**REPUBLIC OF KENYA**

# SECTOR PLAN FOR HEALTH

# 2013 – 2017

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## STATEMENT BY THE CABINET SECRETARY MINISTRY OF DEVOLUTION AND PLANNING

In keeping with the decision that Kenya Vision 2030 be implemented through five year Medium Terms the Government successfully launched the Second Medium Term Plan (Second MTP 2013-2017) in October 2013. The Ministry of Devolution and Planning then embarked on the process of preparing the second round of Kenya Vision 2030 Sector Plans detailing policies, programmes and projects to be implemented in each sector. A total of twenty one Sector Plans have therefore been produced based on the work of nineteen medium term plan sector working groups and three thematic working groups formed to prepare detailed plans as background documents for the Second MTP.

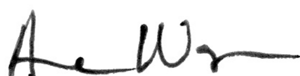
The Sector Plans outline in greater detail specific plans for implementation in each sector during the 2013-2017 period. The Plans have been prepared through a participatory and inclusive process involving representatives from the government, development partners, private sector, NGOs, civil society, faith based organizations, professional associations, research institutions, and organizations representing women and youths, among others. Apart from the technical inputs, the Sector Plan priorities have been aligned and taken into account the priorities and inputs from nationwide Second MTP county consultation forums which captured views and priorities of Kenyans at the grass root and local level. Additionally, the Sector Plans have taken on board the key issues and priorities outlined in the Manifesto of the Jubilee Government in line with Second MTP.

The Sector Plans implementation matrices outline the broad goals and strategic objectives, the specific objective of each programme and project, the expected output and outcomes, the indicators for monitoring progress, the entity responsible for implementation, the implementation timelines, the source and mode of funding for each planned programme and activity starting financial year 2013/14 to 2017/18.

In accordance with the Constitution of Kenya, it is expected that the programmes and projects outlined in the Sector Plans will be implemented in close consultation and collaboration with county governments, keeping in mind, the distribution of functions between the national and county governments as outlined in the fourth schedule; and the capacity of county governments. Involvement of the private sector, including through Public Private Partnerships (PPPs), in implementing the Sector Plans will also be crucial to deliver the expected outputs and outcomes of various prioritized programmes and projects.

To ensure successful implementation of the Sector Plans, and the activities outlined in the implementation matrices, my Ministry will put in place the necessary monitoring and evaluation framework and systems including the reporting formats and templates for production of quarterly progress reports by implementing entities.

In conclusion, let me take this opportunity to thank the respective Cabinet and Principal Secretaries involved in various sectors and all those involved in preparation of the Sector Plans.



**Anne Waiguru, O.G.W.**
**Cabinet Secretary, Ministry of Devolution and Planning**

## FOREWORD

This document is the health sector's excerpt of the national Second Medium Term Plan (Second MTP 2013-2017) for the implementation of Kenya Vision 2030. It is the framework for the sector's key priority programme areas. The provisions herein will be the basis for subsequent sector programming where priorities will be focused on programmes listed in the sector specific Plans.

This Plan reflects the desire of Kenyans for a healthy population that contributes to nation building. Kenya Vision 2030 goals would be a delusion if the health sector does not institute and implement measures to generate a healthy productive population. These priorities are enshrined within Article 43 of the Constitution which states that, "every person has a right to the highest attainable standard of health, including sexual reproductive health". The Plan has also been guided by the Sessional Paper No. 6 on the Kenya Health Policy 2012-2030 which gives the parallel sub-frame for the long term health sector goals and strategies.

While taking into account the evolving socio-political environment, this second Sector Plan builds upon the achievements and shortfalls of the first Plan. It explores the problems and challenges that would likely emerge over the implementation period, including the stagnating health outcome indicators, changing epidemiological patterns and inadequate coverage of services. Special consideration is given to those health problems that affect the majority of the population. Flagship programmes have been designed to have the farthest reach by reducing inequalities, mitigating priority health problems and implementation of cost-effective interventions. Physical and financial access to quality health care services will be improved. Provisions are made for the private sector to participate and invest in health programmes under this Sector Plan.

The successful implementation of this Plan will fast-track achievement of the anticipated health outcomes. The expanded coverage and improved access to quality and effective health care will result in a better performing health care system. It is therefore incumbent upon the various actors to play their respective roles in implementation of this Plan, and particularly for the Ministry of Health to provide stewardship and leadership in subsequent programming.

Overall, Vision 2030 Delivery Secretariat provided the national multi-sector guidance while the Ministry of Health led sector stakeholders, including implementing partners, development partners and beneficiaries at the national and county levels in deciding priorities for inclusion within the Sector Plan. The sector priorities were determined following an in depth situation analysis, a critical review of achievements of the previous planning period. These priorities formed the basis for resource allocation in line with the Sector Strategic Plan and Medium Term Expenditure Framework.

As the Cabinet Secretary responsible for this Ministry, I express my gratitude to the Ministry of Devolution and Planning, for guiding and coordinating the Sector Plan preparation process. I also wish to thank all the stakeholders including development partners who contributed direct and indirect to the preparation of this plan.

**Mr. James W. Macharia**
**Cabinet Secretary, Ministry of Health**

# PREFACE

The goal of the health sector is to provide equitable, affordable and quality healthcare of the highest standard to all citizens. The Health Sector will focus on strengthening and scaling up of cost-effective, preventive and promotive healthcare system, with special attention to control of communicable and non-communicable diseases, reproductive, child-health and emergency services, environmental and rural health services. Other areas of focus will be healthcare financing, ensuring quality of health commodities, improvement of infrastructure and provision of medical equipment.

The Sector Plan sets the national strategic priorities for the health sector during the plan period (2013-2017), and identifies health programmes that are likely to make the highest impact towards improving health. Due to the nature of these programmes they will be accorded higher priority ranking in subsequent sector programming.

This Sector Plan identifies 11 (eleven) priority investment areas where flagship projects are drawn from. These areas primarily focus on improving the physical and financial accessibility of health services to the general population, and using the most proven interventions while addressing key problems such as high maternal mortality during pregnancy and childbirth among others. The Plan also includes projects that aim at improving effectiveness and efficiency in health care service delivery systems through innovation. Public-Private Partnership (PPP) programmes are also included as mechanisms for additional investment to the health sector for areas that public resources are limited, such as medical tourism and locally derived natural medicinal products.

The priorities of this Health Sector Plan are drawn from the Second MTP and will be implemented by all sector stakeholders over the five years period (2013-2017). It is therefore necessary to ensure that all actors (state and non-state actors) are conversant with the provisions of this Plan and are committed to executing their roles for successful implementation.

We take this opportunity to thank all our partners for their invaluable contributions, through either direct or indirect support. We particularly appreciate the role provided by USAID- Health Policy Project, World Health Organization, World Bank, United Nation Fund Population (UNFPA), DANIDA, UNICEF, Vision 2030 Delivery Secretariat (VDS), Ministry of Devolution and Planning, German Development Cooperation, Hennet. I also appreciate all staff of the Ministry of Health under guidance of the Directorate of Policy, Planning and Healthcare Financing.

We therefore call for collaboration from all players in the health sector to ensure the realization of Kenya's Vision 2030 Development Agenda.

**Prof. Fred H.K. Segor**
**Principal Secretary, Ministry of Health**

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# LIST OF ACRONYMS

| | | |
|---|---|---|
| AIDS | - | Acquired Immune Deficiency Syndrome |
| AOPs | - | Annual Work Plans |
| ANC | - | Ante Natal Care |
| CHEWs | - | Community Health Extension Workers |
| CHC | - | Community Health Committee |
| CoG | - | County Government |
| CSO | - | Civil Society Organizations |
| DPs | - | Development Partners |
| ESP | - | Economic Stimulus Programme |
| FBO | - | Faith-based Organizations |
| GDP | - | Gross Domestic Product |
| GOK | - | Government of Kenya |
| JPWF | - | Joint Programme of Work and Funding |
| HPP | - | Health Policy Project |
| HSC | - | Health Services Commission |
| HIS | - | Health Information System |
| HSSF | - | Health Sector Services Fund |
| HSMF | - | Hospital Management Services Fund |
| HIV | - | Human Immune -Deficiency Virus |
| HRH | - | Human Resources for Health |
| ICT | - | Information Communication and Technology |
| IMR | - | Infant Mortality Rate |
| KDHS | - | Kenya Demographic and Health Survey |
| KeBS | - | Kenya Bureau of Standard |
| KEMSA | - | Kenya Medical Supplies Authority |
| KEMRI | - | Kenya Medical Research Institute |
| KEPH | - | Kenya Essential Package Health |
| KNH | - | Kenyatta National Hospital |
| KNBS | - | Kenya National Bureau of Statistics |
| KHSSP | - | Kenya Health Sector Strategic Plan |
| ERS | - | Economic Recovery Strategy |
| EMMS | - | Essential Medicines and Medical Supply |
| MCH | - | Maternal and Child Health |
| MDGs | - | Millennium Development Goals |
| MFL | - | Master Facility List |
| MTEF | - | Medium Term Expenditure Framework |
| MTP | - | Medium Term Plan |
| MoH | - | Ministry of Health |

| | | |
|---|---|---|
| MMR | - | Maternal Mortality Rate |
| MTP | - | Medium Term Plan |
| MTRH | - | Moi Teaching and Referral Hospital |
| NCDs | - | Non Communicable Diseases |
| NHA | - | National Health Accounts |
| NHIF | - | National Hospital Insurance Fund |
| NCST | - | National Council for Science and Technology |
| NGO | - | Non-Governmental Organizations |
| NT | - | National Treasury |
| NR | - | No records |
| NSA | - | Non State Actors |
| OBA | - | Output Based Approach |
| OOP | - | Out of Pocket Expenditure |
| PHC | - | Primary Health Care |
| PPB | - | Pharmacy and Poison Board |
| PPP | - | Public Private Partnerships |
| SARA | - | Service Availability and Readiness Assessment |
| SWAP | - | Sector Wide Approach |
| SRH | - | Sexual Reproductive Health |
| R&D | - | Research and Development |
| RMCHN | - | Reproductive Maternal |
| TB | - | Tuberculosis |
| TGE | - | Total Government Expenditure |
| UHC | - | Universal Health Coverage |
| USAID | - | United State Agency for International Development |
| UNFPA | - | Untied Nation Population Fund |
| WB | - | World Bank |

# EXECUTIVE SUMMARY

This Health Sector plan provides a framework for implementation of strategies aimed at improving the health status of the Kenyan people. The Sector Plan is aligned with the Kenya Vision 2030 blueprint, the second Medium Term Plan II, the Kenya Health Policy (2012-2030) and provide a platform for KHSSP III (2013-17). The Constitution of Kenya places a greater emphasis on the right to health. Article 43 of the Constitution states that, “every person has a right to the highest attainable standard of health, including sexual reproductive health” thus raising expectations from the citizens regarding healthcare. With the devolution of the health service delivery to the Counties, it is envisaged that service delivery for the poor, under-served populations and accountability will improve.

The development of this Plan was informed by the achievements, challenges and emerging issues realized after the successful implementation of the first Medium Term Plan (2008 -2012). Despite the unsettling regional variations, IMR dropped from 77 to 52 per 1000 live births, Under-five mortality rate from 115 to 74 per 1000 and immunization coverage increased from 77 to 83 percent. Number of health facilities increased from 5,589 to 7,111 with those providing basic health services from 6,190 in 2005 to 8,496 in 2012, a 37% increase. The number of health workers increased from 95,390 to 100,301 while the training capacity expanded from 5,932 to 6,699. Additional 2,530 community units were established under the community strategy.

This Plan also identifies and addresses the persistent and emerging issues and challenges. Communicable diseases including those that can be prevented still constitute the highest proportion of disease burden and further confounded by the emergence of drug resistant strains of TB and co-infection with HIV/AIDS. Malaria persistently remains serious health problem. Funding of HIV/AIDS programmes remain donor dependent at 80%.

