REPUBLIC OF KENYA

Transforming Health: Accelerating Attainment of Universal Health Coverage

DRAFT

KENYA HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN (KHSSPI)

JULY 2013-JUNE 2017

KHSSP PERFORMANCE MONITORING INDICATORS AND TARGETS

Policy Objective	Indicator	Targeted trend's		
		Baseline (2012)	Mid Term (2015)	Target (2017)
IMPACT				
Improve health outcomes	Life Expectancy at birth	52	56	65
	Total annual number of deaths (per 100,000 population)	106	95	80
	Maternal deaths per 100,000 live births	*400*	*300*	*150*
	Neonatal deaths per 1,000 live births	*31*	*25*	*15*
	Under five deaths per 1000	*74*	*50*	*35*
	Youth and Adolescent deaths per 1000	*45*	*30*	*20*
	Adult deaths per 1000	*30*	*20*	*10*
	Elderly deaths per 1000	*80*	*80*	*80*
	Years of Life lived with illness / disability	12	10	8
	Due to communicable conditions	*6*	*5*	*4*
	Due to non-communicable conditions	*4*	*4*	*3*
	Due to violence / injuries	*2*	*1*	*1*
Distribution of health	% range of Health Services Outcome Index	45	30	20
Services Responsiveness	Client satisfaction index	65	78	85
HEALTH & RELATED SERVICE OUTCOME TARGETS				
Eliminate Communicable Conditions	% Fully immunized children	79	90	90
	% of target population receiving MDA for schistosomiasis	50	95	95
	% of TB patients completing treatment	85	90	90
	% HIV + pregnant mothers receiving preventive ARV's	63	90	90
	% of eligible HIV clients on ARV's	60	90	90
	% of targeted under 1's provided with LLITN's	44	85	85
	% of targeted pregnant women provided with LLITN's	30	70	85
	% of under 5's treated for diarrhea	40	10	5
	% School age children dewormed	49	85	90
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	50	40	35
	% Women of Reproductive age screened for Cervical cancers	50	70	75
	% of new outpatients with mental health conditions	<1	2	1
	% of new outpatients cases with high blood pressure	1	5	3
	% of patients admitted with cancer	1	2	2
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender based violence	<1	3	2
	% new outpatient cases attributed to Road traffic Injuries	4	2	2
	% new outpatient cases attributed to other injuries	<1	0.5	0.5
	% of deaths due to injuries	10	5	3
Provide essential health services	% deliveries conducted by skilled attendant	44	60	65
	% of women of Reproductive age receiving family planning	45	80	80
	% of facility based maternal deaths	400	100	100
	% of facility based under five deaths	60	20	15
	% of newborns with low birth weight	10	6	5
	% of facility based fresh still births	30	10	5
	Surgical rate for cold cases	0.40	0.85	0.90
	% of pregnant women attending 4 ANC visits	36	80	80
Minimize exposure to health risk factors	% population who smoke	18		
	% population consuming alcohol regularly	35		
	% infants under 6 months on exclusive breastfeeding	32		
	% of Population aware of risk factors to health	30		
	% of salt brands adequately iodized	85		
	Couple year protection due to condom use			
Strengthen collaboration with health related sectors	% population with access to safe water	60		85
	% under 5's stunted	35		15
	% under 5 underweight	17		5
	School enrolment rate	60	80	80
	% of households with latrines	34		70
	% of houses with adequate ventilation	65		80
	% of classified road network in good condition	30		50
	% Schools providing complete school health package	15		50
HEALTH INVESTMENT OUTPUT				
Improving access to services	Per capita Outpatient utilization rate	2	3	4
	% of population living within 5km of a facility	80	90	90
	% of facilities providing BEOC	65	80	90
	% of facilities providing CEOC			
	Bed Occupancy Rate	85	95	95
	% of facilities providing Immunisation	80	100	100
Improving quality of care	TB Cure rate	83	88	90
	% of fevers tested positive for malaria	45		20
	% maternal audits/deaths audits	10	70	85
	Malaria inpatient case fatality	15	8	5
	Average length of stay (ALOS)	5.6	4.5	4

Any part of this document may be freely reviewed, quoted, reproduced or translated in full or in part, provided the source is acknowledged. It may not be sold or used in conjunction with commercial purposes or for profit.

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

Published by: Ministry of Health
Afya House
PO Box 3469 - City Square ,Nairobi 00200, Kenya
Email: ps@health.go.ke
http://www.health.go.ke

TABLE OF CONTENTS

1 INTRODUCTION 0
1.1 Background 0
1.2 Process for development of the KHSSP 4
1.3 Health Situation Analysis 5
2 HEALTH STRATEGIC DIRECTIONS 10
2.1 Overview of the Kenya Health Policy 10
2.2 Overall vision, mission, goal and objectivesof KHSSP I 11
2.3 KHSSP design framework 13
3 ACHIEVING HEALTH OUTCOMES THROUGH THE KENYA ESSENTIAL PACKAGE FOR HEALTH 15
3.1 The Kenya Essential Package for Health description& services 15
3.2 Rationalization of the KEPH 19
3.3 KEPH indicators and targets 22
3.4 KEPH Interventions, by strategic objective 23
4 HEALTH OUTPUTS: ACCESS, QUALITY OF CARE& DEMAND FOR KEPH 32
4.1 Improving access to KEPH services 32
4.2 Improving demand for KEPH services 33
4.3 Improving quality of care for KEPH services 34
4.1 KHSSP output indicators 35
5 HEALTH INVESTMENTS 36
5.1 Investment area 1: Organization of Service Delivery 38
5.2 Investment area 2: Health Leadership 41
5.3 Investment area 3: Human Resources for Health 45
5.4 Investment area 4: Health Infrastructure 49
5.5 Investment area 5 Health Products and Technologies 54
5.6 Investment area 6: Health Information 59
5.7 Investment area 7: Health Financing 62
6 RESOURCE REQUIREMENTS 64
6.1 Resource requirements for KHSSP implementation 64
6.2 Available resources 66
6.3 Financial gap analysis 68
7 IMPLEMENTATION FRAMEWORK FOR THE KHSSP 69
7.1 Health Sector and Devolution 69
7.2 Partnership and coordination framework 74
7.3 Planning and budgeting process 79
7.4 Communication plan for KHSSP 80
8 MONITORING AND EVALUATION FRAMEWORK FOR KHSSP 83
8.1 Establishment of a common data architecture 84
8.2 Performance monitoring and review processes 86
8.3 Enhance sharing of data and promoting information use 87
8.4 KHSSP Evaluations 88

TABLES AND FIGURES

Table 1: Main constitutional articles that have implications on health 1
Table 2: Leading causes of deaths and DALY's in Kenya 6
Table 3: Leading risk factors and contribution to mortality and morbidity (WHO 2009) 7
Table 4: What has worked and what has not worked during 7 years of NHSSP II implementation 7
Table 5: Kenya Health Policy targets 10
Table 6: Flagship Projects 14
Table 7: Key shifts in the Kenya Essential Package for Health 16
Table 8: Description of KEPH services for the KHSSP 16
Table 9: KEPH services, by selected disease program areas 17
Table 10: Sector 5 year targets for indicators against Health Policy Objectives 22
Table 11: KEPH interventions for accelerating reduction in the burden of communicable conditions by level of care and life cohort 23
Table 12: KEPH interventions for reversing rising burden of NCDs by level of care and life cohort 25
Table 13: KEPH interventions for managing the rising burden of violence and injuries, by level of care & cohort 26
Table 14: KEPH interventions for improving person centred essential health services 27
Table 15: **KEPH interventions for addressing health risk factors by level of care & cohort** 29
Table 16: Critical health related sectors and their effect on health 30
Table 17: KEPH interventions for collaboration with health related sectors, by level of care & cohort 31
Table 18: Priority targets to improvements in access to services 33
Table 19: Priority targets to improvements in demand for KEPH services 34
Table 20: Priority targets for improvements in quality of care for KEPH services 35
Table 21: KHSSP Output targets 35
Table 22: Investment targets during the KHSSP period 37
Table 23: Strategies against each Service Area 38
Table 24: Priority processes to invest in Organization of Service Delivery 39
Table 25: Priority Health Leadership actions 43
Table 26: Staffing needs and norms by population, type of facility and staff category 45
Table 27: Available staff cadres, by sex 46
Table 28: Staff availability in facilities, and reasons for absence 47
Table 29: Priority HRH investments for 2014-2017 48
Table 30: Kenya requirements by type of facilities 49
Table 31: Health infrastructure priority investments 51
Table 32: HPT Priority Areas for Investment 56
Table 33: Health Information Systems investments 60
Table 34: Kenya Health Care financing priorities 62
Table 38: Total costs by strategic objectives and investment areas (KSh Millions) 65
Table 39: Total costs by levels of care & cross-cutting investment areas (KSh Millions) 65
Table 40: Total costs of the KHSSP-III by disease programmes and health system investment areas (KSh Millions) 66
Table 35: Estimated and projected financial resources available by source (Kshs Millions) 67
Table 36: Projected financial resources by Sources and Investment Areas (Kshs Millions) 67
Table 37: Available Resources by Investment Areas by year (Mn) 67
Table 41: Financial gap analysis for the health sector (Kshs Millions) 68
Table 42: Categories of functions and implications 69
Table 43: Exclusive Functions of National Government and County Governments 70
Table 44: Concurrent Functions of National and County Government 70
Table 45: Residual Functions of the National Government 70

Table 46: National and County stewardship Roles ... 71
Table 47: The SAGAs and their key mandates ... 75
Table 48: Communication focus for different stakeholders ... 81

Figure 1: Planning framework for health ... 0
Figure 2: Trends in Health Impact indicators during the period of the policy review ... 5
Figure 3: Projections of Disease Burden 2011 - 2030 ... 9
Figure 4: Framework for Policy directions ... 10
Figure 5: KHSSP mission, goal and targets ... 12
Figure 6: KHSSP Framework for Implementation ... 13
Figure 7: Focus of different Health Outcomes in KHSSP ... 14
Figure 8: Focus of the Kenya Essential Package for Health (KEPH) ... 15
Figure 9: Rationalization of KEPH across different provider institutional arrangements ... 19
Figure 10:Organization of Health Services ... 20
Figure 11: Attributes associated with health outputs ... 32
Figure 12: Attributes of health investments ... 36
Figure 13: Organization of Service Delivery elements and priorities ... 38
Figure 14: Effective Health Sector Leadership requirements ... 41
Figure 15: Health Sector Leadership framework ... 42
Figure 16: General Service index by manning agency and ownership ... 49
Figure 17: General service readiness index and domain scores (N=7995) ... 49
Figure 18: Scope of health products and technology intervention areas ... 54
Figure 19: Mean availability of products for different program areas ... 54
Figure 20: Health Information System ... 59
Figure 21: Dimensions and focus of health financing ... 62
Figure 22: Comprehensive National Level Coordination framework ... 77
Figure 23: Scope of the Monitoring and Evaluation Framework ... 83

ACRONYMS

AIDS	Acquired Immuno deficiency syndrome
ALOS	Average length of stay
AMR	Adult Mortality Rate
ANC	Antenatal Care
AOP	Annual Operational Plan
ARV	Anti-Retroviral
AWP	Annual Work Plan
BEOC	Basic Emergency Obstetric care
BMI	Body Mass Index
CDF	Constituency Development Fund
CFMT	County Health facility management teams
CHC	Community Health Committee
CHMT	County health management teams
CMA	Common Management Arrangements
CoC	Code of Conduct
CPD	Continuous professional development
CRD	Civil Registration Department
CSO	Civil Society Organizations
CT Scan	Computerized Tomography
DAC	Development Assistance Committee
DALYs	Disability Adjusted Life Years
DfID	Department for International Development
DHIS	District Health Information System
DHS	Demographic and Health Survey
DHSF	District Health Stakeholders Forum
DNA	Deoxyribonucleic Acid
DPHK	Development Partners for Health in Kenya
DQA	Data Quality Assessment
DSRS	Department of Standards and Regulatory Services
EHPT	Essential health products and technologies
EML	Essential Medicines List
EMMS	Essential Medicines and Medical Supplies
EMR	Electronic Medical Records
FBOs	Faith Based organizations
FTP	File Transfer Protocol
GAVI	Global Alliance for Vaccines and Immunization
GDP	Good Dispensing Practices
GFATM	Global Fund for AIDS TB and Malaria
GIZ	GesellschaftfürInternationaleZusammenarbeit
GoK	Government of Kenya
GPP	Good Prescribing Practices
HFC	Health Facility Committee
HIS	Health Information System
HIV	Human Immunology Virus
HMIS	Health Management and Information System
HRD	Human Resource Development
HRH	Human Resources for Health
HSCC	Health Sector Coordinating Committee
HSS	Health System Strengthening
HSSC	Health Sector Steering Committee
HSSF	Health Sector Service Fund
HTC	HIV Testing and Counselling
HW	Health Workforce
ICC	Inter Agency Coordinating Committee
ICT	Information Communication Technology
ICU	Intensive Care Unit
IDP	Internally displace persons
IDSR	Disease Surveillance and Reporting
IMR	Infant Mortality Rate
JAR	Joint Annual Review
JICA	Japan International Cooperation Agency
JICC	Joint Inter Agency Coordinating Committee
JPWF	Joint program of Work and Funding
JRM	Joint Review Mission
KAIS	Kenya AIDS Indicator Survey
KEMRI	Kenya Medical Research Institution
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KHP	Kenya Health Policy
KHSSP	Kenya Heath Sector Strategic and Investment Plan
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
KQM	Kenya Quality Model
LLITN's	Long Lasting Insecticides Treated Nets
M/F	Male/Female
MCH	Maternal Child Health
MDA	Multi Drug Administration
MDG	Millenium Development Goal
MDR/TB	Multiple Drug Resistant Tuberculosis
MHC	Health Centres
MIS	Malaria Indicator Survey
MMR	Maternal Mortality ratio
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MOT	Ministry of Transport
MRI	Magnetic Resonance Imaging
MTC	Medicines and Therapeutics Committee
MTEF	Medium Term Expenditure Framework
MTPP	Medium Term Procurement Plan
MTRH	Moi Teaching and Referral Hospital
MUAC	Mid Upper Arm Circumference
NACC	National AIDS Coordinating Council
NCD's	Non Communicable Diseases
NGOs	Non GovernmentalOrganisation
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan

NMR	Neonatal Mortality rate
NQCL	National Quality Control Laboratory
OBA	Output Based approach
OCPD	Oversight Continuous Professional Development
OECD	Organization for Economic Cooperation and Development
OOP	Out of pocket
OPD	Outpatient
PAS	Performance Appraisal System
PHSF	Provincial Health Stakeholders Forum
PPB	Pharmacy and Poisons Board
PPPH	Public Private Partnership for Health
RAC	Resource Allocation Criteria
RBM	Result-based management
RFW	Result Framework
SAGA	Semi Autonomous Government Agency
SARS	Severe acute respiratory syndrome
SWGs	Sector Working Groups
TB	Tuberculosis
THE	Total health expenditure
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
UNDAF	United Nations Development Assistance Fund
UNFPA	United Nations Population Agency
UNICEF	United Nations Emergency Children's Fund
WB	World Bank
WHO	World Health Organization
XDR/TB	Extreme Drug Resistant Tuberculosis

FOREWORD

The development of the Kenya Health Sector Strategic and Investment Plan 2013-2017 is guided by the Kenya's Vision 2030. It acknowledges that improved health is a critical driver to the achievement of this vision. Kenya's Vision 2030 aims to transform Kenya into 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 industrialized, middle income country. The strategic also plan mirrors the aspirations of the Constitution 2010 which guarantees the highest attainable standard of health as a right while devolving governance to ensure improved service delivery, greater accountability, improved citizen participation and equity in the distribution of resources. The plan is further guided by the Kenya Health Policy 2012-2030 which targets to attain a level and distribution of health commensurate with that of a middle income country, through attainment of specific health impact targets. The plan has been developed using a consultative approach involving all the key stakeholders in the health sector, while taking cognizance of all new actors under a devolved system of governance. It includes key recommendations from the end term review of the National Health Sector Strategic Plan (NHSPII), and takes into account evidence from emerging health trends, and global priorities. These recommendations have guided prioritization of interventions for implementation during this strategic plan.

The strategic plan provides the Health Sector Medium Term focus, objectives and priorities to enable it move towards attainment of the health goals described in the constitutional and strategic imperatives mentioned above. It provides a detailed description of health outcomes to be sought, priority health investments necessary to achieve the outcomes, resource implications and financing strategy, and the organizational frameworks required to implement the plan.

The Ministry of Health is thankful to its staff, partners and other health stakeholders who contributed to various efforts in shaping the development of this plan. The Ministry is also committed to the full realization of this plan. It has developed a robust monitoring framework to track the achievement of milestones in a way that is responsive and accountable to the health needs to Kenyan people. We look forward to working collaboratively across the national and county governments, partners and all other stakeholders to ensure successful implementation.

James W Macharia

Cabinet Secretary

Ministry of Health

DRAFT

PREFACE

The Government of Kenya has committed itself to providing **e**quitable, **a**ffordable and **q**uality **h**ealth **c**are of the **h**ighest **s**tandard to all Kenyans through the Constitution 2010 under the Bill of Rights. This will be achieved through appropriate policies and programs **the health sector** will undertake.

This strategic plan conveys the Health Sector Vision, Mission, goal and the core functions; policy priorities, strategic objectives, investment areas, implementation framework and the resource requirements between 2013 and 2017. The plan implementation will also be closely monitored through the health sector monitoring and implementation framework at both National and county levels. The plan recognizes the strengths, challenges and some of the underlying weaknesses within the current social, economic and political environment under which this plan will be implemented. Being the first strategic plan within the new devolved system of governance it is expected all players rally around the strategic directions outlined in the plan to the health goals.

My acknowledgement goes to all various stakeholders who contributed towards development of this plan. In particular I applaud the Policy Planning and Health care Financing Directorate, division and unit for their tireless efforts in stewarding this process. I commend them for the able manner in which they guided the process and the facilitation of the various working groups. Efforts from officers of other Directorates towards this plan were also commendable Inputs and contributions from development and implementing partners were similarly commendable. Their collective opinions and wisdom contributed greatly to the drafting and finalization of the plan.

The development of the plan was made possible through the technical advisors obtained from our development partners to whom we are very grateful.

Successful implementation of this plan will requires the coordinated efforts action of many sectors and the participation of all stakeholders in the health sector. I am confident that this plan will inform the process of joint annual planning, sector coordination, partnerships and monitoring. I request and urge all members of the Health sector to put great effort into implementing this plan as a means of accelerating attainment of universal health coverage in our country and improving Kenyans' quality of life.

Prof. Fred H.K.Segor

Principal Secretary

Ministry of Health

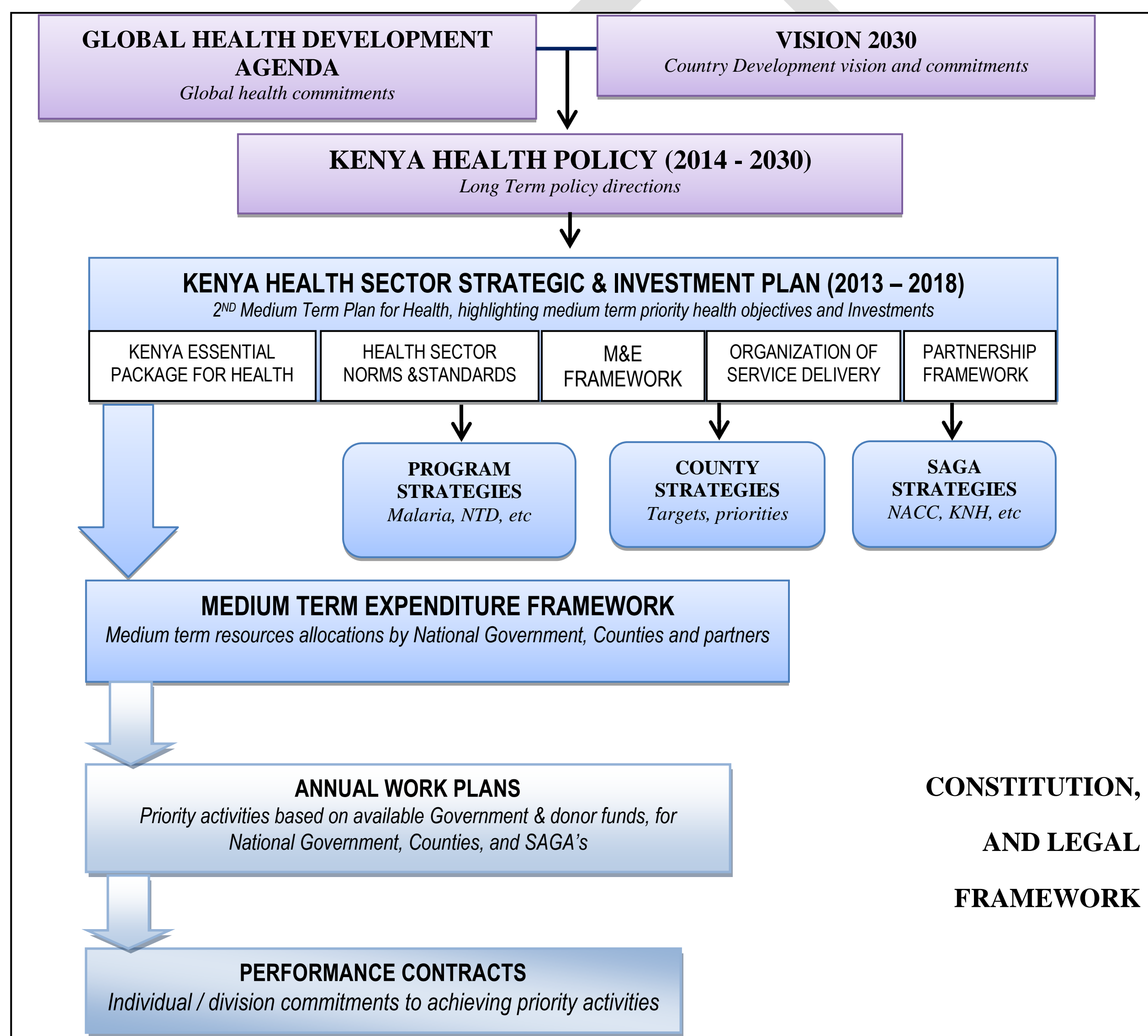
EXECUTIVE SUMMARY

1 INTRODUCTION

1.1 Background

The Government of Kenya developed the Kenya Vision 2030[1] as a 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 industrialized, middle income country. This Vision 2030, together with the overall global health agenda and within the framework of the constitution and legal framework form the over-arching guidance for health sector planning in Kenya.

Figure 1: Planning framework for health



[1]Government of Kenya, 2007. Vision 2030: A globally competitive and prosperous Kenya

A Kenya Health Policy (KHP 2012 – 2030)[2] was elaborated to detail the strategic intent in health the Country as a whole will focus on. It derives its focus from the Vision 2030, and the global health commitments, is elaborated within the context of the constitutional and legal framework, and is informed by the recommendations arising from the end term review of the KHPF 1994-2010[3].

1.1.1KHSSP and the Constitution

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

The constitution of 2010 provides an overarching conducive legal framework for ensuring a more comprehensive and people driven health services, and a rights – based approach to health is adopted, and applied in the country[4]. All the provisions of the constitution will affect the health of the people in Kenya in one way or another. However, two critical chapters introduce new ways of addressing health problems, and have direct implications to the health sector focus, priorities and functioning: The Bill of Rights, and the devolved Government.

Table 1: Main constitutional articles that have implications on health

Articles and Thematic Areas	Implication on Health
Rights and Fundamental Freedoms	
26 (1-3) Rights 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
43(1) Right to the highest attainable standard 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 marginalized groups with respect to health	
Devolved Governments	
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
175 Objectives of devolution	A devolved health system should bring services closer to the people, improve allocative efficiency, promote transparency , accountability and put citizens at the drivers' seat to determine their health agenda
176 (2) Principles of devolved government	County health departments should transfer functions to the smallest capable unit that is capable of delivering that 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

[2] Kenya Health Policy, 2012 - 2030
[3] End Term Review of the Kenya Health Policy Framework, 1994 – 2010
[4]United Nations, 1948. Universal Declaration of Human rights, Article 25

Articles and Thematic Areas	Implication on Health
	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[5]	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 standard of health.
204 Establishment of the equalization fund	Counties in marginalized areas of the country can in addition to the equitable share leverage on the equalization fund to support the development of health infrastructure to bring it to par with other counties enjoying higher level infrastructure
235 Staffing county governments	Counties are now vested with managing the health force of their respective counties
236 Protection of public officers	Health staff are protected from victimization or discrimination from counties where they are seconded

1.1.2 KHSSP and global health commitments

The KHSSP is aligned to support the Country Health Sector implement the various global commitments it has entered into. While these are numerous, the critical ones that have informed the KHSSP focus and priorities include:

- Implementation of the International Health Regulations – to guide the Country on key actions needed to assure adherence to international health regulations
- Ouagadougou declaration on Primary Health Care 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
- Millennium Development Declaration(MDGs) and the post 2015 agenda – a focus of global efforts in improving health impacts through implementing a Universal Health Coverage agenda in health
- Abuja Declaration – to support the improvements of health systems in the country by domesticating the provisions through national legislation, the country committed in theAbujaDeclarationtoallocate15%ofgovernment expenditure budget 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

[5]County health facilities and pharmacies; Ambulance services; Promotion of primary health care; Licensing and control selling of food in public places; Veterinary services; Cemeteries, funeral parlours and crematorium; Refusal removal, refuse dumps and solid waste

1.1.3 KHSSP and the Vision 2030

The Government of Kenya developed 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 industrialized, middle income country. To improve the overall livelihoods of Kenyans, the country aims to provide an efficient integrated and high quality affordable health care system. Priority will be given to preventive care at community and household level, through a devolved health-care system. With devolution of funds and decision-making to county level, the Ministry headquarters will then concentrate on policy and research issues. With the support of the private sector, Kenya also intends to become the regional provider of choice for highly-specialized health care, thus opening Kenya to “health tourism”. Improved access to health care for all will come through: (i) provision of a robust health infrastructure network countrywide; (ii) improving the quality of health service delivery to the highest standards (iii) promotion of partnerships with the private sector; (iv)providing access to those excluded from health care for financial or other reasons.The country recognizes that achieving the development goals outlined in Vision 2030 will require increasing productivity. The health sector is expected to play a critical supportive role in maintaining a healthy workforce which is necessary for the increased labour production that Kenya requires in order to match its global competitors. Health is, therefore, one of the key components in delivering the social pillar ‘Investing in the People of Kenya’ for the Vision 2030.

1.1.4 KHSSP and the MTP II

The wider Government medium term focus is highlighted in the Medium Term Plans, which define medium term priorities and flagships Government intends to focus on as it moves towards attaining the objectives of the Vision 2030. This KHSSP has been elaborated in line with the MTP II priorities, with a focus on implementing the Kenya Health Policy. The *Health Sector* in this strategic plan refers to all the health and related sector activities needed to attain the health goals in Kenya. It is not restricted to the actions of the Health Ministry, but includes all actions in other related sectors that have an impact on health. It will guide both County and National Governments on the operational priorities they need to focus on in Health. Key focal areas of access, equity, quality, capacity and institutional framework will be achieved through a devolution approach that will allocate 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 care:

Thehealth sector objectives stipulated in the MTP II are to:

- Reduce Maternal Mortality Rate (MMR) from 488/100,000 to 150/100,00
- 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 percentage of HIV/AIDS prevalence from 5.6% to 4%
- Improve under one immunization coverage from 83% to 90%
- Reduce Malaria in-patient case fatality from 15% to 5%

Therefore, the MTP II highlights the following as the health sector flagship projects it needs to focus on, to move towards attaining the health objectives of the Vision 2030:

- Country-wide Scale up of Community Health High Impact Interventions
- Improve Access to Referral Systems

- Construct Model Level 4 Hospitals
- Health Care Subsidies for Social Health Protection
- Re-engineering Human Resource for Health
- Health Products and Technologies
- Establish E-Health Hubs in 58 Health Facilities
- Mainstreaming Research and Development in Health
- Health Tourism
- Locally Derived Natural Health Products
- Modernize Kenyatta National Hospital
- Modernize Moi Teaching and Referral Hospital

1.1.5 KHSSP and its operationalization

This KHSSP will form the guidance for allocation of resources in the MTEF process, for both Government and partners. This resource allocation will inform annual planning, and therefore performance contracting in health.

