway to Devolution, Socio-economic development and National Unity*”, all Government ministries are required to develop Ministerial Strategic Plans (MSPs) for the period 2013/14 to 2017/18.

### 1.1 Rationale for Ministerial Strategic Planning

For the Ministry of Health (MoH), this strategic plan, like others within the public sector, is expected to support the implementation of the Vision 2030 and MTP II 2013-2017, along with the broad goals of the Kenya Health Sector Strategic and Investment Plan (KHSSP), July 2014-June 2018. The plan will also form the basis for identifying deliverables under the performance contracting mechanism and for individual annual performance appraisal. The plan is also a resource mobilisation tool. The financial resources required to implement the plan, indeed, exceed the estimated available resources, which are based on the Medium Term Expenditure Framework (MTEF) for the next three years and projections for the remaining years. In addition, this plan will inform the optimisation of human resources required to facilitate a successful implementation of the mandate of the Ministry of Health. Schedule 4 of the Constitution assigns to the County Governments the function of delivering county health services and to the National Government the functions of stewardship for health policy and oversight of national referral health facilities. This, therefore, calls for both levels of governments to develop health strategic plans as per their mandates to implement the Constitution, Kenya Health Policy 2014-2030, KHSSP 2014-2018 and MTP II 2013-2017. These linkages are schematically presented in Figure 1.

Figure 1: MSP Linkage with the National Planning Framework



## 1.2 Process for Development of the Strategic Plan

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A consensus building meeting with all heads of parastatals, national referral facilities, regulatory bodies, departments, divisions, and units was held to share the guidelines from Ministry of Devolution and Planning and agree on the roadmap for the development of the Ministerial Strategic Plan (MSP). Representatives from all departments, divisions and units conducted a situation analysis on the implementation of key MoH policy agenda outlined in documents such as National Health Sector Strategic Plan II 2005-2012, the first Medium Term Plan (MTP I) 2008-2012, previous Ministerial Strategic Plans and other relevant ministerial documents through a desk review and the lessons learned were documented. A five-day workshop was conducted to develop the first draft of the Ministerial Strategic Plan based on the guidelines provided by Ministry of Devolution and Planning to all ministries/departments and Semi-Autonomous Government Agencies (SAGAs). The draft plan was shared with both internal and external stakeholders for inputs and comments. These were incorporated into the plan. A consensus meeting was held with all key stakeholders and the plan adopted.

## 1.3 Organization of the Ministerial Strategic Plan

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This introductory chapter contextualizes the MSP's within the national developmental agenda explaining the planning requirements that it meets, while outlining the processes applied to reach to the final content of the document. Chapter 2 outlines and analyzes the international, regional and national health and politico-socio-economic environments against challenges posed and anticipated in the medium term.

The basis for setting the health developmental agenda is provided in the next three chapters. Chapter 3 explores the foundational basis for the strategic plan while Chapter 4 demonstrates the relevance and importance of MoH's institutional arrangement to execute health agenda. Chapter 5 reviews the health situation, analyses the lessons from previous planning period in order to align the MoH strategic plan agenda on the working approaches.

Chapter 6 presents the strategic model that outlines the overall intentions, defines what is to be realized and specifies the tangible outputs that will be generated by the ministry over the plan period. Specific outcome and output measures for every Department and Division are clearly spelt out for monitoring of performance.

Chapters 7 and 8 assess the organizational and institutional capacity to implement the measures anticipated in Chapter 6. The analysis of resource requirements and the available envelope and related issues are presented in Chapter 9. Measures that will mitigate the arising risks and promote accountability are outlined in Chapter 10. The elaborate process for monitoring, evaluation and reporting is presented in Chapter 11.

Appendix 1 presents the human resource capacity of the Ministry while Appendix 2 presents the specific interventions every ministerial department will deliver and demonstrates how these interventions are contributing to the investment areas spelt out in the Kenya Health Policy 2014-2030 and Kenya Health Strategic and Investment Plan 2014-2018.

## **CHAPTER 2. KENYA'S HEALTH DEVELOPMENT CHALLENGES**

### **2.1 Global, Regional and National Environments**

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Health, with all its socio-economic ramifications, remains one of the major global challenges and a big obstacle to human capital development. Although there have been immense investments in the sector and international policy and strategic efforts to improve the human conditions over the years, challenges still remain.

Globalisation, political instability and the emerging regional and national macroeconomic challenges triggered by the global economic downturn and climate change, have adversely impacted on health. In addition, the increased cross-border movements of goods, services and people as well as international rules and institutions have had a considerable influence on national health risks and priorities. To respond to these challenges, a number of regional and global initiatives focusing on health have been undertaken. These include major reforms within the United Nations and international and regional declarations and commitments.

This plan has been developed at a time when the global development efforts towards attainment of Millennium Development Goals (MDGs) are coming to a close while other global initiatives such as those targeting non-communicable diseases, social determinants of health and managing the emerging and re-emerging health threats are gaining momentum. Further, there are emerging global efforts and commitments towards achievement of universal health coverage and to implement the principles of Aid Effectiveness that focus on aligning donor support to country policies, strategies and priorities and using country systems in implementation for purposes of ownership. These include Rome 2003, Paris 2005, Accra 2008, and Busan 2011. This strategic plan is, therefore, aligned to these unfolding global events.

### **2.2 Persistent Health Conditions and Risks**

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Kenya faces a number of health challenges especially among children, including high mortality from diseases that can be prevented through immunisation and high maternal mortality arising from pre-partum, child birth and post-partum conditions. Many people are also exposed to a heavy and wide-ranging disease burden partly because of the country's geographical and climatic conditions. The difficult, disaster-prone environment in the arid and semi-arid regions of the country, and the lush but malaria-prone regions in the better endowed parts of the country, all have specific health risks associated with them. Political instability in the Eastern African region and subsequent displacement of people has resulted in increasing the demand for health services in the country and raising the risk of spreading communicable diseases. These factors are compounded by inadequate resources to fully mitigate the impact of these health risks.

At present, Kenya faces problems of emerging and re-emerging diseases. Tuberculosis has resurfaced as a major cause of ill-health. In addition, while the HIV prevalence has been steadily reducing, the number of newly infected people continues to increase. The threat from haemorrhagic fevers such Ebola and Marburg remains real. Moreover, the country faces an

increasing health burden from injuries and non-communicable diseases for which additional efforts are required. These are exacerbated by the negative underlying social determinants of health in the country. Poverty still remains a major challenge affecting people's ability to maintain health and to seek health services when needed.

### 2.3 Kenya's Health System Challenges

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Limited resources and inefficiencies in resource utilisation have constrained the health sector's ability to fully harness existing technology to manage most of the direct causes of ill health and death. For instance, many of the public hospitals do not have the basic requirements such as adequate human resource, adequate stocks of essential medicines, operating theatres and supplies and functional ambulances. The county governments, under whose docket these facilities now lie, will thus require continued support to bring them to the required standards.

Existing efforts and support to respond efficiently and effectively to the health challenges are far from sufficient. Although mechanisms for improved coordination and partnership have been defined, including a Kenya Health Sector-wide Approach (SWAp), and its formal instrument, the Code of Conduct (CoC), adherence to the obligations of both the SWAp and the CoC by all partners has been poor. The principles of the 2005 Paris Declaration on Aid Effectiveness have not been fully inculcated into the thinking of some players in the sector. Parallel financing continues and not all funds are being channelled to the defined sector priority areas. This leads to inefficiencies in the use of available limited resources. A well-coordinated and managed devolution process in the health sector will result in further efficiency gains.

Weak regulatory structures and the liberalised health market are additional challenges, as they have led to the proliferation of counterfeits and substandard health care services and products. The unionisation of health workers and the now recurrent industrial actions also continue to present new demands and challenges to the sector.

In spite of these challenges, however, the health sector has had many successes that are presently leading to the emerging trends of reduced mortality and prevalence in disease conditions. With accelerated focus on key areas, the health sector should be able to accelerate and sustain the reversal of the downward trends in health indicators in the country.

## **CHAPTER 3. LINKAGES WITH KENYA'S DEVELOPMENT AGENDA**

In the past few years, the Government of Kenya continued with the implementation of an ambitious economic reform agenda known as the Economic Recovery Strategy (ERS) that has seen improvements in public sector management in all sectors of the economy. The health sector has benefited from these changes, which have led to improvements in some of the health indicators, including child health and HIV/AIDS. Overall, the implementation of the ERS 2003-2007 saw the economy grow from 2.9 % in 2003 to 7.1 % in 2007.

However, during the 2008-2012 period, growth slowed as a result of multiple adverse shocks, namely; the post-election crisis, drought, the global financial and economic crisis, high international oil and food prices and slowdown in global economic activity. These factors contributed to low attainment of projected GDP growth, and investment and savings targets. For instance, GDP growth declined in 2008 to 1.7%. However, the Government continued to reorient its budget to allocate a much larger share of expenditure to priority areas such as infrastructure, education, agriculture and rural development and health. The implementation of the Economic Stimulus Programme (ESP) by the Government was meant to boost economic growth and lead the Kenyan economy out of the recession situation brought about by the slowdown. The allocation to the health sector continued to increase from 5.3% in 2004/05 to 7.3% in 2007/08 and 7.8% in 2012/13. However, this is still below the Abuja declaration (2001) which called for governments to increase funding and allocate 15% of the national budget to health.

### **3.1 The Constitution of Kenya**

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The promulgation of the constitution of Kenya on 27<sup>th</sup> August, 2010 was a major milestone towards the improvement of health standards. Kenyans' high expectations are grounded on the fact that the new Constitution states that every citizen has right to life, right to the highest attainable standards 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 also provides a conducive overarching legal framework for ensuring more comprehensive and people-driven, rights-based approach to health. These are premised on the principles of equity and participation which also resonate with the principles of the health care system. Additionally, two critical chapters of the Constitution, the Bill of Rights and the devolved Government, introduce new ways of addressing health problems, and have direct implications on the health sector's focus, priorities and functioning.

**Table 1: Main Constitutional Articles that have Implications on Health**

Constitutional Article	Implication on Health
<b>Rights and Fundamental Freedoms</b>	
26 (1-3) Right to life	Both county and national governments must create an enabling environment to ensure every Kenyan is healthy. The governments must ensure health services are available, accessible, acceptable and of high quality.  The health sector needs to work collaboratively with other sectors such as water, education, agriculture, justice, immigration, roads etc. to ensure health rights are realized.  Citizens are empowered to demand for services by law.
35 (3) State shall publish and publicize any important information affecting the Nation	
43(1) Right to the highest attainable standards of health Right to housing, sanitation, food, clean and safe water	
43 (2) Right to emergency treatment	
43 (3) Right to social protection	
46 (1) Consumer rights with respect to health	
53 (1) Child rights with respect to health	
56 (e) Rights of minorities and marginalised groups with respect to health	
<b>Devolved Governments</b>	
6 (2) Relationship between the two levels of government	The national Ministry of Health and respective County Departments of Health are required to work in a collaborative manner to ensure the achievement of health goals.
174 Objects of devolution	A devolved health system should bring services closer to the people, improve efficiency, promote transparency , accountability and put citizens at the driver's seat to determine their health agenda.
176 (2) County Governments	County health departments should transfer functions to the smallest capable unit that is capable of delivering that service.
186 (2),187 Functions of county governments	Concurrent functions require the cooperation of both levels of government for their successful implementation. There is room for transfer of functions between either levels of government as long as it makes sense from an efficiency of service delivery standpoint.
Fourth Schedule-Assignment of functions Part 1- National Government Functions 23. National referral facilities 28. Health Policy 32. Capacity building and technical assistance to counties Part 2-County Government Functions 2. County health services County health services include: County health facilities and pharmacies Ambulance services; Promotion of primary health care; Licensing and control of selling of food in public places; Veterinary services; Cemeteries, funeral parlours and crematorium; Refuse removal, refuse dumps and solid waste	Functions analysis has been done to ensure clarity of responsibility between the two levels of government. Analysis is contained in the Health Sector Transfer Policy Paper.  Functions need to be further unbundled to facilitate costing for each level of government to ensure that health is adequately funded to meet the constitutional aspirations for the right to the highest attainable standards of health. ... Schedule 4 sees to it that there is Increased access of health services
204 Establishment of the equalisation fund	Counties in marginalized areas of the country can in addition to the equitable share leverage on the equalisation fund to support the development of health infrastructure to bring it at par with other counties enjoying higher level infrastructure.
235 Staffing county governments	Counties are now vested with the responsibilities of managing the health workforce of their respective counties.
236 Protection of public officers	Health staff are protected from victimisation or discrimination from counties where they are seconded.

### 3.2 Global Health Commitments

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The Ministerial Strategic Plan aims to support the country's health sector implement the various global commitments it has entered into. While these are numerous, the critical ones that have informed the strategy's focus and priorities include:

- The International Health Regulations – to guide the country on key actions needed to assure adherence to international health regulations.
- The Ouagadougou Declaration on Primary Health Care (PHC) and Health Systems – a re-iteration of the principles of the PHC approach, within the context of an overall health system strengthening approach.
- International Health Partnerships (IHP+) on Aid Effectiveness.
- The Millennium Development Goals (MDGs) declaration and the post 2015 agenda – a focus on global efforts towards improving health impacts.
- The Abuja Declaration – to support the improvements of health systems in the country by domesticating the provisions through national legislation. By signing the Abuja Declaration, Kenya committed to allocate 15% of government expenditure to health.
- International Human Right agreements such as 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. Regular monitoring and reporting on progress will be carried out.

### 3.3 The Kenya Vision 2030

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The Government of Kenya developed the Vision 2030 as a national 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 by transforming the country from a third world country into an industrialising middle income country, providing a high quality of life to all its citizens in a clean and secure environment”. To improve the overall livelihoods of Kenyans, the country aims to provide an efficient, integrated, high-quality and affordable health care system. Priority will be given to preventive care at community and household level, through a devolved health care system.

With devolution of service delivery to county level, the MoH is in a better position to focus on policy, regulations and standards setting, sector performance monitoring and capacity building. With the support of the private sector, Kenya also intends to become the regional provider of choice for highly-specialised health care, thus opening Kenya to “health tourism”. Improved utilisation of health care services by all will be achieved 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 flagship projects under the social pillar of the vision 2030 and which have already been integrated in the new Constitution, devolved governance and policy framework include the following:

- Channel funds directly to health facilities.
- De-linking the health ministry from service delivery.
- Fast tracking implementation of community strategy.
- Development of a Human resource strategy.
- Establishing equitable financing mechanisms.

The country recognises 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 increased labour production that Kenya requires in order to match its global competitors. Health is, therefore, one of the key sectors in delivering the social pillar by 'Investing in the People of Kenya'. Vision 2030 is being implemented through the national five-year medium term plans and sector plans.

### 3.4 The Kenya Health Policy 2014-2030

The health sector has established its Kenya Health Policy (KHP) to guide attainment of the long- term health goals sought by the country as outlined in the Constitution of Kenya 2010 and Vision 2030. It focuses on adopting a 'human rights based approach', and maximising the 'health contribution to overall national development'.

The overall objective of the KHP is to ***attain universal health coverage with critical services that positively contribute to the realisation of the overall policy goal.***

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

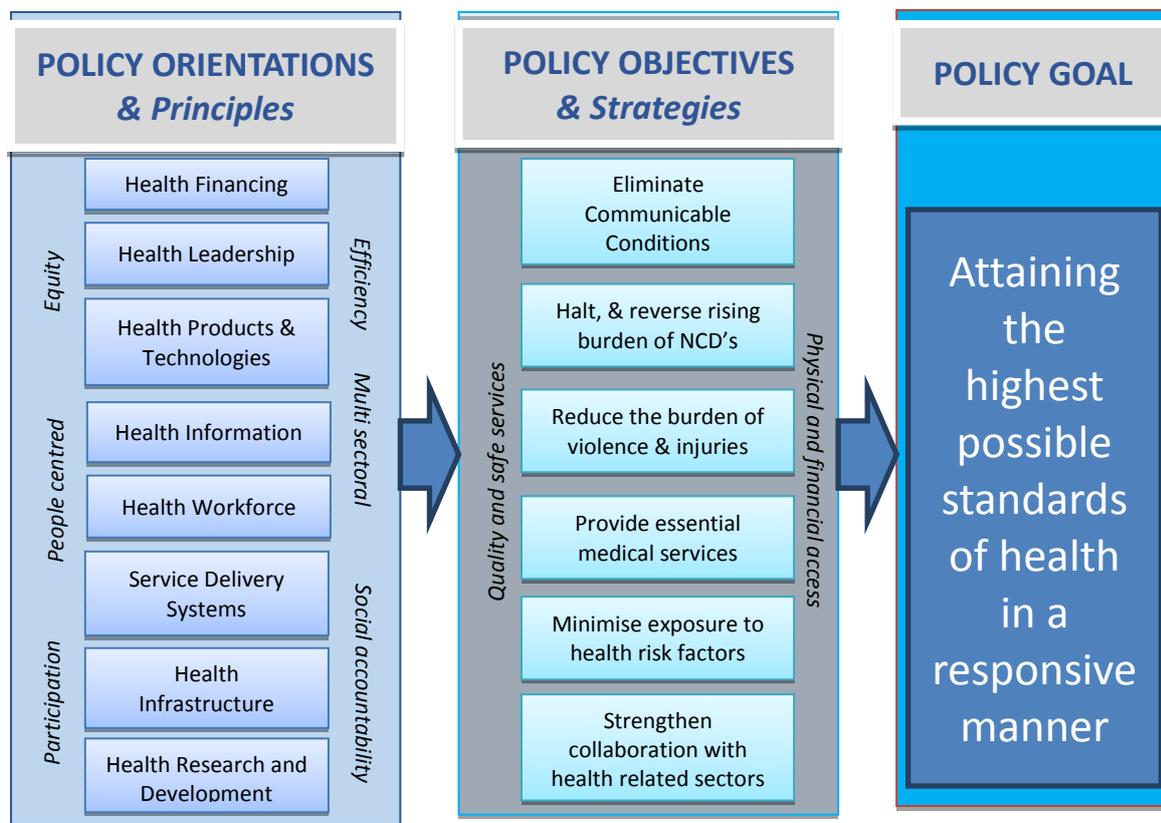
The target of the policy is to attain a level and distribution of health commensurate with that of a middle income country. Six policy objectives and eight policy orientations, therefore, are defined, which address the current situation. Each has specific strategies to focus on so as to enable attainment of the policy objectives. The objectives include to:

1. *Eliminate communicable conditions*: This aims at reducing the burden of communicable diseases until they are a minor public health concern.
2. *Halt and reverse the rising burden of non-communicable conditions*. This aims at ensuring the implementation of clear strategies addressing all the identified non communicable conditions in the country.
3. *Reduce the burden of violence and injuries*. This aims at instituting strategies that address all the causes of injuries and violence.
4. *Provide essential health care*. This aims at providing medical services that are affordable, equitable, accessible and responsive to clients' needs.

5. *Minimise exposure to health risk factors.* This aims at strengthening the health promotion interventions which address risk factors to health and also facilitate the use of products and services that lead to healthy behaviours in the population.
6. *Strengthen collaboration with health related sectors.* This aims at adopting a ‘Health in all Policies’ approach, which ensures that the health sector interacts with and influences design, implementation and monitoring processes in all health related sector actions.

These are interlinked as shown in the conceptual framework on Figure 2 below.

**Figure 2: KHP Framework for Policy Directions**



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. This will apply every 5 years, as the health sector moves towards attaining the overall policy goal. The five-year plans are aligned to the MTPs to ensure they are well integrated into the overall Government agenda (Kenya Vision 2030).

### 3.5 The Kenya Health Sector Strategic and Investment Plan 2014-2018

Kenya Health Sector Strategic and Investment Plan (KHSSP) define the medium term focus, goal, mission, objectives and priorities of the health sector which will facilitate the attainment of the KHP objectives. It is not restricted to the actions of the Ministry of Health, but includes all actions of other state, non-state and external actors. It guides national and county

governments plus partners on the operational priorities that they need to focus on in addressing the health agenda in Kenya. KHSSP has been elaborated in line with the sector's Medium Term Plan (MTP) II priorities (see below), with a focus on implementing Kenya Health Policy. Devolution will facilitate the achievement of key KHSSP principles and strategies of access, equity and quality of health care. This will be achieved through the allocation of funds and responsibility for delivery of health care to hospitals, health centres and dispensaries, thereby empowering Kenyan households and social groups to take an active role in maintaining and managing their health.

The strategic plan has, as its goal, '*Attaining equitable, affordable, accessible and quality health care for all*'. This goal encompasses the focus of the health sector in the medium term, informed by the need to improve numbers of available services, scale up coverage of required services and reduce financial implications of accessing and using health services. The mission of the sector in the medium term is '*To build a progressive, responsive and sustainable health care system for accelerated attainment of highest standards of health to all Kenyans*'. This mission will be attained through focusing on the implementation of a broad based health and related services that will impact on the health of persons in Kenya. It places emphasis on implementing interventions and prioritising investments relating to maternal and newborn health.

Appendix 2 shows the MSP priority interventions for each KHSSP investment area. The vast majority of these are also KHSSP priority interventions, with some of them being adjusted to reflect the role of national government in delivering on these KHSSP interventions.

### 3.6 The Medium Term Plan II 2013-2017

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The second Medium Term Plan, 2013-17 (MTP II) focuses on "*Transforming Kenya: Pathways to Devolution, Socio-economic Development, Equity and National Unity*". The country recognises that achieving the development goals outlined in Vision 2030 will require a stable macroeconomic environment, supported by real time structural reforms. These reforms focus on accelerating the devolution of services, rehabilitation and expansion of infrastructure; developing quality human capital to raise productivity and enhance global competitiveness and maximising economic opportunities for all Kenyans through targeted programmes to reduce inequality and poverty.

Health is one of the key components in delivering the social pillar, "Investing in the People of Kenya", which intends to build the country into a cohesive society that enjoys equitable social development in a clean and secure environment. The health sector also plays a critical supportive role in the economic pillar by maintaining a healthy working population that is necessary for the increased labour production required if Kenya is to match its global competitors.

MTP II defines medium term priorities and flagship projects the Government intends to focus on as it moves towards attaining the objectives of the Vision 2030. The health sector objectives stipulated in the MTP II are to:

- Reduce Maternal Mortality Rate (MMR) from 488/100,000 to 150/100,000.

- Reduce under five mortality rate from 74/1,000 to 35/1,000.
- Reduce infant mortality rate (IMR) from 52/1,000 to 30/1,000.
- Reduce HIV/AIDS prevalence rate from 5.6% to 4%.
- Improve under one immunisation coverage from 83% to 90%.
- Reduce Malaria in-patient case fatality rate from 15% to 5%.

In order to achieve these objectives, the health sector will focus on universal access to health care, preventive and primary health care, management of communicable diseases, maternal and child health and non-communicable diseases. Focus will also be given to medical research, pharmaceutical production and health tourism as a means of diversifying external revenue sources and serve as a regional hub for health services. The specific sector flagship projects and their relationship with the ministry's priorities are further elaborated in the Strategic Model of this Strategic Plan (Chapter 6).



## CHAPTER 4. ROLE OF THE MINISTRY OF HEALTH

Overall, the Ministry of Health aims to provide a policy framework that will facilitate the attainment of the highest possible standard of health in a manner responsive to the needs of the population, including access to quality services with adequate financial risk protection. This approach is designed to take the country beyond the current health services approach towards a focus on health, using a primary health care approach which remains the most efficient and cost-effective way to organise a health system.

### 4.1 Responsibilities of the Ministry of Health

The plan finally takes cognizance of the roles of the national and county governments which are distinct and interdependent. The key functions of the ministry as per the 4<sup>th</sup> schedule of the Constitution include: Health policy, health regulation, national referral facilities, capacity building and technical assistance to counties. The Government has also outlined the mandates of the Ministry of Health through Executive Order No 2 of May 2013, as shown in Table 2.

