Republic of Kenya

Reversing the trends

The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

Ministry of Public Health and Sanitation

STRATEGIC PLAN 2008–2012

Ministry of Public Health and Sanitation

December 2008

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STRATEGIC PLAN

2008–2012

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Message from the Minister

As the statement of the investment priorities of the Ministry of Public Health and Sanitation for the period 2008–2012, this Strategic Plan is in line with the Government's first Medium-Term Plan and Kenya Vision 2030. The plan has been developed through the collaborative efforts of various health sector stakeholders. It builds on the achievements and challenges arising during the implementation of the Second National Health Strategic Plan II (NHSSP II – 2005–2010), which had as its goals "to reduce health inequalities and to reverse the downward trends in health related outcome and impact indicators".

The vision of my Ministry is to make Kenya "a nation free from preventable diseases and ill health", through primary health care interventions at individual, household, community and primary health facility levels. The strategic plan for the Ministry is a milestone in the history of Kenya, as it is specific to public health and sanitation interventions. Thus, it is envisaged that the national resource allocation for public health and sanitation services will increase significantly.

Priority will be given to scaling up the implementation of interventions aimed at enhancing the equitability of access to public health and sanitation services. Such measures will include improving immunization coverage for children, ensuring that most deliveries are conducted under the care of skilled health attendants, and reducing morbidity and mortality from malaria, HIV/AIDS, tuberculosis and non-communicable diseases.

Government will invest substantial resources in building the capacity of communities to take charge of their health care development and to manage resources for health. This will be done by scaling up the roll out of the Community Strategy to progressively cover the entire nation in a manner that is responsive and sensitive to the socio-cultural values and practices of the various communities in the country. In order to accelerate the Community Strategy, the Ministry plans to channel health sector services funds directly to all dispensaries and health centres.

Successful implementation of this plan will require the coordinated action of many sectors and the participation of all stakeholders in the health sector. I am confident that this plan will inform the process of joint annual planning. I request and urge all members of my Ministry to put great effort into implementing this plan as a means of averting preventable morbidity and mortality in our country and improving Kenyans' quality of life.

Hon. Beth Mugo, EGH, MP
Minister for Public Health and Sanitation
December 2008

Acknowledgements

Extensive consultations among various stakeholders marked the development process of this strategic plan. The process was organized through clearly defined working groups reflecting three broad thematic areas: Service Delivery, Support Systems, and Governance and Financing. The appointed senior ministry staffs provided the required leadership to these groups, under the direct supervision of the acting Director of Public Health and Sanitation, Dr. S.K. Sharif. The effective stewardship by Head of Technical Planning and Monitoring Dr. Samuel Were was laudable. The outputs from the groups were harmonized and summarized before being consolidated to produce the first draft. This draft was then shared internally and with stakeholders who provided invaluable inputs that have been duly incorporated into this final document.

I thank all the members of the working teams, who included:

- *Service Delivery Team:* Dr. John Odondi, Primary Health Services; Dr. Josphine Kibaru, Family Health; Mr. Kepha Ombacho, Sanitation and Environmental Health; and Dr. Salim Ali, Health Promotion.
- *Support Systems Team:* Mr. S. Kaloki, Human Resources for Health; Mr. Ochola Ondari, Procurement; Mr. Edward Were, Principal Accounts Controller; Mr. N.K. Waweru, acting senior deputy secretary; Ms. Rachel Wairimu, Information and Communications Technology; Dr. Ruth Kitetu, Technical Planning; Dr. Kibet Sergon, Monitoring and Evaluation and Health Management Information System; and Mr. Kamande, Radiation Protection Board.
- *Governance and Finance Team:* Dr. Samuel Were, Technical Planning and Monitoring; Mr. Kennedy Nyamao, Chief Financing Officer; Mr. Ayub Mwando, Policy and Planning; and Mrs. Zipporah Momanyi, Health Administrator.

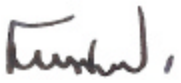
In particular much appreciation goes to the plan secretariat – Dr. Were, Dr. Kitetu, Dr. Sergon, Dr. Richard Pendame and Mr. Mwando – who patiently worked for long hours towards the successful preparation of this plan.