Non-communicable diseases and conditions also persist in exerting pressure to the health system. Childbirth related conditions continue to pose significant challenges, especially inadequacy of emergency services for delivery, underutilization of existing antenatal services and inadequate skills and competences of health workers in this area, a situation which leads to newborns (<28 days) constituting 63% of all infant deaths. Malnutrition and micronutrient deficiency disorders persisted with declining or stagnated nutritional status of children especially in food insecure areas, exacerbating other diseases and vice versa. Other non-communicable disease like cancer, hypertension, heart disease and diabetes are rising and emerging as major health problem, cancer alone is estimated to cause 21,000 deaths annually. Injuries from road traffic accidents contribute to 50-70% of bed occupancy in hospitals.

The sector still faces challenges of skewed distribution of health workers with some areas of the country facing significant gaps while others have optimum/surplus numbers. This inequity still exists with higher concentration in urban and private sector services. It is also important to note that a serious disparity exists between the rate of production of health workforce and absorption to the system. Health financing and purchasing of health care services still has a serious implication on access and quality of health care. Currently the Government health expenditure as a percent of Total government expenditure range between 4-7% which is below the Abuja target of 15% of GDP going to health.

The sector made tremendous achievements in implementation of the flagship projects under the First MTP. Health facilities were rehabilitated and one hospital, Mama Lucy Kibaki Hospital was constructed. The sector introduced the demand driven ‘PULL’ system of distributing Essential Medicines and Medical Supplies (EMMS) from KEMSA to public health facilities which has potential to reduce wastage and improve efficiency in procurement, warehousing and distribution of EMMS. Under healthcare financing, HMSF and HSSF were implemented to reduce delays, wastages, and empowered the health management

boards to manage and supervise resource use. Subsidized reproductive, maternal, child health and gender based violence recovery services were provided in the poorest regions of Kenya under the Output Based Approach (OBA). Under the Human Resources Strategy, a total of 5,595 nurses, 2006 community extension health workers and 535 public health officers were recruited country-wide under ESP. The sector established 2530 community units under Community Strategy in order to increase access to equitable and quality health care.

To address emerging issues and challenges in the health sector, this Plan outlines the strategies and flagship projects to be implemented during the plan period 2013 – 2017. These include: Scale up of Community Health High Impact Interventions; Fully functioning Referral systems; Model level 4 Hospitals; Health care subsidies for social health protection; Re-engineering human resource for health; E-health hubs in 58 health facilities; Modernize Kenyatta National Hospital; Modernize Moi Teaching and Referral Hospital; Translation of research into policy and practical solution. Two more flagships will be implemented under PPP arrangements i.e Health and Medical Tourism and; locally derived Natural Health Products.

This Plan has been developed through a participatory process from all stakeholders in health and led by the Planning Division in the Ministry. The sector acknowledges the private sector as an important stakeholder for health in Kenya tandem with the Government emphasis on Public Private Partnership engagement. In Kenya, the health private sector is growing and studies show that service providers are a significant source of health services (approximately 47%), particularly in urban areas (private-for-profit), and in hard to reach areas (private-not-for-profit).

In moving forward, the Ministry remains steadfast to deliberately build progressive, responsive and sustainable technologically-driven, evidence-based and client-centered health system for accelerated attainment of the highest standard of health to all Kenyans. The focus still remains access to quality health care services through Universal Health coverage under sustainable mechanisms. The policies, legal and institution frameworks necessary for the successful implementation of this plan will be fast-tracked and a concerted effort from all stakeholders and cross linkages from other sectors will be key during the implementation period.

# 1 SETTING THE CONTEXT FOR HEALTH SERVICE DELIVERY IN KENYA

## 1.1 Introduction

The goal of the health sector is to provide equitable, affordable and quality healthcare to all citizens. The Constitution, through the chapter on Bill of Rights, puts a heavy responsibility on the health sector to ensure that the right to health is realized. The provisions of this Bill, especially the right to life and the right to the highest attainable standard of health, including reproductive health and emergency treatment, have also raised the expectations of the citizens regarding healthcare.

Health sector is one of the key areas in the Social Pillar that aims at building a just and cohesive society that enjoys equitable social development in a clean and secure environment. A healthy nation is critical for economic development, and poverty reduction. In this regard, a sector-specific plan is essential in spelling out the specific issues that the sector will address and which priority programmes will be implemented with focused attention.

The first Medium Term Plan covered the period 2008-2012: during this period the health sector implemented programmes domiciled under the NHSSP II. The key programmes under this plan included the community strategy, output based approaches, rehabilitation of health facilities, restructuring of KEMSA, designing of the KEPH, direct disbursement of funds to facilities, enhancement of partnership mechanisms. These programmes were geared towards addressing the MDG goals 4, 5 and 6 that address infant and child mortality, maternal mortality ; combating HIV/AIDS , TB and Malaria and other communicable diseases.

The development of Second MTP was guided by lessons learned from the programmes implemented in First MTP and the respective Health sector strategic plans. The Pan is further informed by the Constitution and the Vision 2030 whose aim is to create "a globally competitive and prosperous country with a high quality of life by 2030" through transforming the country from a third world country into an industrialized, middle income country.

The Sessional Paper No.6 of Kenya Health Policy (2012 – 2030) has six policy objectives and seven strategic measures, which provide a framework for the attainment of Vision 2030's goal for the health sector. The six policy objectives are:

- Eliminate communicable diseases;
- Halt and reverse the burden of non-communicable diseases;
- Reduce the burden of violence and injuries;
- Provide essential healthcare;
- Minimize exposure to health risk factors; and
- Strengthen collaboration with sector providers.

These policy objectives will be achieved through implementation of strategic measures under health financing; leadership; product and technologies; health work force; infrastructure; and information and service delivery systems.

## 1.2 Health Service Delivery in Kenya

The Constitution of Kenya devolves the responsibility of delivering essential health services to the Counties while the National Ministry of Health will provide policy support and technical guidance to

priority national programs. With changes in roles and responsibilities and equitable resource allocation to Counties, it envisaged that service delivery for the poor, underserved populations and accountability will improve. The details of the mandates, roles and responsibilities of both tiers of the government are defined under schedule four (4) of the Constitution.

# 2 SITUATION ANALYSIS

## 2.1 Introduction

This section provides detailed highlights of the health sector's performance in service delivery, referrals, health infrastructure, human resources for health, health information systems, health financing, public private partnerships, research and development, and sector wide approach.

## 2.2 Causes of Morbidity and Mortality

The common causes of death and disabilities have remained relatively the same over a period of time. The table below shows the top ten causes of death and disability in Kenya. Other causes of disability include congenital anomalies and unipolar depressive disorder, which account for 1.7% and 1.5% of all disability respectively.

**Leading causes of death and disability in Kenya**

| Causes of death | | | Causes of disability | | |
|---|---|---|---|---|---|
| Rank | Disease or injury | % total deaths | Rank | Disease or injury | % total Disabilities |
| 1 | HIV/AIDS | 29.3 | 1 | HIV/AIDS | 24.2 |
| 2 | Perinatal conditions | 9.0 | 2 | Perinatal conditions | 10.7 |
| 3 | Lower respiratory infections | 8.1 | 3 | Malaria | 7.2 |
| 4 | Tuberculosis | 6.3 | 4 | Lower respiratory infections | 7.1 |
| 5 | Diarrhoeal diseases | 6.0 | 5 | Diarrhoeal diseases | 6.0 |
| 6 | Malaria | 5.8 | 6 | Tuberculosis | 4.8 |
| 7 | Cerebrovascular disease | 3.3 | 7 | Road traffic accidents | 2.0 |
| 8 | Ischaemic heart disease | 2.8 | 8 | Congenital anomalies | 1.7 |
| 9 | Road traffic accidents | 1.9 | 9 | Violence | 1.6 |
| 10 | Violence | 1.6 | 10 | Unipolar depressive disorders | 1.5 |

## 2.3 Service Delivery - Access to Health Services

Access to basic primary health care (PHC) and referral services remains a significant challenge despite ongoing investments. 52% of Kenya's population has access to basic health services within 5km. 80% of public primary healthcare facilities are understaffed; infrastructure and equipment are below standards in many dispensaries and hospitals; availability of essential medicines and medical supplies is inconsistent; and access to quality referral services and emergency transportation is poor. Significant disparities in service availability exist between rural and urban areas and in hard to reach areas and cost of services remains a critical barrier to access particularly for the 46% of the population living below poverty level.

Strengthening of the referral system is critical in ensuring holistic delivery of services, though it has not been appropriately coordinated or targeted. Strengthening of referral services is a highly prioritized service delivery element in the Health policy and strategic plan.

The referral mechanism between communities and facilities is still very weak while majority of maternal deaths are due to obstetric complications such as hemorrhage, sepsis, eclampsia, abortion and obstructed labour which can be prevented through skilled delivery at health facility. A robust referral mechanism will also be effective as it will facilitate referral of specimen and sharing of information between service providers.

## 2.4 Health Infrastructure

The number of health facilities providing Kenya Essential Package for Health (KEPH) increased by 37%

from 6,190 in 2005 to 8,496 in 2012. The health centres and dispensaries that provide primary health care at lower level have also seen remarkable increase in provision of these essential services. The number of health centres increased from 536 in 1997 to 935 in 2012 while dispensaries increased from 1,882 to 3,929 in the same period. Improvement of infrastructure development in the health sector is attributed to development of a comprehensive primary health facility concept which aimed to construct 210 'model health facilities'. This increase contributed to improved health outcomes with exception of nutritional status of the under-fives, skilled delivery and maternal mortality.

In addition, lack of a policy on development of physical facilities and major equipment has resulted to non-adherence of the set norms and standards in upgrading of health facilities. This also advances inequalities in accessing quality health care services. Most of the health centers in the country have been upgraded to level 4 hospitals and continue to operate without requisite infrastructure and equipment compromising the quality of services provided. This weakens the referral system resulting to primary health facilities offloading basic health conditions to level 5 facilities. In view of this, there is need to provide the upgraded health facilities with requisite infrastructure and equipment to enable them optimize their functions.

## 2.5 Human Resources for Health

Although there has been improved access to health facilities, health resources are still distributed inequitably. Human resource distribution remains skewed overall, with some areas of the country facing significant gaps while others have optimum/surplus numbers. Inequity of some categories of health workers still exists with higher concentration in urban and private sector services.

The skewed distribution of human resource is likely to be a bottleneck to effective delivery of health care. The development of Human Resource Strategy to guide recruitment, deployment and retention of health workers was implemented in the sector, however during the First MTP period; the ratio per 100,000 populations for doctors, nurses, and clinical officers was 17; 153 and 12 respectively. Although higher than peer countries in the Sub-Saharan Africa, the rates are still below the WHO recommended rates of 21.7, and 228 doctors and nurses per 100,000 populations.

Even though the low ratios can be attributed to lack of trained skilled personnel, it is noted that there exists a large number of unemployed health personnel in the country. The number of institutions that train HRH has increased during the past decade to include Moi University, Kenyatta University, Mount Kenya University and other institutions. This has increased the number of skilled health personnel, though absorption in the public sector has not been realized as required. The biggest attempts to increase staff numbers was through the Economic Stimulus Programmes (ESP) and Return to Work formula of 2008 and early 2011.

## 2.6 Health Information Systems

Collection and collation of Health and related information has been a major weakness in the health sector. Availability of timely and accurate information is important for management and informing inter-alia Strategic planning for development of health infrastructure, Commodities distribution, Human Resources, Disease Mapping and Outbreak response. During the First MTP period, the Ministries of Health strengthened the Health Information System with a view to ensure accurate, timely and consistent health information for planning. Towards this end, the Ministry developed an online inventory of all health facilities in Kenya detailing the type and ownership of the facility, services available and the Geo-code location of each facility. The inventory has been dubbed the 'Master Facility List' (MFL) and is envisaged to form the foundation of all health care services offered in the country.