**Table 2: The Core Mandates of the Ministry of Health**

<ul style="list-style-type: none"> <li>• Health Policy and Standards Management</li> <li>• Registration of Doctors and Para-medics</li> <li>• Training of Health Personnel</li> <li>• National Medical Laboratories Services</li> <li>• Pharmacy and Medicines control</li> <li>• Public Health and Sanitation Policy Management</li> <li>• Medical Services Policy</li> <li>• Reproductive Health Policy</li> <li>• Preventive, Promotive and Curative Health Services</li> <li>• National Health Referral Services</li> <li>• Health Education Management</li> <li>• Health Inspection and other Public Health Services</li> <li>• Quarantine Administration</li> </ul>	<ul style="list-style-type: none"> <li>• Coordination of campaign against HIV/AIDs</li> <li>• Cancer Policy</li> <li>• Nutrition Policy</li> <li>• KEMSA (KEMSA Act 2012)</li> <li>• KEMRI, science and technology(amendment act 1979)</li> <li>• KMTTC legal notice no.14 of 1990</li> <li>• NHIF(NHIF act 1998)</li> <li>• KNH(Legal notice No.109 of 1987)</li> <li>• MTRH(legal notice no.78 of 1998)</li> <li>• Government Chemist (health act)</li> <li>• Pharmacy and Poisons Board(cap 244)</li> <li>• Radiation Protection Board(cap 243)</li> <li>• Referral Hospitals Authority</li> <li>• National Aids Control Council (legal notice No.170 of 1999)</li> </ul>
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### 4.2 Core Values

Values are an integral part of any organisation's culture and create a sense of identity, belonging and purpose. Accordingly, the ministry is guided by the following core values:

- **Professionalism and ethics:** All staff shall uphold the highest moral standards and professional competence in service delivery.
- **Transparency and Integrity:** To be responsible, accountable and devoid of corrupt practices in service delivery.
- **Communication:** To ensure smooth information flow for both internal and external stakeholders.

- **People centred and customer satisfaction:** To treat customers with courtesy and respect and delight in their satisfaction.
- **Commitment:** To devote all our official time to our duties and undertake to serve customers without unnecessary delays.
- **Team work:** To encourage team spirit, collaboration and consultation as a way of maximising the synergy of working together for improved service delivery.
- **Innovativeness and creativity:** To be open and proactive in seeking better and more efficient methods of service delivery.
- **Social justice and equity:** Human rights approach and equitable access are fundamental guiding principles to inform delivery of public health services in the country.
- **Partnership and collaboration:** Close working relationship with all stakeholders to promote synergy.
- **Result oriented:** Results for Kenyans.

## CHAPTER 5. LESSONS LEARNT

### 5.1 Current Status of Health in Kenya

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Child health has in the last ten years shown improvements, even though infant and under-five mortality rates have remained relatively high at 39/1000 and 52/1000 respectively (KDHS KIR 2014). The main causes of death include: HIV/AIDS (29.3%), prenatal conditions (9.0%), lower respiratory tract infections (8.1%), Tuberculosis (6.3%), diarrhoea (6.0%) and Malaria (5.8%). Deaths due to diseases that can be prevented through immunisation have declined gradually, as the percentage of infants who have received all basic vaccines currently stands at 68 % (KDHS KIR 2014). However, coverage is low in some counties. The ministry introduced pneumococcal vaccine for pneumonia and Rotavirus for diarrhoea respectively in 2012 and July 2014. Ill-health among children still remains a challenge. Child malnutrition remains rampant with stunting levels of 26 % in UFs. About 40,000 children die annually due to underweight, vitamin A deficiency and wasting especially in populations in the chronically food-insecure arid and semi-arid lands (ASAL).

Infectious diseases including, but not limited to, HIV/AIDS, Lower Respiratory Tract Infections, TB, diarrhoeal diseases and Malaria account for over 50% of all deaths in Kenya. This is, partly due to the high prevalence of HIV/AIDS, TB and Malaria. They also account for almost half of all Disability Adjusted Live Years (DALYs) lost in Kenya.

HIV/AIDS is still estimated to be the leading cause of death - accounting for about 30% of all deaths- and the leading cause of disease burden -causing 24% of total disease burden in terms of DALY's lost. Currently, 1.6 million people are living with HIV in Kenya out of whom 680,000 are on life saving Antiretroviral drugs. In the 1994-2010 period, HIV/AIDS control showed progress with the prevalence reducing, though the rate of reduction has slowed. HIV prevalence declined from 6.3% to stand at 5.6% currently. Coverage with critical HIV interventions such as use of ART, Prevention of Mother to Child Transmission (PMTCT) and condom use significantly improved.

TB control has shown considerable improvements in the past several years. Kenya's case detection rate (83%) and treatment success rate (88%) surpass even the WHO global targets (70% and 85% resp.). This can be attributed to successful roll out and implementation of high impact interventions for TB control. However, the emergence of drug resistant TB strains is a very serious threat that requires the full attention of the MoH in particular and WHO in general.

The Malaria burden remains high, but there are indications that effective interventions such as use of Insecticide Treated Nets (ITNs), Intermittent Prophylactic Treatment (IPT) and Indoor Residual Spraying (IRS) have shown improvements in the targeted areas. The Malaria epidemiological map in the country has significantly improved. 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 has not yet been explored.

Neglected Tropical Diseases (NTDs) include a variety of diseases that exist in specific populations. Most studies on NTDs show a decline in prevalence. However, they are yet to be eliminated.

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 mental disorders. Together, they represented 50%-70% of all hospital admissions during the policy period and up to half of all inpatient mortality. All available evidence shows that the public health importance of these conditions will further increase during the MSP period.

Injuries and violence also feature among the top 10 causes of morbidity and mortality in the country and show an increasing trend over the years (especially in young and unemployed people). Without concerted multi-sectoral efforts, a further rise in road traffic accidents causing injuries and deaths can be expected.

Moreover, health interventions will be required to be gender sensitive integrating socio-cultural and socio-economic diversity of men and women in line with government policy on gender. These interventions must find innovative ways to enhance gender equity in health. In addition, concerns for youth, adolescents and persons with disabilities, marginalised and vulnerable population will be mainstreamed and specific programmes and interventions tailored for them.

Maternal deaths remain a major challenge. This is to a large extent a problem of insufficient access to skilled birth attendants (62% of all deliveries in 2014) and an inadequate referral system, including the availability of emergency transportation. Besides, about half of mothers are anaemic with an uptake of recommended iron supplements during pregnancy below 3 per cent.

Introduction of free maternity services under the presidential directive of May 2013 is expected to improve access to skilled birth attendants and reduce maternal deaths. Although some gains have been achieved in use of modern contraceptives, the rate of contraceptive use is still low at 58 % in 2014. Consequently, Kenya's population growth and fertility rates remain high at 2.7 percent and 3.9 per Woman of Reproductive Age respectively.

**Table 3: Key Indicators on Health Status in Kenya in 2010, with 2015 and 2017 Targets**

Indicators	Baseline (2014)	2015/16 Target	2017/18 Target
Life expectancy at birth	61	62	65
Total annual number of deaths (per 100,000 population)	106	95	80
Maternal deaths per 100,000 live births	350	300	150
Neonatal deaths per 1,000 live births	14	25	15
Under five deaths per 1000	52	50	35
Youth and adolescent deaths per 1000	45	30	20
Adult deaths per 1000	23	20	10
Elderly deaths per 1000	80	80	80
Years of life lived with illness / disability	12	10	8
Years of life lived with illness/disability due to communicable conditions	6.8	5	4
Years of life lived with illness/disability due to non-communicable conditions	2.8	4	3
Years of life lived with illness/disability due to violence / injuries	1.0	1	1

Source: KDHS KIR 2014, KHP 2014-2030, KHSSP 2014-2018

All indicators point to high mortality rates and in particular the maternal and neonatal mortality rates in the coming years unless concerted efforts are taken to implement the strategies in this plan.

## 5.2 Lessons Learnt from Sector Stewardship and Governance under NHSSP II

The previous planning and implementation period coincided with the split of the Ministry of Health into two ministries, namely: Ministry of Medical Services and Ministry of Public Health and Sanitation. A number of lessons were learnt during this period, some of which provide information for interventions during this plan period as given below.

The improving trends presented above with regard to HIV/AIDS, TB, Malaria and child health are undoubtedly related to increased funding of the health sector from partners, though in nominal terms only, with a greater focus on funding and programming of health promotion and prevention programmes, and this without significantly compromising on curative services. A well-functioning partnership coordination framework was a crucial factor in this. Overall, public funding of the sector steadily increased over the plan period from about KShs. 34 billion in 2007/08 to KShs. 87 billion by 2012/13, with funding for primary health care increasing to about 45 per cent by 2012/13.

External partners contributed significantly, including through the supply of the required health commodities. However, overall public funding to the sector constituted just about 6-7 per cent of public expenditure, way below the Abuja target of 15 per cent. In order to achieve the KHSSP and MSP objectives, there is need to continue efforts to ensure sufficient funding for the health sector, with adequate funding for health promotion and prevention programmes, in particular the programmes listed in Chapter 6, with the support of all partners.

Access to and quality of health services in general was improved by increased investment by government in infrastructural development under the Economic Stimulus Package (ESP). This led to the construction of 201 model health centres across the country, the rehabilitation of 92 hospitals, the construction of one hospital and the upgrading of 48 health facilities to hospital status. In addition, 5 referral hospitals were equipped with renal equipment and cancer equipment was installed at Kenyatta National Hospital. However, health infrastructure for comprehensive primary, secondary and tertiary health care remains inadequate. Under MSP, the MoH will, therefore, in close collaboration with the county governments, continue to support infrastructural development, in particular in an effort to increase utilisation of primary care services in the slum areas of Nairobi, Mombasa and Kisumu. In addition, the MoH will support equipping two public sector hospitals in each county.

Having increased the GoK health infrastructure, it became necessary to increase the number of health workers in the sector, with over 6,000 new GoK employees coming on board during the period. However, public health facilities remain understaffed with an inequitable distribution of health workers across the country, in particular for some cadres. Doctor to population and nurse to population ratios remain low.

The developments in service delivery and funding were accompanied with strengthened management systems. The strengthening of supportive supervision through hospital

management reforms in particular contributed greatly to better quality of services – an approach that requires proper frameworks to realise greater results. However, this system of management partly led to weakening of the role and position of district and facility level managers. Progress was also made in improving the availability of essential medicines and medical supplies (EMMS) at GoK primary care facilities through the national roll-out of the ‘pull system’. Through this system, facilities order EMMS according to their needs and based on clearly defined drawing rights. However, despite this progress, facilities often still lack EMMS.

Other positive developments that need continuation under MSP include: The joint sector planning and monitoring processes with external actors, the focus on developing a better health management information system (HMIS) and careful quantification of health commodities for the key HIV/AIDS, TB, Malaria and childhood vaccination programmes, which enabled the continuous availability of the strategic commodities at facility level. However, there are also some major outstanding issues, in particular with regard to health financing, including the high cost of health care and the low coverage of health insurance.

The devolved system of government now offers opportunities to adjust the role of the MoH under this MSP and strengthen areas which have not received adequate attention so far.

In particular, the greater emphasis at national level on policy development, development of guidelines, setting of norms and standards on all health system components and capacity building and technical assistance to the counties is expected to result in:

- A more coherent and comprehensive regulatory and policy framework for the entire sector, including on the key issue of health financing.
- A more rational use of all resources.
- Greater capacities at county and local levels to manage and deliver county health services.

## CHAPTER 6. THE STRATEGIC MODEL

This section describes the ministry's vision, mission, goal, objectives, outcomes, outputs, key indicators and annual targets for the planning period. The section also briefly describes the linkages between this plan, KHP 2014-2030 and KHSSP 2014-2018, as well as the ministry's MTP II Flagship Projects and other key priority interventions during this planning period,

### 6.1 MoH Vision, Mission, Goal and Strategic Objectives

The KHP 2014-2030 defines the long term policy framework which the sector actors adapt to respective vision, mission, and strategic objectives for medium term programming, cascaded through the KHSSP 2014-2018. Specific MoH statements are listed in Figure 3.

Figure 3: MoH Vision, Mission Goals and Strategic Objectives

<b>Vision:</b>	A healthy, productive and globally competitive nation
<b>Mission:</b>	To build a progressive, responsive and sustainable health care system for accelerated attainment of the highest standards of health to all Kenyans
<b>Goal:</b>	To attain equitable, affordable, accessible and quality health care for all
<b>Strategic Objectives:</b>	
	i. To accelerate the reduction of the burden of communicable conditions.
	ii. To halt and reverse the rising burden of non-communicable diseases.
	iii. To reduce the burden of violence and injuries.
	iv. To improve access to, and quality of, person-centred essential health services.
	v. To reduce exposure to health risk factors through inter-sectoral health promotion.
	vi. To strengthen collaboration with the private sector and other sectors that has an impact on health.

The priority interventions to be carried out by all actors in the sector for achieving these strategic objectives are clearly elaborated in the KHSSP document. The interventions the MoH intends to carry out for achieving these objectives are shown in Annex 2. However, particular attention will be paid to implementing the five Flagship Projects from the MTP and the other key strategic national programmes described in the next sections.

## 6.2 MTP II Flagship Projects of the MoH

The identification of the flagship projects is premised on the lessons learnt from implementing the previous plans. The high maternal mortality rate in Kenya has been partly due to the high cost of services, poor geographical and infrastructure access and socio-cultural barriers. Addressing these barriers will, therefore, lead to increased access.

The poor geographical and physical access for maternity services and other disease conditions is compounded by the poorly equipped public hospitals that do not conform to the norms and standards of the sector. The weak referral system for the patients and/or the specimens also means that those who need more specialised care cannot get it. Although efforts have been made in the past to introduce e-health approaches in a number of health facilities as part of the process to strengthen efficient use of resources and the referral system, the investments have minimal and low impact. The slum areas, with their high population density, are the least served in most of the indicators. The low coverage of social health insurance in the country has made the situation worse, especially for those in the informal sector and the low brackets of the economic strata. It is due to the foregoing that the National Assembly and Senate, in their resolutions in June 2013, recommended the establishment of at least one Level 5 hospital in every county and one Level 4 hospital in every sub-county.

The selection of the flagship projects, in the MTP II 2013-2017 and in this Strategic Plan has been made to enhance their complementarity and linkages. These projects are as shown in table 4 below.

**Table 4: MoH Flagship Projects of the MTP II 2013-2017**

	Medium Term II Sector Flagship Projects	Ministry Priority Flagship Projects
1	Country-wide scale up of Community Health High Impact Interventions	1. Free Maternity Services
2	Construct Model Level 4 Hospitals	2 (a) Equipping of public hospitals (b) Health infrastructure in Slum Areas
3	Health care subsidies for Social Health Protection	3. Health Insurance Subsidy program
4	Establish E-Health Hubs in 58 health facilities	4. Digitisation of Health Facilities
5	Improve access to referral systems	
6	Re-engineering human resource for health	
7	Health Products and Technologies	
8	Mainstreaming research and development in health	
9	Health Tourism	
10	Locally Derived Natural Health Products	
11	Modernise Kenyatta National Hospital	5. Equipping of Public Hospitals
12	Modernise Moi Teaching and Referral Hospital	

Although the ministry's top priority is in the five projects, all the flagship projects in MTP II are considered of utmost importance for MSP to realise its objectives. The cost of implementing these flagships is included in the costs required to implement MSP (Chapter 7).

## 6.3 Other Strategic National Health Programmes

Based on the situation analysis presented in Chapter 5, the Sector Strategic Objectives listed above and the notion of 'strategic health programmes', i.e. Health programmes that should be considered national security issues, and are, therefore, the prerogative of the National Government, the MoH will also pay special attention to the following strategic programmes:

### A. Child Health

*Intervention focus:* Continuous supply of all necessary childhood vaccines.

### B. HIV prevention and Control

*Intervention focus:* The Ministry aims at scaling up ART uptake and elimination of mother to child transmission of HIV.

#### **C. Control of Tuberculosis**

*Intervention focus:* Case Detection, TB Drug Resistance monitoring, TB Defaulter Tracing, TB/HIV Integration.

#### **D. Non-Communicable Diseases (NCD) and Neglected Tropical Diseases (NTDs).**

Among the NCDs, the MoH will focus on cancers, diabetes and hypertension. Among the NTDs, the focus will be on Kala azar, Trachoma, Schistosomiasis and Helminthes.

*Intervention focus:* Health promotion and health education, tobacco control, nutrition policy including promotion of healthy diets and physical activity, cancer control policy, screening NCDs, violence and injury prevention.

#### **E. Disease Outbreak Response**

*Intervention focus:* Disease surveillance and epidemic response.

### **6.4 Structure of the Strategic Model**

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The model aligns with the current organizational structure of the Ministry. Specific outcomes and outcome indicators are defined for each of following the six departments;

- i) Health Sector Coordination and Inter-Governmental Affairs
- ii) Policy Planning and Healthcare Financing
- iii) Standards, Quality Assurance and Regulations
- iv) Preventive and Promotive Health
- v) Curative and Rehabilitation Health
- vi) Administrative Services

Outputs are derived from the the departmental outcomes based on the “result areas” that are expected from the assigned functions of the Ministry. More detailed breakdown of outputs to specific activities and their linkages to KHP/KHSSP interventions is appended in Appendix 2. The “result areas” are;

1. Health legislation and regulation
2. Policy formulation and strategic planning
3. Ensuring standards and quality assurance
4. National reporting and monitoring systems
5. Coordination and partnerships
6. Resource mobilisation
7. Capacity building and technical support to counties
8. Research for health
9. Development of guidelines and protocols on health service delivery
10. Advocacy
11. Health service delivery – for national referral health facilities.
12. Ensuring security of public health commodities for national public health programs.

The model presents six matrices corresponding to the six Departments, with the outputs, indicators and targets grouped against the Divisions responsible for their delivery in the next pages. International Health Relations reports directly to the Director of Medical Services irrespective of where it is shown in the matrices.

## Matrix 1: Department of Health Sector Coordination and Intergovernmental Affairs

### **Departmental Outcome**

*A well-coordinated and synchronised national and county health systems*

### **Outcome indicators:**

1. *Health sector and intergovernmental coordination framework*
2. *Policies/strategies/plans on specific technical areas formulated*
3. *Percentage of compliance with coordination framework*

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
<i>1. Office of International Health Relations</i>						
Kenya Foreign Health Relations Framework developed and disseminated	The Kenya Foreign Health Relations Framework percentage done	0	25%	75%	100%	
	The Guidelines on International Travel at National Level percentage done	0	25%	100%		
International Health Relations activities monitored and evaluated	Percent of expected reports on monthly Ministerial briefs on IHR activities completed	100%	100%	100%	100%	100%
	Percent of expected reports on County briefs on national, regional and international instruments completed	100%	100%	100%	100%	100%
International Health Relations activities coordinated	Country position paper on WHO for the WHA. Done once annually	1	1	1	1	1
	Country position paper on WHO-AFRO committee meeting. Done once annually	1	1	1	1	1
	Country briefs on ECSA-HC Health ministers conference, Principal Secretary advisory committee, directors' joint coordinating committee. . Done once annually	1	1	1	1	1
	Country briefs on Commonwealth Health Ministers' Meetings. Done once annually	1	1	1	1	1
	Country position paper on EAC: Health Sectoral Council of Ministers, Coordinating committee, Sectoral committee- directors and technical officers. . Done once annually	1	1	1	1	1
	Country position paper on the AU Summit. . Done once annually	0	1	1	1	1
	Country position paper on the IGAD Meeting. Done once annually	0	1	1	1	1
	Number of due country position	0	3	3	3	3

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
	paper on the JCCs Meetings done					
	Percent of annual subscriptions paid for ECSA-HC, WHO, GLIA and FCTC	100%	100%	100%	100%	100%
	Percent of targeted National level and County level Officers continuously trained on Global health diplomacy	100%	100%	100%	100%	100%
Capacity building and technical support at National level, IHR staff and counties built	Percent of targeted IHR staff trained in Foreign language (2 French, 1 chinese, 1 Spanish) and on Negotiation Skills	0%	50%	100%		
<b>2. Division of Health Sector Coordination</b>						
	Percent of scheduled Health Sector Coordination Committee meetings held	100%	100%	100%	100%	100%
Health sector operations coordinated	A health sector partnership framework finalised and adopted	0%	0%	100%		
	Health sector policy and strategy/plans documents discussed	0%	100%	100%	100%	100%
	Percent of scheduled Stakeholders meetings/forums held	25%	100%	100%	100%	100%
<b>3. Division of Health Sector Inter-Governmental affairs</b>						
Inter-governmental Relations coordinated	Number of health sector intergovernmental consultative forums held as planned	2	4	4	4	4
	Number of technical working groups on inter-governmental affairs established and held	2	1	4	4	4
	Number of annual policy dialogue meetings between county governments and private sector held	0	1	1	1	1
	Inter-governmental health guidelines formulated –percent done	0%	0%	100%		
	Percent coverage of Inter-governmental monitoring and Evaluation	0%	0%	100%	100%	100%
	Number of capacity and training forums coordinated and conducted	0	3	3	3	3

## Matrix 2: Department of Policy, Planning and Health Financing

### **Departmental Outcome**

*Responsive, appropriate, efficient and cost-effective healthcare systems*

### **Outcome indicators:**

1. *Percentage subsector strategies aligned to health policy*
2. *Percentage of health sub-sectors with policy development capacities*
3. *Percentage of the Annual MOH Work Plan funded*

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
<i>1. Division of Health Sector Policy and Planning</i>						
Sector policies and strategies developed and disseminated	Kenya Health Policy –percent done	75%	100%			
	Kenya Health Sector Strategic and Investment Plan –percent done	90%	100%		10%	100%
	Ministerial Strategic Plan – percent done	50%	100%			100%
	Policy and strategic plans Communication Strategy – percent done	0%	25%	100%		
	PPP in Health Strategy – percent done	10%	100 %			
	Gender In Health Policy – percent done	50%	100%			
	Youth in Health Strategy – percent done	0%	50%	100%		
	Percent of new policies audited per annum	0%	50%	100%	100%	100%
	Percent of new strategies and policy guidelines reviewed and archived per annum	0%	50%	100%	100%	100%
	Percent of Annual Planning Formats available at all levels	0%	100%	100%	100%	100%
	Toolkits and Guidelines on investing in health through PPP –percent developed and disseminated	0%	25%	50%	75%	100%
	Integrated Youth Friendly Service Provision Guidelines – percent developed and disseminated	0%	15%	80%	100%	
	Social Accountability Manual –percent developed and disseminated	80%	100%			
M & E mechanisms for	PPP Projects register operational	0	100%	100%	100%	100%

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
PPP developed and implemented	Percent of PPP plans reviewed on schedule	0	0	100%	100%	100%
	Number of planned policy dialogue meetings between public and private sector held (or number of meetings held?)	0	0	4	4	4
Health sector Youth operations coordinated	Number of National Youth Health Coordination Committee meetings held	0	0	4	4	4
Capacities of MoH units and counties in health stewardship and governance strengthened	Percent of MoH units with capacities to develop policies, policy guidelines and strategies	25%	50%	100%	100%	100%
	Percent of County Departments of Health with capacities to develop policies, policy guidelines and strategies	na	na	50%	100%	
	Number of county governments with annual plans as per agreed standards		n/a	23	47	47
	Policy dialogue forums with private sector	1	2	2	2	2
	Percent of County Departments of Health with Youth, Gender and disability sensitive budgets	na	na	50%	100%	100%
	Percent of Counties/health institutions with focal persons trained on Youth, Gender and disability sensitive budgeting	0%	0%	50%	100%	
	Number of Counties implementing Social Accountability interventions	na	25%	50%	100%	100%
Studies and policy analyses conducted	Number of KHP related policy analyses (operations research) conducted	na	1	2	2	2
	Number of private sector analyses (operations research) conducted	na	tbd	tbd	tbd	tbd
	Number of Biennial market surveys on existing and potential markets for health tourism conducted	na	na	1	na	1
<b>2. Division of Health Informatics, M&amp;E and Health Research Development</b>						
HIMER policies and strategic plans developed,	Revised HIS Policy and Strategic Plan –percent done	na	100%			
	E-Health Policy and Strategic Plan –percent done	50%	70%	100%		

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
revised and disseminated	Sector M&E Framework - percent done	na	100%			
	National Health Research Policy –percent done	0	10%	100%		
HIS and M&E guidelines, SOPs and tools developed and disseminated	Percent coverage in applications of HIS SOPs	0	0	100%		
Health Sector effectively monitored	Cumulative No. of certified EHR and EMRs integrated in DHIS	0	3	5	5	5
	Proportion of health facilities reporting directly on DHIS	10%	10%	20%	30%	40%
	% of county referral facilities hooked onto E-health platform	0%	2%	5%	8%	10%
	Annual Health Sector Performance Report	1	1	1	1	1
	Percent of counties with timely annual performance reports	na	25%	50%	100%	100%
	Mid-term and end term strategic plans reviews	na		1		1
	Real-time GOK and DP resource tracking system operational	na	na	100%	100%	100%
	National Research Repository	0	0	100%		
Annual ministerial performance contracts developed and monitored	Signed Ministerial Annual Performance Contracts	1	1	1	1	1
	Quarterly Performance Contracts reports	4	4	4	4	4
	Mid-Year and End-Year PC Evaluation reports	2	2	2	2	2
Capacity for data management, information use and sharing built at National and County levels	Number of counties with enhanced capacity in data management	35	45	47	47	47
	Number of research activities done for each national and county level unit	na	1	1	1	1
	Percent of targeted research institutions covered in the database	na	50%	75%	100%	100%
Operational research and surveys carried out	SARAM report					1
	Data Quality Audit Reports	1			1	
<b>3. Division of Healthcare Financing</b>						
Policies and Strategies	Health Care Financing Strategy -percent completion	0	50%	100%		

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
developed and disseminated	Framework for health financial risk pooling and institutional arrangements for purchasing/ providing a defined benefit package -percent completion	20%	80%	100%		
	Framework for conditional grants from MOH to sub-national entities -percent completion	20%	80%	100%		
	Comprehensive mechanism for financing of emergency health services -percent completion	20%	80%	100%		
	Framework for Strengthening programming of external funding of health through improved harmonization and alignment to sector priorities and improved reporting - percent completion	20%	80%	100%		
Increased and diversified resource flows into the sector for delivery of a defined benefit package	Allocation to health as % of combined national and county governments annual budgets (MTEF)	6%	8%	10%	12%	15 %
	Total Health expenditure as a percentage of GDP	1.6	1.8	2	2.2	2.5
	Increased on- budget donor support	20%	25%	30%	35%	40%
	Off budget resources for health as % of total public sector resources	40	35	30	25	25
	% of Total Health Expenditure (THE) from Pooled Funds	na	20%	30%	40%	50%
	Pooled funds as a% of GDP of THE	na	2	2.5	3	3.5
Enhanced social health protection	% of indigent/poor population enrolled in pre-payment schemes	20%	30%	40%	45%	50%
	% of the total population in prepaid social schemes	20	25	30	40	50

## Matrix 3: Department of Health Standards, Quality Assurance and Regulations

### Outcome

*Strengthened systems for management of health care quality and safety*

### Outcome indicators:

1. Percentage of county health facilities complying with current health norms and standards
2. Percentage of health institutions complying with the new/reviewed health laws and regulations.