Indeed, I cannot underplay the significant inputs and contributions from development and

implementing partners. Their collective opinions and wisdom contributed greatly to the drafting and finalization of the plan.

The development of the plan was made possible through the technical advisors obtained from our development partners, in particular the UK's Department for International Development (DFID) through Essential Health Services (EHS), as well as the German Development Cooperation (GDC); we are very grateful to both of them. I am especially thankful to Dr. Richard Pendame (EHS) and Prof. Peter Nyarang'o (GDC) for their great contributions to the development of this plan.

Finally I thank DFID, which through the EHS programme provided financial support to develop the plan.



Mark Bor, EBS
Permanent Secretary
Ministry of Public Health and Sanitation
December 2008

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List of Abbreviations

AIDS	Acquired immune deficiency syndrome
AIE	Authority to incur expenditure
ANC	Antenatal care
AOP	Annual operational plan
ART	Anti-retroviral therapy
BCC	Behaviour change communication
BCG	Bacille Calmette-Guerin (TB vaccine)
CBHMIS	Community-based health management information system
CDF	Constituency Development Fund
CFO	Chief Financing Officer
CHEW	Community health extension worker
CHW	Community health worker
CORP	Community-owned resource person
CP	Chief Pharmacist
DCH	Division of Child Health
DEH	Division of Environmental Health
DFID	Department for International Development (UK)
DHMB	District Health Management Board
DHMT	District Health Management Team
DHP	District health plan
DHSF	District Health Stakeholder Forum
DMOH	District Medical Officer of Health
DOMC	Division of Malaria Control
DPHS	Director of Public Health and Sanitation
DRH	Division of Reproductive Health
DSRS	Department of Standards and Regulatory Services
EMMS	Essential Medicines and Medical Supplies
ERS	Economic Recovery Strategy (for Wealth and Employment Creation)
EU	European Union
FBO	Faith-based organization
FP	Family planning
GDC	German Development Cooperation
GFATM	Global Fund to Fight AIDS, TB and Malaria
GOK	Government of Kenya
P4H	Providing for Health
HACCP	Hazardous analysis critical control point
HBC	Home-based care
HIV	Human immuno-deficiency virus
HMIS	Health management information system
HQ	Headquarters (generally refers to MOPHS)
HRD	Human Resource Development
HRH	Human resources for health
HRIO	Health records and information officer
HSCC	Health Sector Coordinating Committee
HSSF	Health Sector Services Fund

ICT	Information and communication technology
IDSR	Integrated disease surveillance and response
IEC	Information, education and communication
IFMIS	Integrated financial management information system
IHP	International Health Partnerships
IMCI	Integrated management of childhood illness
IMR	Infant mortality rate
IPT	Intermittent prophylactic treatment (for malaria)
JICC	Joint Inter-Agency Coordinating Committee
JPWF	Joint Programme of Work and Funding
JSP	Joint Support Programme
KEMSA	Kenya Medical Supply Agency
KENWA	Kenya Network of Women with AIDS
KEPH	Kenya Essential Package for Health
KEPI	Kenyan Expanded Programme of Immunization
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
Ksh	Kenya shilling
LBW	Low birth weight
LLITN	Long-lasting insecticide treated bed net
M&E	Monitoring and evaluation
MCH	Mother and child health
MDGs	Millennium Development Goals
MDR	Multi drug resistant
MMR	Maternal mortality ratio
MMU	Ministerial Management Unit
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MOU	Memorandum of understanding
MPER	Ministerial public expenditure review
MTEF	Medium-term expenditure framework (three-year rolling plan)
MTPP	Medium-term procurement plan
MTRH	Moi Teaching and Referral Hospital
NA	Not available
NASCOP	National AIDS and STD Control Programme
NBTS	National Blood Transfusion Service
NGO	Non-government organization
NHSSP II	Second National Health Sector Strategic Plan 2005–2010
NLTP	National Leprosy and TB Programme
NPHLS	National Public Health Laboratory Services
NS	Not stated
NSHIF	National Social Health Insurance Fund
OBA	Output-based approach
PAC	Principal Accounts Controller
PDMS	Provincial Director of Medical Services
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	Public finance and management
PGH	Provincial General Hospital
PHMT	Provincial Health Management Team
PME	Performance-based monitoring and evaluation
PMO	Provincial Medical Officer
PMSMT	Provincial Medical Services Management Team
PMTCT	Prevention of mother-to-child transmission (of HIV)
PRM	Planning, review and monitoring
PS	Permanent Secretary
PU	Procurement Unit
RBM	Results-based management
RH	Reproductive health
RRI	Rapid results initiative
SCC	SWAp Coordinating Committee
SOP	Standard operating procedures
SSOP	Sanitary standard operating procedures
SWAp	Sector-wide approach
TB	Tuberculosis
TOR	Terms of reference
TOT	Training/trainer of trainers
TSC	Technical Stakeholders Committee
VCT	Voluntary counselling and testing
WG	Working group
WHO	World Health Organization
WIT	Work Improvement Teams
WRA	Women of reproductive age