This KHSSP provides the overall framework for sector guidance in the Medium Term. It is informed by a series of sector documents, which provide more detailed information and data on different elements in this plan. These documents include:

- **The Kenya Essential Package for Health:** A description of the service package for different levels of care in Kenya, to guide movement towards UHC and attainment of the right to health
- **Health sector norms and standards:** The human resources, and infrastructure norms and standards to be attained, for adequate delivery of the Kenya Essential Package for Health
- **Partnership framework:** A guide for the alignment and harmonization of health actors support at nnational and ccounty levels, for improved effectiveness of delivery of the KEPH
- **M&E framework:** A description of the Monitoring, Evaluation and Review processes the sector needs to focus on, for concise and appropriate follow up of the implementation of the KEPH

From this KHSSP, the sector shall elaborate its operational documents to guide different priority areas of implementation. These operational documents include:

- **County Specific Health Strategies:** These define County specific targets and investment priorities for implementation, based on specific County realities and priorities
- **Service delivery program specific strategies:** These bring together specific program targets and investment priorities for implementation, to assure attainment of the KHSSP priorities. Programs include Malaria, HIV, TB, NCD's, NTD's, Child Health, Maternal and Newborn Health, etc.
- **SAGA specific strategies:** These are specific strategic plans for the SAGA's, which define their specific targets and investment priorities they will focus on to contribute towards attaining this KHSSP priorities. Such SAGA's include KNH, MTRH, NHIF, NACC, etc.
- **Investment program strategies:** These highlight the specific targets and priorities for different investment areas to facilitate attainment of the KHSSP priorities.

1.2 Process for development of the KHSSP

The development of this Strategic Plan followed comprehensive consultative processes, over a 3 year period. The process was initiated by the sector, prior to the end of the previous 2nd National Health Sector Strategic Plan (NHSSP II) in 2011. Six thematic working groups (Leadership & Governance,

Organization of Service Delivery, Health Workforce, Medical Products and technologies, Health Financing and Health Information/M&E) consisting of members from Government, Development and implementing Partners were constituted with specific terms of reference. The working groups conducted literature review on the existing policy documents such as the Kenya Constitution 2010, Kenya vision 2030, Kenya Health Policy 2013- 2030, Acts of Parliament, Function Assignment and Transfer Policy Paper, Ministerial strategic plans 2008-2012, KHPF 1994-2010 ETR report, NHSSP II, JPWF, NHSSP II ETR report, Norms and standards, Roadmap of acceleration of implementation of interventions to achieve the objectives of NHSSP II, and other relevant ministerial documents and generated group reports.

These group reports were consolidated into the first draft of this plan in 2012 by representatives of the groups during a 14 day workshop in 2012.

This first draft was subjected to stakeholders review in 2012, with additional perspectives and inputs included as a result. These stakeholders included then provincial Governments, together with donor and implementing partner agencies plus the Transition Authority and the Commission on Implementation of the Constitution.

With the creation of County Governments following the election of 2013, the updated draft was shared with the county Governments, together with the draft National Health Policy for their review and coherence. This draft also provided County governments with national level guidance on the medium term health focus and priorities, which facilitated their development of County health strategies, and so inputs into the County Integrated Development Plans.

As a result of this interaction with County Governments, the draft was further updated by the end of 2013. This final draft was then shared with the Counties, plus the Transition Authority, Commission on Implementation of the Constitution, and the National / County Government coordination mechanism, private sector, development partners and implementing health partners for their concurrence before being considered a final draft.

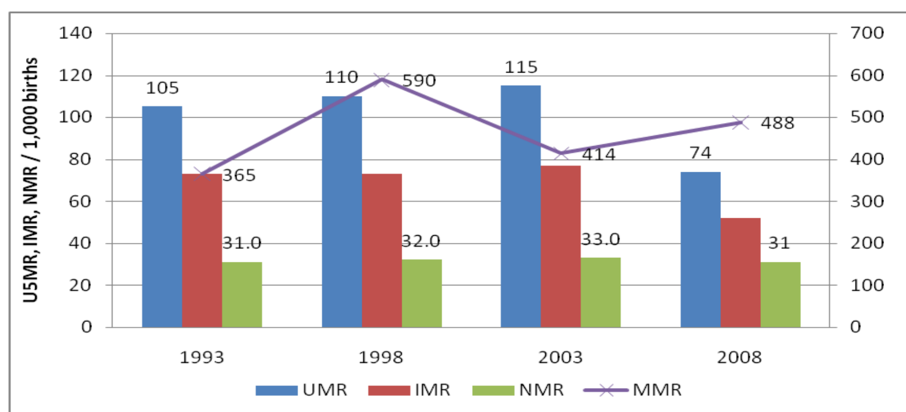
1.3 Health Situation Analysis

The Health Sector undertook recently several detailed and exhaustive studies that aimed (i) to provide evidence what had been done and with what result over the period of the previous KHP 1994-2010 and (ii) to identify the direction and priorities for the next Strategic Plan, the Kenya Health Sector Strategic & Investment Plan (KHSSP, July 2012 - June 2017) . In addition, an end term review of the NHSSP II 2005 – 2012 provided valuable inputs to the process.

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

Figure 2: Trends in Health Impact indicators during the period of the policy review

Recent trends in Health Impact



Source: Respective Demographic and Health Surveys

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

Table 2: Leading causes of deaths and DALY's in Kenya

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

DALY's = Disability Adjusted Life Years.

Communicable conditions continue to dominate causes of ill health (morbidity) and death (mortality). HIV/AIDS accounts for one in three deaths, and 25% of all ill health in the country. Infectious conditions in total are still accounting for 50% of all deaths and disability in Kenya.

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

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

- The high population growth rate (3% annually) with a young and dependent population;

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

Looking at health risk factors, the major ones affecting health in Kenya are shown below.

Table 3: Leading risk factors and contribution to mortality and morbidity (WHO 2009)

Mortality (deaths)			Burden (DALYs)		
Rank	**Risk factor**	***% total deaths***	**Rank**	**Risk factor**	***% total DALYs***
1	Unsafe sex	29.7%	1	Unsafe sex	25.2%
2	Unsafe water, sanitation, and hygiene	5.3%	2	Unsafe water, sanitation, and hygiene	5.3%
3	Suboptimal breast feeding	4.1%	3	Childhood and maternal underweight	4.8%
4	Childhood and maternal underweight	3.5%	4	Suboptimal breast feeding	4.3%
5	Indoor air pollution	3.2%	5	High blood pressure	3.1%
6	Alcohol use	2.6%	6	Alcohol use	2.3%
7	Vitamin A deficiency	2.1%	7	Vitamin A deficiency	2.1%
8	High blood glucose	1.8%	8	Zinc deficiency	1.8%
9	High blood pressure	1.6%	9	Iron deficiency	1.2%
10	Zinc deficiency	1.6%	10	Lack of contraception	1.2%

There is evidence of improvements in unsafe sexual practices[6], with Knowledge and attitudes of communities towards Sexually Transmitted Infections and conditions improving steadily, as has use of barrier methods. Breastfeeding practices have however changed, with exclusive breastfeeding up to 5 months showing significant improvements. Tobacco use remains high, particularly amongst productive populations, urban areas, and women. One in five males between 18 – 29 years, and one in two males between 40 – 49 years are using tobacco products. The same pattern is seen for use of alcohol products, particularly that of impure alcohol products in the rural areas. Cases of alcohol poisoning have continued to appear sporadically during the policy period, with over 2% of all deaths in the country are attributed to alcohol use. Obesity appears to be increasing, with an increasing population of Kenyans who are overweight. It is estimated 25% of all persons in Kenya are overweight or obese, with prevalence highest amongst women in their mid to late 40's, and in urban areas.

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

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

Table 4: What has worked and what has not worked during 7 years of NHSSP II implementation

	NHSSP II objectives	What worked during NHSSP II	What has NOT worked during NHSSP II
1.	**Equitable**	- CHS developed and implemented;	- Issue of remuneration of CHW not solved, CHW demotivated;

[6]Unsafe sex leads to many conditions affecting Health, such as HIV, reproductive tract cancers / conditions and other Sexually Transmitted Infections, unwanted pregnancies, psychosocial conditions, amongst others.

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

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

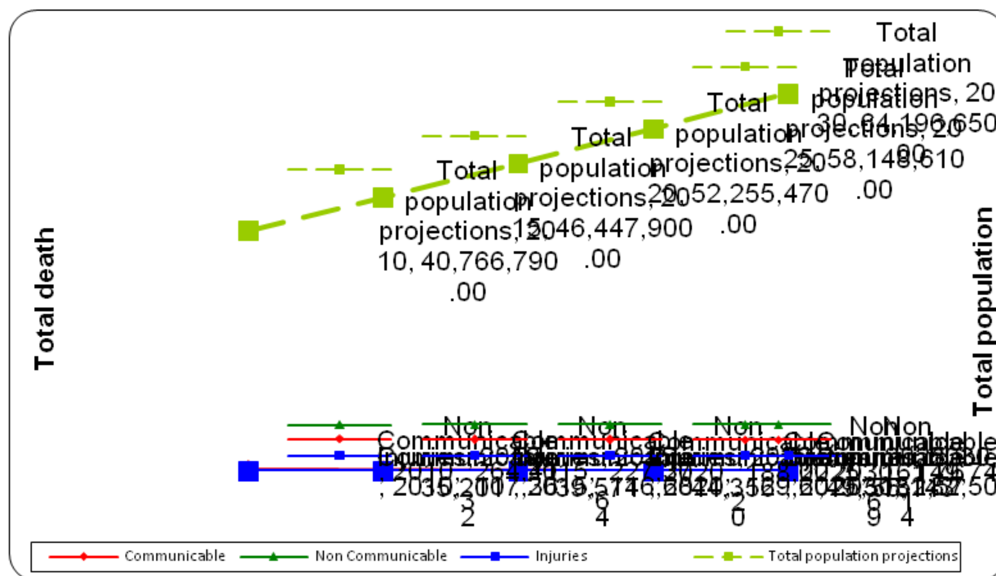
1. Implement a comprehensive approach to address health that includes not only the sector itself but also the various contextual factors around health. Focus not just on services but on ALL determinants and risk factors affecting health impact.
2. Develop a clear service delivery strategy to attain Universal Coverage of Interventions (UCI) for health services. Together, - the interventions for health services, the other contextual health

determinants and the risk factors - are likely to move more rapidly towards the attainment of health impact. This could make the difference with the previous strategic plan!

3. Institute mechanisms for regular monitoring of impact of the various contextual factors on health outcomes. Priorities should be determined in terms of overall plus equity disaggregated coverage.
4. Given the persistent causes of the high Maternal Mortality Ratios over the last 20 years (since 1993), include reduction of MMR as a Flagship Program in the MTP / KHSSP 2012-2017.
5. The development of 'National Products' in the KHSSP will involve (i) developing a customized regulatory framework to assure acceptable standards of product quality, safety and efficacy, (ii) make provision for natural product procurement through KEMSA. This could become the second Flagship Program of the sector.
6. Balance the relative contribution of the various service delivery programs on the basis of the findings of this situational analysis (e.g. HIV/AIDS);
7. In terms of resource allocation, ensure that priorities for preventive and promotional health will match the resources allocated to curative and hospital care. In terms of equity, resources should be preferentially allocated to hard-to-reach areas and vulnerable populations.
8. Revitalize the Community Health Strategy (CHS), providing guidelines to the County Health Departments on how to realize its implementation with regard to the remuneration of CHW.
9. Include a specific objective on the Non-Communicable Diseases (NCD) in the KHSSP; Include interventions related to violence and injuries in the NCDs.
10. Undertake a tertiary Hospital Strategy / feasibility study that will ensure a coordinated distribution of specializations and quality and efficient care at the highest referral levels.

Failure to address these recommendations would lead to a disease trend associated with increasing disease burden, from all the disease domains as seen in the projections of disease burden in the country below.

Figure 3: Projections of Disease Burden 2011 - 2030



2 HEALTH STRATEGIC DIRECTIONS

2.1 Overview of the Kenya Health Policy

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

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

The **target** of the policy is to attain a level and distribution of health at a level commensurate with that of a middle income country, through attainment of the following targets as shown in table 6 below:

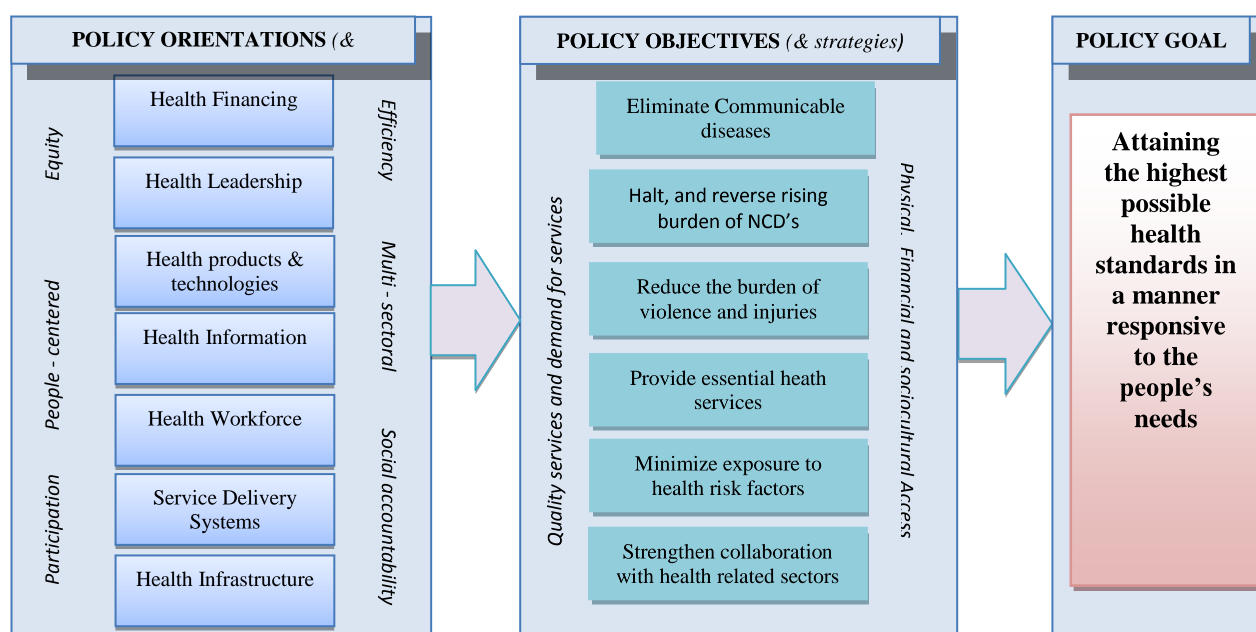
Table 5: Kenya Health Policy targets

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

The Kenya Health Policy is guided by both the Constitution, and the Kenya Vision 2030 and has focused on implementing a 'human rights based approach', and maximizing 'health contribution to overall national development'

Policy directions to guide the attainment of the policy intent are defined in terms of six policy objectives (relating to health and related services), and seven policy orientations (relating to investments needed). These are interlinked as shown in the conceptual framework below.

Figure 4: Framework for Policy directions



Six policy objectives are defined, which address the current situation – each with specific strategies for focus to enable attaining of the policy objective.

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

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

2.2 Overall vision, mission, goal and objectivesof KHSSP I

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

VISION

A globally competitive, healthy and productive nation

MISSION

To deliberately build progressive, responsive and sustainable technologically-driven, evidence-based and client-centred health system for accelerated attainment of highest standard of health to all Kenyans

GOAL

Accelerating attainment of universal health coverage

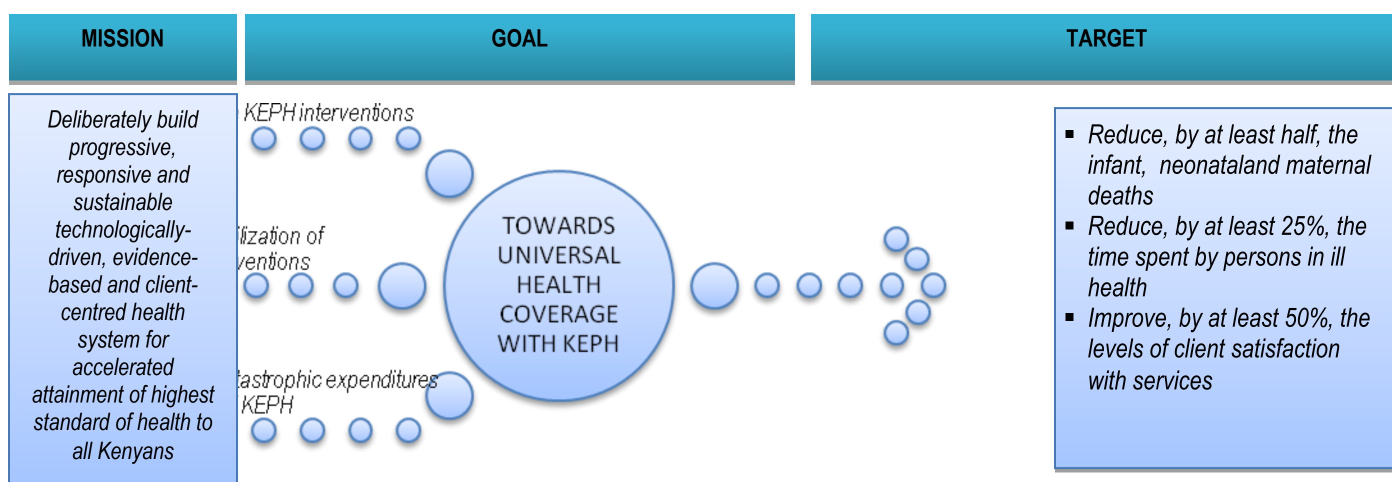
IMPACT TARGETS

Reduce, by at least half, the infant, neonataland maternal deaths
Reduce, by at least 25%, the time spent by persons in ill health
Improve, by at least 50%, the levels of client satisfaction with services
Reduce by 30%, the catastrophic health expenditures

This KHSSP is designed around the need to attain Universal Health Coverage with the Kenya Essential Package for Health (KEPH). This implies, activities of the health sector during this period shall focus on:

i) Increasing the numbers of KEPH interventions being provided across the Country ***(introduction of interventions as and where needed)***
ii) Increasing the coverages of populations using the different KEPH interventions ***(scale up of intervention use)***, and
iii) Reducing the household financial burden incurred at the point of access and utilization of KEPH services ***(reduce catastrophic health expenditures)***

Figure 5: KHSSP mission, goal and targets



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

The KHSSP is designed to provide information on:

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

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

- Ensuring a comprehensive plan that which brings together all the health and relates services by all actors. The KHSSP, as opposed to the NHSSP II, focuses on giving guidance not only for priorities, but on all health and related actions needed to attain health objectives
- Consolidation of all sector Medium Term Plans into one plan. In the past, the health sector medium term focus was guided by the NHSSP II, Joint Program of Work, MTP 1, Ministry

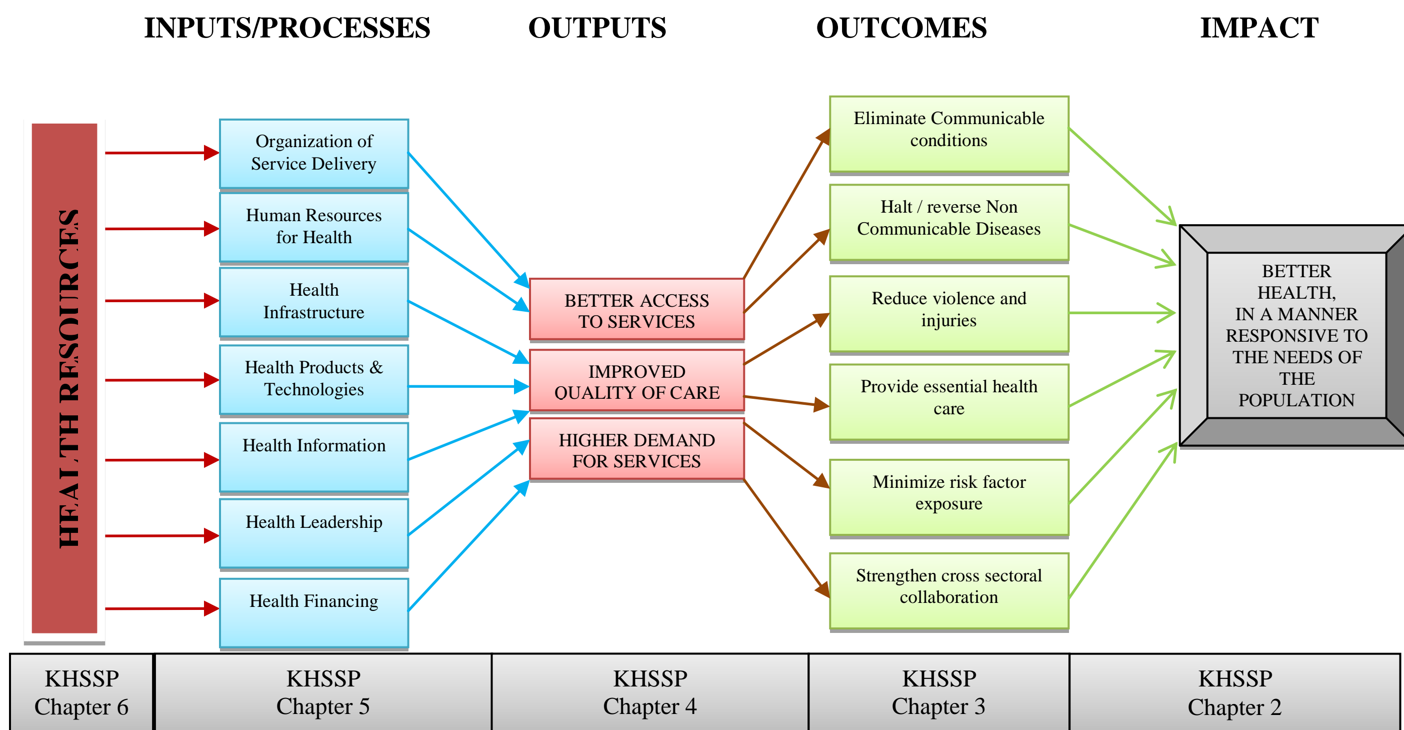
Strategies, and specific program strategic plans that were not necessarily all aligned to each other. This KHSSP now defines clearly the role of each planning tool, and how it contributes to the KHSSP objectives

- Redefinition of the service package (KEPH), to ensure it provides appropriate guidance to health investments and targeting of services
- Incorporation of the environment within which the plan is being developed in the process of defining targets and interventions. As such, efforts towards implementing devolution, and the right to health are an integral part of the plan implementation process, as opposed to the NHSSP II when the environmental issues were not adequately integrated into the plan
- An M&E plan is being developed to guide follow up of implementation of the strategic objectives

2.3 KHSSP design framework

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

Figure 6: KHSSP Framework for Implementation



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

Figure 7: Focus of different Health Outcomes in KHSSP

CONDITIONS TARGETED FOR ERADICATION	CONDITIONS TARGETER FOR ELIMINATION
1. Polio 2. Guinea Worm Infestation	1. Malaria 2. Mother to Child HIV transmission, 3. Maternal and Neonatal Tetanus 4. Measles, 5. Neglected Tropical Conditions **6.** Leprosy
CONDITIONS TARGETED FOR CONTROL	**RISK FACTORS TARGETED FOR CONTAINMENT**
1. HIV / AIDS 2. Conditions in the perinatal period 3. Lower Respiratory infections, 4. Tuberculosis 5. Diarrhoeal diseases in children, 6. Cerebrovascular diseases, 7. Ischaemic Health disease, 8. Road traffic accidents, 9. Violence including Gender Based Violence **10.** Unipolar depressive disorders **11.** Other Immunizable diseases **12.** New / re-emerging infections	1. Unsafe Sex 2. Unsafe water, sanitation & hygiene 3. Suboptimal breastfeeding 4. Childhood and maternal underweight, 5. Indoor air pollution, 6. Alcohol use, 7. Tobacco use 8. Vitamin A deficiency, 9. High blood glucose, 10. High blood pressure, 11. Zinc deficiency, 12. Iron deficiency, 13. Lack of contraception

These service delivery outcomes will be attained through ensuring attainment of the health sector output targets relating to access, quality of care, and demand for health services.

These outputs will be attained through investing in priorities across the 7 policy orientations.

MTP II identified 12 flagships projects that are expected to generate greater impact in a number of areas in health. These Flagship projects shall form the investment areas to be prioritized by all sector programs, and in allocating financingresources as illustrated in the table 7 below

Table 6: Flagship Projects

Policy Orientation	Sector Flagship Projects (for prioritization by National and/or County Governments)
Organization of Service delivery	Improve access to referral systems Country-wide Scale up of Community Health High Impact Interventions
Health Workforce	Re-engineering Human Resources for Health
Health Infrastructure	Construction, upgrading and equipping of 100 level 4 hospitals to conform to the norms and standards ModerniseKenyatta National Hospital ModerniseMoi Teaching and Referral Hospital
Health Products	Health Products and Technologies Locally Derived Natural Health Products
Health Financing	Health Care Subsidies for Social Health Protection
Health Leadership	Health Tourism
Health Information	Establish e-Health hubs in 58 health facilities Mainstreaming Research and Development in Health

3 ACHIEVING HEALTH OUTCOMES THROUGH THE KENYA ESSENTIAL PACKAGE FOR HEALTH

This chapter describes the range of services and interventions that the health sector will make available in the period covered by this Plan. Services to be provided are comprehensively defined in the Kenya Essential Package for Health (KEPH).

3.1 The Kenya Essential Package for Health description& services

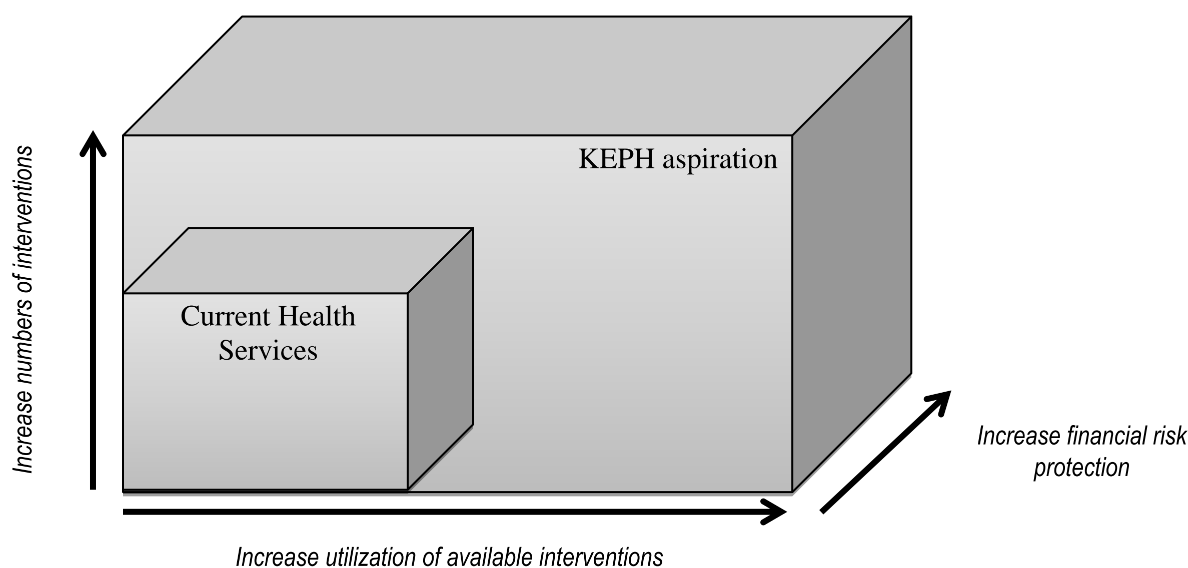
The Essential Health Services are defined in the Kenya Essential Package for Health (KEPH) – an integrated and comprehensive package of services and interventions that all service providers in health shall aim at offering during the KHSSP period in order to meet the strategic objectives set for this period.