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
<i>1. Division of Quality Assurance &amp; Standards</i>						
Operational guidelines on norms and standards in the 8 health systems areas developed and reviewed	No. of expected existing health norms and standards documents reviewed.	3	2	2	2	2
	Web portal for norms and standards ,policies ,guidelines –percent complete	0%	50%	80%	100%	
	Percent of expected new norms and standards developed.	100%	100%	100%	100%	100%
Policies and strategies on quality assurance developed, reviewed and disseminated	National QA/QI policy approved and disseminated – percent accomplished	80%	100%			
	National IPC policy guidelines –percent accomplished	0%	100%			
	IPC strategic plan –percent accomplished	0%	100%			
	National Accreditation framework –percent accomplished	0%	50%	100%		
Capacity building and technical assistance on quality assurance and quality improvement provided to counties	No. of counties trained on KQMH and QI activities	8	10	12	15	20
	Percent. of hospitals with TOTs trained on hand hygiene	na	10%	50%	100%	
	Kenya Patient Safety Impact Evaluation Report produced			1		
	No. of NIPCC meetings conducted	4	4	4	4	4
	No. of counties trained on accreditation implementation plan	0	0	12	15	15
	No. of counties trained on IPC	na	10	10	10	10
Regulation and legislation on accreditation framework reviewed	Accreditation Framework regulation updated			1		

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
<b>2. Division of Health Regulation and Legislation</b>						
Legislative and Regulatory frameworks in place	Percent of the required Legislative and Regulatory frameworks developed and implemented.	na	80%	100%		
	Joint inspection checklist percent coverage	na	90%	100%		
Continuous professional development framework developed ,reviewed and disseminated	1.Continuous professional development framework available 2.Number of regulatory bodies/councils implementing the CPD regulatory framework 3. Coordinated framework for setting pre-service and in-service training standards	na	1. 100% 2. 8	3. 1		
<b>3. Division of Traditional and Alternative Medicine</b>						
Operational guidelines and code of practice on traditional and alternative medicine developed	Code of practice for traditional medicine practice -percent done	na	40%	100%		
	Code of practice for alternative medicine –percent done	na	40%	100%		
	Guidelines on traditional and alternative medicine practice completed –percent done	na	20%	40%	80%	100%
Alternative and traditional medicine operating in a regulated manner.	Percent of required policies and regulations for Alternative and Traditional Medicine developed	na	0%	50%	100%	
Capacity building and technical assistance on traditional and alternative medicine practice provided	No. of counties with traditional medicine practitioners mapped					3
	No. of counties with practitioners trained					2
	No. of counties with conventional health workers sensitized on traditional and alternative medicine					2

## Matrix 4: Department of Preventive and Promotive Health

### Departmental Outcomes

1. *Reduced burden of preventable conditions and events*
2. *Improved health awareness and practices of positive health behaviour*

### Outcome indicators:

1. *Prevalence and incidence of preventable conditions*
2. *Level of public awareness and of practices of positive health behaviour*

OUTPUTS	OUTPUT INDICATORS	BASELINE		TARGET		
		2013/14	2014/15	2015/16	2016/17	2017/18
<i>1. Division of Strategic National Health Programmes</i>						
Legislation and regulation on communicable disease prevention and control enacted and disseminated	Malaria Prevention Bill – percent accomplished	0	50%	100%		
	HIV Prevention and control Act of 2006 reviewed –percent accomplished	0	50%	100%		
Policies and Strategic Plans developed and disseminated	Kenya National AIDS Strategic Framework -percent accomplished	0%	100%			
	Work place TB policy reviewed and disseminated –percent done	10%	50%	100%		
	Vaccination policy developed and disseminated –percent done	na	50%	100%		
Operational guidelines developed/ reviewed and disseminated	Indoor Residual Spraying Business Plan developed and disseminated –percent done	50%	100%			
	Number of reviews on diagnostic guidelines and job aids on Leprosy, TB and Lung diseases	na	na	1	na	1
	Number of reviews on malaria surveillance guidelines and tools	na	1	na	1	
Monitoring and evaluation framework strengthened	Number of data quality audits of Malaria, HIV and TB Leprosy & Lung diseases conducted biennially	na	4	na	4	
	Data collection tools for HIV, TB, Malaria revised and disseminated	100% done (TB)	100% done (HIV, Malaria)	na	na	100% done (HIV, Malaria, TB)
Coordination and	Number of Annual partnership meetings of STOP TB	1	1	1	1	1

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
partnerships established and maintained	conducted					
Capacity building and technical assistance	Harmonised TB training curriculum for health workers and Community-based workers developed –percent done	20%	40%	60%	80%	100%
	Number of training sessions on introduction of new vaccines (Rota and IPV) conducted –percent done	50%	70%	90%	100%	
	Percentage of training materials for County and sub-county Malaria Control Coordinators developed	na	30%	60%	100%	
Studies and research on preventive and promotive services conducted	Number of Malaria drug efficacy monitoring studies (done every 2 years)	1		1		1
	Kenya Malaria Indicator Survey conducted –percent done		50%	100%		
	Number of operational research and survey report				30%	100%
	TB Drug resistance survey – percent done		50%	100%		
	TB prevalence survey – percent done		0%	50%	100%	
Advocacy and awareness conducted	Percentage of IEC materials for TB, Leprosy and Lung Disease prevention and care reviewed, developed and disseminated	20%	40%	60%	80%	100%
	ACSM strategy for Malaria and TB revised and disseminated	100% (TB)	50% (Malaria)	100%(Malaria)	100%(TB)	
	Number of Planned quarterly bulletins and news letters on vaccine initiatives developed and disseminated	4	4	4	4	
	Number of annual World AIDS and TB days held	2	2	2	2	2
	Vaccination documentary developed and disseminated – percent done	0%	50%	100%		
Commodities secured	Number of annual forecast, and quantification reports: HIV, TB, Malaria, vaccines and reproductive health	4	4	4	4	4
<b>2. Division of Non-Communicable Diseases</b>						
Policies and Strategic Plans	Global strategy on healthy diets and physical activity		100% done			

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
on Non-communicable disease prevention and control developed and disseminated	adopted and disseminated					
	Reviewed cancer prevention and control strategy –percent done					100%
	Violence and injury strategic plan developed and disseminated		60%	100%		
Operational guidelines developed and disseminated	Guidelines on management of NCDs at primary health level developed and disseminated		50% done	100% done		
	Guidelines on Cancer screening, prevention and management developed and disseminated		100% done			
	Guidelines on Epilepsy management developed and disseminate			100% done		
	Guidelines on tobacco cessation developed, and disseminated				100% done	
	Reviewed Diabetes management guidelines					100% done
Monitoring and evaluation on framework strengthened	Reviewed NCD indicators	50% done	100% done			
	Established population based cancer registry		25%	50%	75%	100%
	Integrated NCD indicators into DHIS system		50%	100%		
Coordination and partnerships established and maintained	Number of NCD partner audit conducted		1			
	Established NCD coordinating mechanism for implementers			50%	100%	
	Functional NCD ICC established			100%		
Capacity building and technical assistance conducted	Percentage of Counties with ToT trained on NCD		10% done	40% done	70% done	100%
Studies and research conducted	Global Adult Tobacco Survey conducted	na	1	na	na	na
	Global Youth Tobacco Survey conducted	100% (2014 survey)	na	na	na	50% (2018 survey)
	STEP Survey conducted		20%	100%		
Advocacy and awareness conducted	Percentage of IEC materials on NCD developed (Cancer prevention and Control,		50% done	100% done		

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
	Alcohol and drug abuse, healthy diets and tobacco control)					
	Number of Counties that have received IEC materials on NCP			23	47	
	Number of NCD related World Health Days commemorated annually	4	4	4	4	4
	Number of Media messages on road safety developed	na	1	1	1	1

### 3. Division of Environmental Health

Legislation and regulation enacted and disseminated	National Food Safety policy (NFSP) Bill drafted and presented to Parliamentary Health Committee	20% done	40% done	60% done	80% done	100% done
	The Public Health Act Cap 242 reviewed and presented to Parliamentary Health Committee	20% done	40% done	60% done	80% done	100% done
	The Food, Drugs and Chemical Substances Act Cap 254 reviewed and presented to Parliamentary Health Committee	20% done	40% done	60% done	80% done	100% done
Policies and Strategic Plans on developed and disseminated	National Environmental Health Services Policy and strategy developed, reviewed and disseminated to counties	20% done	40% done	60% done	80% done	100% done
	Port Health Services Policy and Strategic Plan and developed and disseminated to counties	20% done	40% done	60% done	80% done	100% done
	Electronic waste disposal strategy developed and disseminated to counties	20% done	40% done	60% done	80% done	100% done
	Occupational Health and Safety Policy formulated and disseminated to county governments	20% done	40% done	60% done	80% done	100% done
	WASH policy, strategy, manuals and guidelines disseminated to counties	20% done	40% done	60% done	80% done	100% done
Operational guidelines developed and disseminated	National Open defecation free (ODF) road map revised and disseminated	20% done	40% done	60% done	80% done	100% done
	National Jigger Control Guidelines developed and disseminated to counties	20% done	40% done	60% done	80% done	100% done
Monitoring and evaluation	Surveillance of Genetically Modified (GM) foods	20% done	40% done	60% done	80% done	100% done

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
strengthened	strengthened					
	Establish an M&E framework for ODF eradication			20%	50%	100%
	Monitoring for compliance of fortified foods with National standards strengthened	20% done	40% done	60% done	80% done	100% done
	Monitoring of residues and contaminants in meat products strengthened	20% done	40% done	60% done	80% done	100% done
Coordination and partnerships established and maintained	Points of Entry (POEs) automated to facilitate interface with Kenya National Electronic Single Window System (KNESWS)	20% done	40% done	60% done	80% done	100% done
	Number of Quarterly EH ICC meeting held	4	4	4	4	4
Capacity building and technical assistance strengthened	Proportion of POE staff trained on IHR, KNESWS and OSBP operations	20%	40%	60%	80%	100%
	Number of counties with TOTs trained on healthcare waste management			23	24	
	Proportion of aflatoxin prone counties with TOTs trained on Management and Control of Aflatoxin in Maize Value Chain	20% done	40% done	60% done	80% done	100% done

#### 4. Division of National Public Health Laboratories

Policies and Strategic Plans developed and disseminated	NPHLS manuals developed and disseminated: Quality manual; Safety manual, Service charter	10% done	100% done			
	NPHLS Strategic Plan developed		100% done			
	Policy on chemical waste disposal for public health laboratories developed and disseminated		100% done			
Operational guidelines developed and disseminated	Number of operational guidelines developed and disseminated		4	4	4	3
	Number of NPHLS reference labs enrolled into regional and international external quality assurance (EQA) schemes	2	4	5	6	7
Monitoring and evaluation strengthened	Monitoring and evaluation plan developed and disseminated	50% done	100% done			
	Surveillance laboratory data collection tools for specific disease-causing agents reviewed and disseminated	50% done	100% done			

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
	Number of counties with TOTs trained on laboratory surveillance data management and use		24 counties	23 counties		
	Biennial service and commodity consumption Data Quality Assessment for laboratory conducted		1	1	1	1
	Curricula for training health personnel on laboratory data management developed and disseminated	50% done	100% done			
Coordination and partnerships established and maintained	Courier services contract for referral of samples and Proficiency testing specimen transportation in place	100% done	100% done	100% done	100% done	100% done
	Percentage of testing sites with satisfactory EQA results		60%	75%	80%	90%
	Technical Assistance checklist for county laboratories developed and disseminated	50% done	75% done	100% done		
Capacity building and technical assistance strengthened	NPHLS division enrolled into ISO certification program (Quality management) process		20% done	50% done	75% done	100% done
	Number of NPHLS reference labs (units) in ISO certification program	2	3	4	5	7
	Quarterly mentorship support sessions to laboratories on SLMTA/SLIPTA accreditation process		8	12	12	12
	Number of counties with TOTs trained on biosafety/biosecurity TOTs	25	25	25	25	25
	Number of operationalised/functional Public health reference labs established		1	1	1	1
Field Epidemiology and Laboratory Training Program	Number of Epidemiologists graduated	20	20	20	20	20
	Number trained in Basic Epidemiology		70	70	70	70
	Number trained in intermediate level epidemiology		30			
	Number of health workers trained in Ebola surveillance, preparedness and response		60			
<b>5. Division of Family Health</b>						
Legislation and regulation on	Child Health Bill drafted and presented to Parliament		40% done	60% done	80% done	100% done

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
maternal, adolescent and child health and community health enacted and disseminated	Breast milk substitute (BMS) bill drafted and presented to Parliament		40% done	60% done	80% done	100% done
Policies and Strategic Plans on maternal, adolescent and child health and community health developed and disseminated	Community Health Services Policy developed, and disseminated		50%	100%		
	Community Health services strategy developed and disseminated	50%	100%			
	National Health Promotion Policy developed, and disseminated	50%	80%	100%		
Operational guidelines on maternal, adolescent and child health and community health developed and disseminated	standards for tier 1 services development and disseminated		50%	100%		
	Guidelines for motivation and retention of community health workforce developed and disseminated			50% done	80% done	100% done
Monitoring and evaluation on maternal, adolescent and child health and community health developed and disseminated strengthened	M&E plan for community health services revised and disseminated	50%	75%	100% done	90% done	100% done
	Community data tools revised and disseminated		50%	75% done	90% done	100% done
	Standard operating procedures on routine data quality checks developed and disseminated		50%	75% done	90% done	100% done
	Curricula for community health personnel developed and disseminated	50%	75% done	90% done	100% done	
Coordination and partnerships on maternal, adolescent and child health and community health established and maintained	Number of quarterly community health interagency coordination meeting for CHS held		4	4	4	4
	Joint (unit and partners) Annual Work planning and quarterly reviews on Community Health held		5	5	5	5
	A guide on building and managing Inter and Multi-sectoral Action for health at national and county level developed and disseminated	10% done	50% done	75% done	100% done	
	Number of annual HPR conference to share best practices held	1	1	1	1	1

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
Capacity building and technical assistance on maternal, adolescent and child health and community health strengthened	Proportion of Counties with ToTs trained on the management of CHIS and MCHUL	50% done	70% done	90% done	100% done	
	County level staff trained in advocacy		50% done	75% done	100% done	
Studies and research on maternal, adolescent and child health and community health conducted	Number of KAP studies/ Survey on key risky behaviour practices		1	1	1	1
	Number of community-based assessments on health promotion issues and effectiveness of interventions conducted		1	1	1	1
<b>6. Division of Disease Surveillance and Epidemic Response</b>						
Policies and Strategic Plans developed and disseminated	Number of prevention and control strategies for priority zoonotic diseases developed and disseminated	0%	1	1		
	Disease Surveillance and Epidemic Response strategic plan developed and disseminated		100% done			
Operational guidelines developed/ reviewed and disseminated	Integrated Disease Surveillance and Response technical guidelines developed and disseminated			100% done		
	International Health Regulations 2005 technical guidelines customised and disseminated			100% done		
Monitoring and evaluation framework strengthened	Number of data quality audits of IDSR		1		1	
	Number of annual One Health review meetings between National and County levels held		1	1	1	1
Capacity building and technical assistance	Number of CHEWs and CHWs trained on IDSR and IHR		500	500	500	500
Studies and research conducted	Number of priority zoonotic diseases risk mapping conducted		1	1	1	

## Matrix 5: Department of Curative and Rehabilitative Health

### Departmental Outcomes

#### 1. Improved access to quality curative and rehabilitative health services

#### Outcome indicators:

1. Increased access to quality clinical care services in slum areas
2. Increased access to emergency medical care and disaster management
3. Increased access to quality national forensic and pathology services

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
<b>1. Division of Clinical Practice</b>						
Legislation & Regulation on HPT developed and enacted	HPT legal framework in place	25%	50%	100%	-	-
	Revised Mental Health Act in place	-	50%	100%	-	-
Policies & Strategies developed and disseminated	National HPT Policy in place	-	25%	50%	75%	100%
	National Mental Health Policy in place	15%	50%	75%	90%	100%
Operational Guidelines developed and disseminated	Nursing Standards document in use	15%	25%	50%	75%	100%
	Number of Revised Clinical Guidelines in use	-	50%	75%	100%	-
	Guidelines on Appropriate Medicines Use & Prevention of AMR	0	50%	75%	100%	-
	Revised Essential Health Commodity Lists in use	25%	50%	75%	100%	-
Capacity-Building mechanisms developed; training & TA provided	% of targeted county managers trained in Cancer Management	-	25%	50%	75%	100%
	% of the 141 County Managers capacitated in EHPT Forecasting & Quantification	30%	50%	75%	100%	-
Studies & Research promoted and conducted	Feasibility report/road-map on establishment of HTA body produced	-	20%	50%	75%	100%
Advocacy & Awareness methods developed and implemented	IEC materials on mental health & substance abuse in use	50%	75%	100%	-	-
County personnel radiation monitoring done	% of the 650 targeted personnel monitored	70%	75%	85%	90%	100%
<b>2. Division of Health Emergencies and Disaster Risk Management</b>						
Policies & Strategies developed and disseminated	Emergency medical care legal framework –percent done	40%	60%	80%	90%	100%
	Policy on Emergency Medical services and pre-	40%	60%	80%	90%	100%

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
	hospital care policy in place					
	Number of Counties with National referral strategy in use	10	13	20	40	47
Health sector capacity for emergency preparedness and response enhanced	National health sector policy on DRM developed Health Sector Preparedness planning institutionalised at national and sub-national levels	-	50%	75%	90%	100%
Coordination & Partnerships mechanisms developed and operationalized	DRM streamlined within county health departments National level DRM ICC in operation	-	50%	100%	100%	100%
<b>3. Division of Forensic and Pathology Services</b>						
Operational Guidelines developed and disseminated	Mortuary management guidelines in use percent of mortuaries with mortuary management guidelines.	-	50%	75%	100%	-
Capacity-Building mechanisms; 150 Nurses trained on sexual assault victim management.	Percent of nurses trained on sexual assault victim management	-	25%	50%	75%	100%
<b>4. Division of National Blood Transfusion Services</b>						
Policies & Strategies developed and disseminated	Revised National Blood Transfusion Policy in place.	25%	50%	75%	100%	-
Operational Guidelines developed and disseminated	% of NBTS centres with Operational Guidelines and No. of Operational Guidelines printed.	-	50%	100%	-	-
<b>5. Division of National Referral Facilities</b>						
Health facility access improved in slum areas	Percent completion of construction of 20 health centres	-	15%	60%	100%	-
94 hospitals equipped through equipment lease	Percent of targeted hospitals equipped through leasing.	0	100%	100%	100%	100%
-Appropriate medical devices specification developed.	Specifications for medical devices -percent done	25%	50%	75%	90%	100%
Standards and norms for physical infrastructure developed	Percent of infrastructures constructed as per physical infrastructure Norms and Standards	25%	50%	75%	90%	100%

## Matrix 6: Department of Administrative Service

### Departmental Outcomes

#### *1. Efficient and responsive administrative support systems*

#### Outcome indicators:

1. Composite score for ministerial performance contract: Improved from 2.8 to 2.5 by 2017.
2. Percentage of staff scoring 100 and above in Performance Appraisal System(PAS): increase from 50% - 90% in 2017
3. Operational units functionally linked to MOH WAN network system: 100 % by 2017.