## 2.7 Health Care Financing

Health care financing remains a critical element of the social and economic development of this country. The overall goal for health care financing efforts is to ensure Universal access to the defined Kenya Essential Package of Health (KEPH) by the population. However, increasing demand for health care due to population growth coupled with inadequate funding for the sector has undermined Government's efforts to provide health services of acceptable quality to the vast majority.

The country is spending approximately 5.4% of its GDP on health (equivalent to 42.2 US$ per capita), with Government health expenditure equivalent to only 4.6% of Total Government Expenditures (TGE) which has ranged between 4 - 7 % over the last two decades. This level of spending is far below the Abuja target of 15% and the Economic Recovery Strategy (ERS) target of 12% of total Government allocations. This suggests that we are below target and the country may not meet the MDGs by 2015.

The health sector continues to be predominantly financed by the private sector sources (including household out of pocket spending) contributing 37% of total health spending followed by external (donors) at 34.5 % but without strict adherence to the objects of Aid Effectiveness, harmonization or in the context of long term strategies for sustainability. Among the private sources, over 24 % of total health expenditures are borne by households to obtain health care services through out - of- pocket payments (OOP). The high share of out-of-pocket expenditures raises concern about whether access to health care is equitable.

Kenya has a large population without health insurance currently at 80%. The total membership for NHIF is currently Ksh.3.2 million with the formal sector having Ksh.2.4 million and the informal sector Ksh.0.8 million. The proportion of the population being covered by NHIF stands at approximately 20% while private health insurance covers approximately 3% of the population. The total contribution towards NHIF is Ksh.9.4 billion with the civil servant medical insurance package giving an additional of Ksh.4 billion. During the First MTP period there was an institutional and strategic review of NHIF and the recommendations are being implemented.

In an effort to streamline health sector financing, the Government and Development partners came up with innovative ways to channel/pool resources. The Joint Financing Arrangements and a Joint Programme of Work were developed to inform funding in the sector. Other innovative ways explored to finance health care was Output Based Approach that targeted poor to access family planning, safe motherhood and gender based violence treatment services.

## 2.8 Public Private Partnership (PPP)

Public Private Partnerships (PPP) brings together two main parties: public sector and private sector. The public sector refers to an interface with national, intergovernmental structures. The private sector on the other hand comprises of organizations and individuals working outside the direct control of the government, including for-profit organizations (companies and individuals) and not-for-profit organizations. In the health sector these may include medical practitioners, diagnostic centers, ambulance providers and health institutions such as hospitals and clinics, pharmaceutical companies, healthcare insurers and community based welfare organizations.

The private sector in Kenya is acknowledged as an important stakeholder for health and GoK is increasingly promoting the idea for PPP's as indicated in Kenya Vision 2030, the National PPP Act (2012), and the National Health Policy Framework 2012-2030.The health private sector is growing and studies show that service providers are a significant source of health services (approximately 47%), particularly in urban areas (private-for-profit), and in hard to reach areas (private-not-for-profit). The private sector has contributed to innovative technologies and platforms which may improve the quality, efficiency and

effectiveness of healthcare service delivery. However within the private sector, there is a wide discrepancy between actors in terms of quality of services and management capacities. The government will require to enhance its capacity in regulation, accreditation and inspection to harness the potential of the private sector for health contribution towards improving healthcare in Kenya

## 2.9 Research and Development

Currently, Kenya lacks the infrastructure and mechanism to exercise governance of research needed to maximize research and innovation for health, equity and development. Health research is conducted, managed, and financed by numerous organizations with limited coordination and accountability. Therefore, there is need to strengthen national research capacity in order to address social development and equity agenda in the sector. However, a major challenge remains low utilization of research for evidence-based policy formulation and implementation in the health sector.

With respect to research funding, the significance of increasing investment in research for health has been emphasized globally. The "Call to Action" urges national governments to allocate at least 2% of budgets of ministries of health to research and development agencies, and to earmark at least 5% of funding for research. The funding for Kenya Medical Research Institute (KEMRI) from exchequer largely takes care of only personnel emoluments with no direct funding for research and other core mandate activities.

## 2.10 Sector Wide Approach (SWAP)

Fostering partnerships has been one of the major goals of reforms undertaken in the Health Sector as part of recognizing and harnessing the contributions to service delivery and financing of NGOs, FBOs, Donors and the Private Sector. To date the Ministry has embarked on initiatives aimed at aligning itself with the global efforts that target harmonization and effectiveness of funding and service delivery of the Government and partners in line with the Paris Declaration of 2000. Achievements made include setting up the Sector Wide Approach (SWAp) initiated in July 2005 leading to an agreed a country-led one health sector plan, one monitoring and evaluation framework and an agreement to strengthen and use the country's public financial management and procurement system. As part of the SWAp process, a Joint Programme of Work and Funding (JPWF) for 2006-2010 was developed that highlights the key priority health interventions that would be implemented to achieve the health sector objectives. The JPWF that was adopted in 2006 has been used to coordinate the activities of all stakeholders in the health sector. Through the Joint Annual Implementation Planning process and the Annual Review of the Sector Performance, the sector is able to determine its resource envelop as part of the Medium Term Expenditure Framework (MTEF).

# 3 PROGRESS IN IMPLEMENTING FLAGSHIP PROJECTS UNDER FIRST MTP

The sector implemented 5 flagship projects during the plan period that resulted to the achievements as highlighted below:

## 3.1 Progress in implementation of Flagship Projects

### Rehabilitation of Health Infrastructure

During the First MTP period, the sector constructed one hospital (Mama Lucy Kibaki Hospital) and upgraded 48 health centres to hospital status while 92 hospitals were rehabilitated. The sector commenced construction of 210 Model Health Centers of which 133 health facilities were 100% complete while 98 facilities were 90% to 99% complete under the Economic Stimulus Package (ESP). In the same period, about 5 referral facilities (KNH, MTRH, Coast PGH, Rift Valley PGH and Nyanza PGH) were equipped with renal equipment. In addition, one cancer equipment was installed at Kenyatta National Hospital (KNH).

### Strengthening of KEMSA

Health Sector introduced the demand driven 'PULL' system of distributing Essential Medicines and Medical Supplies (EMMS) from KEMSA to public health facilities. Unlike the 'PUSH' system, the demand driven approach was meant to respond better to the needs of individual health facilities where by allocations for EMMS are based on virtual 'Drawing Rights' was also introduced.

The 'PULL' system allows the facilities to quantify and place orders for EMMS as per their need. This is a major shift from the traditional 'PUSH' system of allocating EMMS, where the facilities were given standard 'KITS' independent of their needs. This system of distributing EMMS was introduced on a pilot basis in 2006 and since 2007, a gradual scale-up has been going on. Early evidence suggests that the 'PULL' system has potential to reduce wastage and improve efficiency in procurement, warehousing and distribution of EMMS. In view of this and in the face of devolved systems, the health sector should make a deliberate effort to replicate the 'PULL' system in all 47 counties.

### Health Care Financing

Under the Development of Equitable Health Financing Strategy, a draft Health Financing Strategy was developed that defines a long-term, fiscally sustainable, equitable, and efficient approach to financing health services in Kenya and was reviewed by external experts with a view to finalize the strategy. A Cabinet Memorandum on review of National Health Insurance Fund (NHIF) was developed and submitted to the Office of the Prime Minster; the NHIF cover for outpatients was piloted in Mumias and Nairobi. NHIF is currently providing inpatient and outpatient cover to all civil servants. Currently the total number of members including dependants covered through NHIF increased from 4million in 2006/07 to 6.6 million 2011/2012.

Health Sector Services Fund (HSSF) and the Hospital Management Services fund (HMSF) were established through Legal Notices No. 401 and 155 respectively both under the Government Financial Management Act (No.5 of 2004). The funds were set up as a mechanism for pooling resources from the Government and Development Partners through a Sector-Wide Approach (SWAp) and availing resources directly to Health Facilities to implement their Annual Operational Plans (AOPs). Since its inception, the fund has improved efficiency in allocation and management of financial resources through empowerment of the Facility Management Committees. Further, it has also managed to reduce bureaucracies in the disbursement of financial resources to the grass root level that hitherto occasions delays and wastages, and empowered the health management boards to manage and supervise resource use.

To address quality of reproductive health and gender based violence services, the Ministry continued to offer free maternal deliveries in all public facilities. Under the Output Based Approach (OBA), 79,231 deliveries, 23,746 family planning and 352 gender based violence vulnerable groups were sufficiently supported through vouchers system during Phase I of the project implementation. Phase II saw 47,318 ANC visits, 75,258 deliveries, 30,510 FP and 1383 gender based violence being supported. The project was scaled up to Kilifi District during the third phase and it is expected that more deserving districts will be included at the end of Phase III implementation.

### Human Resource Strategy

A comprehensive Human Resource for Health Strategic Plan was developed and launched to address inter-alia issues of staff recruitment, deployment, and training among health workers. About 5,595 nurses, 2006 community extension health workers and 535 public health officers were recruited country-wide under ESP. Through the Community Health Strategy approach, a Community Unit (CU) to serve a local population of 5,000 people was to be established, instituting Community Health Workers (CHWs) who each provide level 1 service to household and supporting CHWs with Community Health Extension Workers (CHEWs), and ensuring recruitment and management of CHWs by Community Health Committee (CHC). The 2010 evaluation report on Community Strategy indicates that 2,530 community units were established. A total of 600 CHEW's and 15,000 CHW's were trained to provide integrated and comprehensive health care services.

### Community Strategy

One of the key innovations of KEPH is the recognition and introduction of level 1 (community) service, which is aimed at empowering Kenyan households and communities to take charge of improving their own health (MOH, 2005). The main goal of this approach is to build capacity of households not only to demand services from providers, but also to know and progressively realize their rights to equitable, good quality health care. During the Plan period, Health sector established 2,530 community units.

Family planning awareness in Kenya is rated high at 90%, however the Contraceptive Prevalence Rate (CPR) is slightly less than half at 46%. With regards to water and sanitation, three out of five households in Kenya i.e. 63% get water from an improved source and only one quarter of the household use improved toilet facilities (KDHS, 2010), however, disparities in access still exist amongst the urban and rural residents. Significant improvements in the process indicators monitored under community such as disease prevalence, malnutrition prevalence, maternal mortality rate and infant mortality rate have also been realized during this plan period.

The Sector did not implement two flagship projects namely; De-linking the ministries (of health) from service delivery through the establishment of a Health Service Commission (HSC) in order to allow independent operation of tier 4 and 5, i.e. District and Provincial Hospital, and creating a national health insurance scheme.

## 3.2 Performance in Key Health Indicators

During the First MTP period, the implementation of the earmarked flagship projects and other health sector programmes resulted to improvement of health outcomes except for maternal health. The performance of these initiatives against specific health indicators is presented below:

### Child Health

Significant gains have been made in controlling communicable conditions especially those affecting children resulting in decline in child deaths. Infant mortality dropped by 32% from 77 to 52 deaths per 1000 live births between 2003 and 2008/09. Under-five mortality also declined during the period by

36% from 115 to 74 per 1,000 live births. However, at regional level, disparities exist in child mortality rates. Infant mortality is high in Nyanza (95 per 1000) and Coast (71 per 1000) and lowest in Eastern (39 per 1000). Nyanza also has the highest under-five mortality (149) while Central has the lowest rate (51). The risk of dying under the age of 5years is therefore higher for children in Nyanza.

Another major challenge is newborn deaths (neonatal mortality) that occur in the first 28 days of life. Neonatal mortality currently contributes to 63% of infant deaths. The factors associated with these deaths include: low utilization of health facilities, inadequate skills and competencies of health care workers.