Executive Summary

As part of the Government of Kenya's ongoing public sector reforms, this medium-term Strategic Plan for the Ministry of Public Health and Sanitation (MOPHS) charts the way forward for the Ministry over the next four years. Key policy documents that informed the articulation of the plan were Kenya Vision 2030, the first Medium-Term Plan (2008–2010), Kenya Health Policy Framework 1994–2010, the second National Health Sector Strategic Plan (NHSSP II – 2005–2010) and the Medium-Term Expenditure Framework (MTEF) 2008–2011.

The plan intends to support the implementation of these key policy documents and also to guide the formulation of the Ministry's annual operational plans and performance contracts.

The Process

Using guidelines set by the Ministry of Planning, National Development and Vision 2030, three working groups undertook the process of developing this plan. The process included several steps: Existing policy documents were reviewed, a situation assessment was undertaken to determine successes and challenges for the Ministry, and, through a series of workshops, the priorities, strategies and implementation matrix of the plan were developed.

Internal as well as health sector stakeholder consultations on the draft plan were undertaken and comments incorporated into the final plan.

The Priorities

The priorities of this strategic plan are derived from Kenya's development agenda, public health

Among the priorities of this Plan are:

- Articulating an Infrastructure Investment Policy and Strategy
- Building and/or rehabilitating 780 level 2 and 3 health facilities
- Setting up 40 nomadic clinics
- Creating 2,550 community units
- Recruiting 23,645 new technical staff
- Scaling up behaviour change and communication interventions at level 1 to reduce HIV incidence
- Institutionalizing quality assurance systems
- Developing key health sector policy documents
- Institutionalizing the Health Sector Services Fund

challenges, the MOPHS mandates, and the lessons learnt in the delivery of public health and sanitation services in the country. These priorities are supposed to contribute to the achievement of the objectives of the First Medium-Term Plan for the Government of Kenya.

Strategic Thrusts

Five strategic thrusts define the priority areas for public health and sanitation services during the period 2008–2012. These are:

- Improving equitable access to public health and sanitation services
- Improving quality and responsiveness of public health and sanitation services
- Improving efficiency of public health and sanitation services
- Fostering partnerships
- Improving financing for public health and sanitation services

Specific Goals and Strategies

For each thrust, specific goals and implementation strategies were developed. These are:

Thrust 1: Improving equitable access to public health and sanitation services

1.1) Increase the proportion of communities that live within 5 km of a functional health facility from 52% to 62%

1.2) Increase the proportion of deliveries conducted by skilled attendants from 42% to 60%

Thrust 2: Improve quality of public health and sanitation services

2.1) Reduce the vacancy rate of technical staff by 40%

2.2) Increase the health workforce trained to 40,255 staff by 2012, by carrying out a training needs assessment and develop a training programme

2.3) Rehabilitate and adequately equip 50% of level 2 and 3 and other public health facilities

2.4) Reduce proportion of facilities reporting no stock outs by 100%, by maintaining adequate stock levels of medicines, commodities and supplies through measures such as proper forecasting, timely procurement and efficient distribution.

> The strategic plan anticipates reducing by 20% the incidence of malnutrition among children under five years by providing Vitamin A supplements to 100% of all those eligible.