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
<i>1. Division of General Administration</i>						
Efficient and Responsive Administrative systems at national level	Percentage of external policies and circulars disseminated within the MoH	100%	100%	100%	100%	100%
	Quarterly Performance Management Reports	4	4	4	4	4
	Percentage of functional administrative Committees (e.g. ACU, Safety Committees, Anti-Corruption Committee)	100%	100%	100%	100%	100%
	No of Parliamentary business / petitions addressed on time	100%	100%	100%	100%	100%
Improved standard operating procedures	No of functional registries as per GoK standards	0	4	4	4	4
	Completion of the ISO Certification process of the MoH	10%	35%	70%	90%	100%
Improved work environment	Number of safety and security measures taken	3	5	7	7	7
	Percent of toilets modified for use by PWDs	0%	20%	100%		
	Ramps constructed in Afya house	none	50%	100%	done	done
	% of employees with appropriate office accommodation	10%	60%	80%	90%	100%
	Transport Operating Guidelines	none	done			
	Well-maintained Sanitation services as per service contract	100%	100%	100%	100%	100%
<i>2. Division of Public Communication</i>						
Effective public communication for MoH	Communication strategy developed –percent complete	none	50%	100%	100%	100%
	Number of Biannual MOH Magazines published	0	2	2	2	2
	Percentage of Minister's speeches posted on the MoH's website	100%	100%	100%	100%	100%
<i>3. Division of Information Communication and Technology</i>						

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
Systems for information access and sharing updated to current and emerging technologies.	Ministerial ICT Usage Policy – percent done	50%	80%	100%	100%	100%
	Ministerial ICT Strategy – percent done	0%	50%	100%	100%	100%
	No of units connected to MOH Network(extension of fibre network)	0	0	1	2	3
	Functional LAN and WAN network	0	1	1	1	1
	Ratio of staff to computers	1:3 & 1:13	1:1 & 1:10	1:1 & 1:10	1:1 & 1:10	1:1 & 1:10
	No. of queries responded to by online helpdesk system.	none	500	1000	2000	2000
	No. of IT based system implemented	None	3	4	5	6
Capacity to utilise ICT system enhanced	No. of health staff trained on ICT National and Counties	none	20	30	40	60
<b>4. Division of Human Resource Management</b>						
Strengthened management of staff recruitment, deployment, motivation and separation	% of vacant and funded posts filled annually at the MoH	100%	100%	100%	100%	100%
	Kenya Human Resource for Health Strategy (KHRH)	80%	100%	100%	100%	100%
	Payroll generated by 20th of every month for MOH staff	100%	100%	100%	100%	100%
	Develop county HRH recruitment and deployment guidelines as per staffing norms and standards	none	50%	100%	100%	100%
	% of staff deployed at MoH according to needs and skills	na	na	100%	100%	100%
	% of staff retirement benefits fully processed on time as per GoK standards	100%	100%	100%	100%	100%
Health workers attracted and retained	% of cadres with schemes of service	100%	100%	100%	100%	100%
	% of cadres with reviewed schemes of service for HRH	29%	52%	77%	100%	100%
	Incentive Framework for attraction and retention of HRH in hard to reach areas	none	50%	100%	100%	100%
Strengthened performance appraisal system	% of staff on PAS	50%	100%	100%	100%	100%
	Ministerial Performance management committee	none	100%	100%	100%	100%
	Rewards and sanctions framework	none	50%	80%	100%	100%
	% of rewards and sanctions based on PAS	none	100%	100%	100%	100%

OUTPUTS	OUTPUT INDICATORS	BASELINE	TARGET			
		2013/14	2014/15	2015/16	2016/17	2017/18
<b>5. Division of Human Resource Development</b>						
Enhanced professional and knowledge management for ministry staff	% of staff inducted at the MoH	100%	100%	100%	100%	100%
	% age of MoH staff projected for training, trained	tbd	100%	100%	100%	100%
	Health Sector Training Policy – percent done	50% done	100%			
	Training Master Plan –percent done	none	100%			
	Annual training projection report	done	done	done	done	done
<b>6. Division of Accounts and Finance</b>						
Effective and prudent utilisation of financial resources	Percent of due resource mobilized annually	100%	100%	100%	100%	100%
	Percent of budget utilised annually	100%	100%	100%	100%	100%
	No. of financial statement generated annually	4	4	4	4	4
<b>7. Division of Supply Chain Management</b>						
Efficient and effective supply chain management systems	Annual Consolidated Procurement Plan	100%	100%	100%	100%	100%
	Percent of goods and services procured as per the procurement plan annually (not out of the plan)	n/a	100%	100%	100%	100%
	Percent attainment of 30 % of goods and services procured as per the procurement given to youth, women and PWDs	100%	100%	100%	100%	100%
	Value of goods and services procured as a percent of the procurement budget as per the procurement plan	n/a	100%	100%	100%	100%
	Percent of idle assets disposed annually	100%	100%	100%	100%	100%
<b>8. Division of Legal Affairs</b>						
Legal systems and structures established and operational	Operational office	none	50%	100%	100%	100%
	Legal registry	none	50%	100%	100%	100%
	% of litigation cases addressed	80%	80%	100%	100%	100%
<b>9. Division of Internal Audit</b>						
Financial, accounting and other procedures adhered to	Number of annual audit queries raised by KENAO	tbd	0	0	0	0
	% of annual budget misappropriated	tbd	0	0	0	0

## CHAPTER 7. COORDINATION FRAMEWORK

The implementation of this Plan takes into account the national and devolved system of governance. Institutional arrangements and processes previously responsible for implementing strategic plans have been re-oriented to conform to a devolved health system. This section, therefore, describes the organisation of the Ministry of Health and its linkages with County Departments of Health, partnership arrangements, planning and budgeting processes and communication strategies under the new constitutional dispensation. This plan also provides an over-arching guide for sector coordination on priority programmes and priorities through transition period.<sup>1</sup>

### 7.1 National and County Governments' Coordination

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Specific functions of the Ministry have been aligned with the fourth schedule of the Constitution of Kenya to facilitate progressive realisation of the right to health by all.

Specifically, the ministry's role is to formulate policies, develop strategic plans and set priorities. In addition, it will mobilise budgetary and other resources for the sector, regulate, set standards and formulate guidelines for the provision of services. Issues of capacity building and technical support at county level and national health referral services, monitoring performance and adherence to the planning cycle will also be core activities of the ministry as well as coordinating with all (internal and external) partners.

The Constitution of Kenya requires that the national and county governments, though distinct, shall conduct their mutual relations on the basis of consultation and cooperation. This requirement has formed the basis for the establishment of the Health Sector Intergovernmental Consultative Forum established in August, 2013. The consultative forum will provide a platform for dialogue on health system and issues of mutual interest to the national and county governments. Overall, the forum will seek to ensure that health services remain uninterrupted during the transition period and beyond, while maintaining the focus to delivering the constitutional guarantee to the highest attainable standard of health for all Kenyans. More specifically the Forum has the responsibility to:

- Identify issues for discussion during the intergovernmental consultative mechanisms and establish systems to address these issues.
- Facilitate and coordinate the transfer of functions, power or competencies from and to either level of government.
- Coordinate and harmonise development of health policies and laws.
- Evaluate the performance of the national or county governments in realising health goals, and recommend appropriate action.
- Monitor the implementation of national and counties' sectoral plans for health.
- Produce annual reports on national health statistics pertaining to the health status of the nation, health services coverage and utilisation.
- Promote governance and partnership principles across the health system.
- Implementation and follow up of actions and recommendations from the National and County Government Coordinating Summit.
- Consideration of issues on health that may be referred to the forum by members of the public and other stakeholders and recommend measures to be undertaken.

Technical working groups will be established for specific common interests to both levels of government.

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<sup>1</sup> Transition to devolved Government Act 2012

## 7.2 Partnership and Coordination Framework

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This MSP will be implemented within Kenya Health Sector-Wide Approach (KHSWAp) that has been guiding the sector since 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, harmonisation, 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 will be expected to be working within these 3 frameworks.

## 7.3 Coordination with Other Sector Actors

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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 realisation of the right to health.

The various stakeholders in the health sector include:

**Clients:** These include individuals, households and communities who constitute the main segment of the public in terms of communication and engagement purposes and the final recipients of services. The others are suppliers and other service providers to the ministry.

**State actors:** The public sector stewards (Ministry of Health and Counties, together with health related sectors and autonomous and semi-autonomous government agencies) and regulatory bodies. Regulatory bodies constitute 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 Trade Unions, Professional associations, Private sector, NGOs, CSOs, FBOs, Traditional Practitioners, the pharmaceutical companies, medical devices manufacturers and other industries, media and all other persons whose actions have an impact on health, but don't draw their mandate from the state.

**External factors:** The bilateral, multilateral or philanthropic actors that draw their mandate from out of Kenya, but support national programmes.

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 services related to regulatory functions on behalf of the Ministry of Health. These include: 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. Development of the new Health Act, partly aims to provide mechanisms for strengthening these functions.

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. The ministry will also work with these associations with the aim of strengthening their inputs and support for the health sector. Table 5 presents the critical state actors with whom the MoH collaborates and the underlying rationale.

Table 5: Critical Health Related Sectors and their Role in Health

<b>Ministry, Department, Agency</b>	<b>Role in Health</b>
<b>Ministry of Planning and Devolution</b>	<ul style="list-style-type: none"> <li>▪ Promote sustainable population growth.</li> <li>▪ Ensure youth and gender is mainstreamed in all sector policies.</li> <li>▪ Provide data that is required to inform health (promotion) planning (e.g. KDHS, vital statistics).</li> <li>▪ Create enabling environment for the implementation of the MTP towards achievement of health goals under vision 2030.</li> <li>▪ Support implementation of transition implementation plans to facilitate devolution of the health system.</li> </ul>
<b>Ministry of Agriculture, Livestock and Fisheries</b>	<ul style="list-style-type: none"> <li>▪ Incorporate considerations of health in safe food production systems, manufacturing, marketing and distribution.</li> <li>▪ Ensure food security for the whole population.</li> </ul>
<b>Ministry of Lands, Housing and Urban Development</b>	<ul style="list-style-type: none"> <li>▪ Promote urban and housing designs and infrastructure planning that take into account health and wellbeing of the population's urbanisation.</li> <li>▪ Strengthen access to land, and other culturally important resources, in particular for women.</li> </ul>
<b>Ministry of Transport and Infrastructure</b>	<ul style="list-style-type: none"> <li>▪ Ensure optimal planning of construction and maintenance of roads, bridges with due consideration for location of health services in order to facilitate physical access to health services e.g. express lanes for ambulances.</li> <li>▪ Ensure availability of infrastructure to incentivise and support physical activity (cyclists, pedestrians).</li> <li>▪ Facilitate data and voice communication within health sector and with other sectors.</li> </ul>
<b>Ministry of Industrialisation and Enterprise</b>	<ul style="list-style-type: none"> <li>▪ Ensure work and stable employment and entrepreneur opportunities for all people across different socio economic groups.</li> </ul>
<b>Ministry of Education, Science and Technology</b>	<ul style="list-style-type: none"> <li>▪ Support education of men and women in order to enable them to increase control over the determinants of health and thereby improve their health.</li> </ul>
<b>Directorate of Public Prosecution</b>	<ul style="list-style-type: none"> <li>▪ Have fair justice systems, particularly in managing access to food, water &amp; sanitation, housing, work opportunities and other determinants of wellbeing.</li> </ul>
<b>Ministry of Interior and National Coordination</b>	<ul style="list-style-type: none"> <li>▪ Ensure security (a major determinant of access to health).</li> <li>▪ Ensure coordination of optimal disaster management (mitigation and response).</li> </ul>
<b>Attorney General</b>	<ul style="list-style-type: none"> <li>▪ Ensure wellbeing of refugee populations.</li> </ul>
<b>Immigration</b>	<ul style="list-style-type: none"> <li>▪ Ensure all visitors comply with regulation with respect to required vaccinations and sharing of critical information concerning their health status under special circumstances e.g. bird flu.</li> </ul>
<b>Ministry of Labour, Social Security and Services</b>	<ul style="list-style-type: none"> <li>▪ Promote progressive workplace and safety policies that safeguard the health of workers.</li> <li>▪ Develop social policies for protection of vulnerable groups.</li> <li>▪ Ensure development and enforcement of proper regulation of cultural practitioners.</li> </ul>
<b>Ministry of Sports, Culture and Arts</b>	<ul style="list-style-type: none"> <li>▪ Promote sport and physical exercise.</li> </ul>
<b>Ministry of Environment, Water and Natural Resources</b>	<ul style="list-style-type: none"> <li>▪ Influence population consumption patterns of natural resources to meet the health needs of current generations without compromising the ability of future generations to meet their own health needs.</li> <li>▪ Develop and implement legislation to control/minimise pollution.</li> <li>▪ Promote access to safe and clean water to the population.</li> </ul>
<b>Ministry of commerce tourism and East African affairs</b>	<ul style="list-style-type: none"> <li>▪ Development and harmonisation of health policies and regulations.</li> <li>▪ Coordination of common health sector activities.</li> <li>▪ Regional centres on health.</li> <li>▪ One border stop on health matters.</li> </ul>

## **1. Development Partnership Forum (DPF)**

The DPF seeks to strengthen mutual accountability between the Government and its development partners to accelerate the development of health issues in Kenya. It is a multi-sectoral biannual high-level forum to reflect on on-going 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. It also helps 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. This is done 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, standardising 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 develop effectiveness through improvement in harmonisation, alignment and coordination through the provision of support to the AEG, GCG and SWGs.

## **5. Health Sector Intergovernmental Consultative Forum**

Provided for through Article 6(2) of the Constitution on devolution and access to services and Article 13(2) of Intergovernmental Relations Act, 2012, on intergovernmental sectoral working groups and committees.

## **6. 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. Both national and county governments will establish Sector Working Groups.

## 7. Health Sector Coordinating Committee (HSCC) Technical Working Groups

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, reviewing and reporting.
- Hold all sector partners jointly accountable for achieving results.
- Reduce the number of separate meetings with individual partners.
- Enable harmonisation 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 restructured to follow the seven key policy orientations set out in the Kenya Health Policy. These Technical Groups are chaired by the Director of Health, 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.

### 7.4 Planning and Budgeting Process

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The planning and budgetary process provides another avenue through which the ministry will engage with other stakeholders. Timeline for budgeting, planning and reporting are provided in the Public Financial Management Act, 2012 and other guidelines provided by the national government from time to time.

The planning and budgeting will be an inclusive process that will include all stakeholders, including development partners and the public. Budgeting will be for all resources available to the area of responsibility, and not only public resources. And with budget information available, each management unit in the Ministry will prepare Annual Work plans.

### 7.5 Communication Strategic Plan

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In line with Art 35 in the Constitution on 'Access to Information', all Citizens have a right to information held by the State. The timely and accurate dissemination 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 section focuses on generating a simple guide on developing a communications strategy for the Plan.

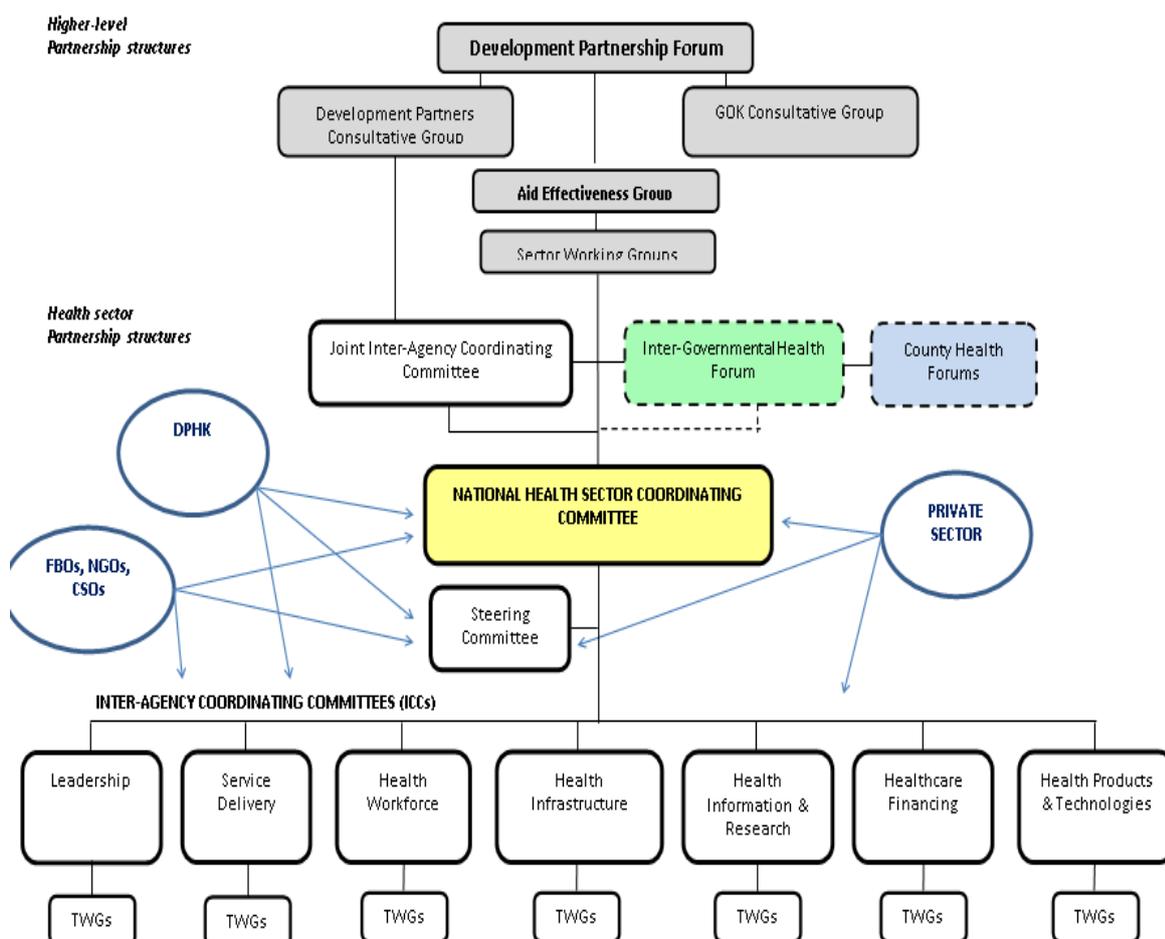
As with any strategy development and planning exercise, this is not a one-off, static process. The analysis will regularly be revisited and the plan kept live and updated. The nature of the process will be that not all communications needs will be evident at the outset of the plan. The communications plan will be incorporated as an element in the implementation of this plan.

The main purpose of the communication strategy is to build greater support and buy in of the MSP among key stakeholders and the public. The strategy will aim to reach 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 MSP.
2. Enhancing consultation with agencies in achieving set outcomes.
3. Ensuring that all stakeholders understand the MSP and on-going health reform process.

A detailed communications plan with intended actions, their timing and responsibilities will 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 MSP. The overall coordination framework that the ministry will be using is presented diagrammatically in Figure 3.

**Figure 3: Comprehensive Health Partnership Framework**



## CHAPTER 8. CAPACITY

The plan takes cognisance of the roles of the national and county governments which are distinct and interdependent. The key functions of the Ministry of Health as per the 4<sup>th</sup> schedule of the Constitution includes: Health policy, health regulation, national referral facilities, capacity building and technical assistance to counties. The Government has also outlined the mandates of the Ministry of Health through Executive Order No 2 of May 2013.

### 8.1 Organization of the Ministry of Health

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The Ministry of Health, which is a merger of the former Ministry of Medical Services and Ministry of Public Health and Sanitation, is headed by a Cabinet Secretary who is responsible for the overall policy, technical direction and coordination of the ministry's functions and activities. He is supported by the Principal Secretary who is the Accounting Officer and the Director of Medical Services who is the head of the technical services.

The Ministry has five technical departments and an International Health Relations Secretariat that are responsible for the various functions and activities. These are: Health Sector Coordination and Inter-governmental Affairs; Policy, Planning and Healthcare Financing; Health Standards, Quality Assurance and Regulations; Preventive and Promotive Health; and Curative and Rehabilitative Health Services, all with designated heads as follows.

#### **A Department of Health Sector Coordination & Inter Governmental Affairs**

The Department is responsible to the Director of Medical Services for forming partnerships and networks and the institutionalisation of sector coordination. This is achieved through the health sector coordination committee and the Technical working groups.

The Department discharges its functions through the following two divisions: Division of Health Sector Coordination and the Division of Health Sector Intergovernmental Affairs.

#### **B The Department of Policy, Planning and Health Financing**

The Department of Policy, Planning and Health Financing is responsible to the Director of Medical Services. It coordinates and leads in the development, implementation and review of sector policy frameworks; health planning (MTP, MTEF, Long term Integrated plans); technical assistance to both National and county governments and the development of policies and strategies relating to the health sector. In addition, the Department is also responsible for developing and reviewing health financing strategies; spearheading change management and transformation and a quality monitoring & evaluation system; the development of a research agenda for the country in collaboration with other relevant institutions and finally embracing and development of a platform for E-health.

The Department discharges its functions through three Divisions namely, Health Policy and Planning; Monitoring and evaluation, Health Informatics and Research & Development and Health Care Financing.

#### **C Department of Health Standards, Quality Assurance and Regulations**

The Department is responsible to the Director of Medical Services for developing policies on the integration of quality management in the healthcare system, norms and standards for human resource and infrastructure and the regulation of health professionals and services. The department is also responsible for the coordination of the development of standards and ensuring compliance through regulatory bodies, control of export and import of biological specimens involved in health research, giving technical advice and capacity development in quality assurance, improvement, norms and standards as well as regulation.

It further coordinates the development of accreditation frameworks acceptable to all stakeholders in the health sector service delivery and coordination of the regulation of alternative and traditional medicine.

The department discharges its functions through three divisions: Division of Health Standards and Quality Assurance, Division of Alternative and Traditional Medicine and Division of Legislation and Regulations.

#### **D Department of Preventive and Promotive Health**

The Department is responsible to the Director of Medical Services for the development and review of policies, guidelines, capacity building and technical assistance in the following key areas: Strategic National Health Programs; Non-communicable Diseases Control; Environmental Health; Family Health; Strategic oversight in selected national referral facilities and training programmes; Field Epidemiology and Laboratory Training.

The Department discharges its functions through the following six divisions: Division of Strategic National Public Health program; Division of Non-communicable Disease Prevention and Control; Division of Family Health; Division of Environmental Health; National Reference Laboratory Services and division of Disease surveillance and epidemic response.

#### **E Department of Curative and Rehabilitative Health Services**

The Department is responsible to the Director of Medical Services for the formulation of policies and guidelines for curative and rehabilitative health services. It provides technical assistance and capacity building to counties on curative and rehabilitation health services. In addition, the department ensures the provision of quality clinical, forensic and pathology services and also handles emergency and disaster management. The department also provides oversight to the National Spinal Injury Hospital and the Mathari National Teaching and Referral Hospital.

The department discharges its functions through the following five divisions: Division of National Referral Health Facilities, Division of Forensic and Pathology Services, Division of Clinical Practice, Division of Health Emergencies and Disaster Management and Division of Blood Transfusion

#### **F The Department of Administration**

The Department of Administration is headed by the Secretary, Administration and supports the above technical departments in terms of providing services related to General Administration; Human Resource Management; Human Resource Development; Finance; Accounts; Supply Chain Management; Legal Services; Public Communications and Information, Communication and Technology.

### **8.2 Semi-Autonomous Agencies (SAGA's) under the Ministry**

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The following semi-autonomous government agencies are under the Ministry:

1. Kenyatta National Hospital (KNH).
2. Moi Teaching and Referral Hospital (MTRH).
3. Kenya Medical Training College (KMTC).
4. Kenya Medical Supplies Authority (KEMSA).
5. National Hospital Insurance Fund (NHIF).
6. Kenya Medical Research Institute (KEMRI).
7. National AIDS Control Council (NACC).
8. HIV/AIDS Tribunal.

The mandates of the semi-autonomous state agencies under the Ministry and who complement the Ministry's mandate are shown in Table 6.

**Table 6: The SAGAs and their Key Mandates**

SAGA	Founded	Corporation status date	Key Mandate
KNH	1901	Legal notice no.109 (April 1987)	Provide specialised care, training and research.
MTRH	1917	Legal notice no.78 (June 1998)	Provide specialised 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	Kenya Medical Supplies Authority Act, 2012	Procure, warehouse and distribute health commodities in Kenya.
NHIF	1966	Act 9 (1998)	Provide quality social health insurance.
NACC	1999	Legal notice 170 of 1999	Coordinate the multi-sectoral response to HIV and AIDS.

The National Spinal Injury Hospital, Mathari National Teaching and Referral Hospital, National Reference Laboratories and Government Chemist are also under the mandate of the Ministry of Health.

The MoH will continue to strengthen its capacities and those of the counties and other stakeholders so as to address challenges and constraints in order to achieve the goals set out in the strategic plan. The ministry will mobilise resources for the implementation of the Strategic Plan through the Medium Term Expenditure Framework (M.T.E.F) and partnerships with development partners as well as the promotion of the Public Private Partnership (PPP) approaches.