Overall, the target of the First MTP was to reduce under-five mortality to 30 deaths per 1,000 live births. The envisaged target was therefore not met. In order to sustain the declining trend in child mortality, high-impact interventions will be critical over the next 5 years to ensure continued progress toward child health MDGs.

### Immunization

Significant progress was made in immunization coverage during the First MTP period. Data shows that immunization coverage increased from 77% in 2008/09 to 83%. According to the KDHS 2008/09, the lowest proportion of fully immunized children was in North Eastern (48%) and Nyanza (65%) compared to the national average of 80%.The target for the Plan period was full coverage (100%). The MTP target was therefore not met, nonetheless significant progress was made due to the intensive immunization campaigns. During the Plan period PCV and Rotavirus were introduced.

### Nutrition

Although Kenya has achieved modest but sustained economic growth over the last two decades, child under-nutrition rates have not improved in this period. Levels of stunting due to long-term under-nutrition currently stand at 35% of children under the age of five, (KDHS 2008/09) and have not improved significantly in the past twenty years. An estimated 2.1 million children are developing poorly as a result of stunting, and these children may never reach their full mental and physical potential if they survive. Every year, 40,000 children die because they are underweight, vitamin A deficient or not exclusively breastfed for the first six months of life.

The prevalence of wasting in children under five years continues to vary, with populations in the chronically food-insecure arid and semi-arid districts being most affected.

### Maternal Health

Maternal health remains poor with maternal mortality (MMR) increasing from 414 to 488 deaths per 100,000 live births between 2003 and 2008/9 according to the Kenya Demographic and Health Surveys. The MTP targeted to reduce MMR to 140 per 100,000 live births during the Plan period therefore the target was not met.

About one half of mothers are anaemic, and uptake of recommended iron supplements during pregnancy is below 3%. Utilization of antenatal care services is high (92%), but use of skilled birth attendance at delivery is just 46%. Some gains have been achieved in use of modern contraceptives, but rates remain relatively low at 46% and Kenya's population growth and fertility rates are still high at 2.7% and 4.72 respectively. There is an estimated unmet need for family planning of 26%, ranging from 15% in more urban areas to 32% in more rural regions. Unsafe abortions are not well documented but it is estimated that one unsafe abortion occurs for every 5 live births in Kenya.

In order to address the high maternal mortality rates, there is need to re-examine maternal health practices and interventions: These include high impact interventions that include family planning, nutrition supplements, ante-natal care, safe delivery and post natal care.

### HIV and AIDS

HIV/AIDS remains a major cause of morbidity and mortality despite improvements in HIV prevalence rates. Considerable gains have been achieved, HIV prevalence rate is 5.6 (KAIS, 2012) as compared to a target of 6.0%. To increase access to HIV/AIDS prevention and treatment services, 90% of eligible patients were targeted, however only 70% are now receiving ARVs. Currently about 80% of financing for HIV/AIDS comes from external sources that supports health-sector related prevention, care and treatment services.

With decreases anticipated in external funding, integrating HIV/AIDS services more effectively into KEPH services needs to be accelerated to make more efficient use of all available resources, while identifying sustainable financing options for the sector. TB control still remains a major challenge due to high prevalence of HIV epidemic and the emergence of drug resistant. However, TB treatment completion rate and case notification, case detection, and treatment success rate have all shown significant improvement during the plan period and needs to be sustained.

### Malaria

Health Sector recognizes malaria as a health and socio-economic burden. Malaria is responsible for 30 per cent of outpatient consultations, 19% of hospital admissions and 3–5% of inpatient deaths. Seventy per cent (70%) of Kenya's population lives in malaria prevalent areas. The malaria case fatality rate at the hospital dropped to 2.5 per cent in 2008, from 5.6% in 2003.

Expanded coverage of parasite and vector control interventions over the life of the 2000–2010 National Malaria Strategy (NMS) yielded a decline in the malaria burden, its severity and transmission patterns: under-five mortality in sentinel districts declined by 44%, attributed to the use of insecticide treated nets. However, despite these significant impacts, the disease continues be one of the leading causes of morbidity and mortality in the country and therefore a concerted effort is still required.

# 4 EMERGING ISSUES AND CHALLENGES

Even though the sector recorded improved performance in various aspects, there still remain important issues that will need to be addressed and foreseeable challenges that are contemplated to be considered in programming for the next cycle. Key among those includes:

## 4.1 Maternal and Child Health

Despite realizing a reduction of infant and child mortality rates, the interventions used over the First MTP period failed to register improvements in maternal and neonatal mortality, indicating inadequate access and a deficient quality of pregnancy and childbirth related health services. Apart from physical access where only 52 % of the population is within 5 kms of a health facility, maternal cases are usually immediate and especially so for obstetric emergencies.

Persistence of high incidences of child illnesses constitutes another area of concern. Children and under-fives are persistently affected by micronutrient deficiency disorders while the overall nutritional status has declined/stagnated over the past Plan period. Fair share of those illnesses are noted to be caused or exacerbated by nutrition-related factors like sub-optimal breastfeeding, low maternal birth weight and child malnutrition among others. There is also need to scale up high impact interventions targeting preventive childhood conditions such as immunization, HIV and malaria control strategies.

## 4.2 Service Delivery

Lack or inadequacy of a rapid referral system and insufficient facilities to handle immediate maternal cases could be one of the key factors underlying the high mortality cases. The rate of delivery by skilled workers remains high notwithstanding the high rates for ante-natal attendance indicating a missing link to accessing the services. Rapid and effective maternity services free of financial barriers should be planned in order to curb this observed trend in mortalities.

Strengthening of the referral system is critical in ensuring holistic delivery of services, though it has not been appropriately coordinated or targeted. An effective referral system ensures close relationship between all levels and ensures that clients receive the best possible care. The benefits include: reduction in waiting time, ensuring that people utilize facilities that are close to them, time for accessing health care will be reduced and thus morbidity and mortality. Better equipped and staffed primary health facilities will lead to improved public confidence in these facilities and thus improved utilization. Health care givers will benefit from regular updates and interactions with upper level specialists hence improve their skills and competence.

Regular outreach services to lower levels ensure that specialized health services are brought closer to the people and hence improved health indicators. In addition, the referral system will include all the spectrum of services offered in both the public and private sectors; consequently public private partnership will be pursued to scale up service delivery.

The referral mechanism between communities and facilities is still very weak while majority of maternal deaths are due to obstetric complications such as hemorrhage, sepsis, eclampsia, abortion and obstructed labour which can be prevented through skilled delivery at health facility. A robust referral mechanism will also be effective as it will facilitate referral of specimen and sharing of information between service providers

## 4.3 HIV/AIDS and Tuberculosis (TB)

While reduction in prevalence of HIV/AIDS was noted over the First MTP plan period, the pandemic continues to contribute to mortality and morbidity. This situation is further confounded by the co-infection with TB and emergence of drug resistant TB strains. While there's need to sustain programmes leading to the reduction of prevalence levels, effort must be made to initiate interventions to address the link with TB co-infections as well as addressing the TB drug resistance.

## 4.4 Non Communicable Diseases (NCD)

There is high number of reported cases of non-communicable diseases. Diseases like cancer; hypertension, heart diseases and diabetes have been a major health problem. Injuries (road traffic accidents) are also significant causes of death. The contribution of injuries and non-communicable diseases to total morbidity and mortality is projected to increase, currently occupying 50-70% of all hospital bed and placing new challenges on the health system. These cases are escalated by the high cost of care needed to treat such cases and poverty levels in the country. Injuries are increasingly becoming a major threat to the health sector gains and there is need to develop systems to halt and reverse the current trend.

## 4.5 Health Care Financing

The plans to expand the social health insurance were neither implemented in the First MTP period and the indigents are still experiencing financial barriers to accessing care. The household out of pocket share of total health spending remains high. In addition, moving towards universal health coverage (UHC) would require finalization of health financing strategy. The right to health, reproductive health and emergency treatment will significantly affect how health financing will be structured in order to accommodate these rights and protect the poor from catastrophic health spending.

## 4.6 Human Resource

The quality of services available in public health facilities is not responsive to client requirement, a fact also supported by a patient satisfaction survey rating of 69%. Inadequate and inequitable distribution of human resources for health (HRH) is hampering health care delivery and ultimately health outcomes. There is high concentration of HRH to levels 4&5 facilities rather than primary health care services. Low quality of infrastructure, long waiting time and slow complaint resolution are some of the frequently reported deficiencies. The referral system is not working well, such that the workload of lower tier facilities in treating basic conditions is pushed to referral facilities. Dispensaries and health centers do not have the capacity to offer comprehensive basic health care as stipulated within their mandate. Moreover, many health centers were elevated to level 4 facilities without the requisite infrastructure.

## 4.7 Research and Development

Research and innovation have been and will be essential to find solutions to health problems, address predictable and unpredictable threats to human security, alleviate poverty, and accelerate development. Pandemics of infectious disease, chronic diseases, antimicrobial resistance, food security and climate change will continue to contribute to health problems globally. In times of financial crisis and competing priorities, it is important that evidence and science informs health policy and decision making. The health sector is set to address the major challenges in the context of demographic and epidemiological changes, widening socio-economic disparities, limited resources, technological developments and rising expectations from the population. This calls for timely context specific research evidence translated into policies and solutions to improve health and quality of life.

Some of the major challenges the sector continues to face in research include: lack of a harmonized national Research Policy, agenda and priorities; inadequate funding for research; poor state of

infrastructure and equipment for research and higher education and training; inadequate R&D expertise in the country and lack of advocacy for R&D at high political and policy levels; weak mechanisms for translation of research into policy, implementation, evaluation and review and over reliance on the use of foreign expertise for research.

## 4.8 Devolution in health

The health sector recognizes the provisions under the Constitution of Kenya, among which is the right to the highest attainable standard of health. The health sector is also aware that the devolution of governance will require properly designed systems of fiscal management, evidence based planning, effective human resources planning, proper and effective coordination, political goodwill and selfless leadership to ensure seamless transition to the devolved governments. Historically, there have been several pieces of legislation attempting to regulate various aspects of the health sector. The proposed Health Bill 2012 is an example of the health sector's effort to bring the scattered pieces of legislation to one umbrella legislation. Consequently, the sector has embarked on an overhaul of the existing policy, legal and strategic framework for health, to conform with and facilitate implementation of the Constitution.

# 5 HEALTH SECTOR PROGRAMMES AND PROJECTS 2013-2017

The overall goal of the flagship projects and programmes under the Health sector is to improve the livelihoods of Kenyans by reducing health inequalities while also improving health care delivery services. During the Plan period the sector will implement the following programmes and flagship projects which are aligned to the health sector building blocks during the Second MTP period;

## 5.1 Programmes for 2013-2017

### 5.1.1 Health Infrastructure

During the Plan period, following activities will be carried out:

- Review the health facility infrastructure norms to address emerging considerations such as distance from facility (enforcement of norms and standards).
- Assessment of the status to identity candidate level 4 hospitals. Results from the from the Service Availability and Readiness Assessment (SARA) survey will inform this process;
- Construction for upgrading and equipping 100 identified facilities to conform to the norms and standard for level 4 Hospitals;

### 5.1.2 Service Delivery

Service delivery cuts across all the other components and will broadly be tackled under the following strategies during this Plan period;

- Putting in place a comprehensive referral system.
- Implementation of an integrated service delivery approach based on client needs.
- Provision of quality emergency health services at the point of need regardless of ability to pay.
- Establishment of systems for provision of health services to marginalized and vulnerable population.
- Scaling up demand creation of health services.