2.5) Increase sanitation coverage from 46% to 66%

2.6) Increase the number of households utilizing safe water by 20% by promoting use of treated water at household level

2.7) Increase the number of facilities with health care waste management systems from 20% to 100%

2.8) Increase client satisfaction by 50% in 2,408 health facilities

2.9) Reduce the incidence of food-borne diseases/illnesses by 5%

2.10) Reduce mortality rate due to emergen-cy to below 1/10,000 persons at risk per day

2.11) Increase the utilization of cost-effective reproductive health services by 50%

2.12) Increase the utilization of cost-effective child health care services by 50%

2.13) Reduce new HIV infections by 50% by scaling up behaviour change initiatives at community/household level

2.14) Increase TB case detection and treatment to 90% by increasing the capacity of level 2 and 3 to diagnose and treat

2.15) Reduce malaria incidence to 15% by utilizing cost effective control measures such as long-lasting insecticide treated nets and indoor household spraying

2.16) Reduce the incidence of malnutrition of children <5 years by 20% by providing Vitamin A supplements to 100% of all those eligible

Thrust 3: Improve efficiency of public health and sanitation services

3.1) Reduce the staff vacancy rate by 60%

3.2) Increase the proportion of staff trained as per government policy by 50%

3.3) Increase the proportion of employee job satisfaction by 90%

3.4) Increase the availability and utilization of information and communication technology (ICT) by 60%

3.5) Improve the utilization of transport services by 50%

3.6) Increase the availability of tracer drugs to 90% at service delivery points
3.7) Achieve 100% disposal of obsolete, unserviceable and surplus assets annually
3.8) Increase the reporting rates of health facilities/districts providing quality health information by 30% at all levels for evidence-based decision making
3.9) Strengthen the management and availability of general supplies facilities.
3.10) Strengthen the financial management systems

Thrust 4: Fostering partnerships
4.1) Strengthen governance structures at 1, 2 and 3 by 2012
4.2) Improve stewardship and partnership arrangements at all levels

Thrust 5: Improve financing of public health and sanitation services
5.1) Ensure all facilities receive financial resources based on needs
5.2) Increase efficiency in utilization of resources
5.3) Increase financial resources to MOPHS by 20%

Flagship Projects

The priority projects for this strategic plan are:
- Infrastructure Investment Policy and Strategy
- Opening and operation of 520 non-functioning level 2 and 3 health facilities
- Construction of 260 new level 3 facilities
- Setting up of 40 nomadic clinics
- Creation of 2,550 community units
- Recruitment of 23,645 new technical staff
- Ensuring households are using treated water
- Fumigating 4,000 households to prevent jiggers
- Creating demand for reproductive health services
- Scaling up of behaviour change and communication interventions at community and household level aimed at reducing HIV incidence
- Institutionalization of quality assurance systems, KQM, citizen charters and ISO 22000
- Implementation of the human resources for health (HRH) strategic plan
- Development of key health sector policy documents: revised Kenya Health Policy Framework, the third NHSSP, the Public Health Act and the Pubic-Private Partnership Policy
- Institutionalization of the Health Services Support Fund

Monitoring and evaluating progress on the implementation of the strategic plan will be facilitated by specific indicators for service delivery, support systems, partnerships and financing.

Coordination Framework for the Implementation of the Strategic Plan

The health sector coordination structures that are currently existing at the national, provincial, district, health facility and community level will be responsible for providing the required guidance to the implementing units and to ensure that stakeholders are well coordinated thereby facilitating the smooth implementation of this plan.

Capacity to Implement the Strategy

The management structures at the national, provincial, district, health facility and community levels will provide the leadership required for each level to ensure that the plan is implemented effectively and efficiently. The identified capacity weaknesses of the existing inadequate human resources – in terms of numbers, knowledge and skills – and lack of equipment and technology at different levels of the health system that would influence the implementation of the plan will be addressed as the plan is rolled out.

Financing the Plan

The financial resources required for the implementation of the plan amount to Ksh195.2 billion. From the MTEF, the total financial resources available to finance the plan amount to Ksh91.6 billion. The indicative financial resource gap is, therefore, Ksh103.6 billion. This gap is expected to be bridged by the off-budget resources from development partners who generously provide technical and financial support to public health and sanitation services.

Risks

The implementation of this plan and hence the realization of the 2008–2012 targets may be affected by a number of factors: reduced financing from Government and development partners, corruption, poverty, non-functioning faith-based services, weak management and coordination systems, food insecurity, and poor quality of Government health care services. The mitigation measures for these perceived risks are outlined in the plan.