KEPH reflects the obligation of the health sector to progressively realise the right-to-health of residents of Kenya as outlined in the 2010 Constitution, which introduces a rights based approach to provision of services and calls for clarity on service provided to the public. This obligation is both for public, and on public service providers.

The sector commitment is to progressively move towards Universal Coverage with the KEPH. This implies all its efforts during the period are geared towards:

i) Introducing KEPH interventions to populations as and where needed;
ii) Scaling up of utilization of KEPH interventions for populations with access to these, and
iii) Reducing potential for catastrophic health expenditures for clients, associated with utilization of KEPH interventions

Figure 8: Focus of the Kenya Essential Package for Health (KEPH)



This focus is to be progressively attained, with the following specific indicators and targets tracking and monitoring progress towards this KEPH Universal Health Coverage.

The KEPH therefore represents the focus and target that the sector is moving towards, as it progressively works to assure the right to health.

3.1.1 KEPH elements and services

The NHSSP II review highlighted issues that related to the KEPH design & operationalization:

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

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

Table 7: Key shifts in the Kenya Essential Package for Health

New alignments in KEPH	Rationale for the alignments
Comprehensive description of the service package	As per constitutional requirements, a clear definition of services and interventions to be provided to persons in Kenya, by level of care
	Addressing the increasing burden on Non Communicable Conditions and Violence / Injuries
	Need for an inclusive package, with rationalization done by expected access / coverage's to be achieved as opposed to limitation of interventions
Elaboration of both interventions (what clients receive) and services (how interventions will be organized – the new basis for integration)	Need for clear description of what clients receive
	Ability to link with investments, and budgeting processes through clear description of services
Alignment of services and interventions to overall Health Sector Policy Objectives	Need to align to overall National Health Policy Objectives
Specification of cohort – specific services and interventions where applicable, not for all services	Highlighting of priorities for specific cohorts
Re-alignment of levels of care, and cohorts	Alignment of levels of care to new devolved system
	Updating cohorts based on experiences gained in implementation
Description of KEPH implementation arrangements	Guide the sector on how the KEPH needs to be applied during implementation

The KEPH in this strategic plan therefore represents a comprehensive description of services, and related interventions to be provided for each Policy Objective. The KEPH services are shown in the table below.

Table 8: Description of KEPH services for the KHSSP

Policy Objective	Services	Policy Objective	Services
Accelerate reduction of the burden of Communicable Conditions	Immunization	**Provide essential health services**	Outpatients
	Child Health		Emergency
	Screening for communicable conditions		Maternity
	Antenatal Care		In patient
	Prevention of Mother to Child HIV Transmission		Clinical laboratory
	Integrated Vector Management		Specialized laboratory
	Good hygiene practices		Radiology
	HIV and STI prevention		Operative services
	Port health		Specialized therapy

Policy Objective	Services	Policy Objective	Services
	Control & prevention neglected tropical diseases		Specialized services
Halt, and reverse the rising burden of non communicable conditions	Community screening for NCDs		Rehabilitation
	Institutional Screening for NCD's	**Strengthen collaboration with health related sectors**	Safe water
	Workplace Health & Safety		Sanitation and hygiene
	Food quality & Safety		Nutrition services
Reduce the burden of violence and injuries	Pre hospital Care		Pollution control
	Community awareness on violence and injuries		Housing
	Disaster management and response		School health
Minimize exposure to health risk factors	Health Promotion including health Education		Water and Sanitation Hygiene
	Sexual education		Food fortification
	Substance abuse		Population management
	Micronutrient deficiency control		Road infrastructure and Transport
	Physical activity		

3.1.2 Implementing disease programs through the KEPH

These KEPH services are critical for the different programs needed in delivery of health services. Programs define services and interventions across the KEPH, as opposed to each service representing a program. This allows comprehensive integration of programs across different services, and so better and more efficient delivery of services to populations.

The situation analysis highlighted the main disease conditions afflicting the population in Kenya. Programs to force down disease burden contributed to by these conditions exist. As shown in the table below, specific program areas relate to many of the KEPH services – as opposed to relating to a specific services. This therefore calls for program areas to review key focus they need to have in each of the KEPH services and interventions.

Table 9: KEPH services, by selected disease program areas

Policy Objective	KEPH Services	Program areas contributing to KEPH services						
		HIV	TB	MAL	NCD	NTD	VIP	NUT
Accelerate reduction of the burden of Communicable Conditions	Immunization		✓					
	Child Health	✓	✓	✓	✓			✓
	Screening for communicable conditions	✓	✓	✓		✓		
	Antenatal Care	✓	✓	✓	✓			✓
	Prevention of Mother to Child HIV Transmission	✓						
	Integrated Vector Management			✓		✓		
	Good hygiene practices				✓	✓		
	HIV and STI prevention	✓	✓					
	Port health		✓			✓		
	Control and prevention neglected tropical diseases					✓		✓
Halt, and reverse the rising burden of non communicable conditions	Community screening for NCDs				✓			✓
	Institutional Screening for NCD's				✓			✓
	Workplace Health & Safety	✓	✓		✓		✓	
	Food quality & Safety				✓			✓
Reduce the burden of violence and injuries	Pre hospital Care	✓	✓	✓	✓	✓	✓	
	Community management of violence and injuries				✓		✓	
	Disaster management and response						✓	
Provide essential health services	Outpatients	✓	✓	✓	✓	✓	✓	✓
	Emergency	✓	✓	✓	✓	✓	✓	✓
	Maternity	✓	✓	✓	✓	✓	✓	✓
	In patient	✓	✓	✓	✓	✓	✓	✓
	Clinical laboratory	✓	✓	✓	✓	✓	✓	✓
	Specialized laboratory	✓	✓	✓	✓	✓	✓	

Policy Objective	KEPH Services	Program areas contributing to KEPH services						
		HIV	TB	MAL	NCD	NTD	VIP	NUT
	Radiology	✓	✓	✓	✓	✓	✓	
	Operative	✓	✓	✓	✓	✓	✓	✓
	Specialized therapy	✓	✓	✓	✓	✓	✓	
	Specialized services	✓	✓	✓	✓	✓	✓	✓
	Rehabilitation	✓	✓	✓	✓	✓	✓	✓
Minimize exposure to health risk factors	Health Promotion (including health Education)	✓	✓	✓	✓	✓	✓	✓
	Sexual education	✓					✓	
	Substance abuse	✓			✓		✓	✓
	Micronutrient deficiency control	✓	✓		✓			✓
	Physical activity				✓			✓
Strengthen collaboration with health related sectors	Safe water	✓	✓	✓	✓	✓	✓	✓
	Sanitation and hygiene	✓	✓	✓	✓	✓	✓	✓
	Nutrition services	✓	✓	✓	✓	✓	✓	✓
	Pollution control	✓	✓	✓	✓	✓	✓	✓
	Housing	✓	✓	✓	✓	✓	✓	✓
	School health	✓	✓	✓	✓	✓	✓	✓
	Water and Sanitation Hygiene	✓	✓	✓	✓	✓	✓	✓
	Food fortification	✓	✓	✓	✓	✓	✓	✓
	Population management	✓	✓	✓	✓	✓	✓	✓
	Road infrastructure and Transport	✓	✓	✓	✓	✓	✓	✓

HIV: HIV/AIDS program; TB – National Tuberculosis and Lung Diseases program; MAL – Malaria control program; NCD – Noncommunicable conditions; NTD – Neglected Tropical Conditions; VIP – Violence and Injury Prevention; NUT – Nutrition program

3.2 Rationalization of the KEPH

The KEPH represents a comprehensive picture of services and interventions to be provided, for Universal Health Coverage goals to be attained. However, the sector recognizes the need to target services and interventions when and where needed, and rationalize their provision to ensure resources are best utilized.

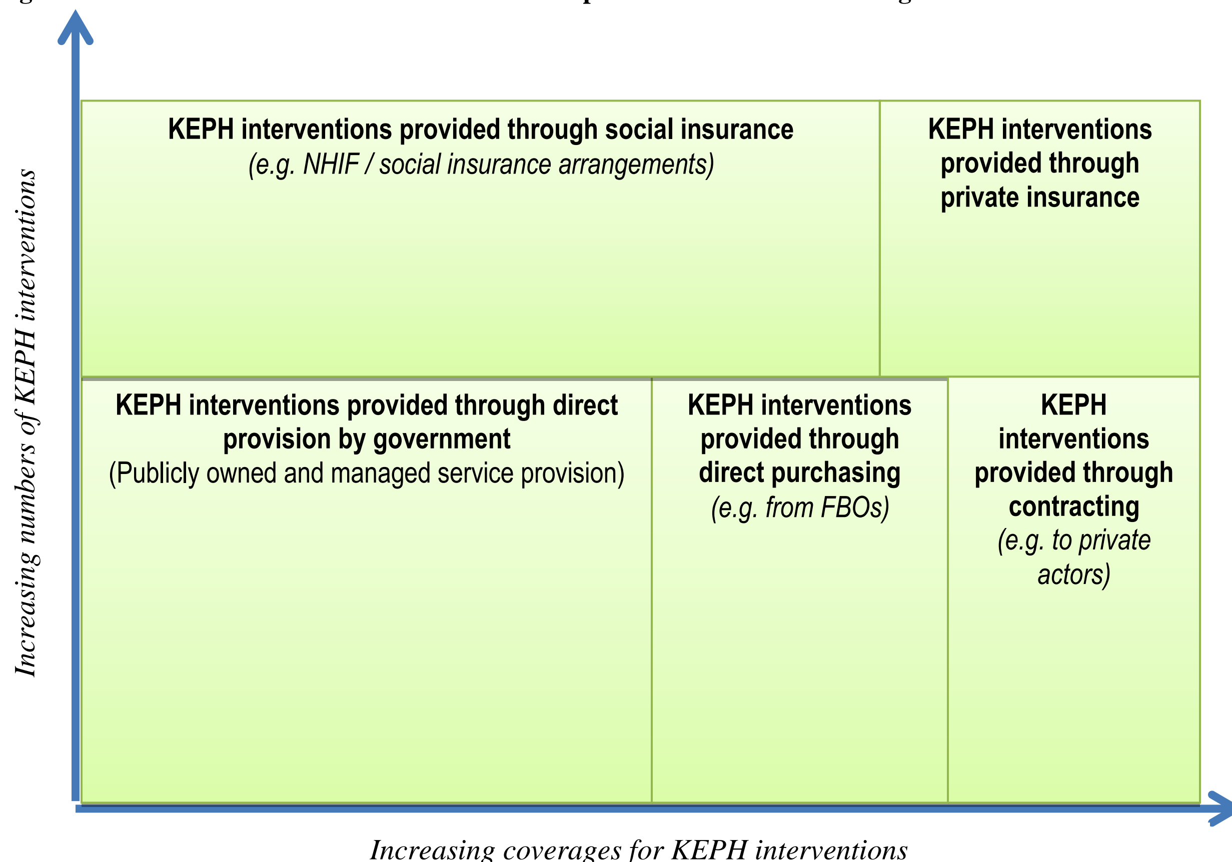
The provision of the KEPH shall be rationalized by service provider institution, level of care, and targeted cohort to assure efficiency and effectiveness in its delivery

3.2.1 KEPH rationalization by institutional arrangements

Rationalization by service provider institutional arrangements calls for clear definition of KEPH interventions that shall be provided through different institutional arrangements. This takes cognizance of the fact that different interventions are best provided through different mechanisms. The different institutional arrangements include those associated with direct purchasing of services, social insurance arrangements (including NHIF and NSHIF), private insurance arrangements, direct provision of services, and contracting of services.

- Basic primary care services shall be provided primarily through direct provision (public health facilities), with coverage of these services complemented through direct purchasing of care (e.g. from FBOs) and contracting out provision.
- In order to increase numbers of KEPH interventions being provided, the sector will scale up insurance arrangements, particularly for those interventions whose use is associated with catastrophic health expenditures. Coverages for these shall primarily be through social health insurance mechanisms (restructuring of NHIF), with additional coverage assured through private health insurance mechanisms

Figure 9: Rationalization of KEPH across different provider institutional arrangements

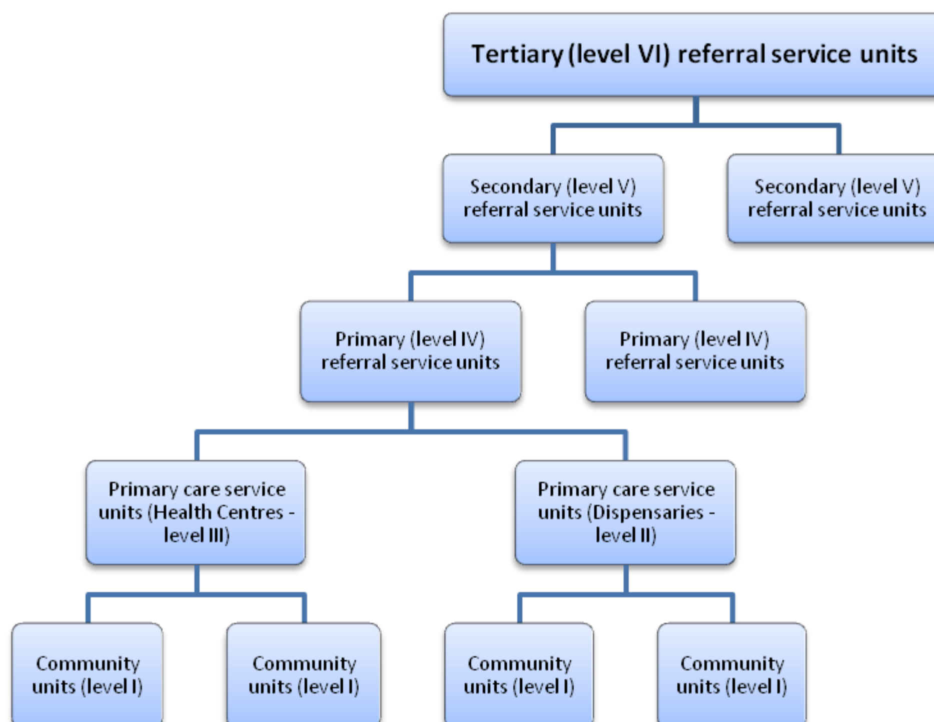


3.2.2 KEPH rationalization by level of care

The second form of KEPH rationalization is by ensuring interventions are provided at the level of care they are most effectively and efficiently provided at. The Kenya Health Policy defines four tiers of care (Community, primary care, County referral and national referral). However, during this KHSSP period, the levels 2 (primary care) and 3 (county referral) will be split into two for pragmatic reasons. As such, the six levels of care around which KEPH is rationalized are further described in the proceeding section. The basic premise is interventions will be provided at the lowest possible level of care.

The levels in the KEPH are the health system levels of organization of service delivery as shown below.

Figure 10:Organization of Health Services



Community level: The foundation of the service delivery system, with both demand creation (health promotion services), and specified supply services that are most effectively delivered at the community. In the essential package, all non facility based health and related services are classified as community services – not only the interventions provided through the Community Health Strategy as defined in NHSSP II. On average, for every 5,000 population a community unit needs to be established.

Primary care service units: The first physical level of the health system. Primary care service units are either health centres, or dispensaries (mobile clinics in areas where population density is very low, and/or mobile). The health sector aspires to upgrade all dispensaries into fully primary care units (model health centres) in the long run, ensuring every facility is able to at least carry out a normal delivery. However, this aspiration will not be achieved in the period of the current KHSSP, so the primary care level is made up of level II (dispensaries) and III (health centres).

- **A level II facility** should exist for every 10,000 persons on average, translating to an average of 30 dispensary OPD visits per day for any services, if everyone in the catchment area is to visit a health facility at least once a year for any form of services (curative, preventive, or health promotion activities). Such dispensary units are physical facilities, but in areas where populations

are mobile and sparse – such as in Arid or Semi Arid lands, mobile facilities would replace dispensaries as much as is rationally possible.

- **A level III facility** should exist for every 30,000 persons, allowing for at least 4 deliveries per day – a workload that is fair on the system and staff.

Primary referral services: The primary / first level hospitals (**level IV facilities**), whose services complement the primary care level to allow for a more comprehensive package of close to client services.

Secondary referral services: The secondary **/** second level hospitals (**level V facilities**) provide a more comprehensive set of services, together with internship services for medical staff, research and serve as training centres for paramedical staff

Tertiary referral services: The tertiary level hospitals, **(level VI facilities)** whose services are highly specialized and complete the set of care available to persons in Kenya. Services also include training for specialists, biomedical research, and serve as internship / apprenticeship centres for specialists

3.2.3 KEPH rationalization by life cohort

The third form of KEPH rationalization is by life cycle cohort. It focuses on improvement of health at different phases of the human development cycle, at the different levels of the health care delivery system. Interventions are defined for each age-cohort that should exist, for health to be maximised.

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

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

3.3 KEPH indicators and targets

The implementation of the KEPH needs to be monitored, across the 3 dimensions of the UHC implementation in the Country.

- Counties shall define, and monitor annual targets towards increasing number of KEPH service (and interventions) being provided, as part of the regular planning and monitoring process
- Reductions in catastrophic health spending shall also be followed up regularly in the sector
- Improvements in coverage with KEPH services will be monitored using the indicators shown below.

Table 10: Sector 5 year targets for indicators against Health Policy Objectives

Policy Objective	Indicator	ANNUAL TARGETS FOR ATTAINMENT				
		2013/14	*2014/15*	*2015/16*	*2016/17*	*2017/18*
Accelerate reduction of the burden of Communicable Conditions	% Fully immunized children	79	85	88	90	90
	% of target population receiving MDA for schistosomiasis	50	70	95	95	95
	% of TB patients completing treatment	85	85	90	90	90
	% HIV + pregnant mothers receiving preventive ARV's	63	80	90	90	90
	% of eligible HIV clients on ARV's	60	70	80	90	90
	% of targeted under 1's provided with LLITN's	44	60	85	85	85
	% of targeted pregnant women provided with LLITN's	30	45	58	70	85
	% of under 5's treated for diarrhea	40	20	10	10	5
	% School age children dewormed	49	60	85	85	90
Halt, and reverse the rising burden of non communicable conditions	% of adult population with BMI over 25	50	50	45	40	35
	% women of reproductive age screened for cervical cancers	50	50	60	70	75
	% of new outpatients with mental health conditions	<1	3	3	2	1
	% of new outpatients cases with high blood pressure	1	3	5	5	3
	% of patients admitted with cancer	1	3	3	2	2
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender based violence	<1	2	3	3	2
	% new outpatient cases attributed to road traffic accidents	4	4	3	2	2
	% new outpatient cases attributed to other injuries	<1	1	1	0.5	0.5
	% of facility deaths due to injuries	10	8	6	5	3
Provide essential health services	% deliveries conducted by skilled attendant	44	46	50	60	65
	% of women of Reproductive age receiving family planning	45	65	75	80	80
	% of facility based maternal deaths (per 100,000 live births)	400	350	150	100	100
	% of facility based under five deaths (per 1,000 under 5 outpatients)	60	50	35	20	15
	% of newborns with low birth weight	10	10	8	6	5
	% of facility based fresh still births (per 1,000 live births)	30	25	20	10	5
	Surgical rate for cold cases	0.40	0.60	0.70	0.85	0.90
	% of pregnant women attending 4 ANC visits	36	50	70	80	80
Minimize exposure to health risk factors	% population who smoke	18		15		6
	% population consuming alcohol regularly	35		25		10
	% infants under 6 months on exclusive breastfeeding	32		50		70
	% of Population aware of risk factors to health	30		60		80
	% of salt brands adequately iodised	85		100		100
	% adult new attendances with Adult Mid Upper Arm Circumference above normal					
	Couple year protection due to condom use					
Strengthen collaboration with health related sectors	% population with access to safe water	60		70		85
	% under 5's stunted	35		30		15
	% under 5 underweight	17		10		5
	School enrollment rate	60	70	75	80	80
	% women with secondary education	34		45		70
	% of households with latrines	65		75		80
	% of houses with adequate ventilation	30		40		50
	% of classified road network in good condition	15		35		50
	% Schools providing complete school health package	34	50	55	70	85

3.4 KEPH Interventions, by strategic objective

3.4.1 Strategic Objective 1: Accelerate reduction of the burden of Communicable Diseases and Conditions

The sector aims to force down -the burden of communicable diseases in the medium term by:

- Enhancing comprehensive control of communicable diseases by designing and applying integrated health service provision tools, mechanisms and processes
- Integrating delivery of interventions, around the service areas for more comprehensive provision of services, with an aim to ensure populations have access to all interventions in a given service area
- Increasing access of the population to key interventions addressing communicable conditions causing the highest burden of ill health and death
- Ensuring that communicable disease prevention interventions directly addressing marginalized and indigenous populations, as well as persons living in congregate settings (prisons, schools, urban slums, army/policy barracks) are available

These strategies aim at the eradication, elimination, or control of the following diseases.

- Eradication, i.e. the complete removal in Kenya during the KHSSP period, of polio and Guinea Worm infestation.
- Elimination, i.e. the reduction of the burden of disease to levels not of a public health concern, of malaria, mother-to--child HIV transmission, maternal and neonatal tetanus, measles, , leprosy, and neglected tropical conditions (including infestations);
- Control efforts will focus on diseases for which the sector will work towards managing their burden to avoid unnecessary ill health and death. Current investments are not at a level to allow elimination / eradication – this will be the focus for these in subsequent strategic plans as investments, and / or strategies to allow this are attained. These include HIV, tuberculosis, diarrheal diseases, immunisable conditions, respiratory diseases, and other diseases of public health concern.

Table 11: KEPH interventions for accelerating reduction in the burden of communicable conditions by level of care and life cohort

Services	Interventions	Lowest level for provision	Primary cohort
Immunization	BCG vaccination	2	1
	Oral Polio Vaccination	2	2
	Pentavalent vaccination	2	2
	Rotavirus vaccination	2	2
	PCV – 10 vaccination	2	2
	Measles vaccination	2	2
	Typhoid vaccination	3	All
	Yellow fever vaccination	3	All
	HPV vaccination	4	1
Child Health	Deworming	1	2
	Management of pneumonia	2	1
	Management of malaria	2	All

Services	Interventions	Lowest level for provision	Primary cohort
	Management of diarrhoea	2	1
Screening for communicable conditions	HIV Testing and counselling (HTC)	3	All
	Active case search for TB	1	All
	Diagnostic Testing for Malaria	1	All
	Screening for drug resistant TB	5	All
	Screening for Animal Transmitted Conditions	4	All
Prevention of Mother to Child HIV Transmission	HIV Testing and Counselling	3	1
	ARV prophylaxis for children born of HIV+ mothers	4	1
	Highly Active Anti retroviral Therapy	4	1
	Cotrimoxazole prophylaxis	2	1
	Counselling on best breastfeeding and complementary feeding practices in HIV	1	1
Integrated Vector Management	Indoor Residual Spraying of malaria	1	All
	ITN distribution	1	All
	Destruction of malaria breeding sites	1	All
	Household vector control (cockroaches, fleas, rodents)	1	All
Good hygiene practices	Food outlet inspections	1	All
	Meat inspections (abattoirs, butcheries)	1	All
	Household water treatment	1	All
HIV and STI prevention	Male circumcision	4	All
	Management of sexually transmitted Infections	3	All
	Pelvic Inflammatory Disease management	4	All
	Post Exposure Prophylaxis	4	All
	Condom distribution/ provision	1	All
	HIV Testing and Counselling (HTC)	3	All
Port health	Monitoring of imported and exported commodities affecting public health	3	All
	Monitoring of people movement in relation to International Health Regulations	3	All
	Cholera vaccination	3	All
	Meningococcal vaccination	3	All
	Yellow fever vaccination	3	All
Control and prevention neglected tropical diseases	Mass deworming for schistosomiasis control	1	All
	Mass screening of NTDS (*KalarAzar, Schistosomiasis, Drucunculosis, Leishmaniasis)*	2	All

3.4.2 Strategic Objective 2: Halt, and Reverse Rising Burden of NCDs

This strategic objective focuses on ensuring efforts are initiated to prevent a rise in the burden of key non-communicable conditions and diseases. However, efforts will also be made to increase access to services that will contribute to reduce the existing burden of ill health such as rehabilitation activities (tertiary prevention). The sector will focus on:

- Integrating health service provision tools, mechanisms and processes for responding to NCDs
- Establishing screening programs at community level and in health facilities for major NCDs.
- Putting in place interventions directly addressing marginalized and indigenous populations affected by NCDs
- Improving working conditions, particularly in the workplace, that pre-dispose persons to NCDs

The NCD's targeted for control during the strategic planning period include mental disorders, diabetes mellitus, cardiovascular diseases, chronic obstructive airway conditions, blood disorders focusing on sickle cell conditions, and cancers. These represent the NCD's contributing to the highest NCD burden. The service package that shall be provided under this strategic area is shown in the table below.

Table 12: KEPH interventions for reversing rising burden of NCDs by level of care and life cohort

Services	Interventions	Lowest level for provision	Primary cohort
Institutional Screening for NCD's	Blood Sugar testing	3	4,5
	Routine Blood Pressure measurement for all adults at the OPD	2	4,5
	Routine Body Mass Index (weight and height) measurement for all outpatients	2	3,4,5
	Cervical cancer screening for all women in the RH age group	4	3,4,5
	Faecal occult blood testing for bowel cancers	4	4,5
	Breast cancer screening for all women over 18 years	5	4,5
	Lung Function Testing	4	4,5
	Lipid profiling	4	4,5
	Annual prostate examination for all men over 50 years	4	4,5
	Screening for sickle cell anaemia (group?)	4	2
Community screening for NCD's	Routine Blood Pressure measurement	1	3,4,5
	Adult Mid Upper Arm Circumference measurement	1	3,4,5
Workplace health and safety	Workplace wellness programme	4	3,4
	Inspection and certification	4	3,4
	Safety education	4	3,4
Food quality and safety	Food demonstrations (at community and facilities)	1	All?
	Food safety testing	4	All
	Consumer Education on food quality and safety	1	All

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

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

- Making available corrective and inter-sectoral preventive interventions to address causes of injuries and violence
- Putting in place interventions directly addressing marginalized and indigent populations affected by injuries and violence
- The health sector's emergency preparedness and response to disasters
- Interventions directly addressing minorities and marginalized groups affected by injuries and violence

The major types of violence and injuries targeted during KHSSP are gender-based violence (including sexual violence), child maltreatment, female genital mutilation and injuries due to road traffic accidents, conflict and war, occupational accidents, poisoning including snake bites, burns/fires and drowning. The service package that shall be provided under this strategic area is shown below.

Table 13: KEPH interventions for managing the rising burden of violence and injuries, by level of care & cohort

Services	Interventions	Lowest level for provision	Primary cohort
Pre hospital Care	Basic First Aid	1	All
	Evacuation Services for Injuries	4	All
Community management of violence and injuries	Community systems for responding to gender based violence	1	All
	Community systems for responding to child maltreatment	1	All
	Capacity building of communities on injury prevention	1	All
Disaster management response	Disaster risk reduction interventions	4	All
	Facility disaster response planning	4	All
	Disaster management	2	All

3.4.4 Strategic Objective 4: Improve person-centred essential health services

The constitution places emphasis on individual rights of persons in Kenya. In line with this, the KHSSP is placing increasing emphasis on person-centred care through this objective. This doesn't replace the public health approach, but rather is aimed at complementing it, to ensure a holistic approach to health, which invests in both population and individual health needs. The sector intends to focus on:

- Scaling up access to person centered health care, with local solutions designed to fore hard to reach, or vulnerable populations
- Ensure holistic approach to provision of services – informed by needs of a client as they use available health services

The scope of interventions planned by services are shown below.