### 5.1.3 Human Resources for Health

Adequacy in terms of numbers, skill mix, competency and attitude of health workforce will be required during this Plan period to deliver on health goals. The sector shall pursue the following strategies;

- Review and application of evidence based health workforce norms and standards.
- Improving management of the existing health workforce by putting in place attraction, retention and motivational mechanism.
- Putting in place systems to measure performance and competence of health workforce.
- Facilitation of rational capacity development.

### 5.1.4 Health Information Systems

The Health Information Systems targets consumers, health managers, policy makers, and all other actors in the health sector, with a view to guide their decision making processes. This shall be attained through focusing on implementation of the following strategies

- Continued strengthening of accuracy, timeliness, completeness of health information for decision making.

- Establishing mechanism to promote, coordinate, regulate and ensure sustainability of health research.
- Putting in place health surveillance and response mechanism.
- Use of ICT (e-health) to support health service Delivery.

### 5.1.5 Health Products

To ensure that effective, safe, good quality and affordable health products and technologies are available and rationally used; health sector will implement the following strategies,

- Defining and applying an evidenced based essential package of health products and technologies.
- Establishing rational appraisal mechanism for health product and technologies.
- Putting in place a harmonized national regulatory framework for health product and technologies.
- Have in place effective and reliable procurement and supply system.
- Promoting local production, research innovation of essential health products and technologies.
- Ensure availability of affordable, good quality health products and technologies.

### 5.1.6 Health Financing

In order to address the challenges in health care financing, the following strategies will be put in place:

- Establish a national social health insurance mechanism that includes the employees, employers and the informal sector for universal coverage.
- Progressive resource mobilization strategies from all sources of funds, both domestic and international.
- Ensure efficient allocation and utilization of resources
- Reduce out of pocket health expenditures and progressively eliminate payment at the point of use of health services, especially by the marginalized and indigent populations
- Review periodically, the criteria for resource allocation and purchasing mechanisms, taking into account national priorities and different sources of funds.
- Advocate for increased financing in health, and related sectors, to meet agreed benchmarks (National and International) and to ensure required interventions are implemented.
- Strengthen programming of external funding for health through improved harmonization and alignment to sector priorities and improved reporting.
- Put in place appropriate financing mechanisms for emergency health services
- Develop mechanisms that promote Public Private Partnership in financing for health.

### 5.1.7 Leadership and Governance

Leadership and governance in health relate to; Management systems and functions, Partnership and coordination on of health care delivery, Governance systems and function, engaging of public and private services providers, Planning and monitoring systems and services, Health regulatory framework and services.

### 5.1.8 Research and development

The utilization of health research in policy-making should contribute to policies that may eventually lead to desired outcomes, including health gains. The activities will include exploration of: priority setting; activities of the health research system at the interface between research and policy-making; and the role of the recipients, or 'receptors', of health research. During this Second MTP, the sector will explore the following strategies under R&D;

- Research & Innovation
- Capacity Building & Training
- Research Governance- Research Ethics & Standards Regulation including General Administration & Planning
- Development, marketing sell of products and services to support the National health programmes

### 5.1.9 Public Private Partnerships

During the Plan period, health sector will implement the following strategies;

- Strengthen MoH stewardship of the private health sector by establishing an institutional framework for PPPs in Health. Once established, resources and assistance should be mobilized to build public and private capacities to design and implement PPPs, to identify key PPP champions and to strengthen their management skills.
- Engage the private sector in relevant health sector coordination structures and increase dialogue with the private sector to build trust, mutual understanding and consensus about the role of the private sector within the health sector.
- Institutionalize health market and consumer research to inform public and private sector decision making.
- Examine performance based incentive mechanisms to motivate the private sector and examine opportunities to contract out some services, or part of health services.
- Strengthen regulations and capacities to enforce policies on quality control of both the public, as well as the private sector

## 5.2 Flagship Projects 2013-2017

In pursuant of the health policy goals and improving the health status of Kenyan, during the period of Second MTP the sector will implement the following flagship projects;

- Scale up of Community Health High Impact Interventions
- Fully functioning Referral systems
- Model level 5 Hospitals
- Health care subsidies for social health protection
- Re-engineering human resource for health
- E-health hubs in 58 health facilities
- Modernize Kenyatta National Hospital
- Modernize Moi Teaching and Referral Hospital
- Translation of research into policy and practical solution

- Flagships Projects to be implemented through Public Private Partnership (PPP) approach include;
- Health and Medical tourism
- Locally derived Natural Health Products.

It is envisaged that health sector will take lead in ensuring standard guidelines; legal frame work and regulatory roles are adhered to in implementing flagship projects proposed under PPP.

### 5.2.1 Investment Area: Service Delivery

**Project Name:** Country- wide Scale up of Community Health High Impact Interventions

### Introduction:

In the Second MTP the community strategy has been recognized as an integral part of healthcare service delivery. This strategy intends to improve the health status of Kenyan communities through the Initiation and implementation of high impact interventions (HII) at level 1.

The priority focus areas within this flagship will be the level 1 MNCH HII which have been identified to accelerate Kenya's progress towards MDG4 and 5 and are integral of the Kenya MNCH roadmap (2010). The level 1 MNCH HII cost effectively prevents and protects women, newborn and children from the main causes of MNCH mortality and morbidity in Kenya.

**Goal:** The overall goal of this flagship project is to reduce MNCH mortality and morbidity

**Outcome:** Country wide scale up and mainstreaming of the MNCH HII

**Strategy:** The community health service delivery approach through progressing towards the following objectives:

1. Provide level 1 MNCH HII services for all cohorts and socioeconomic groups, including the "differently-abled" taking into account their needs and priorities
2. Build the MNCH HII capacity of the community health extension workers (CHEWs) and community based resource persons to provide services at level 1.
3. Strengthen MNCH HII health facility–community linkages through effective decentralization and partnership for the implementation of level one MNCH HII services.
4. Strengthen the community to progressively realize their rights for accessible and quality care and to seek accountability from facility based health services.

### Project name: Fully functional referral system.

### Introduction

The health care delivery system across the country has been organized around four distinct tiers or levels to facilitate achievement of the goals of right to health including reproductive health as envisaged in the Constitution. These tiers are designed to provide a specified package of services as defined in the Kenya Essential Package of Health (KEPH).The Constitution further establishes two independent and yet interdependent national and county levels governments with clearly defined health functions. A clear vertical and horizontal referral mechanism is therefore critical for seamless delivery of health services. Therefore an effective referral system is critical in providing linkages needed across different levels health system to ensure improved accessibility to equitable essential health services to the vulnerable

particularly the rural and poor populations.

**Goal:** To guide establishment of an efficient health service delivery system linkages across levels of care that ensure continuity of care, for effective management of health needs of the population in Kenya.

### Specific objectives are:

1. To increase the utilization of services at lower levels of the health services and reduce self-referral to the higher levels of care.
2. To develop the service provider's capacity to offer services and appropriately refer at each level of the healthcare system
3. To improve the system's ability to transfer clients and specimens between the different levels of the healthcare system.
4. To improve supportive supervision thereby ensuring up to-date management practices in use across the country
5. To improve reverse referral and feedback information system
6. To improve preparedness and response to emergencies and disasters.

### Targets

- All facilities to function for 24 hours to be able to manage referral. N/B For level 2 and 3 that are not 24 hours yet—proper communication device
- Each facility to have a defined area for receipt and management of emergencies (outpatient, casualty, obstetrics/gynecology department)
- Each facility to have an emergency response team and equipment.
- Level 5 and high volume level 4 facilities shall provide referral services e.g. expertise referral services in their respective zones
- Transform the current level 5 facilities into centers of excellence in order to adequately address referral requirements in their respective zones.
- Put in place a Screening services to be undertaken level 1 to 3 facilities as need arises.
- The number of cases of referred
- Responsiveness to customer needs-client satisfaction index
- Reduced waiting time
- Patient history information
- Number of counties with functional ambulance systems

### 5.2.2 Investment Area: Infrastructure Development and Equipment

### Project name: Model level 4 hospitals.

### Introduction:

The Kenya Essential Package for Health (KEPH) defines health services and specific interventions to be provided by level of care (community, primary care, County and National). However, access to KEPH by

different constituents of Kenya's population remains a major challenge due to inadequate and/or lack of budgetary provisions for health facilities. The poor state of public health facilities rents support to this. This state of affairs constrains the capacity of the public health system to provide quality KEPH services that are acceptable to different constituents of Kenya's population. This problem is further compounded by lack of National Policy on to guide development of physical facilities and major equipment resulting to growth of unplanned health facilities which works against the national health sector goals.

**Goal:** The goal of this flagship project is to improve access to comprehensive KEPH services by different constituents of Kenya's population. Specifically, the project is set to contribute towards acquisition of the requisite infrastructure and equipment to about 100 current level 4 county hospitals to the accepted norms and standards. Further these facilities will be fully equipped to enable them provide a wide range of comprehensive health care services as per the norms and standards. During the Plan period, following activities will be undertaken:

- Review the health facility infrastructure norms to address emerging considerations such as distance from facility (enforcement of norms and standards).
- Assessment of the status to identity candidate level 4 hospitals. Results from the from the Service Availability and Readiness Assessment Mapping (SARAM) survey will inform this process;
- Construction for upgrading and equipping 100 identified facilities to conform to the norms and standard for level 4 Hospitals;
- Targets: During the Plan period, the Government will endeavor to construct, upgrade and equip about 100 hospitals countrywide.

### 5.2.3 Investment Area: Health care Financing

**Project Name - Health Care subsidies for social health protection**

### Introduction

Full social health protection corresponds to the term "universal coverage". Universal coverage of health care is defined as effective access to appropriate essential quality health services at an affordable cost. Universal coverage implies equity of access and financial risk protection. It is also based on the notion of equity in financing - people contribute to the system on the basis of capacity to pay.

Universal social health protection ensures that all people in need have effective access to at least essential care and is thus a key mechanism for achieving these objectives. It is designed to alleviate the burden posed by ill health, including death, disability and loss of income. It hence plays a significant role in poverty alleviation. Financial subsidy is one of the enablers of social protection. Expansion of government subsidized health care services improves the overall health of the poor.

**Justification:** Household out of pocket expenditures in Kenya comprises as much as twenty four per cent of total health expenditure thus treatment costs continue to limit access to KEPH services and this can be catastrophic for poor families faced with even common ailments.. These immensely contribute/ results to poor health indicators in the country. The Constitution also alludes to the right to the highest standard of health and treatment of emergencies. This may require the establishment of an emergency fund through a prepayment to facilitate reimbursement to facilities for expenses incurred.

**Goal:** To contribute to better quality of life, poverty alleviation and human development through meeting population health needs; remove financial barriers to health care and reduce incidence of catastrophic health expenditures.

**Overall objective:** Consolidate and expand social health subsidy mechanisms with view of achieving Universal Health Care (UHC)

### Specific objectives

Consolidate (new and existing) and coordinate social health protection initiatives

Expand coverage of health benefits to all the indigents

Target: During the first year, an institutional framework for coordination SA will be developed to facilitate the implementation. The strategy aims to cover 30% of the indigent in the first year, then 50%, 70% and 100% in the subsequent years.

## 5.2.4 Investment area: Human Resources for Health

**Project Name: Re-engineering Human Resource for Health.**

**Goal:** To establish a well-motivated Human Resource for Health.

### Introduction

Health workforce is the most important input for a health system for improved health outcomes. However, there are significant challenges affecting the effectiveness of the health workforce. Internal and external migration of health workforce, training and career path related needs, skewed distributions of HRH, retention and inadequate staff coupled with underutilization of staff are matters of policy concern; Through the preceding MTPI, KHSSP II and the current KHSSP III, The government invested heavily in strategies aimed in sufficiently delivering a comprehensive health care services to public. However, the government has experienced challenges in implementing these strategies basically due to; political and economic conditions, resource constraints, funding for incentives and documentation of best practices limiting support for sustained development.