The ministry has policy oversight over seven semi-autonomous government agencies and eight regulatory bodies for the regulation of various cadres of health workers in the health sector.

### 8.3 Regulatory Bodies under the Ministry

The ministry has the following eight regulatory bodies:

1. Medical Practitioners and Dentists Board (MPDB).
2. Clinical Officers Council (COC).
3. Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB).
4. Nursing Council of Kenya (NCK).
5. Kenya Nutritionist and Dietetics Institute (KNDI).
6. Public Health Officers and Public Health Technicians Council.
7. Pharmacy and Poisons Board.
8. Radiation Protection Board.

### 8.4 Organizational Structure of the MOH

To enable the ministry meet its expanded mandate there is need to develop an appropriate structure that could maximise the efficiency and success, facilitate working relationships between various sections of the ministry and retain order and command while promoting flexibility and creativity.

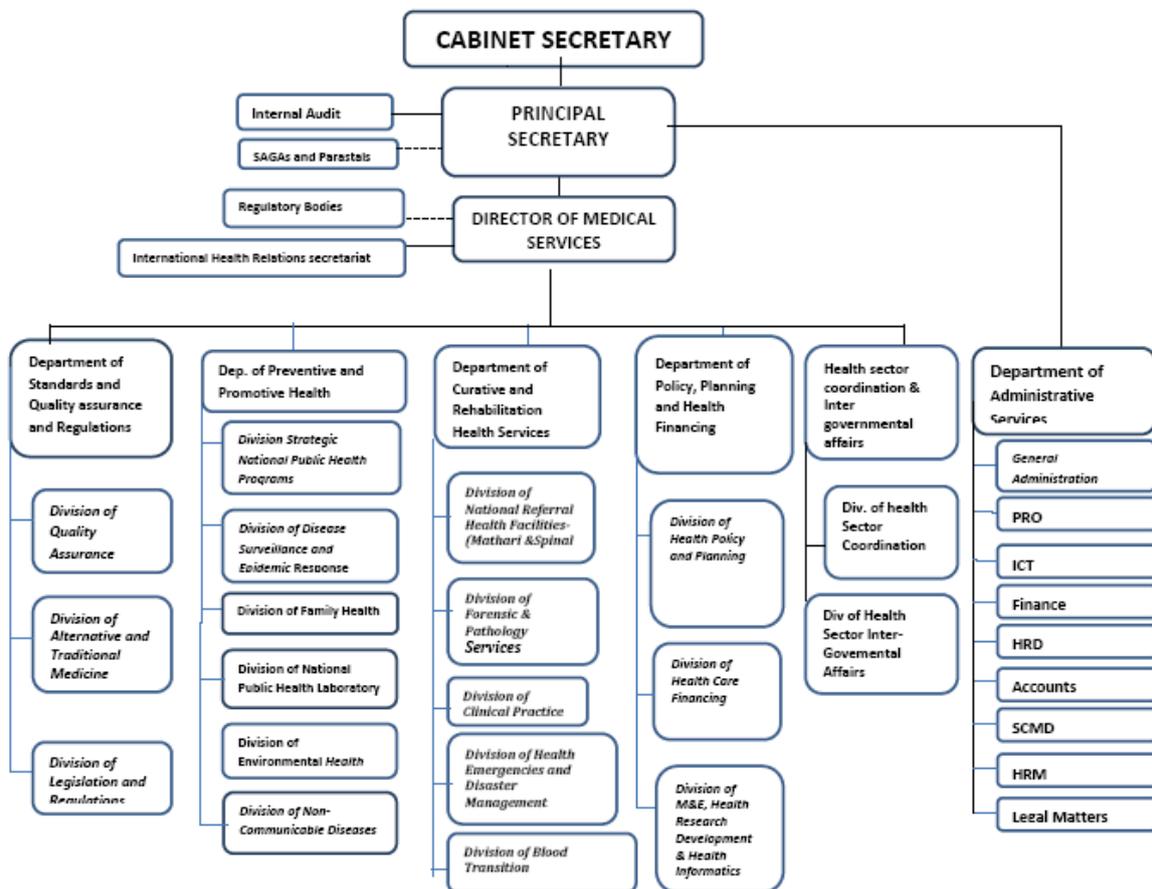
The organisational structure is also meant to create a management framework within which the activities of the ministry can be planned, organised, coordinated and controlled. The

structure will also establish a basis for allocation of duties and responsibilities. In recommending an appropriate structure for the ministry, therefore, the following principal tenets of a good organisation structure have been taken into account:-

- (i) Chain of command
- (ii) Lines of communication
- (iii) Span of control
- (iv) Delegation

The MoH structure is also based on MoH’s roles and functions; supports improved coordination and communication; provides clarity of roles, responsibilities and accountabilities; and by the nature of the ministry, it can either be symmetrical or asymmetrical. Figure 3 below depicts the current organizational structure:

**Figure 4: Organizational Structure of the Ministry of Health**



## 8.5 Human Resource

### A Current Staff Situation

Annex 1 presents the current staff establishment and the staff in post. The Ministry has analysed the staff requirements based on the proposed establishment geared towards meeting the strategic goals of the ministry. Gap analysis will be carried out to optimal staffing levels to enable the ministry perform its mandate. This will be done through a workload analysis.

### B Human Resource Capacities and Skills

The human resource capacities and skills the Ministry of Health requires to implement the strategic mode are highlighted in the section below. HR capacities and skills for each outcome (department) by function required as per the Table 7.

**Table 7: The Human Resource Capacities and Skills of the MOH**

Outcome Area	Capabilities by Function	
Policy Planning and health financing	<b>Policy</b>	<b>Competencies</b>
	Develops overall framework.	<i>Health policy specialist with knowledge of Kenya's health system, ability to translate evidence into policy; capacity building specialty to facilitate departmental capacity building on policy development; health policy communication skills; ability to develop policy briefs for a wide range of audiences; monitoring and evaluation skills to help monitor policy implementation; information management expertise; stakeholder engagement skills; health systems expertise</i>
	Coordinates development of national health policy.	
	Resource for other user departments for development thematic policies.	
	Develops strategy for communicating national and thematic policies.	
	Develops framework for policy monitoring.	
	Establishes and manages health sector policy repository.	
	Multi-sector policy liaison.	
	<b>Strategic Plans</b>	<b>Competencies</b>
	Develops overall framework for strategic & operational planning.	<i>Health sector strategic planning. Health systems specialty to connect various inputs of the health system building blocks. Health economics specialty and experience, to facilitate health financing and budgeting strategies. Monitoring and evaluation skills to help develop strategic plan M&amp;E framework. Technical writing skills to assemble the strategic plan, health background; health information expertise; stakeholder engagement management skills. Background in health. Expertise in health service delivery system in Kenya. Knowledge and skills in strategic planning, with emphasis on the health sector, preferably with experience. Knowledge of the national and county budget and planning cycle. Knowledge of situation analysis, costing methodologies, M&amp;E frameworks, including information systems (health, financial, commodities etc.). Able to communicate with various health professionals in user departments. Knowledge of stakeholder analysis and consultation processes. Good writing skills, including writing sessional papers, cabinet memos.</i>
	Coordinate sector MTEF process.	
	Coordinates development of KHSSP, KEPH.	
	Resource for other user departments for development of thematic strategies.	
	Develops strategy for communicating national and thematic strategies.	
	Develops framework for monitoring strategic plans.	
Establishes and manages health sector strategy repository.		
Multi-sector policy liaison.		
<b>Health Financing</b>	<b>Competencies</b>	
Develop and implement	<i>Knowledge of the Kenyan health sector and financing mechanisms,</i>	

Outcome Area	Capabilities by Function	
<p>financing strategies and innovations.</p> <p>Track and report on health expenditure.</p> <p>Developing conditional grant frameworks.</p>		<p>health economics specialty, financial quantitative and analytical skills, including modelling, costing, specialty in conditional granting, performance based financing. Knowledge, skills and experience in health financing and new initiatives in Kenya and internationally.</p> <p>Understanding of development, welfare /micro-economics. Personal experience in preparing in health expenditure reports, e.g. PETS and NHA. Good understanding of UHC. Knowledge of preparing conditional grant frameworks, including service agreements, MoUs. Working experience in the health sector. Knowledge, skills, experience in health service delivery systems and health management practices. Training background in pharmacy, medicine, nursing, laboratory etc.</p>
	<b>Health Research and Development</b>	<b>Competencies</b>
		<p>Ability to set research priorities, familiar with research methodologies, including data analysis packages; familiar with research application process; competencies in preparing ToR for researchers, manage contracts of consultants; knowledge of research policy development; Presentation skills; Competencies in managing a multi-media resource centre. Familiar with quality assurance methods and quality improvements approaches, including performance improvement</p>
<i>Standards, quality assurance and regulations</i>	<b>Quality assurance</b>	<b>Competencies</b>
	Service delivery norms and standards.	<p>Medical specialty skills (child and paediatric health, reproductive health, obstetrics and gynaecological skills, surgical skills, internal medicine skills); health systems specialty; coordination skills across specialties to facilitate consensus on norms and standards; communication skills to disseminate norms and standards.</p>
	Health systems inputs norms and standards.	
	<b>Regulation</b>	<b>Competencies</b>
	Licensing, gazettement and registration.	<p>Medico-legal skills, legal drafting skills to facilitate writing of Acts and build capacity of counties (on request) to develop county health legislation; understanding of how different health legislation relate to one another; ability to harmonise various types of health legislation. Public health specialists: epidemiologists, health promotion, biostatisticians, environmental health. Competencies in forecasting, quantifying and monitoring commodities (including laboratory supplies) related to these conditions.</p>
	Legal and regulatory frameworks.	
Regulatory bodies.		
<i>Preventive and promotive health</i>	<b>Health Promotion, Disease Prevention and Control</b>	<b>Competencies</b>
	Disease prevention and control programmes.	<p>Public health skills (epidemiological skills, biostatistics) to facilitate quarantine administration, primary health knowledge and experience, health advocacy skills, health communication skills, laboratory technical and management skills, understanding of international and cross border health regulations, certification and inspection skills in aircraft, ship, train, road vehicles, environmental health and sanitation skills to facilitate control of noise dust, smoke, and odour; food inspection skills to facilitate inspection of food imports and exports; ability to respond to health emergencies within port area; skills in building planning for ports. Knowledge of international travel regulations and infectious disease control. Knowledge of cost-effectiveness assessments of various disease control intervention. Supply chain management system specialists. Medical laboratory specialists (microbiologists, virologists, histologists, chemists, toxicologists, forensic medicine, etc.) Health promotion specialists, social marketing skills, communication and advocacy skills, social mobilisation skills. Skills in communication strategies design. Knowledge on both communicable and non-communicable disease control.</p>
	Disease surveillance and outbreak response.	
	Quarantine management.	
	Port Health.	
	National Lab Services.	
Health Promotion.		
<i>Curative and Rehabilitation Health Services</i>	<b>Clinical services</b>	<b>Competencies</b>
		<p>Skill in policy, guidelines, norms and standards developed and implementation, monitoring and evaluation</p> <p>Managerial skills – Financial , Communication, HR, Team building post merging of the ministries to realign the different 'cultures'</p> <p>Succession management skills, skills in specialised areas eg.</p>

Outcome Area	Capabilities by Function	
		<i>anaesthesia, mental health &amp; psychiatry Skills to take care of people with special needs eg the deaf, blind, Skill in policy, guidelines, norms and standards developed and implementation, monitoring and evaluation Managerial skills – Financial , Communication, HR,</i>
<i>Administrative services</i>	<b>Support</b>	<b>Competencies</b>
	HR Management	<i>Fleet management skills to facilitate effective and efficient management of transport, civil engineering skills to facilitate building inspections and improvements planning; recruitment specialist skills to ensure recruitment of high calibre staff, labour law specialist to translate existing legal framework on labour, information management speciality to facilitate effective HRIS, Performance management speciality to facilitate performance management monitoring and development of performance improvement plans ; ICT hardware knowledge and skills to ensure adequate user support for hardware and advice on procurement; ICT software knowledge and skills to ensure adequate user support for software; Procurement (analysts, managers) speciality to facilitate transparent and efficient mechanisms for procurement; Office management skills; Book keeping skills to ensure accurate postings, Financial management skills to facilitate analysis of financial information Negotiation and consultation skills, organizational skills, public administration skills, conflict resolutions skills. In-depth understanding of the Constitution and related laws, in-depth understanding of the health sector; Knowledge of the PFMA. Knowledge of the mutual expectations at NG and CG level. Negotiation, consultation, communication, conflict resolution, counselling skills.</i>
	General Administration	
	Accounting and Finance	
	Procurement	
	Internal audit	
	ICT	
	Facilities and Transport	
	<b>Sector Coordination</b>	
<i>Health sector coordination &amp; inter-governmental affairs</i>	Liaison, linkage, and coordination with County Governments.	<i>Change management skills to oversee transition related to re-organisation of ministry and transition to devolved governments; capacity building skills (basement, training, follow-up) for both national and counties, knowledge management; research management and leadership skills to facilitate effective communication of national health research agenda; negotiation and engagement skills to facilitate effective engagement with counties.</i>

## 8.6 Resources Mobilization and Requirements

The health financing objectives of the ministry will be geared towards a sure resource adequacy for the implementation of the Strategic Plan. The resources mobilisation strategy will consist of mobilising funding from the National Government, Development Partners, private sector (mainly from the out of pocket expenditures for services rendered).

The funding of the ministry has recently witnessed major changes due to the introduction of two levels of government whereby about 65 per cent of the resources were devolved to the counties to meet their recurrent and capital expenditures. However, the ministry will continue to monitor the flow of all these resources for purposes of informing policy development in the country. During the planning period, strategies will be developed that facilitate the re-alignment of resources to contribute to moving towards Universal Health Coverage. In this regard, efforts will be made to generate additional resources by advocating for higher budgetary allocations by both the national and county governments for health, enhance mechanisms that ensure donor support is aligned to the sector goals and objectives and promote financial risk pooling mechanisms. Besides, adoption of payment mechanisms that provide incentives for better productivity and efficiency in service delivery, including an implementation framework that minimises wastage in service delivery and cost-containment across the sector will be encouraged.

The current financial resources (FY 2014/15) consist of Kshs.47 billion, of which the recurrent vote constitute Kshs.26.3 billion (or 55.3 per cent of the total vote) and the development vote that constitute Kshs.21.1 billion (or 44.7 per cent of the total vote). About Kshs.12.2 billion (or 57.8 per cent) of the development vote came from development partners while Kshs.8.9 billion (or 42.2 per cent) came from the Government of Kenya.

Arising from the above, it is projected that development partners will continue to form a significant component of the funding of the development budget of the ministry. A significant part of this funding will be both on budget and off budget resources. The estimated cost of implementing this plan over the four year period is Kshs.152 Billion.

## CHAPTER 9. RESOURCE FLOWS

The World Health Organization (WHO) defines health financing as the “function of a health system concerned with the mobilisation, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system”. It states that the “purpose of health financing is to make funding available, as well as to set the right financial incentive to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO 2000).

A desirable system for providing and financing health care would achieve three goals: (1) preventing the deprivation of care because of a patient's inability to pay. (2) Avoiding wasteful spending. (3) Allowing care to reflect the different tastes of individual patients. These goals should condition and inform the design of a good system for financing health care.

The way in which healthcare is financed is critical for equity in access to healthcare. Kenya has over 45 per cent of its population living below the poverty line with a large share of financing healthcare being out-of-pocket expenditure. This is a cause of the huge inequities we see in access to healthcare and, therefore, calls for a reform of the existing healthcare system by restructuring it to create a universal access to healthcare service.

Ongoing epidemiological, demographic and nutrition transitions will pose significant challenges for health financing systems in LMICs in the near future as the communicable disease burden lessens and the non-communicable disease and injury burdens expand. At the same time, the current communicable disease burden, especially that caused by Malaria, Tuberculosis, and HIV/AIDS, poses a serious threat to public health, health systems and economic growth.

As a result of the international focus on poverty reduction, the HIV/AIDS pandemic and the Millennium Development Goals (MDGs), international health financing policy has evolved over the past decade from defining a basic package of cost-effective health services to figuring out how to finance and deliver those services equitably and efficiently, to recognising the need to scale up health systems to meet basic service needs and achieve the MDGs.

Many developing countries have recently undertaken ambitious health reforms to improve resource mobilisation for health care. Their goals are universal health care coverage for their people and financial protection against impoverishment due to the costs of catastrophic illness.

The Ministry of Health is committed to improve the health status of its people through formulation and implementation of health financing policies in the health sector. In order to effectively sustain financing to the health sector, there is a need for improving allocative and operational efficiency, increasing Government contribution to the health sector budget and employing financial protection measures that will ensure that Kenyans have access to healthcare services that are affordable and of the highest desirable quality, when needed.

To ensure value for money in the health system, the ministry must ensure health system resources are used in the most efficient and effective way possible. In the coming years, the ministry, along with its health system partners, will collaborate on the effective implementation and management of a shared and consistent strategic plan for the health system with built-in accountability and attention to factors needed.

This chapter describes in detail the level of resource requirements for the strategic plan period, the available resources and the funding gap. It further sets out likely future costs for

some of the key strategies being considered as part of MSP 2013/14 to 2017/18. The aim of this costing review is to provide a broad framework on resource requirements as a means of informing donor and government allocations in support of its implementation.

## 9.1 Methodology for Estimating Resource Requirements

The Strategic plan was costed using the Input-Based Costing (IBC) approach. The IBC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve MSP targets for the financial years 2013/14 – 2017/18. The cost over time for all the departments provides important details that will initiate debate and allow MoH senior management and development partners to discuss priorities and decide on effective resource allocation.

According to the Input-Based Costing, the Ministry of Health requires Kshs 152 Billion for the plan period in order to achieve its targets. This further has been disaggregated by departments as shown in the Table 8 below.

**Table 8: Resource requirements by Departments in KES**

Department (s)	FY 2014/2015	FY 2015/2016	FY 2016/2017	FY 2017/2018	TOTAL
D: Admin Services	5,139,407,138	5,155,112,838	5,225,484,002	5,289,171,999	20,809,175,977
D: HP, P & HF	321,439,942	461,439,942	488,223,004	385,341,112	1,656,444,000
D: P&PH	21,859,561,015	23,687,863,839	26,608,186,022	26,569,695,979	98,725,306,855
D: CRHS	7,487,473,560	7,689,450,800	7,548,985,410	7,170,732,450	29,896,642,220
D: HS QA & R	226,109,935	140,000,950	104,132,700	64,749,375	534,992,960
Health Sector Coordination & Inter Govt Affairs + IHR	71,264,000	80,644,000	65,024,000	66,264,000	283,196,000
<b>TOTAL (KES)</b>	<b>35,105,255,590</b>	<b>37,214,512,369</b>	<b>40,040,035,138</b>	<b>39,545,954,915</b>	<b>151,905,758,012</b>

## 9.2 Available Resource (FY 2014/15 – 2017/18)

The government is committed to increasing the health sector's share of the national budget in line with the Abuja target of 15% and shows this commitment by planning to increase the health budget. The analysis defines only the total envelope of costs and resources available; it does not deal with particular programs or line items within the health sector. The starting point for estimating resources available is based on budgets and budget projections because these reflect the total amount of resources available. The analysis was done for four years, starting from 2013/14 to 2017/18.

The national government has budgeted through the Medium Term Expenditure Framework (MTEF) financial support for the Ministry of Health a total of Kshs 90 Billion for the plan period as shown in Table 9.

**Table 9: Available Resources by Departments in KES**

Department (s)	FY 2014/2015	FY 2015/2016	FY 2016/2017	FY 2017/2018	TOTAL
D: Admin Services	3,654,753,616	4,724,236,301	4,817,235,071	5,058,096,825	18,254,321,813
D: HP, P & HCF	253,965,896	282,204,596	301,613,875	316,694,569	1,154,478,936
D: P&PH	12,009,527,459	14,157,891,242	14,912,443,751	15,658,065,939	56,737,928,392
D: CRHS	3,292,535,330	3,466,771,876	3,627,735,691	3,809,122,476	14,196,165,373
D: HS QA & R	346,254	416,529	637,600	669,480	2,069,863
D.Health Sector Coordination & Inter Govt Affairs + IHR	New Dep't				
<b>TOTAL (KES)</b>	<b>19,211,128,555</b>	<b>22,631,520,544</b>	<b>23,659,665,988</b>	<b>24,842,649,288</b>	<b>90,344,964,376</b>

NB: The available funds do not include capital transfers to all SAGAs, Mathari and Spinal Injury hospitals.

### 9.3 Funding Gap (FY 2014/15 – 2017/18)

The Commission on Macroeconomics and Health (WHO 2001) estimated that, in 1997, the 48 poorest developing countries were spending on average US\$11 per capita (US\$6 per year in public funds) and that the level of spending would have to rise to US\$34 per capita to ensure delivery of an essential package. On the basis of these data, the Commission on Macroeconomics and Health estimated that total DAH should rise to US\$27 billion in 2007 and to US\$38 billion by 2015 to scale up coverage (WHO 2001).

This section presents an analysis, based on requirements, to achieve the targets in this MSP and available resources and presents a funding shortfall for the MoH over the plan period. This involves two steps. First, using the costing estimates to compute the resource requirements, then secondly consolidating the available resources from the national government and thereafter computing the funding gap (or surplus) for the Ministry of Health at the national level.

The identification of the funding gap provides an opportunity for potential stakeholders to see when additional resources will be most useful. Overall the MOH has a funding gap of Kshs 62 Billion over the plan period of FY 2014/15 to 2017/18 as shown in Table 10. This presents the financing need that other stakeholders in the health sector need to come on board and fill.

**Table 10: Funding Gap by Departments in KES**

Department (s)	FY 2014/2015	FY 2015/2016	FY 2016/2017	FY 2017/2018	TOTAL
D: Admin Services	1,484,653,522	430,876,537	408,248,931	231,075,174	2,554,854,164
D: HP, P & HCF	67,474,046	179,235,346	186,609,129	68,646,543	501,965,064
D: P&PH	9,850,033,556	9,529,972,597	11,695,742,271	10,911,630,040	41,987,378,464
D: CSRHS	4,194,938,230	4,222,678,924	3,921,249,719	3,361,609,974	15,700,476,847
D: HS QA & R	225,763,681	139,584,421	103,495,100	64,079,895	532,923,097
D. Health Sector Coordination & Inter Govt Affairs + IHR	71,264,000	80,644,000	65,024,000	66,264,000	283,196,000
<b>TOTAL (KES)</b>	<b>15,894,127,035</b>	<b>14,582,991,825</b>	<b>16,380,369,150</b>	<b>14,703,305,626</b>	<b>61,560,793,636</b>

## CHAPTER 10. ACCOUNTABILITY AND RISK

The plan will be implemented when the global economic activity has broadly strengthened and is expected to improve further in the medium term, according to the April 2014 World Economic Outlook (IMF), with much of the impetus for growth coming from advanced economies. In Kenya, although economic performance has been robust in the recent years, the risks of increasing fiscal deficit and rising inflation, the latter due to unpredictable weather conditions could impact negatively on the health ministry.