Table 14: KEPH interventions for improving person centred essential health services

Services	Interventions	Lowest level for provision	Primary cohort
Outpatients	Integrated treatment of common ailments	2	All
	Vaccination for yellow fever, tetanus and rabies	2	All
	Outpatient management of minor injuries	3	All
Emergency	Management of medical emergencies	3	All
	Management of surgical emergencies(including trauma care)	3	All
	Basic life support	4	All
	Advanced life support	5	All
Maternity	Management of pregnancy complications	3	All
	Management of abnormal pregnancies	4	All
	Management of pre-term labour	4	All
	Normal Vaginal Delivery	3	All
	Assisted vaginal delivery	4	All
	Caesarean section	4	All
	Care for the newborn	3	All
	Post partum care	3	All
In patient	Management of medical in patients	3	All
	Management of surgical in patients	3	All
	Management of pediatric in patients	4	All
	Management of gynaecology in patients	4	All
Clinical laboratory	Haematology*(Hb, RBC/WBC counts, hematocrit, peripheral film)*	3	All
	Pregnancy test	4	All
	Bleeding and coagulation time	4	All
	Blood grouping with Rh factors	4	All
	Parasitology *(RDT)*	2	All
	Hepatitis B and C tests	4	All
	Bacteriology *(ZN staining, Alberts staining, Gram Staining)* microscopy	3	All
	ELISA tests	3	All
	Widal tests	4	All
	CD 4 count	4	All
	PCR tests	5	All
	Viral culture	6	All
	Agglutination tests	4	All
	Urinalysis	3	All
	Liver Function Tests	4	All
	Renal Function Tests	4	All
	Blood gases	5	All
	Cardiac enzymes	5	All
	Cholesterol tests (Total / Differential)	4	All
	Blood culture	4	All

Services	Interventions	Lowest level for provision	Primary cohort
	Blood sugar	2	All
	Semen analysis	4	All
	Fecal Occult Blood testing	4	All
	Tumour markers *(PSA, Bence Jones protein, CA125, cytology, biopsy examinations)*	5	All
	Histopathology (FNA, Tru cut, Incision or excision) and cytology	5	All
	Micro nutrient test	4	All
	Cerebro Spinal Fluid analysis *(culture, biochemistry, cytology)*	4	All
Specialized laboratory	DNA testing	6	All
	Food analysis	6	All
	Water analysis	6	All
	Blood analysis *(alcohol, drug)*	6	All
	Stool testing *(e.g. polio)*	6	All
Radiology	Ultra sound scan	3	All
	X – ray	4	All
	Endoscopopy	4	All
	Laparascopy	4	All
	Computerized Tomography Scan	6	All
	Magnetic Resonance Imaging	6	All
	Radio-isotope scanning	6	All
	Angiography	6	All
	AVU / AVP	6	All
	Electro Encephalogram (EEG)	5	All
Reproductive Health	Screening for reproductive health risks	3	All
	Family planning	2	All
	Comprehensive youth friendly services	3	All
Operative	Outpatient operations	3	All
	Emergency operations	4	All
	General operations	4	All
	Specialized operations	5	All
Specialized therapy	Radiotherapy	5	All
	Chemotherapy	5	All
	Interventional Radiology	5	All
	Dialysis	6	All
	Organ transplants *(kidney, liver, bone marrow)*	6	All
	Bypass surgeries	6	All
	Reconstructive surgery	6	All
	Assisted Reproduction *(IVF)*	5	All
Specialized services	HIV/AIDS management	4	All
	Tuberculosis management	4	All
	Palliative care	4	All
	Pediatric conditions management	4	All
	Medical conditions management	4	All
	Surgical conditions management	4	All
	Gynaecological conditions management	4	All
	Ear Nose and Throat conditions management	5	All
	Eye (Ophtmalmic) conditions management	5	All
	Oral condition management	5	All
	Respiratory conditions management	5	All
	Cardiovascular conditions management	5	All
	Gastrointestinal conditions management	5	All
	Genito-urinary conditions management	5	All
	Musculoskeletal conditions management	5	All
	Skin conditions management	5	All
	Neurological conditions management	5	All
	Genetic conditions management	5	All
	Endocrine and metabolic conditions management	5	All
	Haematological conditions management	5	All
Rehabilitation	Physiotherapy	4	All
	Speech and hearing therapy	4	All
	Orthopedic technology (appliances)	4	All
	Occupational therapy	4	All

3.4.5 Strategic Objective 5: Minimize exposure to the major health risk factors through intersectoral health promotion

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

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

These objectives will be achieved through health promotion services and interventions which aim at

- Improving '*health promoting individual behaviour'*, i.e. improving knowledge and awareness of individuals and communities of the importance of the major risk factors
- Creating a '*health promoting physical environment*' by providing product, technologies and installations that minimise exposure to the risk factors
- Providing a '*health promoting social/societal environment' (*social network, social support, the 'social climate')

The table below presents the KEPH interventions for addressing the major health risk factors.

Table 15: **KEPH interventions for addressing health risk factors by level of care & cohort**

Services	Interventions	Lowest level for provision	Primary cohort
Health Promotion	Health promotion on violence and injury prevention	2	All
	Health promotion on prevention of communicable conditions	2	All
	Health promotion on prevention of Non Communicable conditions	2	All
Sexual education	Sensitization of the community on safe sex practices	1	All
	Incorporation of sex education in education curricular	3	3,4
	Targeted education for high risk groups (MARPS) (*commercialsex workers, uncircumcised men, Men Having Sex with men, intravenous drug users, Adolescents)*	4	3,4,5
	Education addressing negative cultural and lifestyle practices	4	All
Substance abuse	Communication on harmful effects of Tobacco use	2	3,4,5
	Communication on harmful effects of Alcohol abuse	2	3,4,5
	Communication on harmful effects of Substance abuse (*Cocaine, Heroine, glue, khat, etc)*	2	3,4,5
	Communication on harmful effects of Prescription drug abuse	2	3,4,5
	Counseling on harmful effects of substance abuse	2	3,4,5
Micronutrient deficiency control	Advocate for food fortification	1	All
	Advocacy for consumption of fortified foods	1	All
	promotion of dietary diversification	1	All
	Food supplementation	1	All
Physical activity	Facility based health messages on benefits and approaches to improving physical activity	2	All
	Activities to enhance physical activity	2	All

3.4.6 Strategic Objective 6: Strengthen Collaboration with health related sectors

As highlighted in the National Health Policy, this strategic objective highlights the key services and interventions that have a secondary effect on health. The critical related sectors in the MTP II and their effects on health are shown in the table below.

Table 16: Critical health related sectors and their effect on health

Ministry, Department, Agency	Role in Health
Ministry of Planning and Devolution	▪ Promote sustainable population growth ▪ Ensure youth and gender is mainstreamed in all sector policies ▪ Provide data that is required to inform health (promotion) planning (e.g. KDHS, vital statistics) ▪ Create enabling environment for the implementation of the MTP towards achievement of health goals under vision 2030 ▪ Support implementation of transition implementation plans to facilitate devolution of the health system
Ministry of Agriculture, Livestock and Fisheries	▪ Incorporate considerations of health in safe food production systems, manufacturing, marketing and distribution ▪ Ensure food security for the whole population
Ministry of Lands, Housing and Urban Development	▪ Promote urban and housing designs and infrastructure planning that take into account health and wellbeing of the population Urbanisation ▪ Strengthen access to land, and other culturally important resources, in particular for women
Ministry of Transport and Infrastructure	▪ 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. ▪ Ensure availability of infrastructure to incentivise and support physical activity (cyclists, pedestrians) ▪ Facilitate data and voice communication within health sector and with other sectors
Ministry of Industrialisation and Enterprise	▪ Ensure work and stable employment and entrepreneur opportunities for all people across different socio economic groups
Ministry of Education, Science and Technology	▪ Support education of men and women in order to enable them to increase control over the determinants of health and thereby improve their health.
Directorate of Public Prosecution **Ministry of Interior and National Coordination** **Attorney General**	▪ Have fair justice systems, particularly in managing access to food, water & sanitation, housing, work opportunities, and other determinants of wellbeing ▪ Ensure security (a major determinant of access to health) ▪ Ensure coordination of optimal disaster management (mitigation and response)
Immigration	▪ Ensure wellbeing of refugee populations ▪ 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
Ministry of Labour, Social Security and Services	▪ Promote progressive workplace and safety policies that safeguard the health of workers ▪ Develop social policies for protection of vulnerable groups ▪ Ensure development and enforcement of proper regulation of cultural practitioners.
Ministry of Sports, Culture and Arts	▪ Promote sport and physical exercise
Ministry of Environment, Water and Natural Resources	▪ Influence population consumption patterns of natural resources meets the health needs of current generations without compromising the ability of future generations to meet their own health needs ▪ Develop and implement legislation to control/minimise pollution ▪ Promote access to safe and clean water to the population

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

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

As many the interventions are being implemented in other sectors, the health focus is on stewardship and guidance to these health related sectors, on the need to implement the interventions for a health in all policies approach. The coordination of these interventions will be done at the County level – not necessarily through health facilities.

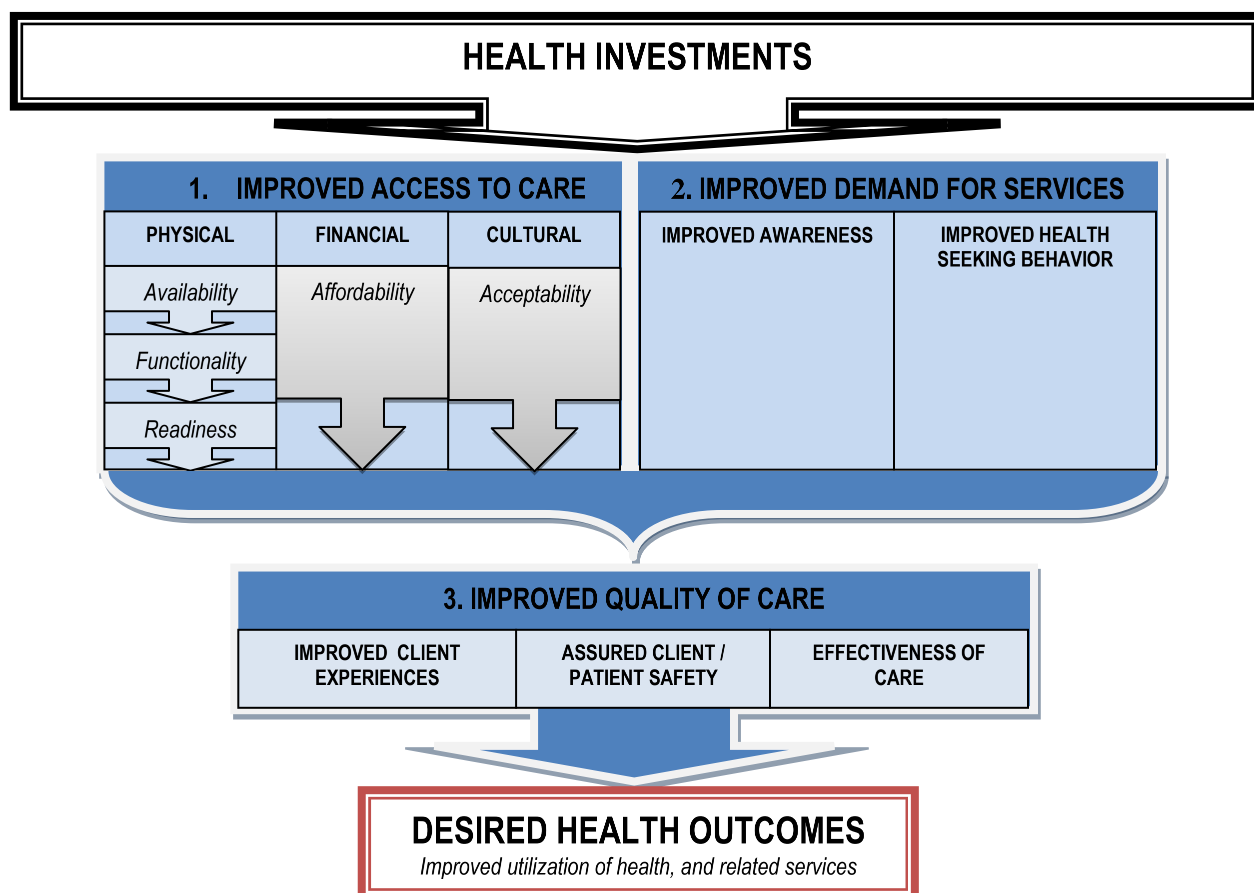
Table 17: KEPH interventions for collaboration with health related sectors, by level of care & cohort

Service area	Interventions	Lowest level of provision	Primary cohort
Safe water	Provision of safe water sources	4	All
	Health Impact Assessment	4	All
	Community sensitization on safe water	1	All
	Water quality testing	4	All
	Water purification / treatment at point of use	4	All
	Water source protection	4	All
Sanitation and hygiene	Monitoring human excreta disposal practices	4	All
	Hand washing facilities	4	All
	Hygiene promotion	1	All
	Home inspections for sanitation adequacy	1	All
	Health Impact Assessment	4	All
	Promotion of safe food handling	4	All
	Sanitation surveillance and audits	4	All
Nutrition services	Nutrition education and counseling	2	All
	Community based growth monitoring and promotion	1	All
	Micronutrient supplementation (e.g vitamin A, IFA)	2	All
	Management of acute malnutrition	3	All
	Health Impact Assessment	4	All
	Health education on appropriate infant and young child feeding	2	All
Pollution control	Indoor pollution management	4	All
	Liquid, solid and gaseous waste management	4	All
	Health Impact Assessment	4	All
	Control of Water body, soil and air pollution	4	All
Housing	Approval of building plans	4	All
	Health and environmental impact assessment	4	All
	Advocacy for enforcement of standards on housing	4	All
	Physical planning and housing environment to promote healthy living including prevention of rickets	4	All
School health	School feeding and nutrition	2	All
	School Health promotion	2	All
	School based disease prevention programme	2	All
	School water sanitation and hygiene	2	All
	Health Impact Assessment	4	All
	Managing children with special needs	4	All
Food fortification	Salt fortification with Iodine	4	All
	Toothpaste fortification with fluoride	4	All
	Health Impact Assessment	4	All
	Micronutrient fortification of food products (*flour, cooking oil, sugar, etc)*	4	All
Population management	Information on child spacing benefits	2	All
	Awareness creation on the impact of population growth	1	All
	Health Impact Assessment	4	All
	Management of population movement particularly to informal settlements	4	All
Road infrastructure and Transport	Improve road infrastructure to health facilities	4	All
	Road safety/Injury prevention	4	All
	Health Impact Assessment	4	All

4 HEALTH OUTPUTS: ACCESS, QUALITY OF CARE& DEMAND FOR KEPH

Health outputs relate to expected improvements in access, demand for services, and/or quality of care. These three represent the expected implications of any investments in health, which when attained should provide the necessary outcomes the sector desires.Each of these elements of health outputs have desired attributes shown below.

Figure 11: Attributes associated with health outputs



4.1 Improving access to KEPH services

By improving access, the sector aims to ensure required KEPH services are brought as close to the population as is feasible. The sector views access in three dimensions:

- **Physical access:** the physical presence of the health services required for people to use them. Services need to be available, functional and ready for use. Failure in any of these impedes physical access. UN-availability of services (service provision sites more than 5 km for medical services, and 2.5km for public health services are termed – unavailable as recommended by WHO), imbalances in geographical distribution of facilities across regions, non-functional inputs

(equipment, etc.), or facilities not ready to provide services (no electricity, water, etc.) all work to limit physical access to services.

- **Financial access:** Services may physically be available but are unaffordable, hindering access. Costs of services, together with costs associated with accessing services all work to affect affordability. Efforts to reduce costs of services include removal of fees at point of use (free services for maternity, primary care, HIV, TB, Malaria, Child health, as well as various voucher schemes), together with efforts to reduce costs of accessing services all work to improve financial access, particularly when targeted at the most poor households.
- **Socio-cultural access:** Social, or cultural barriers in many communities act as other hindrances to accessing care. These barriers include issues like gender biases, religious beliefs, cultural norms, etc. Investments in health are expected to reduce such biases, and so improve access to available services

Specific priority output targets to improve access to services are shown in the table below.

Table 18: Priority targets to improvements in access to services

Dimension of access	Priority targets
Improvements in physical access	- All (100%) KEPH services are available in the hard to reach areas – the northern arid lands, and urban informal settings - At least 40% of all dispensaries are upgraded to fully functional primary care facilities - All (100%) model Health Centres operating as fully functional primary care facilities - All (100%) of facilities have at least 80% of their infrastructure functional - All (100%) facilities are 'ready' to provide services (focus on ensuring availability of stable power, and clean water sources)
Improvements in financial access	- Maternity services are provided free at the point of use in all public facilities - Primary care services are all free at the point of use - Services for addressing major causes of morbidity and mortality (HIV, TB, Malaria, and Neglected Tropical Diseases) are all free at the point of use - Emergency services are provided free at the point of use - Voucher schemes are available for populations most at risk from catastrophic health expenditures
Improvements in socio-cultural access	- All (100%) required KEPH services are available for populations most at risk from cultural barriers – women, persons with disability, elderly, children, youth, marginalized groups, etc - All (100%) required KEPH services are available for populations most at risk from social barriers – health workers, commercial sex workers, etc - All (100%) of required KEPH services are available for populations in congregate settings – prisons, IDP camps, schools, refugee camps, army barracks

4.2 Improving demand for KEPH services

The sector recognizes the fact that having access on its own doesn't guarantee utilization of available services. Real demand for the services needs to exist, for the communities to benefit from the access to available services.

For many services, demand exists naturally – particularly for medical services, where communities / individuals are aware of the challenge to their health and so seek our services they have access to. However, for many services – particularly public health services for which benefits are spread over a large population, not only the person seeking care – the demand for services needs to be built actively. For example, communities would not go utilize immunization services if adequate demand for them is not built – as they are not addressing immediate, and individual health challenges.

The sector aims to improve demand for KEPH services through services and interventions which aim at

- **Improving the awareness**of individuals, households and communities of the health problems they are facing and available services to solve these problems;

- **Improving health seeking behaviours,** so that individuals, households and communities undertake action to protect their own health and make the best use of available health promotive, preventive and curative health services.

Specific priority output targets to improve demand for services are shown in the table below.

Table 19: Priority targets to improvements in demand for KEPH services

Dimension of demand creation	Priority targets
Improving awareness	- All (100%) households are made aware of the range of KEPH services they are entitled to receiving - All (100%) facilities have service charters detailing KEPH services they are providing, which are publicly displayed in the different service units / departments
Improving health seeking behaviors	- All individuals are visiting health services at least twice, each year for any service (2 contacts per person per year) - Incidences of severe illnesses resulting from delays in seeking care are reducing in the clients seen at health facilities

4.3 Improving quality of care for KEPH services

The 2010 Constitution of Kenya clearly spells out the right to the highest attainable standards of health to every Kenyan which therefore calls for an implementation of an effective health improvement and service delivery system. The Vision 2030 similarly calls for the need to improve the overall livelihoods of Kenyans, through provision of efficient and high quality health care systems with the best standards.

The sector views improving quality of KEPH services in three dimensions:

- **Better client experiences**: a focus on the clients' perception of service provision to ensure that the services will be aligned to clients' perception of good health care. The sector needs to focus on assuring 'soft inputs' are maximized, so as to improve client experiences when receiving care. Privacy during interventions, good staff attitudes, a clean facility, all go a long way improving the quality of care clients receive.

- **Assuring patient safety:** a focus on doing no harm / having no negative consequences to clients as a result of seeking care. Care-associated harm (nosocomial infections, injection abscesses, etc.) significantly reduce client outcomes, and so should be minimized.

- **Ensuring effectiveness of care:** the interventions / services provided need to be the most effective feasible, for the best possible client outcomes. An ineffective medicine or procedure affects the quality of care, and confidence the clients have in the services.

The development of the Kenya Quality Model for Health (KQMH) and its subsequent adoption in May 2012 by the Ministry of Health was done to realize this constitutional right. KQMH was designed to guide and facilitate movement towards better quality of services through regular assessment of quality of service delivery (availability, functionality and use of inputs), and quality of care in facilities.

The sector will seek to improve quality of KEPH services through:

- The development of a Kenya Quality Policy that will act as a guide to Quality Management implementation and coordination in the Health Sector

- **The establishment of a National Accreditation Mechanism** for the Health Sector through a recognized legal body to accredit health provider institutions that comply with standards for safe

and reliable care and to certify health care professionals and ensure they maximize their training and skills through lifelong learning

- **Institutionalization of Continuous Quality Improvement** in health facilities as enshrined in the Kenya Quality Model for Health (KQMH) by mainstreaming Quality Improvement as integral part of service delivery in the Health Sector
- Ensuring here is a process of **regular review and dissemination of standards of** care and clinical practice guidelines for the health sector

Specific priority output targets to improve quality of care are shown in the tablebelow.

Table 20: Priority targets for improvements in quality of care for KEPH services

Dimension of quality of care	Priority targets
Improving client experiences	- All (100%) Counties are annually monitoring client satisfaction with services provided - All (100%) Counties are annually monitoring length of stay in facilities to ensure this is reducing
Assuring client / patient safety	- All (100%) of hospitals have infection prevention strategies and committee's in place - All (100%) of deaths in facilities are audited according to set criteria / guidelines
Ensuring effectiveness of care	- All (100%) of Counties are regularly monitoring care outcomes - Success rates for interventions are consistently improving

4.1KHSSP output indicators

The monitoring of progress towards KHSSP outputs shall be done using the indicators in the table below.

Table 21: KHSSP Output targets

Policy Objective	Indicator	Targeted trend's		
		Baseline (2012)	**Mid Term (2015)**	**Target (2017)**
Improving access to services	Per capita Outpatient utilization rate	2	3	4
	% of population living within 5km of a facility	80	90	90
	% of facilities providing BEOC	65	80	90
	% of facilities providing CEOC			
	Bed Occupancy Rate	85	95	95
	% of facilities providing Immunisation	80	100	100
Improving quality of care	TB Cure rate	83	88	90
	% of fevers tested positive for malaria	45		20
	% maternal audits/deaths audits	10	70	85
	Malaria inpatient case fatality	15	8	5
	Average length of stay (ALOS)	5.6	4.5	4
	% facilities with publicly displayed service charters	10		90
	Per capita OPD utilization rate	2	3	4

5 HEALTH INVESTMENTS

This section outlines the investments required to deliver on the Health Services outlined in the previous chapter. Investment areas relate to the different policy orientations in the Kenya Health Policy, which will lead to the attainment of the defined health services. Health Investments are defined as those investments that are primarily made to support attainment of Health Goals.

The Principles to guide prioritization within each of the seven investment areas are:

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

Figure 12: Attributes of health investments

The investment targets are shown in the table below.

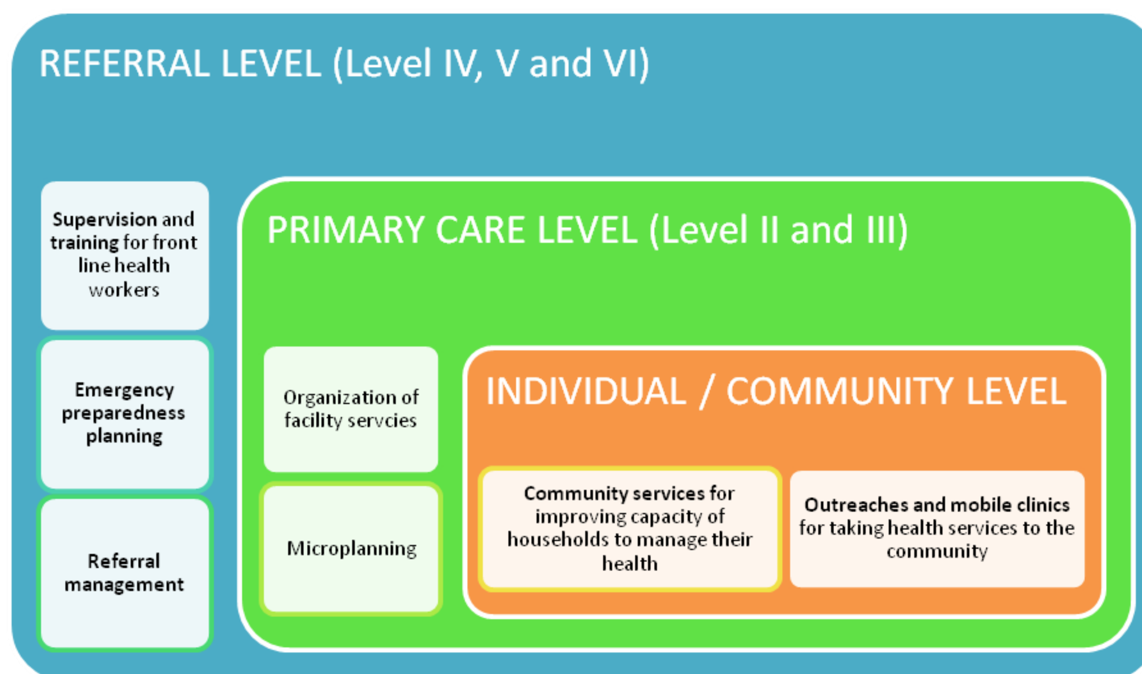
Table 22: Investment targets during the KHSSP period

Policy Objective	Indicator	Targeted trend's		
		Baseline (2012)	Mid Term (2015)	Target (2017)
Service delivery systems	% of functional community units	20	30	45
	% outbreaks investigated within 48 hours	90	100	100
	% of hospitals offering emergency trauma services	35	65	80
	% hospitals offering Caesarean services	45	85	95
	% of referred clients reaching referral unit		70	85
Health Workforce	# of Medical health workers per 10,000 population	5	7	7
	% staff who have undergone CPD	40	65	70
	Staff attrition rate	10	5	2
	% Public Health Expenditures (Govt and donor) spent on Human Resources	55	45	40
Health Infrastructure	# of facilities per 10,000 population	1.5	2.5	2.5
	% of facilities equipped as per norms	25	60	70
	# of hospital beds per 10,000 population	50	150	150
	% Public Health Expenditures (Govt and donor) spent on Infrastructure	30	25	25
Health Products	% of time out of stock for Essential Medicines and Medical Supplies (EMMS) – days per month	8	2	2
	% Public Health Expenditures (Govt and donor) spent on Health Products	10	15	15
Health Financing	General Government expenditure on health as % of the total government Expenditure	4.5	8	12
	Total Health expenditure as a percentage of GDP	1.5	2	2.5
	Off budget resources for health as % of total public sector resources	60	25	5
	% of health expenditure reaching the end users	65	80	80
	% of Total Health Expenditure from out of pocket	33	25	15
Health Leadership	% of health facilities inspected annually	15	80	85
	% of health facilities with functional committees	70	100	100
	% of Counties with functional County Health Management Teams	0	100	100
	% of Health sector Steering Committee meetings held at National level	50	100	100
	% of Health sector steering committees meeting held at county level	0	100	100
	% of facilities supervised	40	100	100
	Number of counties with functional anti-corruption committees	0	47	47
	% of facilities with functional anti-corruption committees	0	80	100
	% of policies/document using evidence as per guidelines	30	100	100
	% of planning units submitting complete plans	65	95	95
	# of Health research publications shared with decision makers	3	20	20
	% of planning units with Performance Contracts	70	100	100
	% of County planning units with Performance Contracts			
Health Information	# of sector quarterly reports produced and disseminated.	50	100	100
	% of planning units submitting timely, complete and accurate information	25	70	85
	% of facilities with submitting timely, complete and accurate information	25	70	85
	% Public Health Expenditures (Govt and donor) spent on Health Information	3	5	5

5.1 Investment area 1: Organization of Service Delivery

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

Figure 13: Organization of Service Delivery elements and priorities



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

Table 23: Strategies against each Service Area

Service Area	Description	Scope and focus
Community services	How communities are able to engage in improving their health	Comprehensive community strategy to build demand for services through improving community awareness and health seeking behaviours
		Program targeted community services to improve supply of services by taking services to the community
Referral Services	How services are planned, and delivered across different types of facilities. The focus is on ensuring holistic delivery of services.	Physical client Movement (physical referral)
		Patient Parameters movement (e-health)
		Specimen movement (reverse cold chain, and reference laboratory system)
		Expertise movement (reverse referral)
Outreach services	How services (preventive and curative) are supplied to communities, as per their needs.	Outreaches by facilities to under-served communities
		Mobile clinics in hard to reach areas
Supervision	How health workers are mentored and supported to continually improve their skills and expertise in providing quality services	Integrated supervision
		Emergency supervision
		Technical supervision
Organization of services within facilities	How the facility organizes itself internally, to provide and manage care delivery.	Micro-planning for service delivery to reach under-served communities
		Epidemic preparedness & planning
		Management of service delivery
		Developing long term facility master plans for long term development

The sector requires establishment of an effective organization of service delivery to deliver the KEPH services and interventions. The Kenya Health Policy defines the expected organization structure for health

services delivery, across four tiers of care (Community, Primary Care, County Services, and National Services).