Monitoring, Evaluation and Reporting

A framework for monitoring and evaluating progress on the implementation of the strategic plan has been developed. Specific indicators for service delivery, support systems, partnerships and financing have been identified for monthly, quarterly, and annual monitoring of progress. Impact indicators for evaluating mid and end-term evaluations are also identified. A dashboard approach to measure performance in the delivery of services will be done jointly with the Ministry of Medical Services.

1 Introduction

Strategic planning constitutes a major plank in the Government of Kenya's ongoing public sector reforms, which have the objective of enhancing public service delivery. In addition, strategic planning provides a forum through which the Government can communicate with all stakeholders on the use of public resources for the common good. Following the launch of Vision 2030 and its First Medium-Term Plan (MTP) 2008–2012, all Government ministries are required to develop ministerial strategic plans for the period 2008–2012.

1.1 The Rationale for Ministerial Strategic Planning

For the Ministry of Public Health and Sanitation (MOPHS), this strategic plan, like others within the public sector, is expected to support the implementation of Vision 2030 and MTP 2008–2012, along with the broad goals of the second National Health Sector Strategic Plan (NHSSP II) 2005–2010.[1] The MOPHS strategic plan will also form the basis for identifying deliverables under the performance contracting mechanism and for individual annual performance appraisal.

Because the strategic plan has linkages to the medium-term expenditure framework (MTEF) as well as human resource planning, it delineates the necessary financial resources for programme

NHSSP II aimed to reduce health inequalities and reverse the downward trends in health-related outcome and impact indicators. The plan has the following objectives:

- Increase equitable access to health services
- Improve the quality and responsiveness of services
- Foster partnerships in improving health and delivering services
- Improve the efficiency and effectiveness of service delivery
- Improve financing of the health sector

This strategic plan is expected to support the implementation of Vision 2030 and MTP 2008–2012, along with the broad goals of the second National Health Sector Strategic Plan (NHSSP II) 2005–2010. The plan also has linkages to the medium-term expenditure framework.

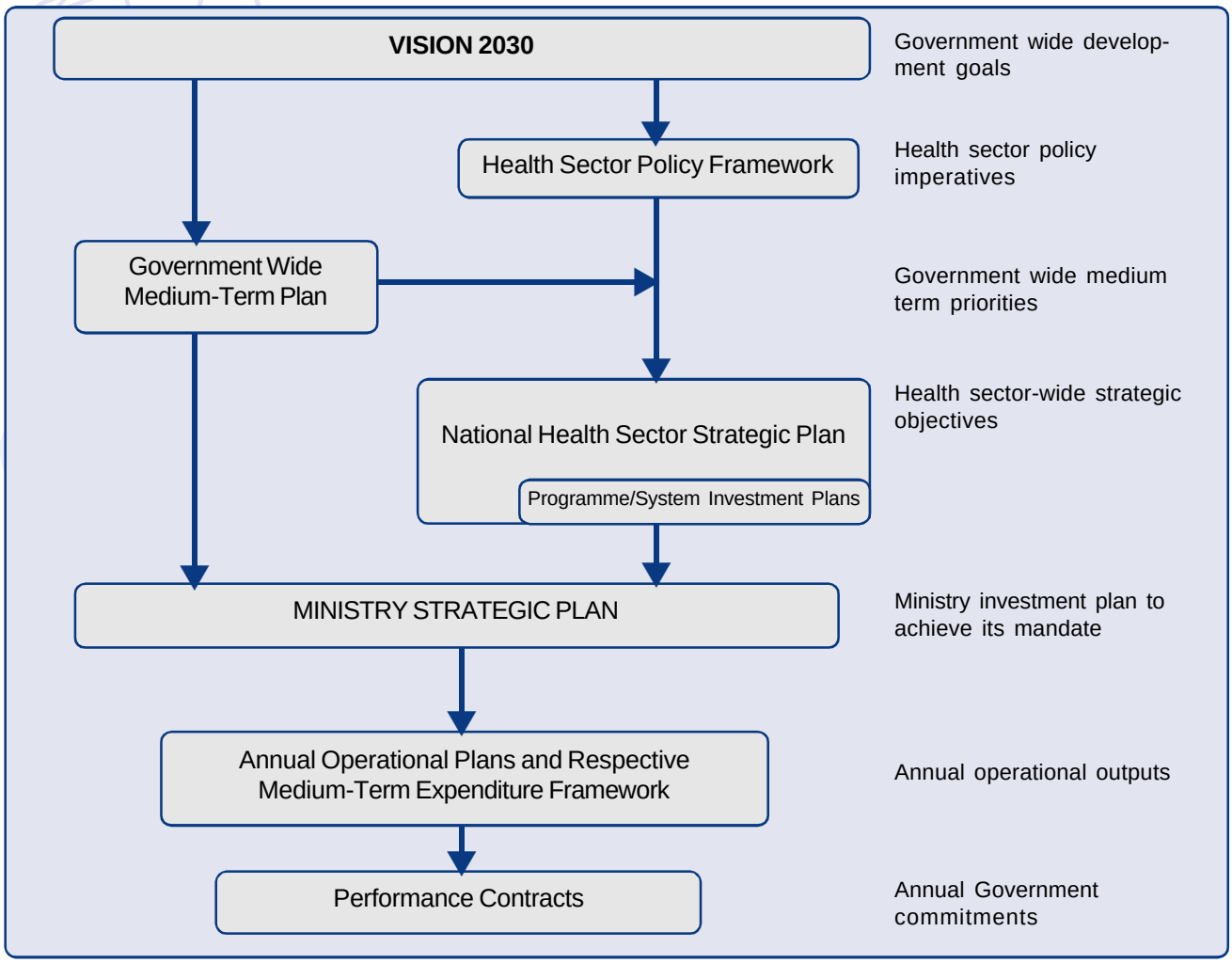
activities, as well as the human capacity to facilitate their successful implementation.