The increase in the cost of services and inadequate provisions for social health protection mechanisms among the economically disadvantaged groups will continue to limit access to basic healthcare services unless the proposed development of the respective policies and strategies are completed and implemented. Further, the implementation of the Constitution, including the devolution of services, continues to face teething problems. The specific expected risks and mitigation measures likely to affect the implementation of this Plan are elaborated in Table 11 below:

**Table 11: Risks and their mitigation**

Risk area	Description of risks	Risk rating		Mitigation of the risks	Monitoring of risk
		Feasibility (1 – low; 5 – high)	Impact (1 – low; 5 – high)		
Strategic risks	Low budgetary allocations.	4	5	Resource mobilisation strategy and cost cutting measures.	NHA and MPER
	Slow implementation of sector reforms.	4	5	Build capacity for reforms.	Reform Plan
	Transitional issues on devolution.	4	4	Strengthen the Inter-Governmental collaboration mechanisms.	Meetings and range of issues on agenda.
Environmental risks	Emerging and re-emerging diseases.	3	5	Strengthen disease surveillance. Strengthen international collaboration.	M & E report on emerging and re-emerging diseases.
	Effects of climatic change.	4	5	Develop disaster preparedness strategy.	Report on disaster response.
Political risks	Insecurity for health workers in some regions.	4	5	Strengthen inter-sectoral collaboration.	Report and minutes of the collaboration.
Organisational risks	Increased trade unionism among health personnel.	5	5	Strengthen engagement with unions, counties and national government.	Minutes of engagement.
Operational risks	Likelihood of a high number of staff underutilised due the reorganisation of Government.	5	5	Undertake a staff rationalisation of the ministry.	Staff rationalisation report.
Technological Risks	Rapid changes in technology.	3	3	Task shifting and capacity building.	Report on task shifting and number on staff trained in new technology.
Legal Risk	Increased medico-legal cases.	3	3	Create awareness for staff on new laws and changes in legislation.	Report on awareness creation among staff.
Financial risks	Likelihood of duplication of functions among department.	3	4	Continuous restructuring of the ministry.	Ministerial Restructuring Report.
	Likelihood of corruption, which may derail implementation of activities.	4	5	Develop an anti-corruption policy/mechanism.	Report on anti-corruption.

## CHAPTER 11. MONITORING, EVALUATION AND REPORTING

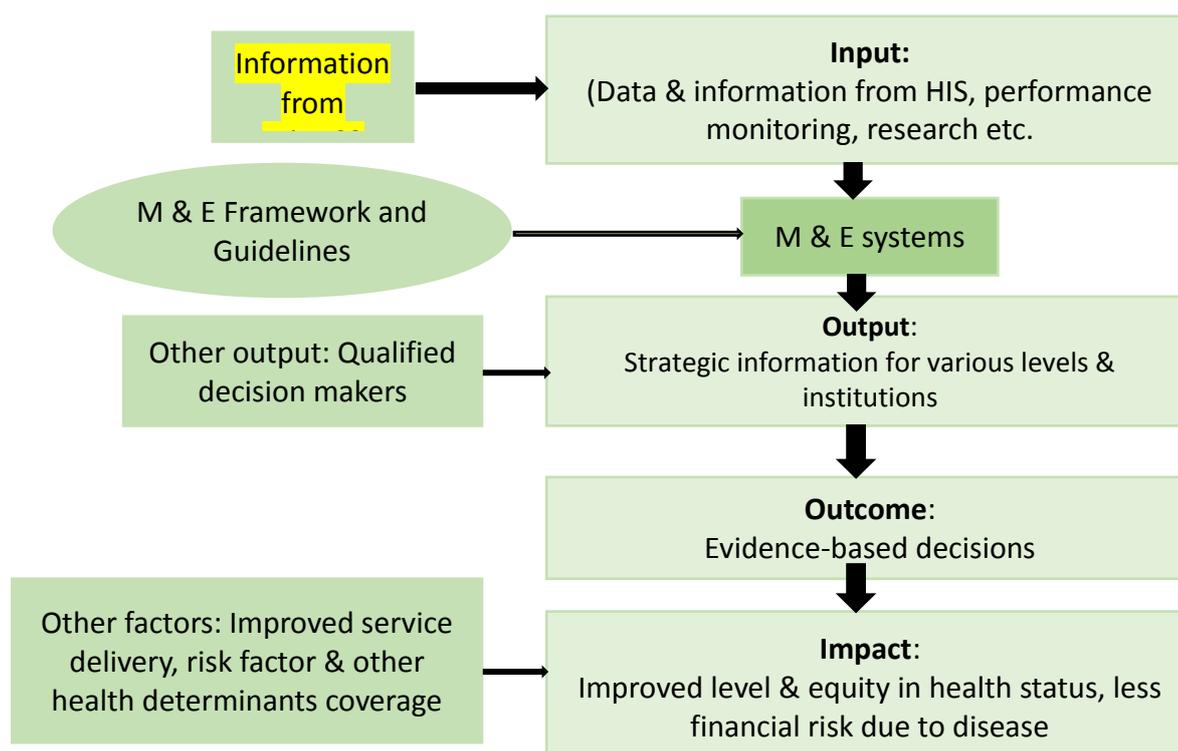
This section highlights the process that the MoH will use to monitor its performance. Monitoring and evaluation are important components of this strategic plan and provide opportunity to track changes in the implementation while monitoring various assumptions and risks.

The ministerial strategic plan has been developed in line with the constitutional mandate of the national government to offer stewardship, standards, regulation and monitoring in the implementation of the Health Sector Strategic Plan 2014-2018. It is, therefore, expected to support the implementation of the Vision 2030 and MTPII 2013-2017.

Monitoring of this strategic plan will be done by tracking key elements of each department's performance using agreed upon indicators generated from inputs, processes and outputs of ongoing programmes and activities spearheaded by respective divisions and units within the departments. Monitoring and evaluation of this plan will also assess the extent to which the implementation of planned activities is consistent with the health sector strategic objectives and outcomes. Hence the indicators selected directly measure the activities at the national level. However, the outputs at this level are expected in the long run to lead to favourable health outcomes and impact. The longer term outcome and impact indicators will be assessed periodically through studies and population based surveys.

Overall, the M&E of this strategic plan will be based on the sector M&E framework shown below using agreed upon tools and governance processes to share the information for better understanding and progress monitoring. Various units and programmes in the divisions will be compiling monthly performance reports and evidence, consolidate departmental reports and submit them to the sector M&E unit by the 5th day of the month following the end of the reporting period. The sector M&E unit will consolidate the ministerial performance indicators and present them in various governance forums for deliberation.

Figure 5: Monitoring and Evaluation Processes



Matrix 7 shows the indicators, annual targets, source of information and responsibilities within MoH to monitor and evaluate performance during and after implementation of this strategic plan. These indicators represent key outputs for each division and have been selected from the matrices presented in Chapter 6.

Matrix 7: The Strategic Plan M&E Indicators and Annual Targets

Outcome	Output	Indicator	Source of data	Target					Responsible Dep /Division
				Baseline 2013/14	2014/15	2015/2016	2016/17	2017/18	
<b>A</b> synchronize and functional health system	Health sector operations coordinated	% Of Health Sector Coordination Committee meetings held annually as per the framework	Departmental Reports	1	4	4	100	100	HSC
	Inter-governmental Relations coordinated	Number of planned health sector intergovernmental consultative forums held	Departmental Reports	2	4	4	4	4	HIGA
	Kenya Foreign Health Relations Framework developed and disseminated	The Kenya Foreign Health Relations Framework	Departmental Reports	0	25%	75%	100%		IHR
	International Health Relations activities monitored and evaluated	Percent of scheduled international health relations briefs prepared	Departmental Reports	12	12	12	12	12	IHR
	International Health Relations activities coordinated	Number of Country position papers prepared	Departmental Reports	8	8	8	8	8	IHR
	Sector policies and strategies developed and disseminated on schedule	Percent of strategies and policies produced as per the guidelines	Departmental Reports	10	10	10	10	10	HPP
		Percent of planning units supported with guidelines	Departmental Reports	50%	75%	80%	90%	100%	MEHRDI
	M & E system strengthened	Number of Quarterly and annual Performance reports analysed and disseminated	Departmental Reports	1	1	1	1	1	MEHRDI
		Number of planning units applying the common M&E framework	Departmental Reports		12	30	45	58	MEHRDI
	Increased and diversified resource flows into the health	Percent of total health expenditure from insurance schemes	Departmental Reports		20%	30%	40%	50%	HF

Outcome	Output	Indicator	Source of data	Target					Responsible Dep /Division
				Baseline 2013/14	2014/15	2015/2016	2016/17	2017/18	
	sector.	per capita health expenditure							
	Studies and research conducted	Percent of health research publications placed in the National Research Repository	Departmental Reports			100 %			MEHRDI
<b>Strengthened systems for management of health care quality and safety</b>	Legislative and regulations frameworks in place	Number of legislative and regulatory framework developed and implemented	Departmental Reports						
	Quality management systems strengthened	No. of counties capacity built on agreed quality management system	Departmental Reports	8	10	12	15	20	SQA
	Traditional and alternative medicine operating in a regulated environment	Number of policies and regulations for tradition and alternative medicine in place	Departmental Reports		30%	80%	90%	100%	SQA
<b>1. Reduced burden of preventable conditions and events 2. Improved health awareness and practice of positive health behavior</b>	Policies and guidelines on control of preventable diseases developed and disseminated	Number of policies and guidelines developed and disseminated		10	50	90	95	100	
	health promotion communication strategy developed and disseminated	Number of IEC materials developed and disseminated		<i>tbd</i>	<i>tbd</i>	<i>tbd</i>	<i>tbd</i>	<i>tbd</i>	<i>tbd</i>
		Percent increase in knowledge attitude and practices in preventable diseases		<i>tbd</i>	<i>tbd</i>	<i>tbd</i>	<i>tbd</i>	<i>tbd</i>	<i>tbd</i>
	Capacity building and Technical assistance conducted	Number of counties with TOTs trained on Health Promotion and prevention	Departmental Reports	20	20	20	20	20	FELTP
	Studies and research on preventive and promotive health conducted	Number of operational research and survey reports	Departmental Reports	1	none	1	none	1	SNPHP
	Public Health Commodities Secured	% of annual forecast for public health commodities procured	Departmental Reports	5	5	5	5	5	FH/ SNPHP/ NPHL
<b>Improved access to quality</b>	Policies and guidelines developed and	Proportion of policies finalized and disseminated	Departmental Reports	-	25%	50%	75%	100%	CRH

Outcome	Output	Indicator	Source of data	Target					Responsible Dep /Division
				Baseline 2013/14	2014/15	2015/2016	2016/17	2017/18	
<b>Curative and rehabilitative health services</b>	disseminated	Percent of guidelines launched and disseminated	Departmental Reports	15%	50%	75%	90%	100%	CRH
	Infrastructure Developed	Percent of the planned number of HFs in slum areas constructed	Departmental Reports	-	15%	60%	100%	-	CRH
		Percent of targeted hospitals equipped	Departmental Reports	0	100%	100%	100%	100%	CRH
	Capacity building and Technical assistance conducted	Percent of coverage of use of Mortuary management guidelines	Departmental Reports	-	100%	100%	100%	100%	CRH
		Percent of County Managers capacitated in EHPT Forecasting & Quantification	Departmental Reports	30%	70%	100%	100%	100%	CRH
		Percent of targeted nurses trained on sexual assault victim management	Departmental Reports	-	33%	67%	100%		CRH
<b>Efficient and Responsive Administrative support systems</b>	Efficient and Responsive Administrative systems at national level	Percentage of external policies and circulars disseminated within the MoH	Departmental Reports	100%	100%	100%	100%	100%	GA
		Quarterly Performance Management Reports	Departmental Reports	4	4	4	4	4	GA
		Percentage of functional administrative Committees (e.g. ACU, Safety Committees, Anti-Corruption Committee)	Departmental Reports	100%	100%	100%	100%	100%	GA
	Effective and prudent utilization of financial resources	Number of annual audit queries raised by KENAO and responded to	Departmental Reports	tbd	0	0	0	0	IA
		Percent of budget utilized annually	Departmental Reports	100%	100%	100%	100%	100%	FA
		Annual financial statement prepared	Departmental Reports	4	4	4	4	4	FA
	Efficient and effective supply chain management systems	Annual Consolidated Procurement Plan	Departmental Reports	100%	100%	100%	100%	100%	SCM
		Percent of goods and services procured as per the procurement plan annually (not out of the plan)	Departmental Reports	n/a	100%	100%	100%	100%	SCM
		Percent of procurement of goods and services given to youth, women and PWDs	Departmental Reports	30%	30%	30%	30%	30%	SCM

Outcome	Output	Indicator	Source of data	Target					Responsible Dep /Division
				Baseline 2013/14	2014/15	2015/2016	2016/17	2017/18	
	Legal systems and structures established and operational	Percent of litigation cases addressed	Departmental Reports	80%	80%	100%	100%	100%	LA
	Systems for information access and sharing updated to current and emerging technologies	Functional LAN and WAN network	Departmental Reports	0	1	1	1	1	ICT
		Ratio of staff to computers	Departmental Reports	1:3 & 1:13	1:1 & 1:10	1:1 & 1:10	1:1 & 1:10	1:1 & 1:10	ICT
		No. of IT based systems implemented	Departmental Reports	None	3	4	5	6	ICT
	Effective public communication for MoH	Number of Communication strategies developed	Departmental Reports	0	2	2	2	2	PR
	Strengthened management of staff recruitment, deployment, motivation and separation	Percent of cadres with reviewed schemes of service for HRH	Departmental Reports	29%	52%	77%	100%	100%	HRM
	Enhanced professional and knowledge management for ministry staff	Percent of staff inducted at the MoH	Departmental Reports	0%	100%	100%	100%	100%	HRD
		Percent of MoH staff projected for training and trained	Departmental Reports	tbd	100%	100%	100%	100%	HRD



## APPENDICES



## APPENDIX A: Staff Establishment as of January 2014

The following table shows the current MoH staff establishment. This establishment will be reviewed from time to time to accord with optimal staffing levels based on workload analysis.

S/No	Designation/Cadre	J/Group	Authorised Establishment	Total In-Post
1	Cabinet Secretary	4	1	1
2	Principal Secretary	U	1	1
	<b>Sub-total</b>		<b>2</b>	<b>2</b>
	<b>Administration</b>			
3	Principle administrative Secretary	U	1	1
4	Director Administration	T	0	1
5	Senior Deputy Secretary	R	3	3
6	Deputy Secretary	Q	3	2
7	Under Secretary	P	5	2
8	Senior Assistant Secretary II/I	N	5	2
9	Assistant Secretary III/II/I	J/K/L	8	1
	<b>Sub-total</b>		<b>25</b>	<b>12</b>
10	Director of Medical Services	U	1	1
11	Secretary /Director of Medical Services	T	0	0
12	Snr. Deputy Dir. Of Med. Services/ chief medical specialist	S	8	8
13	Deputy Dir. Of Med. Services/ chief Specialist	R	17	17
14	Senior Assistant Dir. Of Med. Services/ chief Specialist	Q	7	7
15	Medical Off./SMO/ Med Specialist II	M/N/P	113	113
16	Medical Intern	L	910	710
	<b>Sub-total</b>		<b>1056</b>	<b>856</b>
17	Chief Clinical Officer	R	1	0
18	Senior Deputy Chief Clinical Officer	Q	4	0
19	Deputy Chief Clinical Officer	P	19	1
20	Senior Assistant Chief Clinical Officer	N	12	12
21	Assistant Chief Clinical Officer	M	9	9
22	Clinical Officer III/II/I/Senior	H/J/K/L	72	72
23	Bsc Clinical Interns	K	150	57
	<b>Sub-total</b>		<b>267</b>	<b>151</b>
26	Plaster Technician III/II/I/Senior	G/H/J/K	9	9
27	Chief Dental Specialist	S	2	1
28	Senior Dental Specialist	R	2	1
29	Dental Specialist I	Q	13	13
30	Dental Officer/SDO/ D. Specialist II	M/N/P	13	13
31	Dental Intern	L	100	76
	<b>Sub -total</b>		<b>130</b>	<b>104</b>
	<b>Chief Dental</b>	N	1	0

S/No	Designation/Cadre	J/Group	Authorised Establishment	Total In-Post
<b>Technologist</b>				
33	Deputy Chief Dental Technologist	M	1	1
34	Dental Technologist III/II/I	H/J/K/L	7	7
35	Community Oral Health Officer III/II/I	H/J/K/L	5	5
	<b>Sub-total</b>		<b>14</b>	<b>13</b>
36	<b>Chief Pharmacist</b>	S	<b>1</b>	1
37	Senior Deputy Chief Pharmacist	R	<b>6</b>	6
38	Deputy Chief Pharmacist	Q	<b>23</b>	23
39	Senior Pharmacist/Pharmacist/Asst. Chief Pharm	M/N/P	<b>28</b>	28
40	Pharmacist Intern	L	<b>200</b>	170
	<b>Sub-total</b>		<b>258</b>	<b>228</b>
41	<b>Chief Pharmaceutical Technologist</b>	N	<b>1</b>	1
42	Deputy Chief Pharmaceutical Technologist	M	<b>7</b>	7
43	Pharmaceutical Technologist III/II/I	H/J/K/L	<b>32</b>	32
	<b>Sub-total</b>		<b>40</b>	<b>40</b>
43	Chief Nursing Officer	R	<b>1</b>	0
44	Senior Deputy Chief Nursing Officer	Q	<b>3</b>	1
45	Deputy Chief Nursing Officer	P	<b>4</b>	4
46	Senior Assistant Chief Nursing Officer	N	<b>12</b>	12
47	Assistant Chief Nursing Officer	M	<b>30</b>	30
48	BSN Nursing Officer (Graduate)	K/L	<b>100</b>	0
49	Nursing Officer Intern	K	<b>350</b>	307
50	Nursing Officer III/II/I	H/J/K/L	<b>480</b>	480
51	Enrolled Nurse III/II/I/Senior Enrolled Nurse	G/H/J/K	<b>302</b>	302
	<b>Sub-total</b>		<b>1282</b>	<b>1136</b>
52	<b>Chief Medical Laboratory Technologist</b>	<b>R</b>	<b>0</b>	0
53	Senior Deputy Chief Medical Laboratory Technologist	Q	<b>2</b>	0
54	Deputy Chief Med. Laboratory Technologist	P	<b>15</b>	15
55	Senior Assistant Chief Medical Laboratory Technologist	N	<b>28</b>	28
56	Assistant Chief Medical Laboratory Technologist	M	<b>6</b>	6
57	Laboratory/Medical Laboratory Technologist III/II/I/Senior	H/J/K/L	<b>157</b>	157
58	Laboratory/Medical Laboratory Technician III/II/I/Senior	G/H/J/K	<b>89</b>	89
59	Mortuary Attendant III/II/2a/2b	D/E/F/G	<b>2</b>	2
	<b>Sub-total</b>		<b>299</b>	<b>297</b>
60	<b>Chief Occupational Therapist</b>	R	<b>1</b>	0
61	Senior Deputy Chief Occupational Therapist	Q	<b>2</b>	0
62	Deputy Chief Occupational Therapist	P	<b>7</b>	1
63	Senior Assistant Chief Occupational Therapist	N	<b>10</b>	0
64	Assistant Chief Occupational Therapist	M	<b>50</b>	1
65	Occupational Therapist III/II/I/Senior	H/J/K/L	<b>24</b>	24
	<b>Sub-total</b>		<b>94</b>	<b>26</b>
66	<b>Chief Physiotherapist</b>	R	<b>1</b>	0

S/No	Designation/Cadre	J/Group	Authorised Establishment	Total In-Post
67	Senior Deputy Chief Physiotherapist	Q	1	0
68	Deputy Chief Physiotherapist	P	3	1
69	Senior Assistant Chief Physiotherapist	N	10	0
70	Assistant Chief Physiotherapist	M	50	0
71	Physiotherapist III/II/I/Senior	H/J/K/L	30	30
	<b>Sub-total</b>		<b>95</b>	<b>31</b>
72	<b>Chief Health Records and Information Officer</b>	N	2	0
73	Deputy Chief Health Records and Information Officer	M	31	6
74	Health Records & Information Officer III/II/I	H/J/K/L	34	34
75	Health Records & Information Technician III/II/I	G/H/J/K	31	31
	<b>Sub-total</b>		<b>97</b>	<b>71</b>
76	<b>Chief Orthopaedic Technologist</b>	N	1	0
77	Deputy Chief Orthopaedic Technologist	M	11	1
78	Orthopaedic Technologist III/II/I/Senior	H/J/K/L	9	9
79	Orthopaedic Appl. Mkt Asst	D/E/F	9	9
	<b>Sub-total</b>		<b>30</b>	<b>19</b>
80	<b>Chief Radiographer</b>	R	1	0
81	Senior Deputy Chief Radiographer	Q	1	1
82	Deputy Chief Radiographer	P	12	1
83	Senior Assistant Chief Radiographer	N	15	0
84	Assistant Chief Radiographer	M	50	2
85	Radiographer III/II/I/Senior	H/J/K/L	20	20
	<b>Sub-total</b>		<b>99</b>	<b>24</b>
86	<b>Chief Health Administration Officer</b>	R	1	0
87	Senior Deputy Chief Health Administration Officer	Q	3	2
88	Deputy Chief Health Administration Officer	P	8	1
89	Senior Assistant Chief Health Administration Officer	N	3	3
90	Assistant Chief Health Administration Officer	M	5	5
91	Health Administration Office II/I (Graduates)	<b>J/K</b>	<b>0</b>	<b>0</b>
92	Health Administration Officer III/II/I/Senior	H/J/K/L	14	14
	<b>Sub-total</b>		<b>34</b>	<b>25</b>
93	<b>Principal Medical Social Worker</b>	<b>S</b>	<b>0</b>	<b>0</b>
94	Senior Deputy Principal Medical Social Worker	R	0	0
95	Deputy Principal Medical Social Worker	Q	0	0
96	Senior Assistant Principal Medical Social Worker	P	0	0
97	Assistant Principal Medical Social Worker	N	1	0
98	Chief Social Welfare Officer	M	3	1
99	Social Welfare Officer III/II/I/Snr.	H/J/K/L	7	6
	<b>Sub-total</b>		<b>11</b>	<b>7</b>
100	<b>Chief Inspector Of Drugs</b>	N	1	0
101	Deputy Chief Inspector of Drugs	M	3	0
102	Inspector of Drugs III/II/I	H/J/K/L	8	8

S/No	Designation/Cadre	J/Group	Authorised Establishment	Total In-Post
	<b>Sub-total</b>		<b>12</b>	<b>8</b>
103	<b>Chief Medical Engineer</b>	P	1	0
104	Deputy Chief Medical Engineer	N	3	0
105	Assistant Chief Medical Engineer	M	12	0
106	Assistant Engineer /Engineer (Medical)	K/L	2	0
	<b>Sub-total</b>		<b>18</b>	<b>0</b>
107	<b>Chief Medical Engineering Technologist</b>	N	1	0
109	Deputy Chief Medical Engineering Technologist	M	1	1
110	Medical Engineering Technologist III/II/I/Senior	H/J/K/L	3	3
111	Medical Engineering Technician III/II/I/Senior	GH/J/K	21	21
	<b>Sub-total</b>		<b>26</b>	<b>25</b>
112	<b>Director, Human Resource Management</b>	S	1	0
113	Deputy Dir. Human Resource Management	R	1	1
114	Snr. Assistant Dir. Human Resource Management	Q	0	0
115	Assistant Dir. Human Resource Management	P	1	1
116	Principal Human Resource Management Officer	N	1	2
117	Chief Human Resource Management Officer	M	3	3
118	Human Resource Management Officer II/I/Snr	J/K/L	7	7
119	Human Resource Management Assistant III/II/I/Snr	H/J/K/L	17	17
120	Clerical Officer/HCO/SCO/CCO	F/G/H	136	133
121	Support Staff III/II/I/Senior	A/B/C/D /E	186	186
	<b>Sub-total</b>		<b>353</b>	<b>350</b>
122	<b>Assistant Accountant General</b>	P	1	1
123	Principal Accountant	N	1	0
124	Chief Accountant	M	2	2
125	Senior Accountant	L	12	12
126	Accountant I	K	22	22
127	Accountant II	J	33	33
128	Accounts Assistant	G/H	90	0
	<b>Sub-total</b>		<b>161</b>	<b>70</b>
129	Deputy Dir. Supply Chain Management Services	R	1	1
130	Snr Deputy Dir. Supply Chain Management Services	Q	1	0
131	Assistant Director, Supply Chain Management Services	P	1	1
132	Principal Supply Chain Management Services	N	1	0
133	Chief Supply Chain Management Services	M	4	4
134	Senior Supply Chain Management Services Officer	L	3	1
	<b>Sub-total</b>		<b>11</b>	<b>7</b>
135	Principal Supply Chain Management Assistant	N	0	0
136	Chief Supply Chain Management Assistant	M	0	0
137	Senior Supply Chain Management Assistant	L	8	8
138	Supply Chain Management Assistant I	K	0	12