Community units are non facility based, with their functions extensively described in the community strategy. On average, for every 5,000 population a community unit needs to be established. This translates to over 8,800 community units nationally.

Primary care service units are either health centres, or dispensaries (mobile clinics in areas where population density is very low, and/or mobile). The health sector aspires to upgrade all dispensaries into fully primary care units (model health centres) in the long run, ensuring every facility is able to at least carry out a normal delivery. However, this aspiration will not be achieved in the period of the current KHSSP, for which these norms and standards are developed. Therefore, this has necessitated inclusion of dispensary norms.

- A dispensary should exist for every 10,000 persons on average. This should allow for an average of 30 dispensary OPD visits per day for any services, if everyone in the catchment area is to visit a health facility at least once a year for any form of services (curative, preventive, or health promotion activities), as suggested in the Kenya Health Policy. Such dispensary units are physical facilities, but in areas where populations are mobile and sparse – such as in Arid or Semi Arid lands, mobile facilities would replace dispensaries as much as is rationally possible.
- Looking at health centres, an average population of 30,000 per health centre allows for at least 4 deliveries per day – a workload that is fair on the system and staff. These estimates translate to a targeted 4,404 dispensaries, and 1,468 health centres nationally.

Hospitals on the other hand focus on management of referral care, and are of three types: primary, secondary, or tertiary referral units. the scope and complexity of services increase from primary to tertiary referral units.

- For primary referral facilities, a population of 100,000 is targeted for each primary level hospital, allowing for at least one complicated delivery per day – a workload fair on the system and staff. This would call for approximately 440 County level primary hospitals across the Country. These currently are of various capacities (from sub district hospitals, through to high volume facilities), and would require at least ensuring capacity to carry out emergency surgery is functional in all.
- The secondary referral facilities are required to serve a population of approximately 1 million persons – usually crossing a number of Counties. These facilities shall be managed jointly by the national and affected County governments, and will provide a higher level of specialized services, and provide clinical supervision and support to the primary referral facilities.
- The tertiary referral facilities finally would focus on highly specialized services, and serve a cross County population of approximately 5,000,000 persons.

In addition to service units, there are stand alone management units at the national, and County levels. Management units below the County differ – with two recommendations on how Counties can arrange these:

(a) By having a stand-alone sub County health team that is either at the constituency, or former districts level made up of teams that focus only on management of service delivery, or
(b) By having sub county management carried out by the hospital management teams

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

Table 24: Priority processes to invest in Organization of Service Delivery

Area	Priorities	Milestones	Base line	Mid Term	Target

Area	Priorities	Milestones	Base line	Mid Term	Target
Referral Services	- Establishment of comprehensive **referral services**	Updated referral tools and guidelines		1	
		Number of County Health Management teams oriented on referral roles and functioning	0	47	47
		Number of Counties establishing comprehensive referral system	0	6	20
Outreach Services	- Conducting of **outreaches** in areas of responsibility for facilities - Establishment of **mobile clinics** in all hard to reach areas	Updated tools and guidelines for conducting outreaches	1		
		Number of Counties with monthly Outreaches from at least 80% of their facilities	0	25	47
		Number of Counties in hard to reach areas regularly conducting monthly mobile clinics	2	5	8
Community Services	- Roll out of the comprehensive **community strategy**	Number of Community units established and functional	439	1,000	3,000
Supervision	- Carry out **integrated supportive supervision** using updated Kenya Quality Model for Health	Number of Counties carrying out quarterly supportive supervision using KQMH	0	47	47
Organization of services within facilities	- Support development of **emergency preparedness plans** at County and facility levels - Support **facility micro planning** to cover communities in area of responsibility with defined services - Update **clinical management** guidelines - Facilitate **facility therapeutic committee** functioning - Establish County **Electronic Health Records** systems allowing information exchange within and across facilities	Number of Counties with updated Standard Clinical guidelines and EML available in all facilities	47	47	47
		Number of Counties with at least 80% of hospitals having emergency preparedness plans	0	47	47
		Number of Counties where ALL hospitals have functional therapeutic committee's	0	6	30
		Number of Counties with at least 80% of facilities having micro-plans	0	20	47
		Counties with at least 80% of facilities linked with Electronic Health Records System	0	6	20

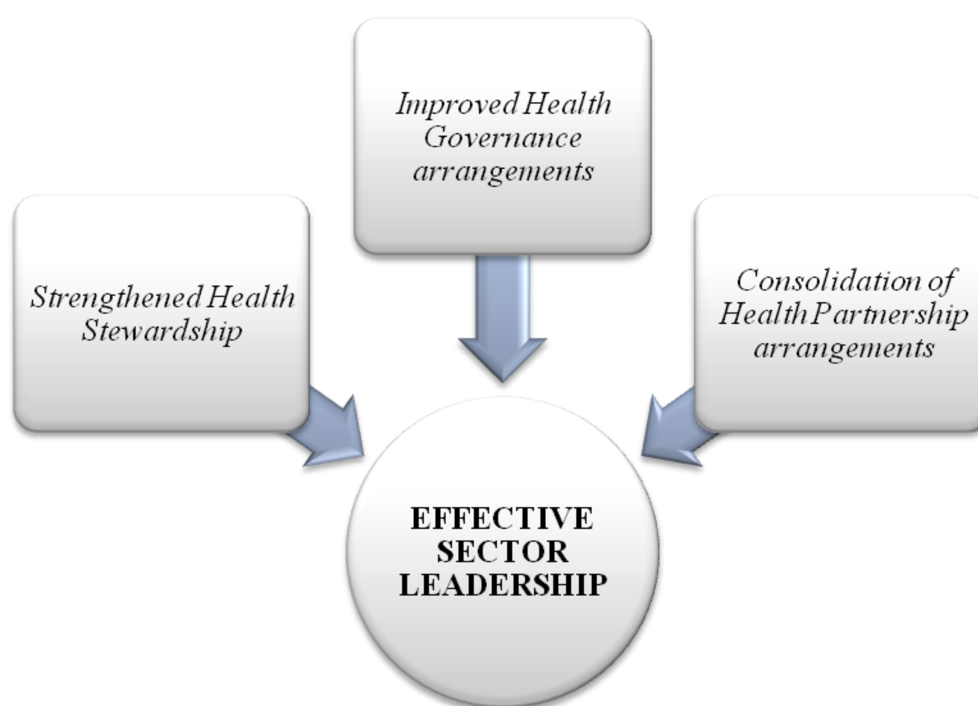
The establishment of comprehensive referral services is the health sector flagship program in this investment area.

5.2 Investment area 2: Health Leadership

Health Sector Leadership addresses three key objectives:

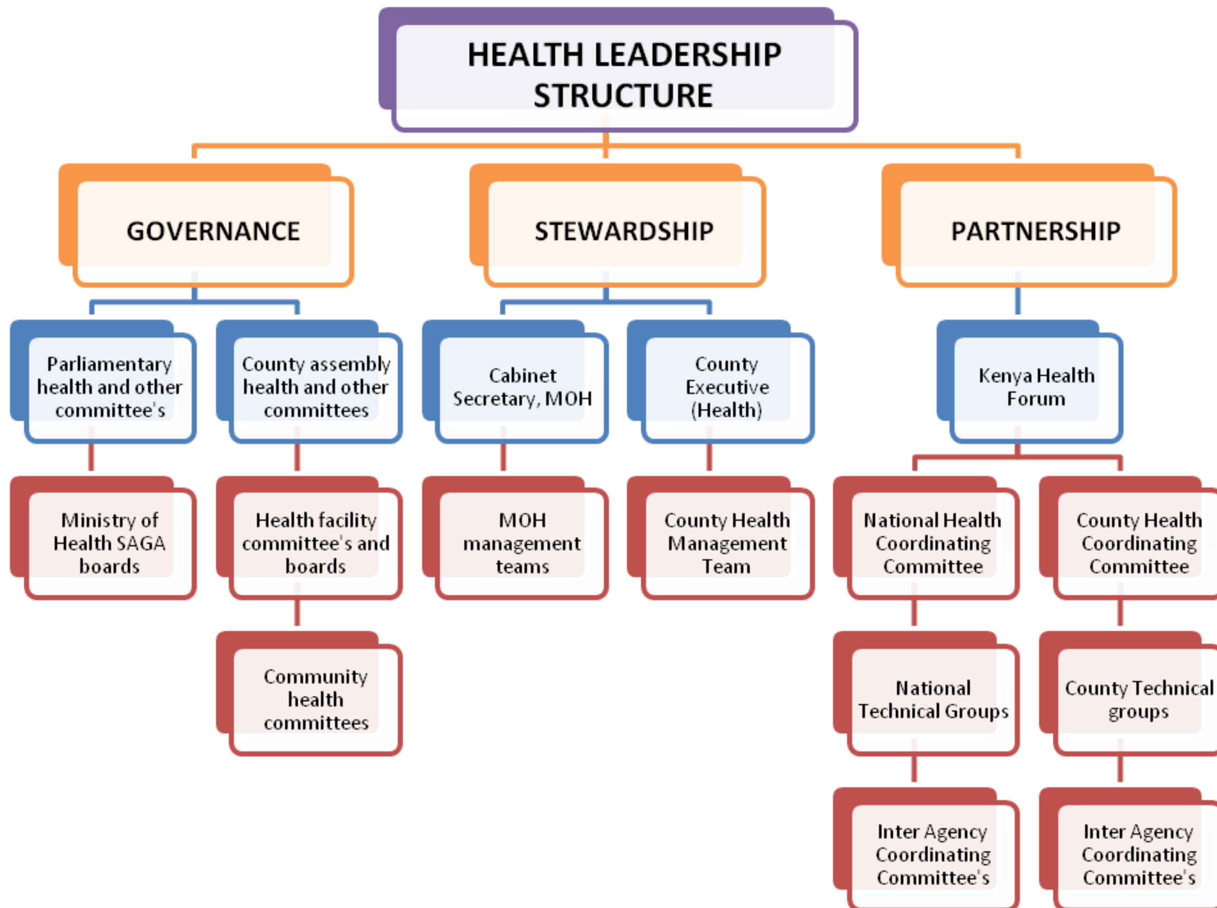
- Improved **the stewardship** of the national health agenda by the government. Stewardship relates to the management function of the Government, through the Ministry of Health and is built around implementation of the mandate of the Ministry responsible for health.
- Implementation of appropriate systems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

Figure 14: Effective Health Sector Leadership requirements



The overall leadership framework for implementing the health agenda at National and County levels is shown below.

Figure 15: Health Sector Leadership framework



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

The governance functions shall be coordinated through the National, and County Governments, with their functions as defined in the Constitution. Governance and management structures that define ownership, selection and technical responsibility through boards/committees and the management team, respectively, are defined, strengthened and made functional (as part of devolution, in line with the constitutional 2010).

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

- The operationalization of a two level management system corresponding with national and county governments to deliver on the Constitutional functions of each of government as described in Chapter 7 of this Strategic Plan.
- The establishment and operationalisation of THE sector governance, stewardship and partnership structures, in line with devolution

- Development, implementation and monitoring of Health Facility Leadership Norms and Standards for each type of facility; This is related to the development of a Kenya Quality Health Policy, the institutionalisation of continuous quality improvement and the establishment of a National Accreditation Mechanism.
- A sustained focus at the MoH on its core functions through the development of a Ministerial Strategic Plan, annual work plans and regular performance assessment and follow-up action;
- Development and maintenance of an M&E framework that that will provide management at both levels of government with those data that are required for sector-wide monitoring of policy implementation and planning and will include (1) data from health facilities, SAGAs and training institutions from both the public and private sectors (example: HRH planning requires regular analyses of the health labour market; this cannot be done without comprehensive routine data from all training institutions –public and private- and registration data of health professionals by their councils); (2) resource tracking; (3) actionable budget analyses;
- Progressive development of appropriate health financing mechanisms, as envisaged under UHC (section 5.3).
- Development of a Private Health Sector/PPP Policy and Strategic Plan.
- Review of the hospital management structure at government hospitals;
- Development and harmonisation of relevant policies, legislation and norms &standards
- Strengthening of social accountability approaches in health facilities
- Establish a health ombudsman

Table 25: Priority Health Leadership actions

Priority areas for investment	Measure of success	Baseline	Mid Term	Target
Leadership				
Develop, disseminate, implement and monitor *Leadership Norms and Standards for Health Facilities*	*Leadership Norms and Standards* available to health facilities for implementation		1	
	Leadership Norms and Standards appropriately monitored by CGs and MOH		48	
Stewardship				
Advocate with National Treasury for a review of the GoK budget structure in order to facilitate evidence-based decision-making	Result-based national budget structure		1	
Develop and institutionalize 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.	Resource-tracking system available to MoH, CGs and sector partners		1	
	Annual shadow budget timely available for budgeting process		1	1
Review GoK hospital management structure	% of GoK hospitals with management structure in line with new guidelines			
Build capacity at national and county level for evidence-based planning and budgeting, including for budget analysis and tracking studies	To be done			
Develop sector wide annual work plans at county and national level *based on available resources* and guided by strategic plans and PFMA	Number of governments with annual work plans meeting agreed standards	0	47	47
Develop and monitor performance contracts at national and county level, informed by annual work plans	Number of governments with *all* required performance contracts	0	47	47

Priority areas for investment	Measure of success	Baseline	Mid Term	Target
Develop Annual County, National and Sector Health Sector Performance Reports	Number of annual performance reports developed	0	49	49
Orient CDoHs on stewardship for health	Number of counties with at least 80% of CHMT members oriented on strategic leadership	0	10	47
Governance				
Update the health legal framework	New general health law gazetted	0	1	1
Develop specific health laws	Health Professionals Act gazetted			
	Health Financing Act gazetted			
	Health Information Act gazetted			
Strengthen youth, gender and disability mainstreaming in policies, regulations, norms and standards, planning and M&E	*% of County Health Strategic Plans with a gender analysis as part of the situation analysis*			
Strengthen complaints handling mechanisms: locally and at county and national levels	*National Health Ombudsman operational*		*?*	*?*
	No of monthly activity reports of the Ministerial Complaints Handling Committee submitted to the CS		*12*	?
	No of counties with a designated member of staff responsible for complaint handling		?	?
Build capacity in social accountability approaches at CDoHs and public and FBO facilities	Number of CDoHs familiarised with Guidelines for CDoHs on Social Accountability		47	47
	Number of counties where GoK and FBO facility staff have been trained using MoH training materials			
	Number of counties in which at least 80% of facilities have updated service charters informed by KEPH on display	0	10	47
	Number of counties with at least 80% of community units conducting dialogue days at least 4 times in past year	0	10	30
Conduct annual client satisfaction and responsiveness survey	*Number of client* satisfaction survey reports	1	2	4
Partnership and Coalition Building				
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	New Code of Conduct adopted		1	1
	Annual Report on adherence to new Code of Conduct available and discussed among signatories		2	4
	Number of counties with functional stakeholders fora	6	20	47
	Number of annual HSCC meetings		4	4
	% of functional ICCs at national level		100%	100%
	Joint Annual Sector Planning and Review meetings		2	4
	Joint TA plan developed		1	1
Undertake private sector assessments to deepen understanding of the role of the private sector in the health industry				
Establish a coordination forum to enhance policy dialogue between the public and private sector	% of expected annual meetings held	0	100%	100%
Develop and operationalize a PPP Policy and Strategy	Policy and Strategy approved and disseminated	0	2	2
Undertake capacity building of policy makers and private sector players to improve institutional capacity to engage in effective public-private collaborations				

5.3 Investment area 3: Human Resources for Health

The health workforce is defined as the stock of all people engaged in actions whose primary intent is to enhance health.The Human Resources for Health investment area relates to availability of appropriate and equitably distributed health workers, attraction and retention of required health workers, improving of institutional and health worker performance, and training capacity building and development of the Health Workforce

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

The staffing needs and norms, by population, and staff category are shown in the table below.

Table 26: Staffing needs and norms by population, type of facility and staff category

STAFF CATEGORY	Sub categories	Total staff needs	Norms/ 10,000 persons	
			By staff category	*By sub categories*
Dental staff	Community Oral Health Officers	**1,604**	1.1	0.4
	Dental assistant	**1,924**		0.4
	Dental general practitioner	**962**		0.2
	Dental specialist	**359**		0.1
Laboratory staff	Laboratory assistant	**11,137**	4.1	2.5
	Laboratory technician	**5,569**		1.3
	Laboratory technologist	**1,471**		0.3
Medical practitioners	Nutritionist	**2,335**	7.2	0.5
	Clinical Officer	**16,278**		3.7
	Medical Officer	**13,141**		3.0
Midwives	Enrolled Midwife	**0**	3.0	-
	Registered Midwife	**13,308**		3.0
Non surgical specialists	Emergency / trauma specialist	**572**	0.6	0.1
	Physician / internal medicine	**1,544**		0.4
	Psychiatrists	**461**		0.1
Surgical specialists	ENT	**452**	1.1	0.1
	General surgeon	**947**		0.2
	Obstetrics / Gynaecology	**585**		0.1
	Ophthalmologist	**552**		0.1
	Orthopedician	**495**		0.1
	Pediatrician	**506**		0.1
	Orthopedic technician	**831**		0.2
	Orthopedic technologist	**416**		0.1
	Plaster technician	**0**		-
Nurses	Nurse assistant	**0**	8.7	-
	Enrolled nurse	**23,574**		5.4
	Registered nurse	**11,335**		2.6
	BSN nurse	**467**		0.1
	specialised nurse	**2,939**		0.7
Pharmacy staff	Dispenser	**0**	0.9	-
	Pharmacy technologist	**3,106**		0.7
	Pharmacist	**724**		0.2
Radiology staff	Radiology assistant	**1,505**	0.6	0.3
	X-ray technician	**0**		-
	Radiographer	**753**		0.2
	Radiologist	**576**		0.1

STAFF CATEGORY	Sub categories	Total staff needs	Norms/ 10,000 persons	
			By staff category	*By sub categories*
Environmental health staff	Public Health Officers	**4,229**	1.6	1.0
	Public Health Technicians	**2,662**		0.6
Community staff	Trained Community Health Worker	**120,886**	28.3	27.5
	Social Health Worker	**3,528**		0.8
Rehabilitation specialists	Occupational Therapists	**704**	0.6	0.2
	Physiotherapists	**1,768**		0.4
Management staff	Health Records and Information Officer	**4,071**	1.2	0.9
	Health Records and Information Technician	**0**		-
	Medical engineering technologist	**413**		0.1
	Medical engineering technician	**825**		0.2
Administrative staff	Drivers	**7,252**	12.6	1.6
	Clerks	**8,661**		2.0
	Cleaners	**11,890**		2.7
	Security	**9,718**		2.2
	Accountants	**3,846**		0.9
	Administrators	**4,330**		1.0
	Cooks	**6,503**		1.5
	Secretaries	**3,362**		0.8
General support staff	Casuals	**2,593**	2.5	0.6
	Mortuary attendants	**749**		0.2
	Patient attendants	**7,858**		1.8

Source: HRH and infrastructure norms and standards, 2013 - 2018

On the other hand, the available staff cadres in the Country are shown in the table below.

Table 27: Available staff cadres, by sex

Sno	Cadres	Total numbers	Cadres per 10,000 population	% male	% female
1	Medical officers	2239	0.54	69.9%	30.1%
2	RCO	4723	1.13	64.7%	35.3%
3	BSC Nursing	772	0.19	34.7%	65.3%
4	KRCHN	14214	3.41	27.9%	72.1%
5	KECHN	9201	2.21	25.9%	74.1%
6	Occupational Therapist	310	0.07	70.0%	30.0%
7	Dentist	186	0.04	62.4%	37.6%
8	Dental Technologist	180	0.04	60.0%	40.0%
9	Pharmacists	552	0.13	60.3%	39.7%
10	Pharmaceutical Technologist	1144	0.27	53.3%	46.7%
11	Physiotherapist	477	0.11	66.9%	33.1%
12	Orthopaedic technologist	144	0.03	67.4%	32.6%
13	Medical Social worker	291	0.07	34.0%	66.0%
14	Plaster technicians	206	0.05	41.3%	58.7%
15	Laboratory Technologists	2909	0.70	58.7%	41.3%
16	Laboratory Technician	1515	0.36	47.2%	52.8%
17	Health Record & Information Officers	497	0.12	53.7%	46.3%
18	Health Record & Information Technicians	347	0.08	42.7%	57.3%
19	Nutritionists	496	0.12	27.4%	72.6%
20	Public health officer	1232	0.30	70.8%	29.2%
21	Public health technician	737	0.18	73.1%	26.9%
22	Health Administrative Officer	413	0.10	68.3%	31.7%
23	Medical Engineering	417	0.10	82.5%	17.5%
24	ICT Officer	207	0.05	57.5%	42.5%
25	Procurement Officer	239	0.06	57.7%	42.3%
26	Accountant	583	0.14	63.1%	36.9%
27	Drivers	845	0.20	94.2%	5.8%
28	Clerk/cashier	2492	0.60	36.8%	63.2%
29	Cooks	452	0.11	37.2%	62.8%
30	Store Man	131	0.03	61.1%	38.9%
31	Support Staff (Casuals)	9682	2.32	44.2%	55.8%
32	Trained CHW	395	0.09	42.8%	57.2%
33	Radiographer	347	0.08	75.5%	24.5%
34	Community Oral H/ Officer	150	0.04	48.0%	52.0%

Sno	Cadres	Total numbers	Cadres per 10,000 population	% male	% female
35	Biochemist	10	0.00	40.0%	60.0%
36	Economist	6	0.00	100.0%	0.0%
37	Social Worker	28	0.01	32.1%	67.9%
38	Other	8306	1.99	49.7%	50.3%
	Grand Total	**67075**	16.08	44.3%	55.7%

Source: Service Availability and Readiness Assessment Mapping, 2013

The recent SARAM assessment highlighted up to 15.45% of all staff were not present at their duty stations, with the major reason for absence being training.

Table 28: Staff availability in facilities, and reasons for absence

Variable		Numbers of staff
Total staff		67,075
Total numbers of staff available		56,037
Total numbers of staff absent from duty stations		10,361 (15.45%)
Numbers of staff absent, by specific reasons	*On maternity / sick leave*	*408*
	In training	*7,092*
	On official mission	*262*
	Approved absences	*16*
	Gone to retrieve salary	*5*
	Not approved absence	*128*
	Not on shift	*206*
	Other reasons	*2,244*

During this plan period, the sector will aim towards creating an optimal size of health workforce with the right and balanced skills, equitably distributed, productive and delivering quality health services for the realization of the targeted health outcomes. Specific measures will include;

1. ***Support development of an adequate, appropriate and equitably distributed health workforce through;***
   - Strengthen HRH planning function at national and county levels covering the entire health sector
   - Encourage and support various institutions to adhere to the established norms and standards for HRH in delivery of KEPH
   - Create an environment that will encourage rational and equitable deployment and redeployment of the health workers across national, inter and intra county systems
2. ***Improving management of the existing health workforce by putting in place attraction, retention and motivational mechanism***
   - Making working conditions more attractive and safe
   - Making rural and hard to reach areas more attractive
   - Improving staff wellness and welfare

3. ***Improve institutional frameworks that support workforce performance development and management***
   - Putting in place systems to measure performance and competence of health workforce.
   - Strengthen human resource development systems and practice including continuous professional development
   - Strengthen communication, ethics and values in HRH

The design and implementation of the national and county HRH programmes and interventions will be guided by the Kenya Health Policy 2014-30, a revised and evidence-based Human Resource and Infrastructure Norms and Standards and the Health Workforce Forecast Kenya report. In addition, county governments will be expected to prioritize health in their county-wide development agenda so as to contribute towards achievement of the MDGs and the Vision 203 health targets.

Going forwards, therefore, the sector will prioritize towards establishing the minimum staffing standards required nationally and across counties during this strategic plan. Specific targets are outlined in the HRH strategic plan, with the following as priorities;

Table 29: Priority HRH investments for 2014-2017

Priority areas for intervention	Measure of success	Baseline	Mid Term	Target
Adequate, appropriate and equitably distributed health workers				
1. Develop and implement HRH policy including training 2. Review develop and implement evidence based health workforce norms and standards. 3. Definition of County specific HRH priorities as part of County health strategies 4. Development of County-specific HRH staffing targets 5. Re-engineer HRH development and management in line with HRH norms 6. Develop and institutionalize a HRH unified database system	Number of Counties with HRH priorities and targets	0	47	47
	Number of Counties with at least 80% of staff cadres as per their needs and norms	0	15	30
Attraction and retention of HW				
1. Develop and implement an incentive policy for attraction and retention of health workers including for hard to reach areas 2. Establish resource centres and recreation facilities 3. Reward system as a HW motivation strategy 4. Documentation and sharing of County experiences with attraction and retention of HW	Counties applying OBA	1	30	30
	Reports on County experiences with attraction and retention of HWs	0	2	5
	Number of Counties with under 2% of HW attrition rate per year	0	10	30
Institutional capacity and HW performance				
1. Develop, review and harmonize schemes of service for all staff cadres including new and emerging cadres 2. Regularly monitor, and institute corrective measures for improving HW productivity	% of HW cadres with schemes of service	30%	100%	100%
	Report on HW productivity	1	3	5
Training capacity building and development of HW				
1. Update the Pre-Service curricula to align these to the HW needs 2. Develop health systems and services leadership and management capacity at all Counties 3. Develop and implement a training and continuous professional development policy 4. Finalize and implement the NHTP	Updated curriculum for training institutions	0	1	1
	Number of County Management teams oriented on Health systems and services management	0	47	47
	National Health Training Plan for in service HW	0	1	

5.4 Investment area 4: Health Infrastructure

Infrastructure in this strategic plan covers all investments relating to physical infrastructure, medical equipment, communication and ICT, and transport.

Different facilities have different levels of infrastructures. In addition, the Country has an overall gap in lower level facilities required to deliver the KEPH (see below).

Table 30: Kenya requirements by type of facilities

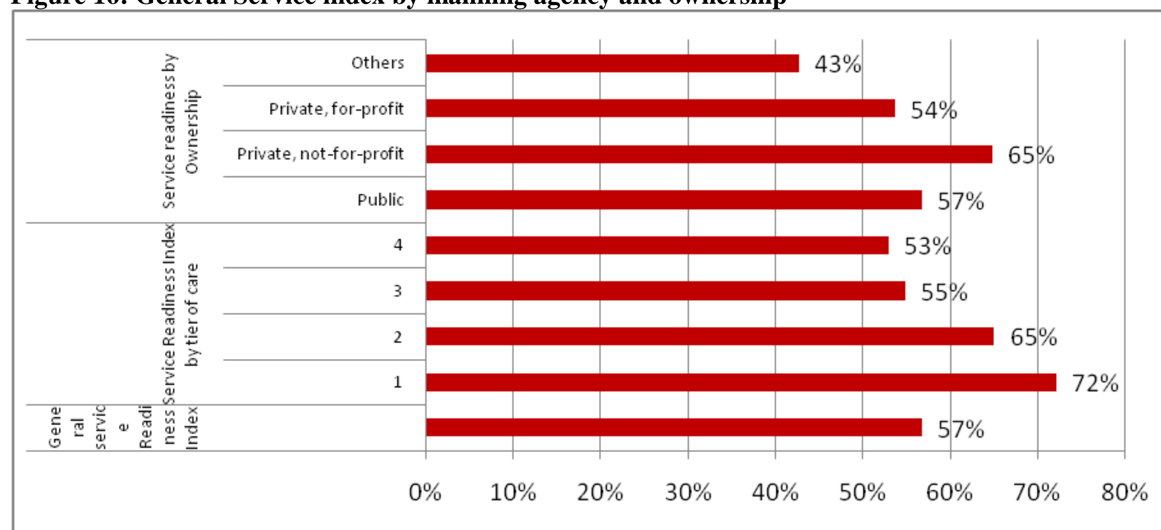
	Hospitals			Primary Care Units		Community Units
	Tertiary (level VI) referral hospital	*Secondary (level V) referral hospital*	*Primary (level IV) hospital*	*Health Centre (level III) services*	*Dispensary (level II) services*	
Catchment populations	5,000,000	1,000,000	100,000	30,000	10,000	5,000
Numbers required	**9**	**44**	**440**	**1,468**	**4,404**	**8,808**
Existing facilities	**9**	**44**	**554**	**1,064**	**3,676**	**439**

Of the existing facilities, 49.8% are public facilities, 16.6% are private not for profit, 31.7% are private for profit (particularly clinics), and 1.9% are classified as other.