### Justification

Given the social dynamic of health, non-financial incentives for HRH are the most appropriate response to the push factors for health workers movement that includes poor work environment staff retention and continued staff skill development. As the Sector devolved to the counties a systematic approach to ensure skewed distribution of HRH, Skills development and staff retention is harmonized is a pre-requisite to achieve MDGs and Vision 2030 targets.

### Targets:

1. Training and career paths development for Human resources.
2. Staff appraisal.
3. Study Scholarship
4. Recognitions and Awards

## 5.2.5 Investment Area: Health Products and Technologies

Policies guidelines, legal frameworks to guide the process of procurement of quality of drugs at both tiers the governments will be institutionalized. This will to ensure availability and rational drugs use.

## 5.2.6 Investment Area: Health Information System

**Project name: E-health Hubs in 58 health facilities.**

**Introduction:** The service delivery system in Kenya is hampered by lack of linkages between the various levels of care. The management of cases is also curtailed by lack appropriate technology and inadequate human resources. The above scenario can be addressed by strengthening the referral mechanism to facilitate sharing of patient information through ICT.

**Goal:** To Promote and facilitate use of ICT to improve Patient care

**Specific objective:** Use of e-health technology to facilitate management of cases encountered in hard to reach areas.

**Specific targets**

1. Establish and equip 50 e-health hubs in the affected areas by 2017
2. Establish 8 national e-health hubs by 2014
3. Establish a Web portal (including Inventory of personnel/ specialists, master Rota etc.) and develop software module by 2017
4. Establish call centres to support e-referral
5. Ethical guidelines(confidentiality of patient information), e-Referral guidelines and SOPs
6. Train health workers in client exchange parameters for e-referral

### Justification:

The use of e-health, e-medicine and e-specimen will improve health services and lead to better health outcomes; some of the immediate fringe benefits that will accrue to clients include the following; Reduction of waiting time for patients by 80%;Reduction of appointment cancellations by 90%; Hard to reach areas will be able access essential health services through scheduled telemedicine clinics. It is also envisaged that it will create a window of opportunity for training and efficient patient management at decentralized level.

### 5.2.7 Investment Area: Research and Development

### Project Name: Translation of research into policy and practical solutions

### Introduction

Translation of research findings into sustainable improvements in clinical outcomes and patient outcomes remains a substantial obstacle to improving the quality of care. Translational research is scientific research that facilitates the translation of findings from basic science to practical applications that enhance human health and well-being. It used to translate the findings in basic research more quickly and efficiently into medical practice and, thus, meaningful health outcomes. Translational research is seen as a key component to finding practical applications, especially within health sector.

With its focus on removing barriers to multi-disciplinary collaboration, translational research has the potential to drive the advancement of applied science for improved quality of life and human health. An example is a research approach that seeks to move “from bench to bedside” or from laboratory experiments through clinical trials to actual point-of-care patient applications.

**Goal:** The overall goal is to improve decisions about health systems in Kenya by improving policymakers’ access to and use of research evidence that is relevant, reliable, accessible and timely.

The purpose will be to provide and disseminate rigorous, reliable evidence-based syntheses and

summaries of currently available research, which can inform policy makers and others to help improve the health care available for the poor and vulnerable groups. Information about evidence-based health care interventions will lead to less wastage on ineffective interventions.

### Justification

Health policies are often not well informed by research evidence. Poorly informed decision making is one of the reasons why services fail to reach those most in need, health indicators are off-track, and it appears unlikely that Kenya will meet the health MDGs. Reasons for this include problems with the production and accessibility of relevant research, and problems with the use of research evidence by policymakers. Research is not easy to use. Research isn't available when policymakers need it and in a form that they can use. Policymakers frequently need access to research evidence that has been appraised and contextualized in a matter of hours or days, if it is going to be of value to them. This flagship project will prospectively study policymakers' daily needs for research evidence, and develop and evaluate mechanisms for responding rapidly to those needs.

### Objectives

- To develop a Research Communication strategy: the purpose is to ensure that research is useful, accessible, actively disseminated, and communicated in a way that enables potential users to engage and make use of research information in their own work in a timely manner
- To establish and maintain a policymaker–targeted website that provides "one-stop-shop" for optimally packaged high quality and high relevance reviews- the "one-stop-shop" should be sensitive to the current and anticipated needs of policy makers, politicians and communities, and able to demonstrate this in their work.

### 5.2.8 Public – Private Partnership (PPP)

During the Second MTP period, the sector will engage in PPPs under the following strategic objectives:

- Mobilize additional resources for investment in priority areas of the health sector, including developing viable financing options, legal and regulatory provisions for private sector participation;
- Leverage the private sector contribution to national health goals in 2013-2017 to improve the delivery of health services; and
- Strengthen the engagement mechanisms between the public and the private sectors in policy and strategy development as well as in monitoring and progress.

### Project Name: Health and Medical Tourism

**Introduction:** The collaboration between Government and the non-state actors in health has evolved and been strengthened over time. The challenges that the parties have endeavored to address include, the quantity and quality of care offered by some mission facilities; increases in the number of private health facilities with a pronounced urban bias and a flow of qualified health professionals away from the Ministries of Health towards the private sector. Given the rapid changing socio-economic environment in the country, the partnership between Government, the private sector and other non-state actors has been changing fast, due to the fact that the health sector is being seen not just as a service provider but also an economic investment area. Towards this end, partnerships are expanding towards policy development, infrastructure development and equipment, management and capacity building.

Medical tourism is a patient movement from nations to a country to seek medical care by bypassing services offered in their own countries. The medical services typically sought by these patients include elective procedures as well as complex specialized surgeries such as cardiac surgery, joint replacement and dental surgery. Kenya has experienced medical tourism mainly from surrounding countries e.g. Uganda, South Sudan, Somalia etc.

**Justification:** Health and Medical Tourism sits under both the Economic (Tourism) and Social (Health) Pillars. The aim of Medical Tourism for Kenya is to market Kenya as a destination hub for medical services as well as a health improvement destination drawing clients from within Sub-Saharan Africa and beyond. The aim of developing medical tourism framework for Kenya is to support improvement in specialized health and medical services and the health system infrastructure in Kenya as well as an economic generator for the country. Medical tourism will have several impacts in the sector e.g. initially building and retaining specialized expertise within the country, allowing Kenyans to get the care they need from within the country, and ultimately be a destination for health and specialized care for other countries in Africa and beyond.

**Overall Objective:** Position the Country as a destination for specialized health and medical services

### Specific objective:

- Training and retaining specialized expertise in the country,
- Giving Kenyans access to specialized medical services within the country
- Creation of employment in specialized health care
- Increase medical tourism in the country

**Goal:** Establish / Expand existing facilities to be center of excellence for Medical Tourism.

### Targets:

- Number of clients leaving the country to seek specialized medical care reduced by 50%
- Number of specific tourists in the country seeking special care increased by 20
- Projects that will be undertaken during this Plan period include;

### Modernize Kenyatta National Hospital:

This will entail:

#### a. Establishment of a 300- bed Private Hospital for Kenyatta National Hospital

The project will involve construction and equipping of a 300-bed private hospital that will be a subsidiary to the Main KNH to be run on private business principles. The proposed hospital will provide both outpatient and inpatient services as well as specialized health care such as renal services, cardiac and renal operations. The objective is to attract clients who are able to pay. This will generate revenue to support those who are not able to pay for health services at the main hospital. The ultimate goal is to reduce reliance on the Exchequer.

#### b. Construction of 2000 accommodation units and a shopping mall

This project will involve expansion of the estate by demolishing dilapidated colonial houses and replacing them with flats, construction of hostels and shopping complex. The objective is to maximize use of space to generate funds to finance the operations of the hospital to reduce reliance on the Exchequer.

**c. Development of ICT network**

This project involves acquisition and implementation of hospital wide integrated information system. The system will have infrastructure and software components. Infrastructure component will include cabling and installation of switches, servers and routers. Software component will be in different modules for finance, store, laboratory, pharmacy, human resource and clinical modules all integrated into the same operating platform.

**Modernize Moi Teaching and Referral Hospital:**

This will entail:

a. Developing Cancer Management Centre

b. Constructing children hospital

c. Modernization of infrastructure and hospital equipment.

**Project Name**: Locally Derived Natural Health Products

**Introduction:** The Chinese applied modern science to add value to their longstanding traditional medicinal practice, leading to the discovery of Artemesin (WHO recommended first line anti-malarial) from their local plants. This example presents a unique prospect for Kenya which has many medicinal plants used by local communities, most of which have been scientifically shown by local researchers to have great potential to treat malaria and other ailments, yet, currently, these traditional medicinal remedies remain in the informal realm. A major hindrance is the lack of a system of value addition (product development and up-scaling) and a customized regulatory framework that ensures acceptable product standards of quality, safety and efficacy. To this end, initiatives by Kenya Bureau of Standards and Pharmacy and Poisons Board to develop product standards and registration guidelines, respectively, are on-going. The cross-sectoral Natural Products Industry (NPI) initiative seeks to create capacity for value addition to alternative and complimentary medicines through product development and up-scaling to enable mainstreaming into the national healthcare system, as envisaged in the Article 13 of the National Health Bill, 2012.

**Justification**: In the last decade, an exponential growth in the global interest in natural health products has occurred in response to growing awareness of the health risks of synthetic chemical products. Significantly, there is a growing number of foreign companies trading locally in externally sourced natural health products. This trend together with our significant reliance on donor-funded pharmaceuticals justifies the need to build homegrown capacity that will ensure sustainable development and production of locally derived value-added and certified products to meet this enormous demand.

**Goal:** To develop capacity for enhanced uptake of locally derived and certified natural health products into the national healthcare

**Specific objectives:** To refine existing regulatory guidelines to allow registration of natural health products of acceptable varying standards of processing

# 6 POLICY, LEGAL AND INSTITUTIONAL FRAMEWORK

In order to create and sustain a responsive health care system, an appropriate framework to guide, promote and regulate the other underlying sub-components of the system must be developed and functionalized in the most effective way. This aspect calls for a responsive and conducive policy to health development, whilst the instruments and structures to be applied for policy implementation should also ensure that the contents and arrangements are appropriate to the local setting. Unbalanced or unstable policy, legal and institutional frameworks are likely to result to inequitable and inefficient allocation and utilization of available resources hence poor health outcomes at the end.

The Kenya Health Policy Framework 1994, and various pieces of health legislations, provided the policy and legal foundation for the programming, organization, management of the health care system. To some extent, the emerging needs and challenges occurring in the sector have been accommodated into health programming through the respective sector strategic plans, but overall review of the policy is currently in process.

The Constitution demands significant changes to the way health services are governed, delivered and financed. Due to the right based approach and devolution, the policy legal and institutional environments need to adjust accordingly to be consistent with the provisions.

Historically, there were various efforts to legislate or regulate the health sector resulting to pieces and fragments of legislation that are not efficient in the management of health care system. The sector is therefore in the process of developing and enacting one over-arching Kenya Health Bill 2012 and has proposed several subsidiary legislations.

The Constitutional provisions limit the national level tier of government to policy, technical leadership, capacity assistance and management of national referral facilities. The main part of service organization and provision will be carried out by the county tiers; however, significant amount of support will need to be provided during and immediately after the transition to devolved systems that call for a robust legal and institutional framework as provided by the Constitution.

The flagship projects identified in this MTP have been designed to build upon other initiatives for improvement of county health systems and further integrate with national health systems. Key projects identified for this purpose includes country-wide ambulance system; infrastructure development for level 4 services and Community strategy. The interventions are intended to address priority issues in health care delivery.