S/No	Designation/Cadre	J/Group	Authorised Establishment	Total In-Post
139	Supply Chain Management Assistant III/II	H/J	28	28
140	Supply Chain Management Assistant IV	G	9	9
	<b>Sub-total</b>		<b>45</b>	<b>57</b>
141	<b>Dir. Human Resource Development</b>	S	1	1
142	<b>Deputy Dir. Human Resource Development</b>	R	0	0
143	Senior Asst. Director Human Resources Development Officer	Q	0	1
144	Asst. Director Human Resources Development Officer	P	2	2
145	Principal Human Resources Development Officer	N	1	1
	<b>Sub-total</b>		<b>1</b>	<b>2</b>
146	<b>Deputy Chief Information Communication Technology Officer</b>	P	1	1
147	<b>Principal Information Officer</b>	N	1	1
148	Deputy Chief Information Communication Technology Officer	M	2	2
149	Senior Information Communication Technology Officer	L	1	1
150	Information Communication Technology Officer I	K	6	6
151	Information Communication Technology Officer II	J	1	1
152	Information Communication Technology Officer III	H	0	0
	<b>Sub-total</b>		<b>12</b>	<b>12</b>
153	<b>Deputy Director, Public Communications</b>	R	1	0
154	Assistant Director Public Communications	P	1	0
155	Senior Public Communications Officer/Chief/Principal	L/M/N	1	1
156	Technical Officer/Cameraman/Photographer/III/II/I	H/J/K	1	0
157	Technical Officer Electrical/Electronics/III/II/I	H/J/K	1	0
	<b>Sub-total</b>		<b>5</b>	<b>1</b>
158	<b>Senior Assistant Director Records Management</b>	Q	1	0
159	Assistant Director / Records Management	P	1	0
160	Principal Records Management Officer	N	2	0
161	Chief Records Management Officer	M	5	1
162	Senior Records Management Officer	L	2	6
163	Record Management Officer III/II/I	H/J/K	11	11
	<b>Sub-total</b>		<b>22</b>	<b>18</b>
164	<b>Librarian I</b>	K/L	3	0
165	Library Assistant II/I	G/H/J	1	1
			<b>4</b>	<b>1</b>
166	<b>Principal State Counsel</b>	SL4	1	0
167	State Counsel II/I	SL 1/2	2	0
	<b>Sub-total</b>		<b>3</b>	<b>0</b>
168	<b>Senior Telephone Supervisor</b>	L	0	1
169	Telephone Supervisor I	K	1	0

S/No	Designation/Cadre	J/Group	Authorised Establishment	Total In-Post
166	Telephone Supervisor II	J	1	2
167	Telephone Supervisor III	H	9	9
168	Telephone Operator II/I/Senior	E/F/G	13	13
	<b>Sub-total</b>		<b>24</b>	<b>25</b>
169	<b>Chief Economist/Statistician</b>	R	0	0
170	Deputy Chief Economist/Statistician	Q	0	3
171	Principal Economist	P	1	1
172	Senior Economist	N	2	2
173	Senior Statistician	M	0	2
174	Economist I	L	1	1
175	Statistical Officer II	K	6	1
176	System Analyst/ Programmer II/I	J/K	6	0
177	Statistical Officer I	J	5	0
178	Statistical Officer II	H/J	0	0
179	Statistical Assistant II/I/Senior	E/F/G	7	0
	<b>Sub-total</b>		<b>28</b>	<b>10</b>
180	Senior Chief Finance Officer	S	0	1
181	Chief Finance Officer	R	1	0
182	Deputy Chief Finance Officer	Q	1	1
183	Senior Principal Finance Officer	P	0	0
184	Principal Finance Officer	N	2	2
185	Senior Finance Officer	M	2	2
186	Finance Officer III / II / I	J/K/L	3	3
	<b>Sub-total</b>		<b>9</b>	<b>9</b>
187	<b>Principal Executive Secretary/ Asst. Dir. of Sec. Services</b>	P	<b>1</b>	<b>1</b>
188	Senior Executive Secretary	N	<b>1</b>	<b>1</b>
189	Executive Secretary	M	<b>5</b>	<b>5</b>
190	Senior Personal Secretary	L	<b>28</b>	<b>28</b>
191	Personal Secretary I	K	<b>24</b>	<b>24</b>
192	Personal Secretary II/III	H/J	<b>16</b>	<b>16</b>
193	Secretarial Assistant II	G	<b>8</b>	<b>8</b>
194	Secretarial Assistant I/Senior	H/J	<b>23</b>	<b>23</b>
	<b>Sub-total</b>		<b>106</b>	<b>106</b>
194	<b>Chief Information Officer</b>	N	<b>1</b>	<b>0</b>
195	Deputy Chief Information Officer	M	<b>1</b>	<b>0</b>
196	Senior Information Officer	L	<b>3</b>	<b>1</b>
197	Information Off. I	K	<b>0</b>	<b>0</b>
198	Information Officer II	J	<b>1</b>	<b>0</b>
199	Information Assistant I	F	<b>1</b>	<b>0</b>
	<b>Sub-total</b>		<b>7</b>	<b>1</b>
200	<b>Principal Driver</b>	J	<b>12</b>	<b>12</b>
201	Driver III/II/I/Senior/Chief	D/E/F/G/ H/J	<b>126</b>	<b>126</b>

S/No	Designation/Cadre	J/Group	Authorised Establishment	Total In-Post
202	Forklift Driver III/II/I/Senior	D/E/F/G	4	0
	<b>Sub-total</b>		<b>142</b>	<b>138</b>
203	<b>Security Officer I</b>	<b>K</b>	<b>0</b>	<b>0</b>
204	Security Officer II	J	3	0
205	Assistant Security Officer	H	6	2
206	Senior Security Warden	G	5	0
207	Security Warden III/II/I	D/E/F	2	3
	<b>Sub-total</b>		<b>16</b>	<b>5</b>
208	Housekeeper/ Cateress I/II/ III	H/J	6	6
209	Assistant Housekeeper/Cateress I/II	G	1	1
210	Artisan (Building) III/II/I/Charge hand/Senior	D/E/F/G/ H	5	5
211	Electrical Technician I	D/E/F/G/ H	1	1
212	Boiler Assistant III/II/I/Senior	D/E/F/G/ H	5	5
213	Ship crew/ Coxswain III/II/ I	D/E/F/G/ H	1	1
214	Graphic Designer/Printer/Printing Assistant III	D/E/F/G/ H	4	4
215	Cook III/II/I/Senior	D/E/F/G/ H	7	7
216	Tailor III/II/I/Charge hand	D/E/F/G/ H	4	4
	<b>Sub-total</b>		<b>34</b>	<b>34</b>
	<b>Total Staff in Complement</b>			<b>3,922</b>
	<b>Less total number of interns</b>			<b>1,320</b>
	<b>GRAND TOTAL</b>			<b>2,602</b>



## APPENDIX B: Strategic Plan Interventions and Responsible Directorates/Units

The following matrices present the Strategic Plan's priority interventions and the Departments and units responsible for implementation, grouped under the eight policy orientations of the KHP 2014-2030 and mirrored as investment areas in the KHSSP 2014-2018. These Strategic Plan priority interventions are structured to realize the outputs outlined in the Strategic Model chapter, and mostly derived from the KHSSP 2014-2018.

When several units are engaged in one intervention, the unit expected to take the technical responsibility for leading the intervention are highlighted. Acronyms used to identify the units are presented at the end of this appendix.

### A. HEALTH SERVICE ORGANISATION

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
<b>1.1 KHP component: organisation of the health service package</b>								
1.1.1	Mainstream KEPH, its conditions/diseases, service areas and interventions in all relevant legislation, policies, strategies and operational guidelines.		HRD	HF division	HR&S	NS, Onco, DRM	NCD, V&IP, HP, TB L &LDs, Malaria, NASCOP, ZD, V&IS	HSIGA Div
1.1.2	Disseminate the KEPH to all stakeholders.		-		HS&N	-	-	
1.1.3	Conduct a review of the KEPH after five years of implementation.			HSM&E	HS&N	-	-	
1.1.4	Establish and operate national and county level coordination and partnership mechanisms required to implement the KEPH in line with the Partnership Framework.						HP, TB L & LDs, Malaria, NASCOP, V&IS	
1.1.5	Ensure health workers have the required knowledge, skills and attitudes to implement the KEPH, its conditions/diseases, service areas and interventions.						NCD, HP, Malaria, V&IS	
1.1.6	Promote, support, commission, manage and conduct KEPH related research.	<i>KEMRI</i>	-				HP	HSIGA Div
1.1.7	Develop and implement awareness creation approaches and materials on KEPH conditions, services and interventions.		-	-	-	MHS	NCD, V&IP, TB L&LDs, Malaria, NASCOP, V&IS	HSIGA Div
<b>1.2 KHP component: organisation of the service delivery system</b>								
1.2.1	Develop legislation that will guide the classification and operations of each level of the				HS&N, HS&L			

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
	health delivery system.							
1.2.2	Develop legislation on the organisation of the health services delivery system, including legislation for specific population groups in 'high concentration settings and marginalised groups and mental health patients.				HS&N, HS&L	MHS		
1.2.3	Develop, disseminate and implement policies and strategies, guidelines, norms and standards related to the organisation of health service delivery.					MHS, FM&MLS	PHS, OH&S, S&WS, V&I S	
1.2.4	Coordination and partnership mechanisms required to organise health services.						PH	HSC Div
1.2.5	Ensure health workers have the required knowledge, skills and attitudes to organise health services.						PHS, S&WS, DSR	HSC Div
1.2.6	Promote, support, commission, manage and conduct research on health service delivery organisation.						TB L & LDs	HSC Div
<b>1.3 KHP component: organisation of community services</b>								
1.3.1	Develop, disseminate, implement and review the Community Health Services Policy and Strategy.						CH	
1.3.2	Integrate the Family Health Concept in the Community Health Services Policy and Strategy.						CH	
1.3.3	Train CHWs in Malaria and TB case management.						Malaria, TB L&LDs,CH	
1.3.4	Train community on pre-hospital care of trauma injuries.						V&I P	
<b>1.4 KHP component: organisation of services within facilities</b>								
1.4.1	Develop, disseminate and implement policies, strategies and guidelines required for the organisation of services provided at health facilities.					FM&MLS, DI		
1.4.2	Develop and disseminate operational guidelines on clinical and nursing care.					Onco, OS, NS, FM&ML	NCD, Malaria, TB L & LDs	
1.4.3	Train county managers and facility staff in service provision (clinical services, clinical support services, general support services).					SCS, DS, MHS, Onco, NS, FM&MLS,	NCD, H&A, Malaria, TB L&LDs,	

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
							V&IP	
1.4.4	Scale up activities of priority services within facilities.					DI	NCD	
<b>1.5 KHP components: organisation of referral services, emergency care and health response in disease outbreaks and disasters</b>								
1.5.1	<b>Establish and operate comprehensive and accessible referral services (a MTP II Flagship Project).</b>		SCM	HCF		DRM		
1.5.2	Improve the quality and scope of NPHL services and expand the network of public health laboratories.						NPHL	
1.5.3	Monitor and evaluate the referral system, including the operations of the national referral facilities.						NPHL	
1.5.4	Develop and operate Emergency Medical Services.					DRM		
1.5.5	Carry out county hazard vulnerability assessment and risk mapping.					DRM		
1.5.6	Establish functional DRM system within the county health departments.					DRM		
1.5.7	Establish, and participate in platform for sharing early warning information.					DRM		
1.5.8	Enhance competencies at national level in Emergency and Disaster Risk Management.					DRM		
1.5.9	Develop and implement policies, strategies and plans for disease outbreaks.						DSR, ZD	
<b>1.6 KHP component: Supervision and mentorship services</b>								
1.6.1	Carry out integrated supportive supervision using updated Kenya Quality Model for Health.				QA			

## **B. LEADERSHIP & GOVERNANCE**

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
<b>2.1 KHP Objective : provide oversight for the implementation of a functionally integrated, pluralistic health system</b>								
	Develop and enact a HPP in Health regulatory framework.			PPP	HR&L			
2.1.1	Develop and operationalise a PPP Policy and Strategy.			PPP				
2.1.2	Establish a coordination forum to enhance policy dialogue between the public and private sector.			PPP				
2.1.3	Undertake capacity building of			PPP				

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
	policy makers and private sector players to improve institutional capacity to engage in effective public-private collaborations.							
2.1.4	Undertake private sector assessments to deepen understanding of the role of the private sector in the health industry.			PPP				
<b>2.2 KHP Objective: put in place mechanisms for engaging with health-related actors</b>								
2.2.1	Create and operate national advisory body on Multisectoral Action for Health.						HP	HSC Div
2.2.2	Advocate for better Multisectoral Action for Health.						HP	HSC Div
<b>2.3 KHP Objective: joint development of operational and strategic plans and review processes.</b>								
2.3.1	Operationalise a health sector intergovernmental consultative and coordination mechanism.						Malaria	HSC&IGA
2.3.2	Develop sector wide annual work plans at national level based on available resources and guided by strategic plans and PFMA.			SP&P				HSC&IGA
2.3.3	Develop Annual County, National and Sector Health Sector Performance Reports.			HSM&E				HSC&IGA
2.3.4	Orient CDoHs (and MoH administrative entities) on stewardship for health, including evidence-based planning and budgeting, budget analysis and budget tracking studies.		HRD?	SP&P	QA?			HSC&IGA
2.3.5	Advocate with National Treasury for a review of the GoK budget structure in order to facilitate evidence-based decision-making.			SP&P, HCF				
<b>2.4 KHP Objective: regulate standards for health services, including quality of services, and their assessment</b>								
2.4.1	Develop, disseminate, implement and monitor Leadership Norms and Standards for Health Facilities.				HS&N			HSC Div
2.4.2	Develop a legal and policy framework for Quality Assurance, Accreditation and Joint Inspections of Health Facilities.				QA			HSC Div
2.4.3	Develop a National Infection Prevention and Control Policy and subsidiary strategies.				QA	Dental		
2.4.4	Develop Operational Guidelines and Assessment tools on Quality Clinical Care.					CRHS		

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
2.4.5	Build capacity in counties on KQMH and Infection Prevention & Control.				QA			HSC&IGA
<b>2.5 KHP Objective: a comprehensive legal and regulatory framework in the Health Sector that guides sector actions</b>								
2.5.1	Update the health legal framework.				HS&R			HSC&IGA
2.5.2	Develop specific health laws.			HIS	HS&R	NBTS, MHS, DRM	PS, FQ&S, NCD, Malaria, NASCOP, S&WS,	HSC&IGA
2.5.3	Develop the legal and regulatory work on Traditional and Complementary Medicine.				HS&R			HSC&IGA
<b>2.6 Subsector and thematic policies and strategies where needed and aligned to Constitution and devolution</b>								
2.6.1	Develop and implement a standard approach to policy and strategic planning in terms of process, methodology and formats.			SP&P				
<b>2.7 KHSSP Strategy: ensure functional health governance mechanisms at all levels of health care</b>								
2.7.1	Strengthen youth, gender and disability and social accountability mainstreaming in policies, regulations, norms and standards, planning and M&E.			G&Y M, SP&P				
2.7.2	Strengthen complaints handling mechanisms: locally and at county and national levels.			SP&P				HSIGA Div
2.7.3	Build capacity in social accountability approaches at CDoHs and public and FBO facilities.			SP&P				
2.7.4	Conduct periodical client satisfaction and responsiveness surveys.			SP&P				
<b>2.8 KHSSP Strategy: functional strategic partnership mechanisms</b>								
2.8.1	Adopt the Draft Health Sector Partnership Framework (November 2013) and implement its recommendations for a new health sector partnership and coordination structures in the context of devolution, including the development and implementation of a new Code of Conduct and a mechanism to monitor adherence to it.						NASCOP, Malaria, TB L & LDs, NCD, CH	HSC&IGA
2.8.2	Develop and institutionalise a			HCF				HSIGA

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
	transparent and comprehensive sector-wide resource tracking information system to provide timely information to national MOH, counties and sector partners on financing requirements, expected inputs, funding gaps, and actual disbursements.							Div

### C. HEALTH WORKFORCE

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
<b>3.1 KHSSP Strategy: Adequate, appropriate and equitably distributed health workers</b>								
3.1.1	Develop and implement HRH policy.		HRD					HSIGA Div
3.1.2	Review develop and implement evidence based health workforce norms and standards.		HRM		HS&N			HSIGA Div
3.1.3	Develop County-specific HRH staffing targets.		HRM					HSIGA Div
3.1.4	Re-engineer HRH development and management in line with HRH norms (a MoH MTP II Flagship project).		HRM					HSIGA Div
3.1.5	Develop and institutionalise a HRH unified database system-including on training needs and projections.		HRD		e-health			HSIGA Div
<b>3.2 KHSSP Strategy: attraction and retention of Health Workforce</b>								
3.2.1	Develop and implement an incentive policy for attraction and retention of health workers including for hard to reach areas, including on establishing resource centres and recreation facilities.		HRM					HSIGA Div
3.2.2	Develop and implement a reward system as a Health Workforce motivation strategy.		HRM	HCF				HSIGA Div
3.2.3	Document and share county experiences with attraction and retention of Health Workforce.		?					HSIGA Div
<b>3.3 KHP Strategy: institutional capacity and Health Workforce performance</b>								
3.3.1	Develop, review and harmonise schemes of service for all staff cadres including new and emerging cadres.		HRM					HSIGA Div
3.3.2	Develop capacity at county level to regularly monitor, and institute corrective measures for improving Health Workforce productivity.		HRM					HSIGA Div
3.3.3	<i>Proposed: Strengthen the Performance Appraisal System at all levels.</i>		HRM					HSIGA Div
<b>3.4 KHP Strategy: training capacity building and development of Health Workforce</b>								
3.4.1	Update the pre-service curricula to align these to the Health Workforce needs.	KMTC	HRD					
3.4.2	Develop health systems and services leadership and management capacity at all.		HRD	SP&P M&E	QA			HSC&IGA

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HF	SQA&R	CRHS	P&PH	HSC&IGA
3.4.3	Coordinate the in-service training programmes of the MoH.		HRD					HSIGA Div
3.4.4	Develop and implement a Training Policy.		HRD					HSIGA Div
3.4.5	Develop a Continuous Professional Development Framework.		HRD		CPD			HSIGA Div

#### D. HEALTH FINANCING

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
			Admin	PP&HCF	QAS&R	C&RHS	P&PS	C&IGA
4.1 KHP Strategy: advocate for greater allocation by both national and county governments to attain universal health coverage.								
4.1.1	Fundraising through PPP and Partners (all).							
4.2 KHP Strategy: Advocate for increased financing for health and health related sectors to meet agreed national and international benchmarks and to ensure that required interventions are implemented.								
4.2.1	Revise and develop annual MTEFs based on public and on-budget donor resources (National and County governments).		Finance					
4.3 KHP Strategy: Establish social health protection mechanism to progressively facilitate attainment of UC.								
4.3.1	Health insurance for all.							C&IGA
4.4 KHP Strategy: Develop and strengthen Innovative HCF for communities by periodically reviewing the criteria for resource allocation and purchasing mechanisms to improve efficiency and utilisation of resources.								
4.4.1	Finalise framework for disbursing conditional grants from MOH to Counties and other sub-national entities.			HCF				
4.4.2	Scale up results based financing initiatives for health care.			HCF				
4.4.3	Increase OBA to cover more counties.			HCF				
4.5 KHP Strategy: Progressively work towards the elimination of payment at the point of use of health services, especially by marginalised and indigent populations through social health insurance and government subsidies.								
4.5.1	Phased implementation of Health Insurance Subsidy Programme (HISP) for the Poor (a MOH MTP II Flagship Project).			HCF				
4.5.2	Develop framework, and support implementation of health financial risk pooling mechanisms.			HCF				
4.6 KHP Strategy: Put in place comprehensive mechanisms for financing of emergency health services.								
4.6.1	Purchase of ambulances.			HCF				
4.6.2	Contingence funds for emergency.	Finance						
4.7 KHP Strategy: Promote private sector participation in financing of health through PPP and other mechanisms.								
4.7.1	See Investment Area 2, strategy 3.			PPP				
4.8 KHP Strategy: Pool resources to increase efficiency in utilisation of health resources.								
4.8.1	Institutionalise preparation of annual National Health Accounts (NHA).			HCF				
4.8.2	Develop framework, and support implementation of health financial risk pooling mechanisms.			HCF				
4.8.3	Phased implementation of Health Insurance Subsidy Programme (HISP) for the Poor (a MoH MTP II Flagship Project).			HCF				
4.8.4	Implementation of free maternity services policy, including increasing coverage and benefit package (a MoH MTP II Flagship Project).			HCF			R&MH	
4.8.5	Develop and implement framework for pooling of resources for primary care services (Health			HCF				

	MSP Priority Interventions	SAGAs	MoH Departments and Units carrying out priority interventions					
	Sector Services Fund, free primary care, County allocations for primary care etc.).							
4.9 KHP Strategy: Develop and implement health care financing policy.								
4.9.1	Finalise and ensure the implementation of the Country Health Care Financing Policy and Strategy and implementation road map for UHC.			HCF				
4.10 KHP Strategy: Enhance fiduciary and social accountability systems.								