These infrastructure requirements vary significantly by County, and by facility type. Therefore, while there are an adequate number of hospitals overall, there are some gaps in some Counties in hospitals. The priorities, therefore, for investment need to be determined by County.

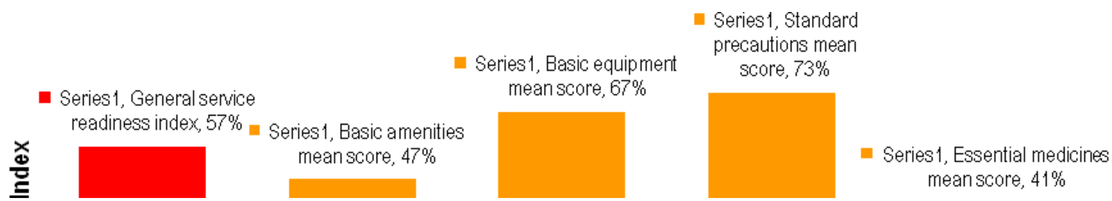
In addition, the readiness for provision of services (the overall capacity of the health facilities to provide the health services) is shown in the figure below.

Figure 16: General Service index by manning agency and ownership



KEY: 1 – Hospital; 2 – Health Centres; 3 – Dispensaries; 4 – Medical Clinics,Stand-Alone HTC/VCT &Others

Figure 17: General service readiness index and domain scores (N=7995)



Source: Service Availability and Readiness Assessment Mapping, 2013

Generally, the service readiness index was 57% - implying 57% of all health facilities are ready to provide KEPH services. Of these, 47% have the basic amenities to provide services; 67% have the basic equipment required, 41% have essential medicines and 73% have the standard precautions. Hospitals had the highest service index of 72% followed by the nursing and maternity homes with 71% and health centres with 65%. On the other hand, the Private not-for-profit facilities have the highest general readiness index (65%) compared with the public (57%) and Private for-profit (54%). There was no significant difference between urban and rural health facilities.

During the period of the KHSSP, the sector efforts shall be geared towards assuring the availability, and readiness of the minimum health infrastructure. Once this is assured, additional funds would be used to provide additional health infrastructure to attain optimum norms that facilities and Counties will have elaborated.

There is need to invest in:

- The development of policies, legislation, norms and standards and guidelines. This will be guided by the gaps identified and include the development and implementation of an adequate PPP framework in support of capital investment in health infrastructure;
- Better compliance with policies, regulations and norms and standards related to the appropriateness of health infrastructure. This requires strengthening the capacities of the relevant regulatory authorities in both pre-market controls and post-market surveillance, and health sector staff at national, county and facility levels in health infrastructure management, including planning, costing and budgeting, the development of facility-specific master plans[7], procurement/contract management, maintenance and disposal. This will require the elaboration of management structures, processes and procedures related to all mentioned management components and appropriate for individual hospitals and CDoHs, including the development and implementation of an information system allowing management teams to have accurate and up-to-date information on the status of health infrastructure at health facilities. Emphasis will be on building capacity in calculating recurrent cost implications of capital investments for health infrastructure such as maintenance costs, consumable operating costs, administrative costs and training costs, as well as the development of facility maintenance plans.

[7]Facility master plans are comprehensive plans showing how a specific facility will transform itself from the current situation to conformity with agreed norms and standards (health infrastructure, HRH, service delivery, leadership)

- Giving due consideration for the complementarity of the private sector in service provision, for alternative/innovative financing mechanisms (e.g. leasing of equipment) and for the need for concurrent investments in HPT, HRH and leadership in order to ensure that capital investment planning and budget allocations in the public sector are efficient, sustainable and achieve conformity of facilities with the standards of each level of service provision.
- Increased budget allocations for capital investment in health infrastructure.

Capital investment priorities:
- Upgrading existing facilities to health infrastructure standards
- Funds allowing, close the gap between currently available facilities and the number of facilities required according to the national, population-based norms, and apply this approach to all counties. Available information (table xx above) points to a major gap in the number of health centres and potentially also primary care hospitals. Indeed, whilst the number of primary care hospitals may appear to suffice (554 vs 440 required by 2017), many of these 'hospitals' do not meet the infrastructure norms and standards and demand rehabilitation and/or extension works to ensure conformity with primary care hospital level. As Government aims to phase out dispensaries, there is no need to close the gap for dispensaries.
- Funds not allowing to close all gaps, Government will prioritise the rehabilitation and upgrading of 100 existing facilities to the norms of primary care hospitals (level IV) (MTP II Flagship Project) and one level V hospital per county, as well as the provision of the necessary logistical support for an effective and efficient referral system (another MTP II Flagship Project).

Table 31: Health infrastructure priority investments

Priority areas for investment	indicator	Baseline	Mid Term	End term
Policy development and regulation				
Formulate, obtain approval, disseminate and monitor and evaluate (in year 5) a comprehensive Health Infrastructure Policy and Strategic Plan	Policy developed, approved and disseminated	0	1	
	Strategic plan developed, approved and disseminated		1	
	Policy and strategic plan evaluated			1
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 at these facilities				
Develop, obtain approval, disseminate, monitor and evaluate a regulatory framework for adequate post-market surveillance of non-medical equipment (ICT equipment? Transportation?) aiming at ensuring effectiveness, quality and safety of equipment	Legislation developed, approved and disseminated		1	
	Regulatory framework assessed			1
Norms and standards				
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	Norms on physical infrastructure, plant and non-medical equipment finalised, published and disseminated		1	
Develop, publish and disseminate norms and standards on IT and transportation				
Define county-specific health infrastructure gaps in requirements for all norms (e.g. service units, quantity of				

Priority areas for investment	indicator	Baseline	Mid Term	End term
equipment and transportation)				
Advocate for the employment of one medical engineer per county	% of counties with at least one medical engineer		20	47
Review the staff establishment for medical engineering (engineers, technologists and technicians) for level III to V) and employ staff accordingly.	*% of level III facilities employing medical engineering technologists (or similar indicator)*			
Stewardship/ Management of health infrastructure				
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 HPT coordination exists	0	1	1
Establish a health infrastructure coordination function at each county health office	County HPT coordination exists	0	47	47
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)				
Develop and implement costed county-specific health infrastructure plans with recurrent cost calculations	Number of counties with costed health infrastructure plan, including recurrent cost calculations	0	15	47
	Number of counties with transportation in line with norms	--	15	30
	Number of counties with at least 80% of their facilities having functional ICT equipment as per norms	?	15	30
Develop and implement an ICT master-plan in national referral facilities as part of the NR MTP Flagship Projects	Number of national referral facilities with ICT master plans	?	2	2
Develop, institutionalise and implement facility-specific maintenance plans and budgets, covering all health infrastructure components, time frame and modalities (including administrative structures)	Number of counties with a complete health facility maintenance plan for all GoK facilities		15	?
	Number of national facilities with a facility maintenance plan		2	2
	Number of counties with at least 80% of hospitals having ICT maintenance teams (is this expected?)	--	15	47
	Number of counties with at least 80% of their transport fleet functional	--	10	30
Capital investment:				
Identify the facilities to be upgraded, identify health infrastructure needs (gap analysis), cost the required capital expenditure and 5-year recurrent cost implications for:				
Progressive transformation of level 2 to level 3 facilities, conform with level 3 infrastructure norms and standards	Number of GOK and FBO level 2 facilities transformed to level 3, meeting infrastructure norms and standards			
Upgrading of existing government level 3 facilities to conform the level 3 infrastructure norms and standards	Number of existing GOK and FBO level 3 facilities meeting level 3 infrastructure norms and standards.			
Upgrading of existing government level 4 facilities to conform the level 4 infrastructure norms and standards.	Number of GOK and FBO level 4 facilities meeting level 4 infrastructure norms and standards.			100?
Upgrading of existing government level 5 facilities to conform the level 5 infrastructure norms and standards	Number of GoK and FBO level 5 facilities, meeting level 5 infrastructure norms and			

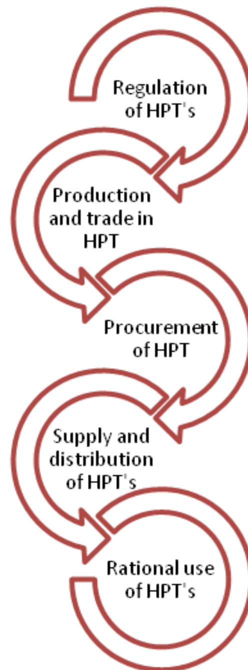
Priority areas for investment	indicator	Baseline	Mid Term	End term
	standards			
Progressive implementation of infrastructure norms and standards at the existing level 6 hospitals	Number of national referral facilities meeting level 6 infrastructure norms and standards			
Establish additional national referral facilities as per need	Number of additional national referral facilities established as per need			
Establish oxygen generating plants at facilities	Number of facilities with functioning plants			11
Procure ambulances as per the National Ambulance Policy				
Procure the vehicles and other investments required to operationalise the national referral system				

The construction / upgrading of 100 level IV hospitals, plus KNH and MTRH in line with the sector norms represent the sector flagship programs in the MTP II.

5.5 Investment area 5 Health Products and Technologies

Health Products and Technologies (HPT) encompass a wide range of items, and are a vital component of health care. The scope of areas in which investments need to be made in Health Products and Technologies include regulation, production & trade, procurement, supply and distribution, and utilisation.

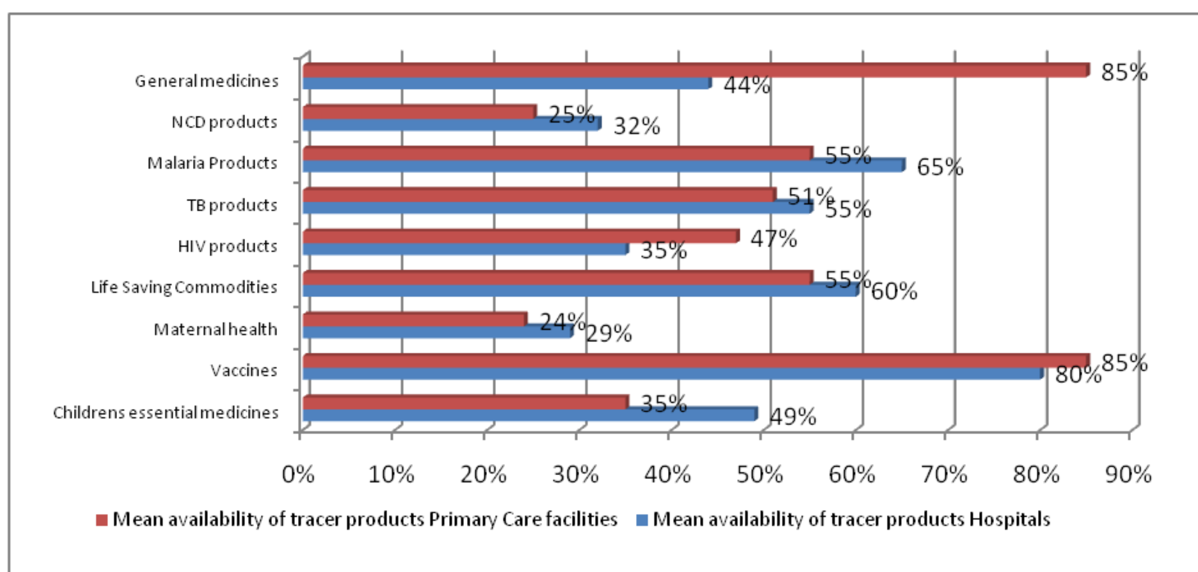
Figure 18: Scope of health products and technology intervention areas



For adequate contribution to health outcomes of better acces quality of care and demand for services, such health products and technologies need to be **available**, **affordable**, **safe**, **efficacious** and of **good quality** and **appropriately used.** The sector will adopt a comprehensive approach to investment in all aspects of HPTs, so as to maintain a reliable supply of these inputs (availability), as well as the requisite management systems for ensuring that they are affordable, effective, of good quality and appropriately utilized.

The mean availability of tracer health products for different program areas are shown below.

Figure 19: Mean availability of products for different program areas



Source: Service Availability and Readiness Assessment Mapping, 2013

At the primary care facility level, health products for general services, and vaccines are the most available (85% of facilities have these), while those for NCD, maternal health and children essential medicines are the least available (25%, 24% and 35% of facilities having these, respectively).

The picture is slightly different at the hospital level, with the most available products being vaccines, malaria commodities, life saving commodities and TB products (80%, 65%, 60% and 55% of facilities having these), while the least available at this level were again maternal health products, NCD products (29% and 32% respectively). The largest difference between hospitals and primary care facilities are in general medicines which are more available at the primary care level. The current levels of investments in Health Products & Technologies represent a major under-investment in the Health Sector. Frequent stock outs, inappropriate prescribing, dispensing and use; the risk of substandard and counterfeit products; and the high out-of-pocket expenditures on medical products all contribute to a major quality gap in service provision.

Besides the cost of procurement and supply of these EHPT, investments will be required to strengthen **three critical functions** of the health system concerned with EHPT access.

a) **Regulation of HPT:** ensuring that HPT meet established standards of quality, safety and efficacy/efficiency/performance. Investments will primarily focus on ongoing restructuring, reform and harmonization of the current fragmented, non-comprehensive and increasingly outdated regulatory system into a fully-fledged national HPT regulatory system managed by a single regulatory authority with the required institutional, managerial, technical, human and financial resources to enable comprehensive regulatory coverage of the full range of human and veterinary HPT, from pre-market controls and sales/supply monitoring to post-market surveillance[8]. More investment is required in post-market surveillance, inspection and quality control to continuously enforce compliance, to extend these activities to cover a broader range of key and vulnerable HPT, and to include such areas as training of users of medical devices/equipment, preventive and corrective maintenance

[8] The regulatory agency will also have responsibility for implementation of control provisions relating to *inter alia* food safety, therapeutic cosmetics, nutraceuticals, poisons, and any other Scheduled Substance (any substance having an impact on human or veterinary health – including mining, agricultural, horticultural and domestic chemicals)

b) **Assessment of HPT**: assessment of clinical effectiveness, cost-effectiveness and appropriateness in the context of the national healthcare system, including cultural and ethical considerations. Health Technology Assessment (HTA) provides evidence-based guidance (guidelines, protocols, lists, etc.) on appropriate HPT for specific levels of care and clinical settings. Investments will focus on strengthening the development processes for the EML, Clinical Guidelines and National Formulary, and establishing an HTA system for HPT with an initial focus on medicines and medical devices (i.e. medical supplies, equipment, diagnostics, etc.), including the definition of standards and specifications for medical devices.

c) **Management of HPTs**: including budgeting and planning for HPT; procurement & supply (at all levels of the system); appropriate prescribing, dispensing and professional administration/use of the products in accordance with established guidelines and protocols; commissioning, user training and corrective and preventive maintenance of medical devices; disposal of HPT; monitoring and educating consumers on appropriate use and storage. Investments will primarily target the ongoing reform of the supply system including the development and establishment of new devolved supply arrangements and agreements with the counties, building the management, technical and human resource capacity of the counties for effective management and appropriate utilisation of EHPTs, mechanisms to create linkages to the supply systems of non-state actors (FBO, NGO & private) through accreditation and effective monitoring; and in securing complete, reliable and comprehensive information on EHPT management and utilisation through the introduction, in public & FBO health facilities, of computerized information systems permitting live entry of information and authorised access to data for review, compilation, evaluation, policy development and intervention planning purposes.

Table 32: HPT Priority Areas for Investment

Activity Area	Investment Priorities	Indicator	Base-line	Mid-term	Target
A. Policy development and regulation of HPT					
Develop and operationalise a harmonised national HPT regulatory framework	Formulate, obtain approval, disseminate and monitor and evaluate (in year 5) a comprehensive HPT Policy with derived 5-year Strategic Plan and AWPs	Policy developed, approved and disseminated		1	
		Strategic Plan developed, approved and disseminated		1	
		Policy and strategic plan evaluated			1
	Develop new law to cover all HPT, from pre-market controls to post-market surveillance (including establishment of a single comprehensive, integrated, harmonised regulatory agency)	HPT law in place	0	1	1
	Restructure the present national regulatory institution (PPB) into a comprehensive national human & veterinary HPT regulatory authority (eg. Food & Drugs Authority) in line with regional & international best practices	Functional national HPT regulatory authority exists	0	1	1
	Expand the mandate and capacity of the NQCL to test EHPT	NQCL with expanded mandate	0	1	1
	Harmonize HPT regulations with EAC Countries	Harmonised regulations exist	0	0	1
	Maintain & strengthen national & county level pharmacovigilance (PCV) and HPT post-market surveillance (PMS)	Effective PCV/PMS at both levels	0	1	1
	Establish county mandate, roles & responsibilities in HPT regulation	Functioning county HPT regulatory system	0	0	1
B. Assessment of HPT					
Establish HTA	Institutionalize Heath Technology Assessment (HTA) to guide	Functioning HTA system	0	1	1

Activity Area	Investment Priorities	Indicator	Base-line	Mid-term	Target
(national HPT appraisal mechanism)*	evidence-based use of EHPT				
	Define specifications for all HPT	Specifications published	n/a	50%	100%
C. Management & Use of HPT					
1. Stewardship of HPT management	Establish an intergovernmental (IG) coordinating function to provide leadership and guidance in national and county HPT policy, investment and systems management	IG HPT coordination exists	0	1	1
	Establish a HPT coordination function at each county health office	County HPT coordination exists	0	47	47
2. Define & apply an evidence-based package of EHPT*	Restructure and operationalise National Medicines and Therapeutics Committee (NMTC) into statutory committee/s covering all HPTs	Restructured NMTC functioning	0	1	1
	Establish hospital & county Medicines and Therapeutic Committees (MTCs) with responsibilities covering all HPT	% hospitals & counties with functional MTCs	n/a	60%	100%
	Review and update Clinical Guidelines, Essential Medicines List; develop National Formulary	Updated documents exist	0	3	3
	Develop national essential lists and specifications for other HPTs (e.g. medical devices, radiological, dental, laboratory supplies)	Individual and consolidated lists exist	0	1	1
3. Rational investment in, and efficient management of EHPT	Facilitate implementation, monitoring, subsequent review & update of the Kenya National Pharmaceutical Policy (KNPP 2012)into a comprehensive HPT Policy	Annual KNPP/HPTP Implementation report	0	1	1
	Institutionalise national level (for national programmes) & county level medium term procurement planning (MTPP) for EHPT	Annually updated MTPPs	0	1	1
	Establish county systems for coordinating and managing EHPT investments	Counties with functional systems	0	30	47
	Enhance and integrate the M&E system for national and county level EHPT management comprehensively to capture key elements of access	Comprehensive M&E system linked to County & National HIS	0	1	1
	Institution of a preventive and corrective medical equipment maintenance and repair system	Functioning system in place	0	1	1
4. Establish effective and reliable EHPT procurement and supply management	Establish a devolved system of pooled EHPT procurement, storage and distribution for GoK facilities in counties	Devolved pooled system for County HPT supplies exists	0	1	1
	Strengthen GoK facility and county level HPT supplies management (including forecasting & quantification, and storage) for supply chain efficiency and reliability, and to maintain EHPT quality	a) Improved facility and county supply management indicators b) County procurement plans	- 0	- 47	- 47
	Institutionalize and strengthen the existing demand-driven (pull) system in the counties, extend this as appropriate to include national programme supplies and establish a supplies chain audit mechanism	Counties with all facilities effectively using a single standardized pull system	0	47	47
	Introduce facility-based IT systems to manage and monitor HPT supplies and link with county and national MoH HIS	% of GOK & FBO facilities with IT supplies management system	0	50%	100%
	Develop an effective system for EHPT supplies management during disasters and emergencies	Disasters & emergencies EHPT management system exists	0	1	1
5. Promote local EHPT production, research and innovation*	Identify, and mobilise resources for, priority HPT research	% of HPT research proposals funded	0	50%	100%
	Develop comprehensive strategies to facilitate research, innovation and local production of HPT for priority health conditions	Strategy on Public Health, Innovation & Intellectual Property (PHI)	0	1	1

Activity Area	Investment Priorities	Indicator	Base-line	Mid-term	Target
		Strategy on Local Production of EHPT	0	1	1
6. Ensure availability of and access to affordable, good quality EHPT*	Promote generic medicines use throughout the whole health system through legal and administrative interventions	% of medicines prescribed by generic name (by subsector)	n/a	75%	100%
	Identify and undertake joint initiatives fully to exploit TRIPS provisions and safeguards in order to secure access to EHPT	Report on TRIPS utilization	0	1	1
	Establish and regularly update an EHPT indicator price guide	Updated EHPT price guide exists	0	1	1
	Ensure mobilisation and allocation ofsufficient national and county resources for the provision of adequate supplies of EHPT	EHPT financing strategy exists (as a key part of a health financing strategy)	0	1	1
7. Introduce locally-derived natural health products (LDNHP)	Formulate regulations to permit registration of eligible LDNHP**	Regulations exist & applied	0	1	1
	Promote research into useful LDNHP, facilitate their subsequent development and incorporation into the health system	LDNHP registered & used	0	0	1
8. Promote appropriate use of HPT and related M&E	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	Annual county and national HPT utilisation indicators	-	-	-
	Systematic training of users of medical equipment devices at time of commissioning/ installation and thereafter as required	Number of users trained	-	-	-
	Institute systematic county and national monitoring of HPT utilisation	Annual county and national HPT utilisation reports	0	48	48
	Devise national and county policies, strategies and interventions effectively to address the issue of inappropriate use of antimicrobials and development of antimicrobial resistance	National & county initiatives being implemented	0	48	48
	Establish a pharmaceutical care[9] system in all facilities, starting with hospitals	Pharmaceutical care indicators	-	-	-

Notes:
** Part of MTP II Flagship Project 'Essential Health Products and Technologies'*
*** Corresponds to MTP II Flagship Project 'LDNHP'*

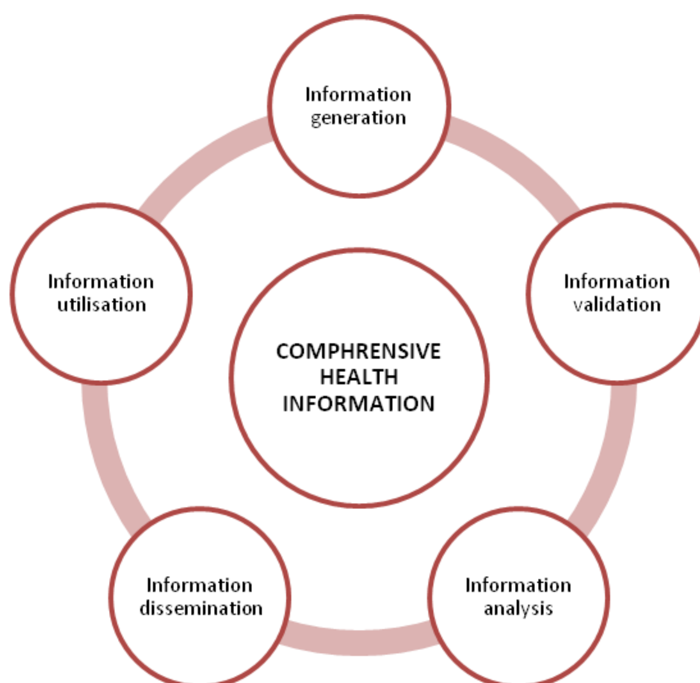
The support to local production of health products and technologies is an MTP II flagship program.

[9] Pharmaceutical care is 'the direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient's quality of life.

5.6 Investment area 6: Health Information

The Health Information System in Kenya covers five inter-linked key areas of information generation, validation, analysis, dissemination and utilization.

Figure 20: Health Information System



The information sources for the Health Sector are:

- **Routine health information:** Information on Health target and management activities occurring in health facilities, and is collected through the routine HMIS
- **Vital statistics information:** Information on vital events occurring in the communities that is collected routinely. These are information on births, deaths and Causes of Death in the community
- **Disease surveillance information:** the information fast track system for critical health events / notifiable conditions occurring in the community
- **Survey information:** Service delivery, or investment information on health and related activities occurring in the communities that is collected on a regular basis. These include the Demographic and Health Surveys, AIDS and Malaria Indicator Surveys, Service Provision Assessments, Availability and Readiness assessments
- **Research information:** Scientific biomedical, and systems researches coordinated through the Kenya Medical Research Institute, but carried out by many different academic institutions
- Given the above-mentioned status and issues in Health Information, a number of innovative approaches need to be put in place and implemented, to assure a comprehensive, effective Health Information System that is guiding decision making. The priority areas for investment, together with their measures of success and annual targets are shown in the table below.

Table 33: Health Information Systems investments

Priority areas for investment	Measure of success	ANNUAL TARGETS					
		12 /13	*13 /14*	*14 /15*	*15 /16*	*16 /17*	*17 /18*
Information generation and warehousing							
Ensure fully functional coordination framework for HIS	Regular HIS Working Group meetings	4	4	4	4	4	4
Develop updated Health Information System legal framework aligned to the Health Policy and general health law	HIS Law			1			
Establish virtual system interlinking different databases of Health Information Systems to ensure information all inter-connected, web-based if possible	Interlinked HIS databases		1				
Ensure national application of DHIS 2, generating complete timely and accurate information	Counties with accurate DHIS information produced in a timely and complete manner	0	20	40	47	47	47
Ensure supply of uniform registers to all facilities – public and non public – for information collation (paper based, or electronic)	% facilities provided with registers	30	70	90	100	10 0	100
Establish coordinated system for Electronic Medical Records management in facilities	% Hospitals with coordinated EMR system	5	15	45	70	10 0	100
Assure data storage capacity for national and County HIS (physical or virtual storage capacity)	Counties with adequate storage capacity	0	30	47	47	47	47
In collaboration with CRD, establish IT based system for collecting information on Vital Events	Counties using IT based system for Vital Events information collection	0	6	20	47	47	47
Strengthening capacity for IDSR and reporting	Counties with adequate IDSR management capacity	0	20	35	47	47	47
Carry out comprehensive Demographic and Health Survey	DHS report			1?	?		
Carry out Service Availability and Readiness Assessment (SARA)	SARA report	1					1
Carry out service provision assessment	KSPA report			1			
Set up, monitor implementation and evaluate results of health research agenda for the medium term	Country Health Research agenda	1					1
Information validation							
Carry out regular Data Quality Audits for DHIS information	Data Quality Audit	1		1		1	
Carry out regular data verification assessments on DHIS data	Reports on data verification included in AWP reports	1	1	1	1	1	1
Assure ethical approval process is adapted (including rapid approval where applicable) for all research carried out in Kenya, which includes clear methodologies	% research for which ethical approval got	40	70	10 0	100	10 0	100
Information analysis							
Establish Country Health Observatory for assuring comprehensive analysis of Health Information linked with other key research institutions eg. KEMRI, universities etc	Number of Health Observatory meetings	0	2	2	2	2	2
Carry out systematic reviews on priority health topics that have been identified by policy makers	Number of systematic reviews	0	4	10	10	15	15
Information dissemination							
Conduct annual Health Information Dissemination forums – as part of Annual Health Summits/ stakeholders for a at national and county levels?	Annual HIS dissemination forum	0	1	1	1	1	1
Publish Annual County and National Health Statistical Abstracts	Health Statistics abstract	1	1	1	1	1	1
Annual publication on 'the state of Health in Kenya', based on analysis of Health Information by Health Observatory	The state of Health in Kenya report	1	1	1	1	1	1
Develop quarterly publications on national? Health Outcome trends	Quarterly Health trends newsletters	1	4	4	4	4	4
Information utilization							

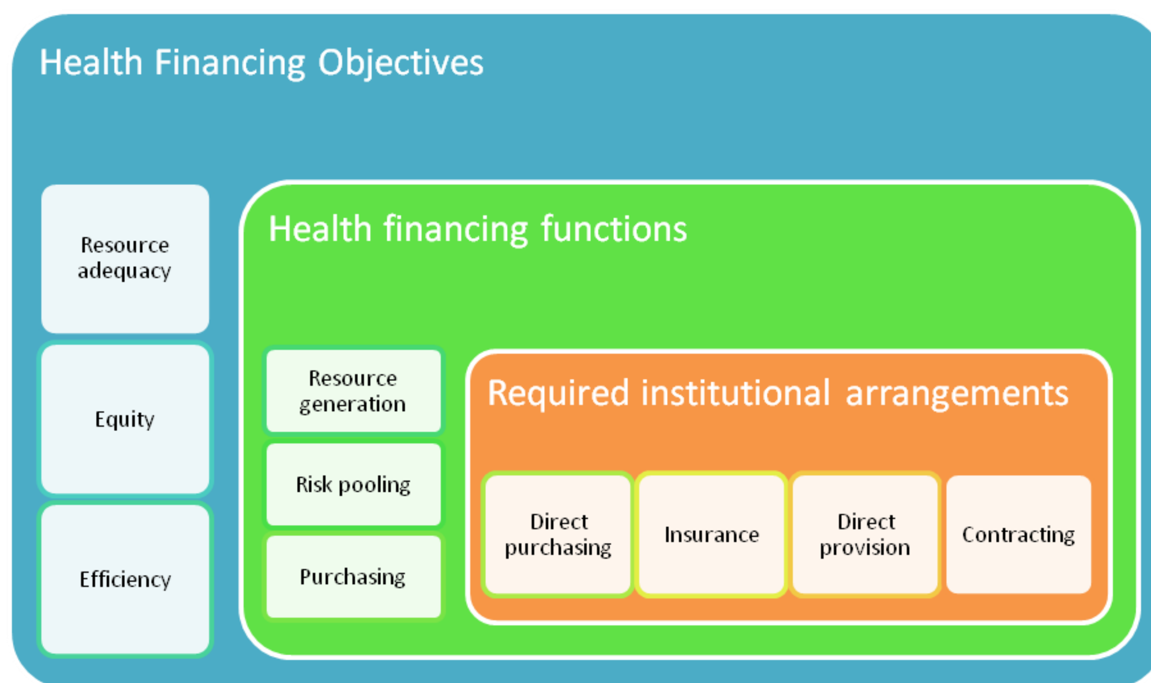
Priority areas for investment	Measure of success	ANNUAL TARGETS					
		12 /13	*13 /14*	*14 /15*	*15 /16*	*16 /17*	*17 /18*
Establish Policy Analysis team, to monitor use of evidence in policy making	Meetings of Policy Analysis team	0	2	4	4	4	4
Establish process to monitor data utilization by decision makers	Report of data utilization by decision makers	1	1	1	1	1	1
Put in place disaster response team to assure response to disasters and epidemics in a timely manner	% disasters responded to within 48 hours	80	100	100	100	100	100

Mainstreaming of research, and establishment of e-health hubs are MTP II flagship programs

5.7 Investment area 7: Health Financing

The health financing objectives in Kenya remain to assure resource adequacy for delivery of the KEPH, in an equitable and efficient manner. This it aims to attain, through focusing on systems of resource generation, risk pooling and purchasing of care. Various institutional mechanisms are required, to establish these required systems. The expected institutional arrangements relate to direct purchasing of care, insurance, direct provision of care, and contracting of care.