Under each specific flagship projects, the sector will fast track remaining phases of Health Bill and work towards strengthening the legal, policy and institutional framework geared towards enhancing leadership and governance agenda; Specifically under each investment area the following will be undertaken:

### Service Delivery

Under this investment area the sector will endeavour to establish health policy and legislation, standard setting and SOPs (standard operating procedures). The Sector will also develop policies to guide and encourage local manufacturers to produce drugs and commodities locally in order to reduce cost of care and further define policies and guidelines to embrace research on alternative medicines (natural products) underpinned in the legal and institutional framework.

### Infrastructure and equipment development

Major policies, legal and institutional frameworks that will be instituted under this include National

Policy on Development of Physical Facilities and legislating the process of accrediting and licensing health facilities.

### Health care financing

To realize equitable health care financing mechanism that ensure social protection, particularly for the poor and vulnerable, a deliberate effort will be taken to finalize Health Care Financing Strategy.

### Health Products and Technologies

To ensure a universal access to essential health products and technologies that are available, affordable, safe, efficacious and of good quality, the sector will institutionalize regulatory framework for the control of health products, health product research and technologies. Further a legal framework to recognize the existence of traditional and complementary medicine will be instituted.

### Health Information system

An e-health strategy and detailed framework for implementation will be pre-requisite

### Research and development

In Research and Development, the health sector will develop an explicit research policy and legal framework to guide research activities by various institutions in Kenya. Furthermore, the sector will progressively increase its budget for research in conformity with national, regional and international standard and targets during the period of Second MTP.

# ANNEX 1: IMPLEMENTATION MATRIX

**Project name: Health care subsidies for social health protection.**
**Project Goal: Comprehensive coverage to health services by the economically disadvantaged**

**Strategic objectives: consolidate and expand social health subsidy mechanisms to contribute towards achieving UHC**

| Project/program | Objectives | Expected Outcomes | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
| Establish a unified framework for management of health subsidies. | To establish mechanisms for health subsidies for the poor | Efficient and effective system for mobilization and dispensation of services | MOH/NT/MoD &P/ CoG /DPs | Jul 2014 | GOK/DPs/ County Gov | 50 | 25 | 0 | 0 | 0 |
| Providing subsidies to the economically disadvantaged countrywide | To increase access to health services through public subsidies to the entire indigent population. | Improved health status for the group Improved access to health services by the indigents. Free Maternity services at all public health facilities provided. | MOH/CoG | 2018 | GOK/DPs/pooled funds | 1,000 | 18,500 | 31,000 | 60,000 | 60,000 |

**Project name: Locally derived natural health products.**
**Project Goal: Regulatory guidelines to allow registration of natural health products**

**Strategic objectives: Refine existing regulatory guidelines to allow registration of natural health products**

| Initiatives | Objectives | Expected Outcomes | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
| Enhancing uptake of locally derived natural health products into national healthcare | Develop regulatory guidelines to allow registration of natural health products of acceptable varying standards of processing | Regulatory framework for certification of locally derived value-added natural health products developed | MOH/ KEMRI, Natural Products Industry Coordination Board, PPB, KEBS, | 2015 | GOK/DPs | 50 | 50 | 35 | 35 | 35 |

**Project name: Health care subsidies for social health protection.**
**Project Goal: Comprehensive coverage to health services by the economically disadvantaged**

**Strategic objectives: consolidate and expand social health subsidy mechanisms to contribute towards achieving UHC**

| Project/program | Objectives | Expected Outcomes | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
| Establish a unified framework for management of health subsidies. | To establish mechanisms for health subsidies for the poor | Efficient and effective system for mobilization and dispensation of services | MOH/NT/MoD &P/ CoG /DPs | Jul 2014 | GOK/DPs/ County Gov | 50 | 25 | 0 | 0 | 0 |
| Providing subsidies to the economically disadvantaged countrywide | To increase access to health services through public subsidies to the entire indigent population. | Improved health status for the group Improved access to health services by the indigents. Free Maternity services at all public health facilities provided. | MOH/CoG | 2018 | GOK/DPs/pooled funds | 1,000 | 18,500 | 31,000 | 60,000 | 60,000 |

**Project name: Locally derived natural health products.**
**Project Goal: Regulatory guidelines to allow registration of natural health products**

**Strategic objectives: Refine existing regulatory guidelines to allow registration of natural health products**

| Initiatives | Objectives | Expected Outcomes | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
| Enhancing uptake of locally derived natural health products into national healthcare | Develop regulatory guidelines to allow registration of natural health products of acceptable varying standards of processing | Regulatory framework for certification of locally derived value-added natural health products developed | MOH/ KEMRI, Natural Products Industry Coordination Board, PPB, KEBS, | 2015 | GOK/DPs | 50 | 50 | 35 | 35 | 35 |

**Project name: Health and Medical tourism.**
**Project Goal: Establish / Expand existing facilities to be center of excellence for Medical Tourism.**

**Strategic objectives: Position the Country as a destination for specialized health and medical services**

| Projects | Objectives | Expected Outcomes | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
| Establish one center of excellence for medical tourism. | To increase medical tourism | Increased access and uptake of medical tourism | MOH/ Private Sector. | 2013 – 2017 | GOK/PPP | TBD | TBD | TBD | TBD | TBD |
| Modernize Kenyatta National Hospital for specialized treatment. | To increase access to specialized medical services | 300 bed private Hospital established | KNH | 2013 – 2017 | GoK/PPP | TBD | TBD | TBD | TBD | TBD |
| | | 2000 capacity accommodation and shopping mall constructed. | KNH | 2013 – 2017 | KNH/PPP | TBD | TBD | TBD | TBD | TBD |
| | | ICT network developed. | KNH | 2013 – 2017 | KNH | TBD | TBD | TBD | TBD | TBD |
| Modernize Moi Teaching and Referral Hospital for specialized treatment. | To increase access to specialized medical services | Cancer Management Center Developed. | MTRH | 2013 – 2017 | GOK/PPP/ MTRH | 240 | 150 | 120 | 60 | 30 |
| | | Children Hospital Constructed | MTRH | 2013 – 2017 | GOK/PPP/ MTRH | 88 | 55 | 44 | 22 | 11 |
| | | Infrastructure and equipment improved | MTRH | 2013 – 2017 | GOK/PPP/ MTRH | 761 | 475 | 380 | 190 | 95 |

**Project name: E-health Hubs in 58 health facilities.**
**Project Goal: To Promote and facilitate use of ICT to improve Patient care.**

**Strategic objectives: Use of e-health technology to facilitate management of cases.**

| Projects | Objectives | Outcomes/Output | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
| Establish and equip 58 facilities to e-health hubs | To increase access to health information | E-health hubs both in the county and national facilities established and | MOH/County Govt. | 2013 – 2017 | GOK/DPs | 50 | 200 | 250 | 300 | 300 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| both in the county and national facilities. | using ICT. | equipped. Increased number of facilities utilizing e-health system. | | | | | | | | |
| **Project name: Improved access to referral system**<br>**Project Goal: Country-wide coverage of efficient and effective referral network and supporting systems** | | | | | | | | | | |
| **Strategic objective** | **To Provide technical support for the establishment of efficient vertical and horizontal country-wide comprehensive referral system with national, intra and inter-county health services** | | | | | | | | | |
| **Project** | **Objectives** | **Expected Outcomes/ output** | **Implementing Agency** | **Time Frame** | **Sources of Funds** | **Indicative Budget (Kshs million)** | | | | |
| | | | | | | **2013/2014** | **2014/2015** | **2015/2016** | **2016/2017** | **2017/2018** |
| Enhance the capacity of referral systems | To Provide technical support for the establishment of efficient vertical and horizontal countrywide comprehensive referral system | Functional national, intra and inter-county referral system. Legal and institutional framework developed Communication related equipment and Ambulances for national and county level procured. | Ministry of Health, Private service providers, police service, County governments | Jul 2013-2017 | GOK, DPs, Private sector and CoG | 170 | 200 | 200 | 200 | 770 |
| Provide communication, related equipment and ambulances for national and county level | Efficient communication, information sharing network and coverage of ambulance services | Improved access to emergency services | Ministry of Health, NSA providers, police service, CoGs | 2014 - 2017 | GOK, DPs, providers, Private and county resources | 120 | 200 | 200 | 200 | |
| **Project name: Mainstreaming research and development in health**<br>**Project Goal: To improve decisions about health systems in Kenya by improving policymakers' access to and use of research evidence that is relevant, reliable, accessible and timely, to help improve the health care available for the poor and vulnerable groups** | | | | | | | | | | |

| Strategic objective | 1. To utilize health research evidence for policy making and Programming<br>2. To establish and maintain a policymaker–targeted website architecture. | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Project** | **Objectives** | **Expected Outcomes** | **Implementing Agency** | **Time Frame** | **Sources of Funds** | **Indicative Budget (Kshs million)** | | | | |
| | | | | | | **2013/2014** | **2014/2015** | **2015/2016** | **2016/2017** | **2017/2018** |
| Research & Innovation | To provide stewardship and oversight on Research. | Improved Evidence based policies and decision making. | MOH, KEMRI, NCST, Universities, Industry, Private health research institutions and DPs | 2013-2017 | MOH, Development partners. | 4 000 | 4800 | 5760 | 6912 | 8294 |
| Research & Innovation | To conduct basic, clinical, operational, implementation and applied research in health and health related areas. | Timely context-specific research evidence translated into appropriate policy recommendations and practical guidelines. Patents on innovations | KEMRI, NCST, Universities, Industry, Private health research institutions, Regional and international collaborators and partners, Health facilities, MOH | 2013-2017 | MOH, Development partners, Philanthropic organizations | 4 000 | 4800 | 5760 | 6912 | 8294 |
| Training & capacity building | To provide specialized training and capacity building in the conduct, dissemination, use and impact measurement of research | Highly skilled human resource for addressing health issues | MOH, KEMRI, NCST, Universities, Industry, Private health research institutions and Development. partners | 2013-2017 | MOH, Development partners. | 500 | 600 | 720 | 864 | 1036.8 |
| Research Products | Development and commercialization of research products. | Appropriate technologies, products and utility models for improved service delivery | MOH, KEMRI, NCST, Universities, Industry, Private health research institutions and | 2013-2017 | MOH, Development partners. | 300 | 360 | 432 | 518.4 | 622 |

| | | | Development. partners | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Project name: Scale up of Community Health High Impact Interventions**<br>**Project Goal: To reduce Maternal neonatal and child health (MNCH) morbidity and mortality** | | | | | | | | | | |
| **Strategic objective** | **Scale up of high impact interventions (HII) at level 1 in order to reduce Maternal and neonatal mortality and morbidity in the country.** | | | | | | | | | |
| **Project** | **Objectives** | **Expected Outcomes/output** | **Implementing Agency** | **Time Frame** | **Sources of Funds** | **Indicative Budget (Kshs million)** | | | | |
| | | | | | | **2013/2014** | **2014/2015** | **2015/2016** | **2016/2017** | **2017/2018** |
| Scale up of community heath high impact interventions | To increase access to health and related services to communities for RMCNH. | Reduced Maternal, neonatal, child mortality and morbidity Community units established Community strategy coverage for nutrition, FP, Immunization, HIV/AIDs and malaria services expanded. | MOH, Community, county governments | 2013-2017 | GoK, Development partners, CoGs | 8,435 | 9,275 | 10,519 | 11,973 | 7,157 |
| **Project name: Construct model level 4 Hospitals.**<br>**Project Goal: To improve access to comprehensive health services** | | | | | | | | | | |
| **Strategic objectives** | **To provide a functional and sustainable infrastructure for comprehensive services** | | | | | | | | | |
| **Initiatives** | **Objectives** | **Expected Outcomes/output** | **Implementing Agency** | **Time Frame** | **Sources of Funds** | **Indicative Budget (Kshs million)** | | | | |
| | | | | | | **2013/2014** | **2014/2015** | **2015/2016** | **2016/2017** | **2017/2018** |
| Rehabilitation/upgrading of infrastructure and equipment for level 4 | To rehabilitate/upgrade health facilities to provide | Improved access to comprehensive services | MOH, county governments | 2013-2017 | MOH, Development partners, county governments | 1000 | 1200 | 1440 | 1728 | 2074 |

| Initiatives | Objectives | Expected Outcomes/output | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| facilities | comprehensive health care services<br>Increased coverage of comprehensive health care services | 100 model level 4 health facilities rehabilitated and upgraded. | | | | | | | | |