## E. HEALTH INFORMATION SYSTEMS

	MSP Priority Interventions	SAGA	MoH Departments and units carrying out priority interventions					
			Admin	PP&HCF	QAS&R	C&RHS	P&PS	C&IGA
5.1 KHP Strategy: Collaborate, harmonise and integrate data collection, storage, analysis and dissemination mechanisms of state and non-state actors to ensure availability of adequate and complete information for decision-making.								
5.1.1	Ensure fully functional coordination framework for HIS (with a HIS working group).			HIS				
5.1.2	Develop/ update HIS legal framework aligned to the Health Policy and Health Act.			HIS	HS&R			
5.1.3	Develop/review the HIS Policy and Strategic Plan.			HIS				
5.1.4	Ensure national application of DHIS, generating complete timely and accurate information as per the HIS legislation.			HIS				
5.1.5	Establish virtual system interlinking different databases of HISs to ensure all information is inter-connected, web-based where possible.			e-Health				
5.1.6	Assure data storage capacity for national and County HIS (physical or virtual storage capacity).			e-Health				
5.1.7	Establish Country Health Observatory for assuring comprehensive analysis of Health Information linked with other research institutions eg. KEMRI, universities etc.			HSM&E				
5.1.8	Establish Policy Analysis team, to monitor use of evidence in policy making.			HP&P, HRS				
5.1.9	Establish process to monitor data utilisation by decision makers			HSM&E, HIS				
5.1.10	Put in place the Health Information System required for disaster management.			HIS		DRM		
5.1.11	Carry out systematic reviews on priority health topics that have been identified by policy makers.			HRS				
5.2 KHP Strategy: Continued strengthening of accuracy, timeliness, completeness of health information from population and health facilities.								
5.2.1	Update and harmonise all reporting tools from health facilities (public and			HIS			TB, L&LDs, NASCOP	

	MSP Priority Interventions	SAGA	MoH Departments and units carrying out priority interventions					
	private).							
5.2.2	Ensure national application of DHIS, generating complete timely and accurate information.			HIS				TB, L&LDs (train on electronic reporting)
5.2.3	In collaboration with CRD, establish IT based system for collecting information on Vital Events.			e-Health				
5.2.4	Carry out regular Data Quality Audits for HIS information.			HIS				TB L& LDs, malaria, NASCOP
5.2.5	Carry out regular data verification assessments on DHIS data.			HIS				
5.2.6	Conduct studies required to provide accurate and timely information from the population and health facilities.							TB L&LDs, malaria, NASCOP
5.3 KHP Strategy: Strengthen mechanisms for health information dissemination to ensure information is available where and when needed.								
5.3.1	Conduct annual Health Information Dissemination forums at national level.			HSM&E				
5.3.2	Publish Annual National Health Statistical Abstracts.			HSM&E				
5.3.3	Annual publication on 'the state of Health in Kenya', based on analysis of Health Information by Health Observatory.			HSM&E				
5.3.4	Develop quarterly publications on national Health Outcome Trends and other regular programmatic publication.			HIS				DSRU, V&IS
5.4 KHP Strategy: Put in place the health information systems required for health surveillance and response mechanisms.								
5.4.1	Develop and implement the health information system required to collect, collate, analyse and utilise data relevant to DSR.		ICT.	HIS				DSR (risk mapping for diseases? Eg done by ZDs.
5.4.2	Strengthening capacity for IDSR and reporting.			HIS				DSR
5.5 KHP Strategy: Progressive utilisation of information and communication technologies to aid strategy II above.								5.6
5.5.1	Review and update the Health Sector ICT Strategy.		ICT	e-Health				
5.5.2	Establish coordinated system for EMR management in facilities.		ICT	e-Health				
5.5.3	Contribute to data storage and transmission capacity for national and County HIS (physical or virtual storage capacity).		ICT	e-Health				
5.6 KHP Strategy: Facilitate access to information to the public while protecting privacy and confidentiality.								
5.6.1	Establish coordinated system for EMRs management in facilities.		ICT	e-Health				

**F. HEALTH PRODUCTS AND TECHNOLOGIES**

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
<b>6.1 KHP Strategy: Define and apply an evidence-based essential package of HPT.</b>								
6.1.1	Devise national and county policies, strategies and interventions to address the issue of inappropriate use of antimicrobials and development of antimicrobial resistance.						PS	
6.1.2	Establish a Pharmaceutical Care System in all facilities, starting with hospitals.						PS	
6.1.3	Restructure and operationalise the National Medicines and Therapeutics Committee (NMTC) into a statutory committee covering all HPTs.						PS	
6.1.4	Prepare operational guidelines for establishing hospital & county Medicines and Therapeutic Committees (MTCs) with responsibilities covering all HPT.						PS	
6.1.5	Review and update Clinical Guidelines, Essential Medicines List (KEML); develop National Formulary.						PS, see 1.4.2	See 1.4.2
6.1.6	Develop national essential lists and specifications for other HPTs (e.g. medical devices, vaccines, radiological, dental, laboratory supplies, blood products).						PS, DI, MET, DS, LD, NS, RS	
6.1.7	Institute systematic county and national monitoring of HPT utilisation.					HSM&E	PS	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
6.1.8	Participate in the work of the intergovernmental structure responsible for providing leadership and guidance in national and county HPT policy, investment and systems management.			PS				
6.1.9	Build county health professionals capacity in Good Prescribing Practices (GPP) and Good Dispensing Practices (GDP) making use of pre- & post-service training, guidelines and targeted supportive supervision.						PS	
6.1.10	Systematic training of users of medical equipment devices at time of commissioning/ installation and thereafter as required.						MET	
6.1.11	Undertake EHPT availability, management & utilisation assessment.						PS.	
6.1.12	Implementation (funds for all EHPT) (all programmes).							Variou s
<b>6.2 KHP Strategy: Establish a national appraisal mechanism for HPT, clinical practice and interventional procedures (ie. Health Technology Assessment or HTA).</b>								
6.2.1	Formulate appropriate HTA legislation within Health Act (including Food Safety).					HS&R		
6.2.2	Develop Policy Guidelines on the National HTA Institution.						PS	
6.2.3	Develop and publish a system for monitoring the performance of the National HTA Institution.					QA		
6.2.4	Conduct a feasibility study and prepare a roadmap on the establishment of the National HTA Institution.				HR		PS	
6.2.5	Based on Feasibility						PS, others	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
	Study and before actual establishment of the Institution, build technical capacity of HTA staff/independent advisors to manage & undertake appraisals.							
6.2.6	Define and publish specifications/N&S for HPT.	HTA Inst.						
6.2.7	Provide for the capital required for the establishment of, and subsequent recurrent expenditure of the National HTA.		GA					
<b>6.3 KHP Strategy: Put in place a harmonised regulatory framework for HPT.</b>								
6.3.1	Formulate a new law to cover all HPT, from pre-market controls to post-market surveillance.	PPB						
6.3.2	Review, amend and develop as required suitable regulations covering each type of HPT and for food safety to provide for the required degree of control and protection of the public.	PPB					NBTS, DI	
6.3.3	Harmonise HPT regulations with EAC Countries.	PPB						
6.3.4	Maintain & strengthen national & county level pharmacovigilance (PCV) and HPT post-market surveillance (PMS).	PPB						
6.3.5	Establish county mandate, roles & responsibilities in HPT regulation.	PPB						
6.3.6	Formulate, obtain approval, disseminate, and monitor and evaluate (in year 5) a comprehensive HPT Policy with derived 5-year Strategic Plan.						PS	
6.3.7	Develop, disseminate and implement policy guidelines on the HPT Act.	PPB					NBTS, DI	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
6.3.8	Develop and operate a comprehensive data collection and reporting system that will allow the regulator to perform duties as per the HPT Act.	PPB						
6.3.9	Build required capacity at national, county and facility level, as appropriate, for implementing current and future HPT regulations.	PPB						
6.3.10	Design a comprehensive national human & veterinary HPT regulatory authority (e.g. Food & Drugs Authority) in line with regional & international best practices.		GA					
6.3.11	Establish and operate the HPT regulatory authority in line with the HPT Act.		GA					
6.3.12	Expand the scope of NQCL in line with the HPT Act to provide for EHPT testing.		GA				NQCL	
6.3.13	Develop and maintain an FDA website which provides easily accessible information for health professionals, patients, consumers and the health industry on all relevant aspects of regulatory control of HPT including Policy Guidelines.	PPB						
<b>6.4 KHP Strategies: Rational investment and efficient management of HPT, including national Government to ensure National Strategic Reserve for key public health commodities.</b>								
6.4.1	Promote generic medicines use throughout the whole health system through legal and administrative interventions.						PS	
6.4.2	Facilitate implementation, monitoring, subsequent						PS+NS+DS+RS+DI+LD+NBTS+MET	Program Units

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
	review & update of the Kenya National Pharmaceutical Policy (KNPP 2012) into a comprehensive HPT Policy.							
6.4.3	Ensure mobilisation and allocation of sufficient national and county resources for the provision of adequate supplies of EHPT.		F					
6.4.4	Develop and disseminate HPT Policy Guidelines including how to allocate sufficient resources at national and county level for all EHPT.				HCF		PS+ Other Technical Units	
6.4.5	Incorporate investment in HPT in Health Financing Strategy, produce, publish and disseminate the Strategy.				HCF			
6.4.6	Institute a preventive and corrective medical equipment maintenance and repair system.						MET	
6.4.7	Establish county systems for coordinating and managing EHPT investments.			PS+ Other Technical Units				
6.4.8	Develop & disseminate EHPT quantification & procurement training curriculum & implementation guideline; undertake county capacity building.						PS+ Other Technical Units	
6.4.9	Develop & disseminate EHPT Supply Management (Inventory) Guidelines; undertake county capacity building.						PS+ Other Technical Units	
6.4.10	Develop and disseminate EHPT Supportive Supervision Guidelines; undertake county capacity building.						PS+ Other Technical	
6.4.11	Establish system for						PS+ Other Technical	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
	collection, monitoring and wide dissemination of prices for a basket of key EHPT and develop a constantly updated price data-base; establish, regularly update, publish an EHPT indicator price guide.						Units	
6.4.12	Enhance and integrate the M&E system for national and county level EHPT management comprehensively to capture key elements of access.				HSM&E		PS+ Other Technical Units	
6.4.13	Assist the counties to attain the required capacity to undertake effective HPT management and ensure appropriate use.						PS+ Other Technical Units	
6.4.14	Undertake relevant operational research (OR) into HPT Investments, Management and Use.						PS+ Other Technical Units	
6.4.15	Participate in the work of the intergovernmental structure responsible for providing leadership and guidance in national and county HPT policy, investment and systems management.				SP&P		PS+ Other Technical Units	
<b>6.5 KHP Strategy: Establish effective and reliable EHPT procurement and supply management.</b>								
6.5.1	Review the current legislation applicable to the import and procurement of health commodities for the public sector and revise as required to facilitate access to required essential items.	PPB				HS&R	PS+ Other Technical Units	
6.5.2	Institutionalise national level (for national programmes) & county level Medium Term Procurement Plan (MTPP) for EHPT.		SCM				PS+ Other Technical Units	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
6.5.3	Undertake an assessment on the feasibility and options for a pooled system of EHPT financing, procurement, distribution and storage for GoK HFs in the counties.	KEMSA			SP&P		PS+ Other Technical Units	
6.5.4	Based on the feasibility study, establish a devolved system of <i>pooled</i> EHPT procurement, storage and distribution for GoK facilities in counties; prepare & disseminate policy & operational guidelines.	KEMSA	SCM		SP&P		PS+ Other Technical Units	
6.5.5	Develop EHPT quantification & procurement training curriculum & implementation guidelines; build county capacity through ToT training.						PS+ Other Technical Units	
6.5.6	Develop and operationalise an effective system for EHPT supplies management during disasters and emergencies including establishment of a National Strategic HPT Reserve (NSHR).						PS+ Other Technical Units+ DRM	
6.5.7	Introduce facility-based IT systems to manage and monitor HPT supplies and link with county and national MoH HIS.		ICT?		e-health		PS+ Other Technical Units	
6.5.8	Develop and implement a National EHPT Logistics Management Information System framework for public sector facilities.		ICT		HIS		PS+ Other Technical Units	
6.5.9	Develop and implement a National Pharmacy Management Information System (PMIS).		ICT		HIS		PS	
6.5.10	Institutionalise and						PS+ Programmes+	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
	strengthen the existing EHPT demand-driven (pull) system in the counties, extend this as appropriate to include national programme supplies and establish a supplies chain audit mechanism.						Other Technical Units	
<b>6.6 KHP Strategy: promote local EHPT production, research and innovation</b>								
6..6.1	Review current legislation applicable to local production and research, and revise/amend as required to facilitate research and local production of EHPT.	PPB				HS&R	PS+ Other Technical Units	
6.6.2	Develop comprehensive policy and strategies to facilitate research, innovation and local production of EHPT for priority health conditions.	PPB				HS&R	PS+ Other Technical Units	
6.6.3	Identify priority HPT research				NHRS		PS+ Other Technical Units	
6.6.4	Review and update of CGMP standards & requirements; publish & disseminate and make easily accessible through the FDA web-site.	PPB						
6.6.5	Develop & disseminate Guidelines on Local Production.	PPB						
6.6.6	Develop & disseminate Guidelines on Innovation & Research.				NHRS			
6.6.7	Establish and operate systems to monitor and report on the adherence to, and results of the application of legislation and policies developed to promote local production, research and innovation of HPT.	PPB			HSM&E			
6.6.8	Create and operate effective communication/collaboration between MoH, FDA, other government	PPB					PS+ Other Technical Units	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
	stakeholders and relevant industries							
6.6.9	Build local capacity in current Good Manufacturing Practice (CGMP) and HPT Research, Innovation and Development (RID).	PPB					PS+ Other Technical Units	
6.6.10	Mobilise resources for priority HPT research.				NHRS			
<b>6.7 KHP Strategy: Identify and undertake initiatives to exploit Trade-Related Aspects of Intellectual Property Rights (TRIPS) provisions and safeguards in order to secure access to HPTs.</b>								
6.7.1	Review current TRIPS, HPT patent, counterfeit and associated legislation & revise as necessary to make provisions to ensure compliance with current recommended (eg. WHO) international best practices.	PPB				HR&L	PS	
6.7.2	Prepare and ensure easy access to Policy Guidelines on implementation of TRIPS provisions in the health sector.	PPB				HR&L	PS	
6.7.3	Develop & disseminate operational guidelines on process for effective application of TRIPS provisions (to accompany Policy Guidelines in single document).	PPB				HR&L	PS	
6.7.4	Develop and implement system for monitoring of the application of TRIPS provisions in facilitating access to lower priced versions of expensive patented medicines.	PPB				HR&L	PS	
6.7.5	Create and operate a coordination mechanism with relevant ministries and government agencies.	PPB				HR&L	PS	
6.7.6	Undertake preparation of TRIPs training materials and train relevant staff of GoK ministries involved in					HR&L	PS	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CRS	P&PS
	TRIPs.							
<b>6.8 KHP Strategy: Introduce locally-derived natural health products (LDNHP) (a MoH MTP II Flagship Project).</b>								
6.8.1	Formulate regulations to permit registration of eligible LDNHP.	PPB				HR&L	PS	
6.8.2	Prepare, publish & disseminate LDNHP-related Policy Guidelines, Operational Guidelines, Norms & Standards.	PPB					PS	
6.8.3	Develop and establish monitoring system for LDNHP control, management & utilisation.	PPB				HR&L	PS	
6.8.4	Build capacity among producers and sellers of LDNHPs to comply with regulations (on safety, quality and efficacy).	PPB				HR&L	PS	
6.8.5	Promote research into useful LDNHP, facilitate their subsequent development and incorporation into the health system.	PPB						

## G. HEALTH INFRASTRUCTURE

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CS	P&PS
<b>7.1 KHP Strategies: (1) Adopt evidence based health infrastructure investments, maintenance and replacement through utilisation of norms and standards in line with government Institutions policies. (2) Develop norms and standards to guide the planning, development and maintenance of health infrastructure.</b>								
7.1.1	Complete existing norms and standards on physical infrastructure with norms on number and size of rooms in each service unit (by level), plant and non-medical equipment (laundry and kitchens); publish and disseminate.					HS&N	MET	
7.1.2	Develop, publish and disseminate norms and standards on IT and transportation.		ICT, GA			HS&N		
7.1.3	Define county-specific health infrastructure gaps in requirements for all norms (e.g. service units, quantity of equipment and transportation).				SP&P		MET	
7.1.4	Build capacity to develop costed county-specific health infrastructure plans with recurrent cost calculations.				SP&P		MET	
7.1.5	Develop, institutionalise and implement facility-specific maintenance plans and budgets for the MoH and develop capacity at counties for the		IT, GA				MET	

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CS	P&PS
	same, county facilities, covering all health infrastructure components, time frame and modalities (including administrative structures).							
7.1.6	Advocate for the employment of one medical engineer per county.			IG				MET
7.1.7	Review the staff establishment for medical engineering (engineers, technologists and technicians) for level III to V) and employ staff accordingly.							MET
<b>7.2 KHP Strategy: Facilitate development of infrastructure that progressively moves towards the prevailing norms and standards. (Note: To equip public hospitals is MoH MTP II Flagship Project).</b>								
	7.2.1 Identify the facilities to be upgraded, identify health infrastructure needs (gap analysis), cost the required capital expenditure and 5-year recurrent cost implications for:							
7.2.1.1	Progressive transformation of level 2 to level 3 facilities, conform with level 3 infrastructure norms and standards. <b>(To equip health facilities in slum areas is a MoH MTP II Flagship Project.)</b>				SP&P			
7.2.1.2	Upgrading of existing government level 3 facilities to conform to the level 3 infrastructure norms and standards. <b>(As 7.2.1.1: to equip health facilities in slum areas is a MoH MTP II Flagship Project.)</b>				SP&P			
7.2.1.3	Upgrading of existing government level 4 facilities to conform to the level 4 infrastructure norms and standards. <b>(To construct Model Level 4 Hospitals is a Sector MTP II Flagship Project.)</b>				SP&P			
7.2.1.4	Upgrading of existing government level 5 facilities to conform to the level 5 infrastructure norms and standards.				SP&P			
7.2.1.5	Progressive implementation of infrastructure norms and standards at the existing level 6 hospitals.				SP&P			
7.2.2	Establish additional national referral facilities as per need.				SP&P			
<b>7.3 KHP Strategy: Both NG and CG shall invest in health infrastructure to ensure progressive increased access to health services.</b>								
7.3.1	Establish an intergovernmental coordinating function to provide leadership and guidance in national and county health infrastructure policy, regulations, norms and standards setting, investment and systems management.			IG	SP&P			
7.3.2	Build appropriate organisational structures, processes and procedures at CDoHs and health facilities to manage health infrastructure (planning, costing, master plans, maintenance, training of users, disposal).				SP&P		MET	
<b>7.4 KHP Strategy: Provide the necessary logistical support for efficiently functioning referral system.</b>								
7.4.1	Procure ambulances as per the National Ambulance Policy.		SCM				NAS	
7.4.2	Procure the vehicles and other investments required to operationalise the national referral system.		SCM					

	MSP Priority Interventions	SAGAs	MoH departments and units carrying out priority interventions					
			Admin	HSC&IG	PP&HCF	QAS&R	CS	P&PS
7.4.3	Develop and implement an ICT master-plan in national referral facilities as part of the MTP Flagship Projects.		ICT					
<b>7.5 KHP Strategy: Promote and increase private sector investments in the provision of health services through infrastructure development. See Investment Area L&amp;G, strategy 3.</b>								
<b>7.6 KHP Strategy: Develop guidelines for donations and purchase of vehicles, medical equipment and the disposal of the same.</b>								
7.6.1			GA				MET	
<b>7.7 KHP Strategy: Strengthen the regulatory bodies to enforce health infrastructure standards.</b>								
7.7.1	Develop, obtain approval, disseminate, monitor and evaluate a regulatory framework for adequate post-market surveillance of non-medical equipment aiming at ensuring effectiveness, quality and safety of equipment.					HR&S	MET	
<b>7.8 KHP Strategy: Develop and implement a Health Infrastructure Policy.</b>								
7.8.1	Formulate, obtain approval, disseminate and monitor and evaluate (in year 5) a comprehensive Health Infrastructure Policy and Strategic Plan.				SP&P	HN&S	MET & other units	
7.8.2	Further develop the regulatory framework for registration and licensing of private health facilities, to encompass all types of facilities/consulting rooms and standards related thereto to ensure quality and safety in these facilities.					HR&S		

#### H. HEALTH RESEARCH AND DEVELOPMENT

	MSP Priority Interventions	SAGA	MoH Departments and units carrying out priority interventions.					
			Admin	PP&HF	QAS&R	C&RHS	P&PH	HSC&IGA
<b>8.1 KHP Strategy: Develop a prioritised national health research agenda.</b>								
8.1.1	Set up, monitor the implementation and evaluate the results of the health research agenda on the medium term.			DM&E				
8.1.2	Establish a process to monitor health research utilisation by decision-makers.			DM&E				
8.1.3	Establish Country Health Research Observatory.			DM&E				
8.1.4	Contribute to the Country Health Research Observatory by ensuring health research information is readily available to the observatory.			DM&E				
<b>8.2 KHP Strategy: Effective dissemination of research findings.</b>								
8.2.1	Develop a virtual IT based health research data base interlinked with other HIS to ensure it is interconnected, web-based and establish <i>and operate a National Research Repository</i> .			DM&E				
8.2.2	Conduct annual Health Research dissemination forums.			DM&E				
8.2.3	Publish annual National Health			DM&E				

	MSP Priority Interventions	SAGA	MoH Departments and units carrying out priority interventions.					
			Admin	PP&HF	QAS&R	C&RHS	P&PH	HSC&IGA
	Research Abstracts.							
<b>8.3 KHP Strategy: Harness the development partners' and government funds to implement the national health agenda.</b>								
8.3.1	Establish a Health Research Fund.			DM&E				
<b>8.4 KHP Strategy: Promote research through policy dialogue in order to ensure that research is relevant to the needs of the people.</b>								
8.4.1	Establish and operate a Health Research Policy Forum			DM&E				
<b>8.5 KHP Strategy: Strengthen health research capacity in institutions at all levels and develop quality human resource and infrastructure.</b>								
8.5.1	Carry out regular audits of Health Research quality.			DM&E				
8.5.2	Build capacity in health research at all levels.		√	DM&E	√	√	√	√
<b>8.6 KHP Strategy: Ensure an ethical code of conduct for health research in Kenya in accordance with the Science, Technology and Innovation Act.</b>								
8.6.1	Ensure an ethical approval process is adopted for all research carried out in Kenya .			DM&E				
<b>8.7 Other Strategies (KHSSP).</b>								
8.7.1	Develop an updated Health Research legal framework aligned to the Kenya Health Policy and Health Act.			DM&E				
8.7.2	Ensure a fully functional coordination framework for Health Research.			DM&E				
<b>8.8 Not in KHP</b>								
8.8.1	Conduct/commission research.	KEMRI	√	√	√	√	√	√

## Acronyms Specific to Appendix B

### Department of Administration Services

GA	General Administration Unit	LA	Legal Affairs Unit	HRM	Human Resources Management Division
PR	Public Relations Unit	F	Finance Unit	HRD	Human Resources Development Unit
IA	Internal Audit Unit	AC	Accounting Unit		
ICT	Information Communication and Technology (ICT) Unit	SCM	Supply Chain Management Unit		

### Department of Policy, Planning and Health Financing

SP&P	Health Sector Policy & Planning Unit	HIS	Health Information Systems Unit	NHRS	National Health Research Strategy Unit
PPP	Public Private Partnership Unit	HSM&E	Health Sector Monitoring & Evaluation Unit	HRD	Health Research Dissemination Unit
GM	Gender Mainstreaming Unit	e-health	e-Health Development Unit	HRC	Health Research Coordination
				HCF	Health Care Financing Division

### Department of Standards, Quality Assurance and Regulations

HS&N	Health Standards & Norms Unit	QA	Quality Assurance Unit	HR&L	Division of Health Regulations & Legislation
NQCL	National Drug Quality Control Laboratory	IPC	Infection Prevention and Control Unit	CPD	Continued Professional Development Unit

### Department of Curative and Rehabilitation Health Services

SCS	Specialised Clinical Services Unit	PS	Pharmaceutical Services Unit	MET	Medical Engineering & Technology Unit
GCS	General Clinical Services Unit	RS	Rehabilitation Services Unit	HA	Health Administration Unit
O	Oncology Unit	NS	Nursing Services Unit	NAS	National Ambulance Services
MHS	Mental Health Services Unit	NBTS	National Blood Transfusion Services	DRM	Disaster Risk Management
DS	Dental Services Unit	LS	Laboratory Services Unit	FM&MLS	Division of Forensic Medicine and Medico-Legal Services
OS	Ophthalmic Services Unit	DI	Diagnostic Imaging Unit		

### Department of Preventive and Promotive Health

NASCOP	National AIDS and STI Control Programme	NCD	Non-Communicable Diseases Unit	NPHL	National Public Health Laboratory
Malaria	Malaria Control Programme	H&A Unit	Health & Aging Unit	HIV Lab	National HIV Reference Laboratory
TB L & LDs	Tb, Leprosy & Lung Diseases Unit	V&I P	Violence & Injury Prevention Unit	TB Lab	TB Laboratory Reference Services
NTD	Neglected Tropical Diseases Unit	R&MH	Reproductive & Maternal Health Unit	S&WS	Sanitation & Waste Safety Unit
ZD	Zoonotic Diseases Unit	NC&AH	Neonatal Child and Adolescent Health Unit	OH&S	Occupational Health & Safety Unit
TC	Tobacco Control Unit	N&D	Nutrition and Dietetics Unit	PHS	Port Health Services
DSR	Disease Surveillance & Response Unit	V&IS	Vaccines and Immunization Services	FS&Q	Food Safety & Quality Unit
FET	Field Epidemiology Training Programme	CH	Community Health Unit	P&WM	Pollution & Waste Manager
		HP	Health Promotion Unit		

### Department of Health Sector Coordination & Inter-Governmental Affairs

HSIGA	Health Sector Inter-Governmental Affairs Division	HSC	Health Sector Coordination Division		
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