Figure 21: Dimensions and focus of health financing



During the planning period, financing of the health sector will be re-aligned to contribute to the overall strategic goal of moving towards Universal Health Coverage. To realise this, deliberate efforts will be made to generate additional resources by advocating for higher budgetary allocations by both the National and County governments, enhance mechanisms that ensure donor support is aligned to the sector goals and objectives, promoting financial risk pooling mechanisms and schemes for financing delivery of KEPH and encouraging adoption of payment mechanisms that provide incentives for better productivity and efficiency in service delivery, including an implementation framework that minimizes wastage in public health facilities and cost-containment across the sector.

In addition, the sector will consolidate and maximize on the benefits of the already existing health care subsidy programmes including Health Insurance Subsidy Programme (HISP) for the poor, free primary care services, free maternity services and Out-put Based Aid (OBA) programmes.

The specific strategies prioritized during the planning period are specified in the table below:

Table 34: Kenya Health Care financing priorities

Priority areas for investment	Measure of success	Baseline	Mid-term	Target
Resource mobilization				

1. Finalize and ensure the implementation of the Country Health Care Financing strategy and implementation road map for UHC	Adopted Kenya Health Care Financing Strategy 2012 - 2030	0	1	1
	Adopted road map for implementing UHC	0	1	1
2. Revise and develop annual MTEFs based on public and on-budget donor resources (National and County governments)	Allocation to health as % of combined national and county governments annual budgets	7.8% (2012/13)	9%*	10%*
3. Finalize framework for disbursing conditional grants from MOH to Counties and other sub-national entities	Adopted conditional grants framework	0	1	1
Financial Risk Pooling				
1. Institutionalize preparation of annual National Health Accounts (NHA)**	Annual NHAs	1	1	1
2. Develop framework, and support implementation of health financial risk pooling mechanisms	% of population ensured	20%	25%	40%
3. Phased implementation of Health Insurance Subsidy Programme (HISP) for the Poor	% of indigent population covered	0%	40%	50%
4. Implementation of Free Maternity services policy, including increasing coverage and benefit package	Number of mothers benefitting per year	200,000	900,000***	1 million
5. Develop and implement framework for pooling of resources for primary care services (HSSF, free primary care, County allocations for primary care etc.)	Number of OPD visits benefiting from a defined package of primary care services	34 mio	36 mio	43 mio
Provider payment mechanisms				
1. Scale up result based financing initiatives for health care	% health care budget paying for outputs (results) (national conditional grants to sun-national entities and County budgets)	<1%	10%	15%
2. Enhance fiduciary and social accountability systems	% of health expenditures questioned in annual audit reports	3%	2%	1%

**Only MOH*

***NHA is a standard term for an analytical report that describes the sources of funding for health in the country. In a devolved system, information from both the National and County governments will be required.*

**** including through the FBO subsector*

The provision of health care subsidies for indigent persons is a flagship program in the MTP II

6 RESOURCE REQUIREMENTS

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

In the first section, the available resources are tabulated and discussed. In the second section, cost estimates are tabulated, given different views on the health sector and its components. Finally, in the third section, the resource gaps for the plan period are provided by comparing resources required (cost estimates) with the resources available, focusing on the seven health sector investment areas. Overall, this information on costs, resources available, and the financing gap should assist stakeholders to develop realistic annual health budgets without which annual operational plans cannot be designed or implemented in a more effective way.

6.1 Resource requirements for KHSSP implementation

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

6.1.1 Costing methodology

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

6.1.2 Cost estimates for the KHSSP-III by SOs and Investment areas

The new Kenyan Health Policy informed by the new Constitution and the Country's development blue print, the Vision 2030, has the objective of ensuring **attainment of universal health coverage for all Kenyans.** Six policy objectives in the KHSSP-III were formulated to address the current situation, so as

to enable the overall policy objective. The One Health model was adjusted to provide cost estimates by these objectives. The table below therefore provides costs estimates by strategic objectives and the health system areas for the public sector.

Table 35: Total costs by strategic objectives and investment areas (KSh Millions)

	2012-13	2013-14	2014-15	2015-16	2016-17	Total
Specific cost estimates for Strategic Objective (SO)						
SO 1: Eliminate Communicable Conditions	92,668	95,344	101,200	106,408	114,298	**509,918**
SO 2: Halt and Reverse Rising Burden of NCD	6,757	9,737	12,830	16,034	19,350	64,708
SO 3: Reduce the Burden of Violence and Injuries	3,177	2,248	3,578	4,669	6,087	**19,759**
SO 4: Person-centered Essential Health Services	51,410	57,813	65,922	74,444	83,382	332,971
SO 5: Minimize Exposure to Health Risk Factors	326	391	458	530	604	**2,309**
SO 6: Strengthen Collaboration with Health Related Sectors	7,231	7,844	8,550	9,236	9,881	42,742
Cross cutting cost estimates for Health System Investment Areas						
Human resources	25,828	30,608	35,794	41,413	47,112	180,755
Health products and technologies	2,998	26,162	8,840	9,523	10,103	**57,626**
Infrastructure and Equipment	47,421	55,906	54,964	43,546	43,741	245,578
Health financing	1,890	335	335	335	335	**3,230**
Health information systems	2,231	2,382	1,971	1,971	1,971	10,526
Leadership & Governance	2,613.00	2,695.00	2,835.00	2,925.00	3,046.00	**14,114**
Total	**244,550**	**286,044**	**291,855**	**305,612**	**334,489**	**1,462,550**

Source: One Health Model

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

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

Table 36: Total costs by levels of care & cross-cutting investment areas (KSh Millions)

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	TOTAL
Levels 1 & 2	42,886	46,129	49,813	54,000	58,551	**251,378**
Level 3	42,303	49,320	57,651	65,713	75,842	**290,830**
Levels 4, 5, and 6	86,734	93,124	100,064	96,532	102,786	**479,239**
National programme	37,067	35,289	34,552	33,202	34,744	**174,854**
Health System Investment Areas (cross-cutting)						
Health products and technologies	2,998	26,162	8,840	9,523	10,103	**57,627**
Human resources	25,828	30,608	35,794	41,413	47,112	**180,756**
Health financing	1,890	335	335	335	335	**3,228**
Health information systems	2,231	2,382	1,971	1,971	1,971	**10,525**
Leadership & Governance	2,613	2,695	2,835	2,925	3,046	14,114
Total	**244,550**	**286,044**	**291,855**	**305,614**	**334,489**	**1,462,550**

Source: One Health model

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

Cost analysis of implementing KHSSP III by health programme areas of Maternal, Neonatal and Reproductive Health; Child Health; Kenya Expanded Programme on Immunization (KEPI); HIV/AIDS; Tuberculosis and Leprosy; Control of Malaria; Water, Sanitation and Hygiene (WASH), Non Communicable Disease (NCD), and the Basic and Emergency Health were also generated, in addition to the six health system investment areas.
The table below shows the cost of implementing the KHSSP-III by its disease programmes and the health system investment areas.

Table 37: Total costs of the KHSSP-III by disease programmes and health system investment areas (KSh Millions)

Disease Program Areas *(all costs of service delivery except human resources)*	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Total**
Maternal/newborn& reproductive health	12,571	14,005	15,531	17,015	18,428	**77,550**
Child health	6,746	7,237	7,720	8,238	8,651	**38,592**
Immunization	5,723	5,045	5,913	5,016	6,281	**27,978**
Malaria	33,561	34,355	37,047	40,374	44,524	**189,861**
TB	17,170	17,233	17,106	17,043	17,035	**85,588**
HIV/AIDS	54,049	57,616	62,651	68,028	73,817	**316,160**
Nutrition	4,217	4,386	4,607	4,849	5,070	**23,129**
WASH	13,002	13,100	13,158	13,521	13,548	**66,329**
Non-communicable diseases	6,770	9,750	12,843	16,048	19,363	**64,773**
Basic services, emergency, trauma care	7,761	10,650	15,962	21,190	26,885	**82,447**
Sub-Total, Disease Program Areas	***161,569***	***173,376***	***192,538***	***211,321***	***233,603***	***972,407***
Health Systems Investment Areas						
Human Resources	25,828	30,608	35,794	41,413	47,112	**180,756**
Infrastructure and Equipment	47,421	50,485	49,543	38,125	38,320	**223,894**
Health products and technologies	2,998	26,162	8,840	9,523	10,103	**57,627**
Health financing	1,890	335	335	335	335	**3,228**
Health information systems	2,231	2,382	1,971	1,971	1,971	**10,525**
Leadership & Governance	2,613	2,695	2,835	2,925	3,046	**14,114**
Sub-Total, Health Systems Areas	***80,368***	***109,973***	***96,482***	***91,366***	***97,840***	**476,029**
Total	**244,550**	**286,044**	**291,855**	**305,612**	**334,489**	**1,462,550**

Source: One Health model

6.2 Available resources

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

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

6.2.1 Available resources by year and source

Overall, a total of KES 1, 255 billion is available to support the KHSSPIII over the next five years. The major financiers are expected to be the Government and Households' contribution 45% and 31% respectively.

The tables below show the total available resources by year and source to support the implementation of the KHSSP-III over the short-term.

Table 38: Estimated and projected financial resources available by source (Kshs Millions)

Sources	Year 1	Year 2	Year 3	Year 4	Year 5	Total	%
GoK	104,465	108,891	111,318	116,670	122,271	**563,615**	45%
DP	45,446	44,315	44,302	43,673	43,043	**220,779**	18%
Household:	60,864	68,762	77,618	87,549	98,686	**393,479**	31%
OOP	*34,483*	*39,695*	*45,590*	*52,257*	*59,796*	**231,821**	
prepayments schemes	*26,381*	*29,067*	*32,028*	*35,292*	*38,890*	**161,658**	
Private Companies	12,748	14,067	15,386	16,705	18,208	**77,114**	6%
Total	**223,523**	**236,035**	**248,624**	**264,597**	**282,208**	**1,254,987**	**100%**

The table below shows the distribution of the available resources by sources and the investment areas during the plan period. The bulk of available resources will be consumed by Human Resources for Health accounting for 45 %. Approximately 63 % of the available Government funding will go towards Human Resources while 49% of available funding from donors will be expended on Service delivery.

Table 39: Projected financial resources by Sources and Investment Areas (Kshs Millions)

Investment Areas	GoK	DP	Households		Private Companies	Total	Percentage
			OOP	Prepayment schemes			
Adequate human resources for health	356,205	272	92,729	80,829	38,557	**568,592**	45%
Efficient service delivery system	80,033	108,416	106,638	48,498	23,134	**366,719**	29%
Adequate Health Infrastructure	59,180	7,960	0	0	0	**67,140**	5%
Access to essential health products	68,197	62,955	32,455	32,332	15,423	**211,362**	17%
Adequate Health information	0	4,972	0	0	0	**4,972**	0%
Adequate health financing	0	23,384	0	0	0	**23,384**	2%
Comprehensive Health leadership	0	12,820	0	0	0	**12,820**	1%
Total	**563,615**	**220,779**	**231,822**	**161,659**	**77,114.19**	**1,254,989**	**100%**

6.2.2 Available resources by year and investment area

The table below summarizes the available resources by year and investment area. The available resourcesfor the sector increases by 26% in 2016/17 over the 202/13 period with Human Resources having the biggest growth at 31% followed by service delivery at 28%.

Table 40: Available Resources by Investment Areas by year (Mn)

Investment area	Year 1	Year 2	Year 3	Year 4	Year 5	Total	% Change
Adequate human resources for health	99,436	106,319	112,350	120,690	129,796	**568,592**	31%
Efficient service delivery system	64,752	68,424	72,758	77,650	83,135	**366,719**	28%
Adequate Health Infrastructure	12,607	13,031	13,286	13,825	14,390	**67,140**	14%
Access to essential health products	38,253	39,996	41,968	44,286	46,860	**211,362**	23%
Adequate Health information,	1,023	998	998	984	969	**4,972**	-5%
Adequate health financing	4,813	4,694	4,692	4,626	4,559	**23,384**	-5%
Comprehensive Health leadership	2,639	2,573	2,572	2,536	2,499	**12,820**	-5%

Total	223,524	236,036	248,624	264,596	282,209	1,254,988	26%

6.3 Financial gap analysis

The table below summarizes the available resources and costs from the previous sections, to provide an estimate of the KHSSP funding gap by year.

Table 41: Financial gap analysis for the health sector (Kshs Millions)

	2012-13	2013-14	2014-15	2015-16	2016-17
Total Resources Available	223,524	236,036	248,624	264,596	282,209
Total Resource Requirements	244,550	286,044	291,855	305,612	334,489
Total Financial Gap	**-21,026**	**-50,008**	**-43,231**	**-41,016**	**-52,280**

The financing gap was estimated by generating the difference between the available resources from all sources and the cost of implementing the KHSSP-

The health sector financing strategy elaborates on the approach the health sector is taking to reduce this funding gaps.

7 IMPLEMENTATION FRAMEWORK FOR THE KHSSP

7.1 Health Sector and Devolution

The implementation of this plan takes into account that the country is now under a devolved system of governance. Institutional arrangements and processes previously responsible for implementing the strategic plan have been re-oriented to conform to a devolved health system. This section will therefore describe the organization of the newly merged Ministry of Health, County Departments of Health, partnership arrangements, planning and budgeting processes and communication strategies under the new constitutional dispensation. This KHSSP provides an over-arching guide for sector on priority programs and priorities through transition period.[10]

Specific functions have been assigned between national and county governments drawing from the fourth schedule of the Constitution of Kenya to facilitate progressive realization by all to the right to health. Policy, National referrals, norms and standards, capacity building and technical assistance to counties have been assigned to the national government while county governments have been assigned service deliv3ery functions. The Functional Assignment and Transfer Policy Paper (2012), further describes in greater detail the rationale for assigning each of these functions to the two levels of government and unbundles the functions for clarity to promote accountability. Table xx below shows the distribution of functions between the two levels of government.

7.1.1 National and County Government functions

The health sector has classified all functions according to the classification developed by the TA as shown in table

Table 42: Categories of functions and implications

Classification	Description	Implications
Exclusive functions	Exclusive to a level of government (according to Schedule 4)	The function should be transferred to the respective level of government
Concurrent functions	Functions assigned to both levels of government within the concurrent jurisdiction of each level of government (CoK, art. 186 (2)) Functions assigned to both levels of government through 'unbundling'	The function needs to be performed collaboratively by both levels of government
Residual functions	Functions not assigned by the Constitution or national legislation to a county (CoK, art. 186 (3)	The function is assigned to the national government

In the sector's understanding, the term 'concurrent' applies when both levels of government are responsible to deliver on one, common function. It does not apply to 'similar' functions that both levels of government have in common to deliver each on their own mandate. The latter functions are actually exclusive to both levels of government. For instance, both the NG (MoH and SAGA's) and the CDoHs need to manage their own institutions, and therefore have to carry out functions such as human resource management, financial management, planning, budgeting, monitoring and evaluation etc.

Exclusive functions

[10] Transition to devolved Government Act 2012

According to article 186 (1) of the CoK, Schedule 4 sets out the functions of the national and county governments. Schedule 4 assigns the functions shown in table 3 exclusively to either national or county governments.

Table 43: Exclusive Functions of National Government and County Governments

National Government	County Government
1. National referral health facilities (part 1, 23) 2. Health policy (part 1, 28) 3. Capacity building and technical assistance to the counties (part 1, 32)	**County health services including (**part 2, 2) 1. County health facilities and pharmacies; 2. Ambulance services; 3. Promotion of primary health care; 4. Licensing &control of undertakings that sell food to the public 5. Veterinary services (excluding regulation of the profession); * 6. Cemeteries, funeral parlours and crematoria; and 7. Refuse removal, refuse dumps and solid waste disposal

Concurrent functions

These are shown below.

Table 44: Concurrent Functions of National and County Government

National government	County government
Disaster management (CoK, schedule 4, part 1, 24)	Disaster management (CoK, schedule 4, part 2, 12)
'liaise with government at the other level for the purpose of enhancing capacity' (CoK, article 189, 1 (c);	'liaise with government at the other level for the purpose of enhancing capacity' (CoK, article 189, 1 (c);

Residual functions

The sector has identified the following functions as residual functions of the national level using the Constitutional definition

Table 45: Residual Functions of the National Government

Function	Institution	MoH functions included in Executive Order No 2 of 2013
Train mid- level health professionals	Kenya Medical Training College (KMTC)	Yes ('health education management')
Procure, warehouse and distribute health commodities in Kenya (primary procurement for public facilities)	Kenya Medical Supplies Authority (KEMSA)	yes
Provide quality social health insurance	National Hospital Insurance Fund (NHIF)	yes
Conduct multi-sector health research	Kenya Medical Research Institute (KEMRI)	yes
National coordination of the multi-sector response to HIV and AIDS	National Aids Control Council (NACC)	Yes
Hear and determine complaints and appeals arising out of the HIV & AIDS Prevention and Control Act.	HIV& AIDS Equity Tribunal	yes
Port Health Services	MoH	yes
Food Safety Policy	MoH	-
International health relations and diplomacy	MoH	-
Ensure implementation in Kenya of International Health Regulations	MoH	-

The assignment of functions under the new constitution provides the primary basis for the re-organisation of health management at the two levels of government.

At the national level, the Ministry of Health has been restructured based on the principles below

1. Alignment to the Constitution of Kenya 2010, Vision 2030, Presidential Executive order No2, and other GOK policy and strategic imperatives
2. Based on needs of its primary clients, the counties
3. Lean but optimal, with reasonable span of control and integration of functions
4. Promotion of clarity of roles, responsibilities and accountabilities

The county health departments have been provided with guidance on how to shape their health management structures in line with their constitutional functions. The guidance takes cognizance of the County Government Act, 2012 that acknowledges the County Executive Committee (CEC) member responsible for health as bearing the responsibility for overall coordination and management of County Health Services including monitoring planning processes, and formulation and adoption of policies and plans for county health services.

The constitution[11] empowers counties to determine the organization of the county and its various departments. The counties therefore have the freedom to modify the organizational structure proposals in a manner that best promotes efficiency in the delivery of services and utilization of resources. The organization of county health management shall further be informed by the constitutional[12] requirement to further decentralize its functions and the provision of services to the extent that it is efficient and practicable to do so.

It is possible that conflicts may arise in the execution of functions between the two levels of government. The Health Sector Intergovernmental Forum will play a critical role in resolving these conflicts and promoting collaboration between the two levels of government. Section xx will describe in greater detail the role of Intergovernmental relations in the KHSSP implementation framework

7.1.2 Stewardship Responsibilities at the different levels of the Health Sector

Stewardship for health cuts across both levels of government. The table below outlines the various responsibilities for each level of Government with regard to health stewardship:

Table 46: National and County stewardship Roles

National Government	County Government
- Formulating policy, developing strategic plans, setting priorities - Budgeting, allocating resources - Regulating, setting standards, formulating guidelines - Monitoring performance and adherence to the planning cycle - Mobilizing resources - Coordinating with all (internal and external) partners - Provision of Technical support to the county level - Capacity building of county level - National health referral services - Training health staff(both pre and in service), ensuring curricula and training institutions are in place	- Provide leadership and stewardship for overall health management in the County, - Provide Strategic and operational planning, Monitoring &Evaluation of health services in the county. - Provide a linkage with the national Ministry responsible for health. - Collaborate with State and Non state Stakeholders at the County and between counties in health services - Mobilize resources for County health services - Establish mechanisms for the referral function within and between the counties, and between the different levels of the health system in line with the sector referral strategy - Coordinating and collaborating through County Health Stakeholder Forums (CHMB, FBOs, NGOs, CSOs, development partners) - Supervise county health services Sub-county level - Delivering services in all health facilities (levels 1–3) - Developing and implementing facility health plans (FHPs) - Supervising and controlling the implementation of FHP (M&E)

[11] Section 46(1)b of the County Government Act of 2012. Section 148(5) of the Public Finance Management Act of 2012

[12] Article 176 (2) of the Constitution of Kenya

	- Coordinating and collaborating through County Health Stakeholder Forums (FBOs, NGOs, CSOs, development partners) - Training and developing capacity (on job training) - Maintaining quality control and adherence to guidelines

The Constitution 2010 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.

This consultative forum is expected to provide a platform for dialogue on health system 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 will:

- 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 harmonize development of health policies and laws
- Evaluate the performance of the national or county governments in realizing 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 utilization
- Promote governance and partnership principles across the health system
- Implement and follow up of actions and recommendations from the National and County Government Coordinating Summit
- Consider of issues on health that may be referred to the forum by member of the public and other stakeholders and recommend measures to be undertaken.

The consultation process between the national and county governments both levels will observe the principles of intergovernmental relations in line with Article 189 of the Constitution and Article 4 of the Intergovernmental Relations Act, 2012. This will include; recognition of the sovereignty of the people as provided for under article 1 of the Constitution; inclusive and participatory and respect for the function and constitutional integrity of the two levels of the government.

Technical working groups will be established for specific of common interest to both levels of Government. The working groups with representation from both levels of government will ensure that policy discussions are specific areas of concern are carried out consistently while reporting to the larger forum for decision making.

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

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

Some of the National values and principles and of governance[13] include:

(i) National unity, sharing and devolution of power, rule of law and participation of the people

(ii) Equity, inclusiveness, equality, human rights, non-discrimination, protection of the marginalized

(iii) Good governance, intergrity, transparence and accountability

(iv) Sustainable development

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

- The National Government shall operate through the National Ministry responsible for Health. National service provision functions shall be provided through semi-autonomous agencies, defined in this strategic plan, and include specialized clinical support functions (National Referral Services including laboratory; National Blood Transfusion Services, Medical procurement, warehousing and distribution), and regulatory functions, through professional councils and or boards.
- The County Government governance of the health agenda shall be exercised by the County Executive Committee, through its Department responsible for Health. The governments at the national and county levels are distinct and inter-dependent and shall conduct their mutual relations on the basis of consultation and cooperation. Both levels of government are distinct and inter-depended[14] and are required to work in collaboration, consultation and cooperation

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

a) Have fully functional governance structures at all the Counties. These include
    i) County Department responsible for Health
    ii) Hospital Boards
    iii) Primary Care Management Committee's
    iv) Community Health Committee's
b) Update sector guidelines for functioning of these structures, in line with the above-mentioned 6 governance dimensions
    i) Update the health sector legal framework, taking into consideration the current needs and aspirations as outlined in the National Health Policy and the 2010 constitution. The legal and regulatory framework shall bring together, in a comprehensive manner, all the health and health related legislation required to guide the implementation of the policy orientations, using the framework below.

---

[13] Article 10(2) Constitution 2010

[14] Article 6(2) Constitution 2010

ii) Implementation of social accountability initiatives with stakeholders, ensuring alignment to national guidelines and legal frameworks on access to information, public participation and responsiveness through proper feedback mechanisms.

7.2 Partnership and coordination framework

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

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

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

7.2.1 Definition and responsibilities of Sector actors

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

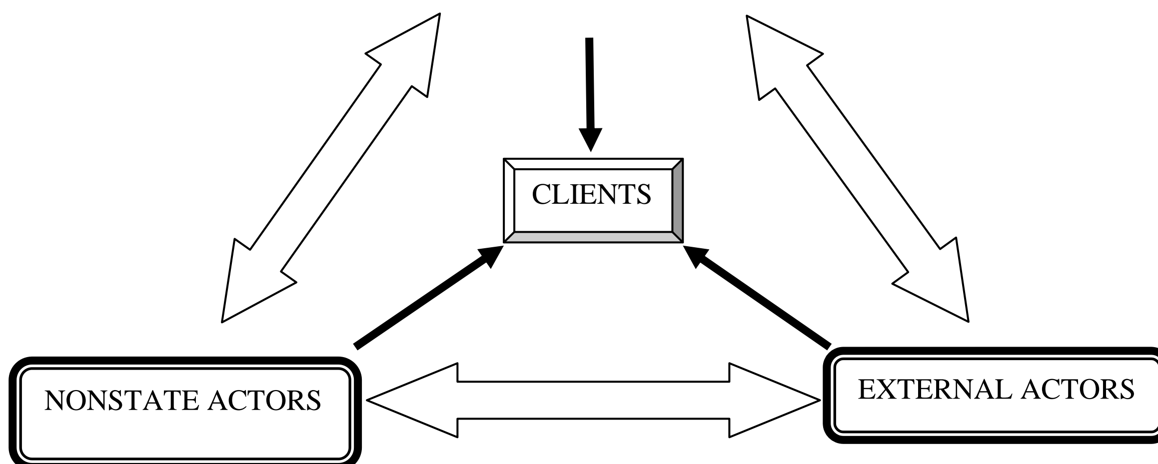
The various stakeholders in the health sector include:

Clients: The individuals, Households, and Communities whose health is the focus of this strategic plan.They are expected to exercise the appropriate healthy and health care seeking behavior required to maintain their health; seek health care intervention at the earliest possible moment; and take up health care services made available, to maintain their health, particularly disease prevention and control services. On the other hand, Households are expected to take responsibility for their own health and well being, and participate actively in the management of their local health services. The communities are expected to exhibit real ownership and commitment to maximizing their health. Communities should define their priorities, with the rest of the health system seen as supportive. They focus on ensuring individuals, households and communities carry out appropriate healthy behaviors, and recognize signs and symptoms of conditions that need to be managed at other levels of the system; facilitate community based referrals; and mobilize community resources to address their identified priorities.