**Project name: Re-engineering Human Resources for Health**
**Project Goal: Improved leadership and management of health services.**

| Strategic objectives | To improve management of the existing work force by putting in place rational capacity development, attraction, retention and motivation mechanism for the work force. | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Initiatives** | **Objectives** | **Expected Outcomes/output** | **Implementing Agency** | **Time Frame** | **Sources of Funds** | **Indicative Budget (Kshs million)** | | | | |
| | | | | | | **2013/2014** | **2014/2015** | **2015/2016** | **2016/2017** | **2017/2018** |
| Re-engineering Human Resources for Health | To develop incentive and retention schemes for health workers in hardship areas. | Reward and health system management institution established | MOH/County GoK | 2013 - 2017 | GOK/County governments | 13 | 60 | 100 | 120 | 150 |

**Project name: Health care subsidies for social health protection.**
**Project Goal: Comprehensive coverage to health services by the economically disadvantaged**

**Strategic objectives: consolidate and expand social health subsidy mechanisms to contribute towards achieving UHC**

| Project/programme | Objectives | Expected Outcomes | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
| Establish a unified framework for management of health subsidies. | To establish mechanisms for health subsidies for the poor | Efficient and effective system for mobilization and dispensation of services | MOH/NT/MoD &P/ CoG /DPs | Jul 2014 | GOK/DPs/ County Gov | 50 | 25 | 0 | 0 | 0 |
| Providing subsidies to the economically disadvantaged countrywide | To increase access to health services through public subsidies to the entire indigent population. | Improved health status for the group Improved access to health services by the indigents. Free Maternity services at all public health facilities provided. | MOH/CoG | 2018 | GOK/DPs/pooled funds | 1,000 | 18,500 | 31,000 | 60,000 | 60,000 |

**Project name: Locally derived natural health products.**
**Project Goal: Regulatory guidelines to allow registration of natural health products**

**Strategic objectives: Refine existing regulatory guidelines to allow registration of natural health products**

| Initiatives | Objectives | Expected Outcomes | Implementing Agency | Time Frame | Sources of Funds | Indicative Budget (Kshs million) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
| Enhancing uptake of locally derived natural health products into national healthcare | Develop regulatory guidelines to allow registration of natural health products of acceptable varying standards of processing | Regulatory framework for certification of locally derived value-added natural health products developed | MOH/ KEMRI, Natural Products Industry Coordination Board, PPB, KEBS, | 2015 | GOK/DPs | 50 | 50 | 35 | 35 | 35 |

# ANNEX 2: HEALTH SECTOR MONITORING INDICATORS

| | Indicator | Frequency | Source | Baseline2012 | TargetYr1 | TargetYr2 | TargetYr3 | TargetYr4 | TargetYr5 | Responsible Organization |
|---|---|---|---|---|---|---|---|---|---|---|
| **OUTCOME 1** | **Essential Health services Provided(Reduction of Maternal Mortality, Infant Mortality and Under five Mortality).** | | | | | | | | | |
| | Maternal Mortality Ratio | 5yrs | Survey (KDHS) | 488/100,000 | 400/100000 | 350/100000 | 300/100000 | 250/100000 | 200/100,000 | MOH |
| | Proxy Indicator% of deliveries conducted skilled attendants. | Monthly | HMIS and RNMCH | 43% | 48% | 53% | 58% | 60% | 65% | MOH |
| | i. % of facilities providing BEOC | Monthly | HMIS and RNMCH | 65% | 70% | 70% | 80% | 90% | 90% | MOH |
| | ii. % of pregnant women attending 4 ANC visits. | Monthly | HMIS and RNMCH | 47.1% | 53.6% | 60.3% | 66.9% | 73.5% | 80% | MOH |
| | iii. % of women of reproductive health receiving family planning by method, by county | Monthly | HMIS/ RNMCH | 45% | 52% | 59% | 66% | 73% | 80% | MOH |
| | iv. % of Women's perception of the quality of maternal health services, by age, and socio-economic status | Survey | KDHS/Household survey | 46% | 50% | 55% | 60% | 75% | 80% | MOH |
| | Under five mortality rate | 5 years | KDHS | 74/1,000 | 65/1,000 | 60/1,000 | 50/1,000 | 40/1,000 | 35/1,000 | MOH |
| | % under 5's stunted | Monthly | HMIS/Nutrition Programme | 35% | 30% | 25% | 20% | 15% | 15% | MOH |
| | % under 5 underweight | Monthly | HMIS/Nutrition Programme | 17 | 15% | 13% | 11% | 9% | 5% | MOH |
| | Infant Mortality rate (IMR) | 5 years | KDHS | 52/1,000 | 47/1,000 | 42/1,000 | 38/1,000 | 35/1,000 | 30/1,000 | MOH |
| | % Fully immunized children | Monthly | HMIS/DVI | 79 | 80% | 85% | 90% | 90% | 90% | MOH |

| | Indicator | Frequency | Source | Baseline2012 | TargetYr1 | TargetYr2 | TargetYr3 | TargetYr4 | TargetYr5 | Responsible Organization |
|---|---|---|---|---|---|---|---|---|---|---|
| | % of targeted under 1's provided with LLITN's | Monthly | HMIS/Malaria Programme | 44 | 56% | 67% | 85% | 85% | 85% | MOH |
| | % of facilities providing Immunization | Monthly | HMIS/DVI | 80 | 85% | 90% | 100% | 100% | 100% | MOH |
| **OUTCOME 2** | **Minimized risk to health Exposure(Reduced HIV prevalence, Reduced Malaria incidences and TB cure rate)** | | | | | | | | | |
| | **HIV prevalence rate** | Survey | KDHSKAIS | 5.6% | 5.3% | 5.0% | 4.9% | <4.5% | <4% | MOH |
| | i. % HIV +ve pregnant mothers receiving preventive ARVs. | Monthly | HMISNASCOP | 63% | 75% | 85% | 90% | 90% | 90% | MOH |
| | ii. % of eligible HIV clients on ARVs. | Monthly | HMIS/NASCOP | 60% | 65% | 70% | 75% | 80% | 90% | MOH |
| | iii. TB cure rate | Survey | KDHS | 83% | 85% | 85% | 88% | 90% | 90% | MOH |
| | iv. % of TB patients completing treatment | Monthly | HMIS/TB Programme | 85% | 87% | 89% | 90% | 90% | 90 | MOH |
| | v. % of targeted under 1's provided with LLITN's | Monthly | HMIS/Malaria Programme | 30% | 50% | 60% | 70% | 80% | 85% | MOH |
| | **Malaria inpatient case fatality** | Monthly | HMIS | 15% | 10% | 8% | 8% | 5% | 5% | MOH |
| | vi. % of targeted pregnant women provided with LLITN's | Monthly | HMIS/Malaria Programme | 30% | 50% | 60% | 70% | 80% | 85% | MOH |

| | Indicator | Frequency | Source | Baseline2012 | TargetYr1 | TargetYr2 | TargetYr3 | TargetYr4 | TargetYr5 | Responsible Organization |
|---|---|---|---|---|---|---|---|---|---|---|
| **OUTCOME 3** | **Communicable diseases eliminated(Immunization, Sanitation and nutrition)** | | | | | | | | | |
| | i. % of children fully immunized | | | 83% | 85% | 90% | 90% | 90% | 90% | MOH |
| | ii. % of under five (5 yrs) children underweight. | | | 17% | 15% | 10% | <10% | 5% | 5% | MOH |
| | iii. % of population with access to safe water | Survey | KDHS | 60% | 70% | 80% | 85% | 85% | 85% | MOH |
| | iv. % of households with latrines | Survey | KDHS | 34% | 40% | 45% | 60% | 65% | 70% | MOH |
| **OUTPUT 4** | **Country wide Scale up of Community MNCH High Impact Interventions** | | | | | | | | | |
| | % of functional community units by county | Quarterly | HMIS/County coordinating Unit | 20% | 40% | 55% | 60% | 75% | 80% | MOH |
| **OUTCOME 5** | **Improved access to comprehensive and emergency health services(Human resource Infrastructure, equipments, Ambulances and e-hubs)** | | | | | | | | | |
| | i. # of facilities upgraded and rehabilitated as per norms. | Yearly | Health Administration | | 40 | 30 | 10 | 10 | 10 | MOH |
| | ii. % of population living within 5 KMS of a facility | Survey (yearly) | Household Survey, Client survey | 80% | 85% | 85% | 90% | 90% | 90% | MOH |
| | iii. # of facilities per 10,000 population | Survey | HMIS | 1.5 | 2 | 2 | 2.5 | 2.5 | 2.5 | MOH |
| | iv. % of referred clients reaching referral units | Monthly | HMIS | 25% | 30% | 45% | 50% | 60% | 75% | MOH |
| | v. # of functional e-health hubs established | Monthly | e-health/HMIS | 0 | 10 | 10 | 15 | 15 | 8 | MOH |
| | vi. Incentive mechanism appraised and working | Yearly | Human resource | 0 | 5% | 10% | 15% | 20% | 25% | MOH |

|  | Indicator | Frequency | Source | Baseline2012 | TargetYr1 | TargetYr2 | TargetYr3 | TargetYr4 | TargetYr5 | Responsible Organization |
|---|---|---|---|---|---|---|---|---|---|---|
| **OUTCOME 6** | **Enhance quality of health care for indigents.** |  |  |  |  |  |  |  |  |  |
|  | i. % of indigents covered. | Yearly | Planning unit | 11% | 15% | 15% | 20% | 20% | 20% | MOH |
|  | ii. % of total health expenditure from out of pocket. | Survey | Household survey, NHA | 33% | 30% | 25% | 20% | 20% | 15% | MOH |
| **OUTCOME 7** | **Reduction of the No. of those seeking treatment outside the country.** |  |  |  |  |  |  |  |  |  |
|  | # of patients seeking specialized treatment locally | Monthly | HMIS | NR |  |  |  |  |  | GOK/PPP |
|  | # of facilities fully expanded to provide specialized treatment. | Monthly | HMIS/Administration | NR |  |  |  |  |  | GOK/PPP |
| **OUTCOME 8** | **Appropriate technologies, products and utility models for improved service delivery** |  |  |  |  |  |  |  |  |  |
| . | # of policies informed by research innovations. | Yearly | KEMRI/MEST | NR |  |  |  |  |  | MOH |
|  | # of utility models developed. | Yearly | KEMRI | NR |  |  |  |  |  | MOH |
|  | # of pieces of legislations enacted to support uptake of locally derived products. | Yearly | KEMRI | NR |  |  |  |  |  | GOK/PPP |
| **OUTCOME 9** | **Improve access to care for gender based violence victims.** |  |  |  |  |  |  |  |  |  |

| | Indicator | Frequency | Source | Baseline2012 | TargetYr1 | TargetYr2 | TargetYr3 | TargetYr4 | TargetYr5 | Responsible Organization |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number of SGBV survivors presenting < 72 hours disaggregated by type, sex, Age and Region | Monthly | HMIS/DRH | NR | | | | | | MOH |
| | **Number of SGBV survivors referred for immediate medical management. (Survey)** | Monthly | DRH/Planning/HMIS | NR | | | | | | MOH |
| | Number of reported cases of sexual violence disaggregated by type of violence, sex, age of victim and region | Monthly | HMIS/DRH | NR | | | | | | MOH |