- **State actors:** The public sector stewards (Ministry of Health and Counties, together with health related sectors), regulatory bodies Regulatory bodies (Boards and Councils) and professional bodies/associations whose mandate is drawn from that of the State, and have an effect on health
- **Non State actors:** The Private sector NGOs, CSOs, FBOs, Traditional Practitioners, media, and all other persons whose actions have an impact on health, but don't draw their mandate from the state
- **External actors:** The bilateral, multilateral, or philanthropic actors that draw their mandate from out of Kenya, but support national programmes

Health Sector Actors

STATE ACTORS



. These work with other state agencies, including

- Autonomous or Semi Autonomous service provision agents. These have some level of operational autonomy to deliver on defined health services. Legally,. Six agencies exist in the sector, as shown in the table below. The sector will, during this strategic plan, provide operational autonomy to all the National Referral facilities in line with the need to separate the National Government from service provision.

Table 47: The SAGAs and their key mandates

SAGA	Founded	Corporation status date	Key Mandate
KNH	1901	Legal notice no.109 (April 1987)	Provide specialized care, training and research
MTRH	1917	Legal notice no.78 (June 1998)	Provide specialized care, training and research
KMTC	1927	Legal notice no.14 (1994)	Train middle level health professionals
KEMRI	1979	Science and technology act no.79 (April 1979)	Conduct multi-sector health research
KEMSA	2001	Act of Parliament cap 446 (2000), Legal notice no.17	Procure, warehouse and distribute health commodities in Kenya
NHIF	1966	Act 9 (1998)	Provide quality social health insurance
NACC	1999	Legal notice 170 of 1999	Coordinate the multi-sectoral response to HIV and AIDS

Key: KNH = Kenyatta National Hospital; MTRH = Moi Teaching and Referral Hospital; KMTC = Kenya Medical Training College; KEMRI =Kenya Medical Research Institute; KEMSA = Kenya Medical Supply Agency; NHIF = National Hospital Insurance Fund; **NACC=National Aids Control Council**

Source: Strategic plans of the respective SAGAs

- Regulatory bodies (for example the Pharmacy and Poison Board and the Medical Practitioners and Dentists Board) are semi-independent institutions that operate under an Act of Parliament. These bodies perform important service related regulatory functions on behalf of the Department of Health:

the definition of professional standards; the establishment of codes of conduct; and the licensing of facilities, training institutions and professional workers. From their work, they often generate considerable revenues that finance their operations. However, the legal position of the various boards and councils does not allow them to undertake effective regulatory functions. Under KHSSP, the sector will strengthen the capacity of these regulatory bodies, aiming for outputs like harmonization of the legal framework of the regulatory bodies.

- Professional associations represent the interests of specific professional groups, including doctors, dentists, nurses, physiotherapists and others. They are independent and are mainly involved in welfare related activities for their members. According to a recent study, the performance and management of professional associations in general is weak. There is little coordination and sharing of information among them. Through a legal framework, the sector will work with these associations with the aim of strengthening their inputs to and support for the health sector.

- The Health related Government Actors are those that either are providing services that directly contribute to health outcomes (Water, housing, education, gender, etc) or whose activities influence actions of the health sector (finance, local government, parliament, constitution authorities and commissions, etc). The Health Stewards need to interact closely with these health related actors, to ensure their actions are all contributing to attainment of health goals.

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

- The Private Sector (for-Profit and Not-for-Profit). Much expertise and many resources are available from the private Sector at national and county levels. These could provide significant support to the health sector in expanding quality care to remote and underserved populations. Even within public service providers, the private sector would have a role in providing non-health services (e.g., laundry services, provision of food, laboratory services, etc.). The County stakeholder forums will be the platform where such collaboration should be promoted

- Traditional Practitioners provide complementary services based on locally available interventions.

External Actors constitute a rather heterogeneous group with a variety of objectives, interventions, technical and reporting requirements, and funding modalities. International initiatives, particularly the Aid Effectiveness for a (Rome 2003, Paris 2005, Accra 2008, Busan 2011) provide an important foundation for guiding actions by the external actors. This role has been structured around principles of aid effectiveness, which places emphasis on government ownership, alignment, harmonization, mutual accountability and managing for results on programmes in the health sector.

7.2.2 Description of the partnership framework

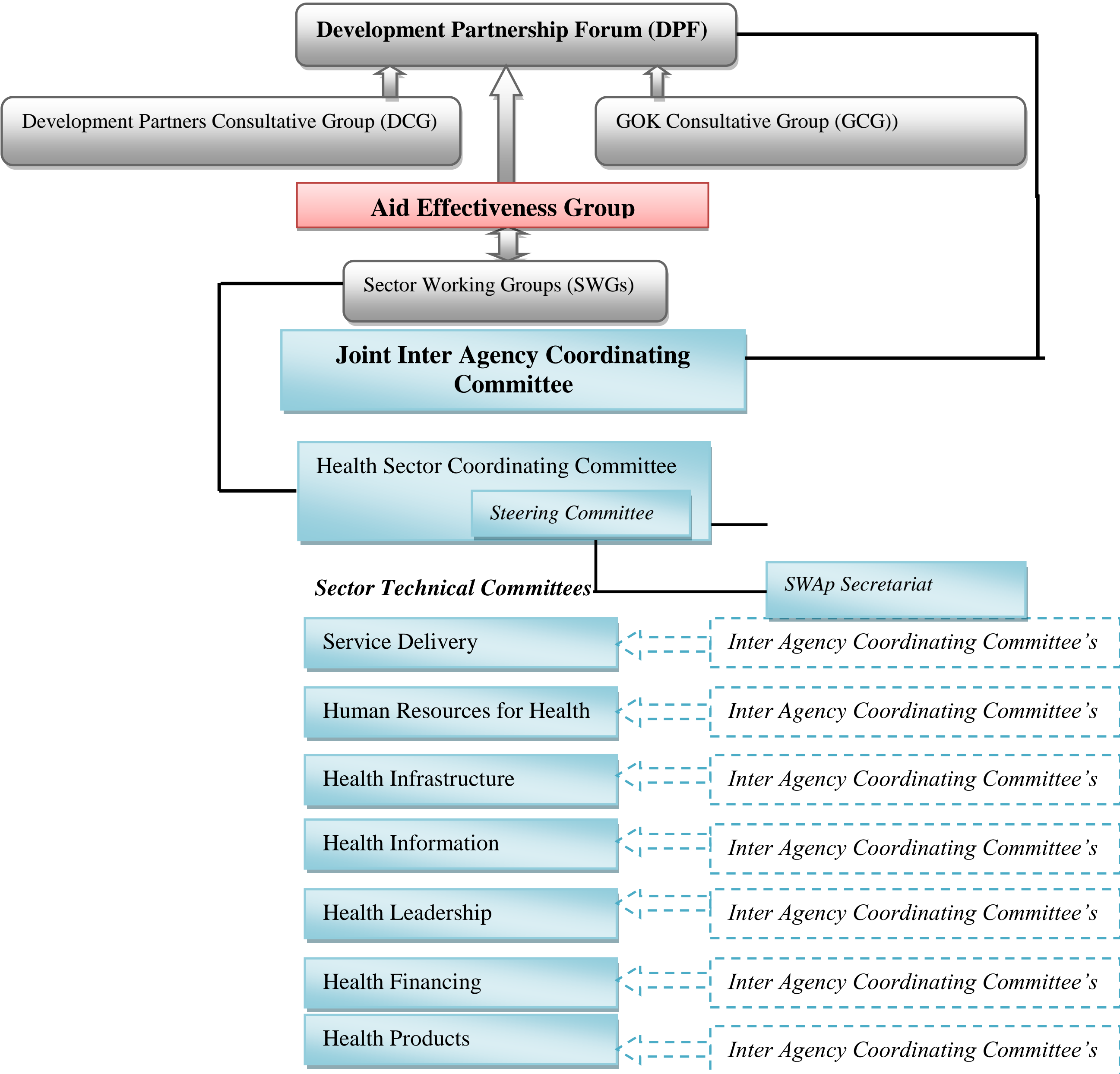
The partnership is guided by an overall instrument, the Code of Conduct, which defines roles and obligations of different sector actors towards attaining its overall goal and objectives. The NHSSP II Code of Conduct needs to be updated to reflect

- The Specific roles and obligations of the National, vs County Governments in implementing the obligations of the State
- Definition of the relationship between the County, and National Governments in executing the obligations of the state

- Clarity on the relationships and processes of engagement between
  - The State and the Non State actors (Objectives relating to Public Private Partnerships for Health – PPPH)
  - The State and the External Actors
  - The Non State actors and the external actors

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

Figure 22: Comprehensive National Level Coordination framework



7.2.3 National and County Government coordination Structures

1. Development Partnership Forum (DPF)

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

2. GOK Coordination Group (GCG)

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

3. Donor Coordination Group (DCG)

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

4. Aid Effectiveness Group (AEG)

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

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

4. Health Sector Intergovernmental Consultative Forum

Pursuant to Article 6(2) of the Constitution 2010, on devolution and access to services and Article 13(2) of Intergovernmental Relations Act, 2012, on intergovernmental sectoral working groups and committees, a consultative framework should be established to facilitate active engagement, consultation, cooperation and mutual accountability between the ministry of health and the county departments of health. This consultative mechanism is expected to provide a platform for dialogue on health system issues of County and National interest in particular. The major focus of the forum will include transfer and delegation of powers between the two levels of governments, shared services, policy gaps and the required statutory amendments, addressing the capacity building and technical assistance needs, consultations within the sector identification of sector specific issues requiring intervention by both levels of the government. The key deliverables of this entity will be among others development of options and agreements for service delivery as provided for in the Article 118 (1) of County Government Act, 2012, to ensure uninterrupted service delivery under devolved system of government.

5. Sector Working Groups (SWGs)

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

6: Health Sector Coordinating Committee (HSCC) Technical Working Groups

Both National and County levels will establish 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, reviews and reporting.
- Hold all sector partners jointly accountable for achieving results.
- Reduce the number of separate meetings with individual partners.
- Enable harmonization of inputs and better coordination of investments in the sector partnership for more effective use of all available resources - reduce duplication of efforts and critical gaps.
- Provide easy access to coordinated TA and support for priority actions.

The Technical Groups will be re-structured to follow the seven key Policy Orientations set out in the 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. These include:

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

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

7.3 Planning and budgeting process

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

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

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

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

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

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

7.4 Communication plan for KHSSP

In line with Art 35 in the Constitution on 'Access to Information', all Citizens have a right to information held by the State. Counties must ensure that County Government Act 2012 part IX 93 -95 on communication is adhered to. The principles highlighted in the County Government act, include Principles of Public communication, objectives of county communication and a County communication framework. The timely and accurate communication of carefully chosen messages to specific individuals and groups, through appropriate and effective channels, is a key enabling factor for any change process. Getting communication to work well requires analysis and planning This guidance focuses on generating a simple guide on developing a communications strategy for the KHSSP .

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

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

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

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

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 KHSSP
2. Enhancing consultation with agencies in achieving set outcomes;
3. Ensuring that all stakeholders understand the KHSSP and on-going health reform process;

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

Table 48: Communication focus for different stakeholders

Stakeholder		Communication focus
Clients	Individual Households Community	• Role in exercising appropriate healthy and health seeking behaviours • Active participation in the management of their local health services • Ownership and commitment of their health through the implementation of the KHSSP
State actors	MoH -National and County,	• Leadership and stewardship role within the sector and across other sectors and partners
	SAGAs,	• Their role in providing specialized health services
	Other ministries	• Their role in contributing to national health outcomes and need for strengthening the inter-sector work and mechanisms
	Ministry responsible for devolution	• Their role in ensuring that quality health care services are provided in all levels including the urban areas and cities as agents of county governments
	Regulatory bodies (Boards and Councils) and professional bodies/associations whose mandate is drawn from that of the State, and have an effect on health	• Their regulatory function in the implementation of the KHSSP
Non State / external actors		Adherence to the sector partnership Code of Conduct incorporating PPPH principles. Adherence to standardized qualities Ensure harmonized collaboration
		Understanding and adherence of Common Management Arrangements (CMA).

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

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

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

8 MONITORING AND EVALUATION FRAMEWORK FOR KHSSP

The NHSSP II End Term Review highlighted the absence of a robust Monitoring and Evaluation framework as one of the challenges in assuring adequate follow up of implemented activities. This chapter provides direction on performance monitoring and evaluation / Review of the implementation of KHSSP.

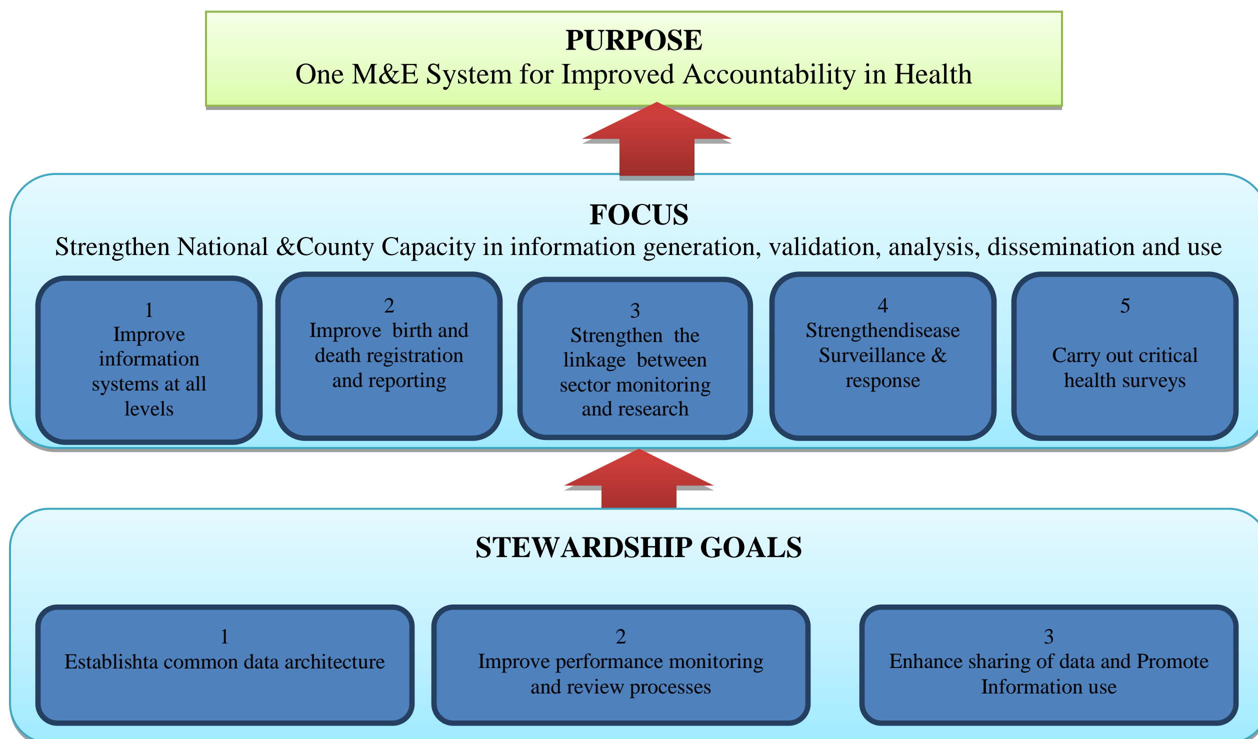
A comprehensive M&E framework shall be the basis for:

- Guiding decision making in the sector, by characterizing the implications of progress (or lack of it) being made by the sector
- Guiding implementation of plansby providing information on progress and results.
- Guide the information dissemination and use by the sector stakeholders and the public.
- Providing a unified approach to monitoring progress by all stakeholders in the sector – Counties, programs, SAGA's, and others

Monitoring and evaluation of KHSSP will be guided by the health sector Monitoring and Evaluation framework. The M&E framework and linkage with health information systemshownin the figure below.

Scope of the Monitoring and Evaluation Framework

Figure 23: Scope of the Monitoring and Evaluation Framework



The overall purpose of the M&E framework is to improve on the accountability of the Health Sector. This shall be achieved through a focus on strengthening of the national and county capacity for information generation, validation, analysis, dissemination and use through addressing the priorities as outlined in the Health Information System investment section of this document. This M&E chapter focuses on how the sector will attain the stewardship goals needed to facilitate achievement of the HIS investment priorities. These stewardship goals are:

The overall purpose of the M&E framework is to improve on the accountability of the Health Sector. This shall be achieved through a focus on strengthening of the Country capacity for information generation, validation, analysis, dissemination and use through addressing the priorities as outlined in the Health Information System investment section of this document. This M&E chapter focuses on how the sector will attain the stewardship goals needed to facilitate achievement of the HIS investment priorities. These stewardship goals are:

a) Supporting the establishment of a common data architecture

b) Enhancing sharing of data and promoting information use

c) Improving the performance monitoring and review processes

8.1 Establishment of a common data architecture

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

Kenya Health Strategic & Investment Plan Targets

Kenya Health Strategic & Investment Plan Targets

Policy Objective	Indicator	Targeted trend's			Source
		Baseline (2012)	Mid Term (2015)	Target (2017)	
IMPACT					
Improve health outcomes	Life Expectancy at birth	52	56	65	KNBS
	Total annual number of deaths (per 100,000 population)	106	95	80	
	Maternal deaths per 100,000 live births	*400*	*300*	*150*	*KNBS*
	Neonatal deaths per 1,000 live births	*31*	*25*	*15*	*KNBS*
	Under five deaths per 1000	*74*	*50*	*35*	*KNBS*
	Youth and Adolescent deaths per 1000	*45*	*30*	*20*	*CRD*
	Adult deaths per 1000	*30*	*20*	*10*	*CRD*
	Elderly deaths per 1000	*80*	*80*	*80*	*CRD*
	Years of Life lived with illness / disability	12	10	8	WHO
	Due to communicable conditions	*6*	*5*	*4*	WHO
	Due to non-communicable conditions	*4*	*4*	*3*	WHO
	Due to violence / injuries	*2*	*1*	*1*	WHO
Distribution of health	% range of Health Services Outcome Index	45	30	20	HIS
Services Responsiveness	Client satisfaction index	65	78	85	Policy and planning
HEALTH & RELATED SERVICE OUTCOME TARGETS					
Eliminate Communicable Conditions	% Fully immunized children	79	90	90	HIS
	% of target population receiving MDA for schistosomiasis	50	95	95	HIS
	% of TB patients completing treatment	85	90	90	HIS
	% HIV + pregnant mothers receiving preventive ARV's	63	90	90	HIS
	% of eligible HIV clients on ARV's	60	90	90	HIS
	% of targeted under 1's provided with LLITN's	44	85	85	HIS

Policy Objective	Indicator	Targeted trend's			Source
		Baseline (2012)	Mid Term (2015)	Target (2017)	
	% of targeted pregnant women provided with LLITN's	30	70	85	HIS
	% of under 5's treated for diarrhea	40	10	5	HIS
	% School age children dewormed	49	85	90	HIS
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	50	40	35	KNBS/HIS
	% Women of Reproductive age screened for Cervical cancers	50	70	75	HIS
	% of new outpatients with mental health conditions	<1	2	1	HIS
	% of new outpatients cases with high blood pressure	1	5	3	KNBS/ HIS
	% of patients admitted with cancer	1	2	2	HIS
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender based violence	<1	3	2	HIS
	% new outpatient cases attributed to Road traffic Injuries	4	2	2	HIS
	% new outpatient cases attributed to other injuries	<1	0.5	0.5	HIS
	% of deaths due to injuries	10	5	3	HIS
Provide essential health services	% deliveries conducted by skilled attendant	44	60	65	HIS/KNBS
	% of women of Reproductive age receiving family planning	45	80	80	HIS
	% of facility based maternal deaths	400	100	100	HIS
	% of facility based under five deaths	60	20	15	HIS
	% of newborns with low birth weight	10	6	5	HIS
	% of facility based fresh still births	30	10	5	HIS
	Surgical rate for cold cases	0.40	0.85	0.90	HIS
	% of pregnant women attending 4 ANC visits	36	80	80	HIS
Minimize exposure to health risk factors	% population who smoke	18			KNBS
	% population consuming alcohol regularly	35			KNBS
	% infants under 6 months on exclusive breastfeeding	32			KNBS
	% of Population aware of risk factors to health	30			KNBS
	% of salt brands adequately iodized	85			KEBS
	Couple year protection due to condom use				HIS
Strengthen collaboration with health related sectors	% population with access to safe water	60		85	KNBS
	% under 5's stunted	35		15	KNBS/HIS
	% under 5 underweight	17		5	KNBS/HIS
	School enrolment rate	60	80	80	MOE
	% of households with latrines	34		70	KNBS
	% of houses with adequate ventilation	65		80	KNBS
	% of classified road network in good condition	30		50	MOT
	% Schools providing complete school health package	15		50	MOE/HIS
HEALTH INVESTMENT OUTPUT					
Improving access to services	Per capita Outpatient utilization rate	2	3	4	HIS
	% of population living within 5km of a facility	80	90	90	KNBS
	% of facilities providing BEOC	65	80	90	HIS/ NCPD
	% of facilities providing CEOC				HIS/ NCPD
	Bed Occupancy Rate	85	95	95	HIS
	% of facilities providing Immunisation	80	100	100	HIS
Improving quality of care	TB Cure rate	83	88	90	HIS
	% of fevers tested positive for malaria	45		20	HIS
	% maternal audits/deaths audits	10	70	85	HIS
	Malaria inpatient case fatality	15	8	5	HIS
	Average length of stay (ALOS)	5.6	4.5	4	HIS
HEALTH INPUT AND PROCESS INVESTMENT					
Service delivery systems	% of functional community units	20	30	45	HIS
	% outbreaks investigated within 48 hours	90	100	100	IDSR
	% of hospitals offering emergency trauma services	35	65	80	HIS
	% hospitals offering Caesarean services	45	85	95	HIS
	% of referred clients reaching referral unit		70	85	HIS
Health Workforce	# of Medical health workers per 10,000 population	5	7	7	HIS
	% staff who have undergone CPD	40	65	70	HIS
	Staff attrition rate	10	5	2	HIS
	% Public Health Expenditures (Govt and donor) spent on Human Resources	55	45	40	HIS
Health Infrastructure	# of facilities per 10,000 population	1.5	2.5	2.5	HIS
	% of facilities equipped as per norms	25	60	70	HIS
	# of hospital beds per 10,000 population	50	150	150	HIS
	% Public Health Expenditures (Govt and donor) spent on Infrastructure	30	25	25	HIS
Health Products	% of time out of stock for Essential Medicines and Medical Supplies (EMMS) – days per month	8	2	2	HIS
	% Public Health Expenditures (Govt and donor) spent on Health Products	10	15	15	HIS/ NHA
Health Financing	General Government expenditure on health as % of the total government Expenditure	4.5	8	12	NHA/ PETS

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

The two levels of government and all the stakeholders in health need to work together in order to achieve the stipulated targets. The monitoring and evaluation framework defines the responsibilities of each actor and stakeholder.

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

8.2 Performance monitoring and review processes

The performance monitoring and review process will be useful for documenting lessons learnt during the implementation of the strategic plan.

- All performance reviews and evaluations will contain specific, targeted and actionable recommendations, the process is outlined in the M&E framework and guidelines.
- All target institutions will provide a response to the recommendation(s) within a stipulated timeframe, and outlining a) agreement or disagreement with said recommendation(s), b) proposed action(s) to address said recommendation(s), c) timeframe for implementation of said recommendation(s).

- All the planning units and institutions will be required to maintain a recommendation implementation tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.

8.2.1 Quarterly reports

At all levels a performance review reports will be produced outlining the performance against the strategic objectives in this plan. The reports will be discussed by the health management teams including all the stakeholders at the quarterly performance review meetings. The discussion will focus on a review of the findings and the agreed action points as well as a review of the recommendations improvement tracking plan for the previous quarter, which will be outlining the status of recommendations/action points agreed on during the previous quarterly review meeting

8.2.2 Annual reports

a) County Annual Health sector report

This is the annual report documenting progress against the implementation of the County Annual Work Plans for all planning units in the county as well as against sector performance (Indicators and targets) set in this strategic plan and any additional county specific indicators. It will include challenges encountered during the period under review and key priorities for the coming year. The report will be developed by the county health stakeholders forum through a consultative process and will be presented at a County Annual Health Review forum and the county assembly.

b)National Annual health sector report

This is the annual report for the state department of health documenting progress against the implementation of the AWP for all planning units at the national level as well as against sector performance targets set in the KHSSP III. The report will be presented to National level senior management for endorsement. It will also be disseminated to all stakeholders in health, including county health management teams for feedback and buy in .It will contribute to the annual state of health in Kenya reportand will be discussed at the national health congress.

c) Annual state of health in Kenya Report

The health sector shall publish annually a state of health report produced by the M & E unit at the national level. This will be a comprehensive analytical report giving a snap shot of performance covering the different strategic objectives articulated in this strategic plan and the oeverall state of health in Kenya. It will be informed by the county annual health sector reports, the national annual health sector report and other health related reports such as KDHS, Economic surveys,KHSPetc The report will also present efficiency and equity analysis considering various dimensions such as gender, poverty, literacy, regions, residence etc This report will be shared at an annual health congress before submission to the MEDof Ministry of devolution and planning for eventual presentation at summit.

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

NB: The sector shall utilize various communication channels such as radio, television, websites, ebulletins, newsletters among other media to disseminate the reports and information to the public and other stakeholders.

8.3 Enhance sharing of data and promoting information use.

The sector recognizes the fact that different data is used by different actors for their decision making processes and investment decisions. For this, data need to be translated into information that is relevant

for different audiences at different levels for decision-making. Data will be packaged and disseminated in formats that are determined by the needs of these stakeholders.

In line with the Kenya 2010 constitution, need for sector transparency, an electronic web platform for learning and knowledge management will be established to support information sharing for both government, non-government actors and the public. Public display of relevant information at the health facility level, county and national level will also be used as a means of dissemination. The inter-agency joint stakeholder forums will also be critical in information sharing. M and E units at the national and county level will cordinate the production and sharing of information products such as bulletins, pamphlets, policy briefs,newletters and reports among all relevant stakeholders at the two levels.

Joint assessments of progress

The principle of joint assessment shall be used at all levels of the health sector during performance reviews. This will involve all stakeholders bothgovernmentand non-government actors in review of performance. A community health servicesstakeholder forum will be responsible for the joint assessment at the community level. The County M&E units in all CHMTs will take lead in the joint assessments at subnational level. The county management teams will prepare the quarterly reports and in collaboration with county stakeholders organizecounty quarterly performance review forums. The national M&E unit will organize for the annual health congress which will bring together all stakeholders in health to jointly review the performance of the health sector for the year under review. The purpose of the joint assessments is to review performance, determine priorities,action plans and spending for the subsequent period.

8.4 KHSSP Evaluations

Evaluations will be undertaken to determine the extent to which the subject objectives of this strategic plan are met. predictions of implications of trends across the different indicator domains – inputs/processes; outputs; outcomes and impact. Two evaluations will be carried out during the KHSSP

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

Priority areas for investment	Measure of success	Baseline	Mid Term	Target
Establishment of a common data architecture	Review of the health sector Indicator manual			
	Review of integrated data capture tools and registers.			
	Establishment of a learning and Knowledge management platform/website			
Performance Monitoring and review	Joint assessments at county level			
	Joint assessments at National Level			
	Quarterly performance review reports at county level		8	8
	National level quarterly performance rview reports		8	8
	County annual heath sector report		2	2
	National level annual health sector report		2	2
	Annual state of health In Kenya report		2	2
	Mid-term evaluation report		1	
	End term evaluation report			1
Enhanced sharing of data and information use	Quarterly county health sector performance review forums			
	Annual county health performance review			
	Information products being produced and shared with relevant stakeholders(national and county level)			
	Health congress held		2	2

The National and County M&E committees will be responsible for overalloversight of M&E activities at the respective levels. Functional linkage of the health sector to the overall national intersectoral

government M&E will be through the M&E directorate in the Ministry of Devolution& Planning M&E units at the national and county level will be responsible for the day to day implementation and coordination of the M&E activities to monitor this strategic plan.