Both the current Health Sector Policy Framework (HSPF) 1994–2010 and NHSSP II, therefore, informed this strategic plan. Together with the medium-term plan of our sister health ministry, the Ministry of Medical Services (MOMS), and the input of our development partners and implementing partners, this strategic plan will serve as the foundation of the public health sector's annual operational plans. The MOPHS strategic plan will also inform the performance contract of the Ministry. These linkages and processes are schematically presented in Figure 1.1.

1.2 Methodology for Developing the Strategic Plan

Working groups in three major areas – service delivery, support systems, and governance and financing – consisting of officers from the central MOPHS were given the responsibility of undertaking the process of developing this strategic plan. The working groups conducted a review of existing policy documents such as Kenya Vision 2030, NHSSP II, the Joint Programme of Work and Funding (JPWF),[2] the Midterm Review of NHSSP II

Figure 1.1: Linkage between Government-specific and health sector planning processes



(MTR), Norms and Standards,[3] *Roadmap for Acceleration of Implementation of Interventions to Achieve the Objectives of NHSSP II*, the Joint Support Programme, and other relevant ministerial documents.

Representatives from all departments and divisions conducted a desk situation assessment, which was followed by a five-day workshop to develop the priorities, strategies, outputs and implementation matrix of the plan. The basic structure of the plan follows guidelines provided to all the ministries by the Ministry of Planning, National Development and Vision 2030. The draft plan was circulated internally and to health sector stakeholders for comments; these were incorporated into the final plan.

Chapter Notes

[1] Ministry of Health, 2005, *Reversing the Trends – The Second National Health Sector Strategic Plan of Kenya: NHSSP II – 2005–2010*, Nairobi, Kenya.
[2] Ministry of Health, 2006, *Joint Programme of Work and Funding for the Kenya Health Sector 2006/07–2009/10*, Nairobi, Kenya.
[3] Ministry of Health, 2006, *Norms and Standards for Health Service Delivery*, Nairobi, Kenya.

2 Kenya's Development Agenda and Challenges

Confronted by pervasive poverty and declining health indicators, Kenya set about overcoming the obstacles and moving forward with deliberate speed and determination to improve the socio-economic status of its citizens, and especially their health. Two important steps have been taken to accomplish this. One is the ambitious declaration of *Vision 2030*, which has a clear view of the role of people's health in the development agenda, and another is the fast-tracking of actions to meet the Millennium Development Goals (MDGs) by 2015.

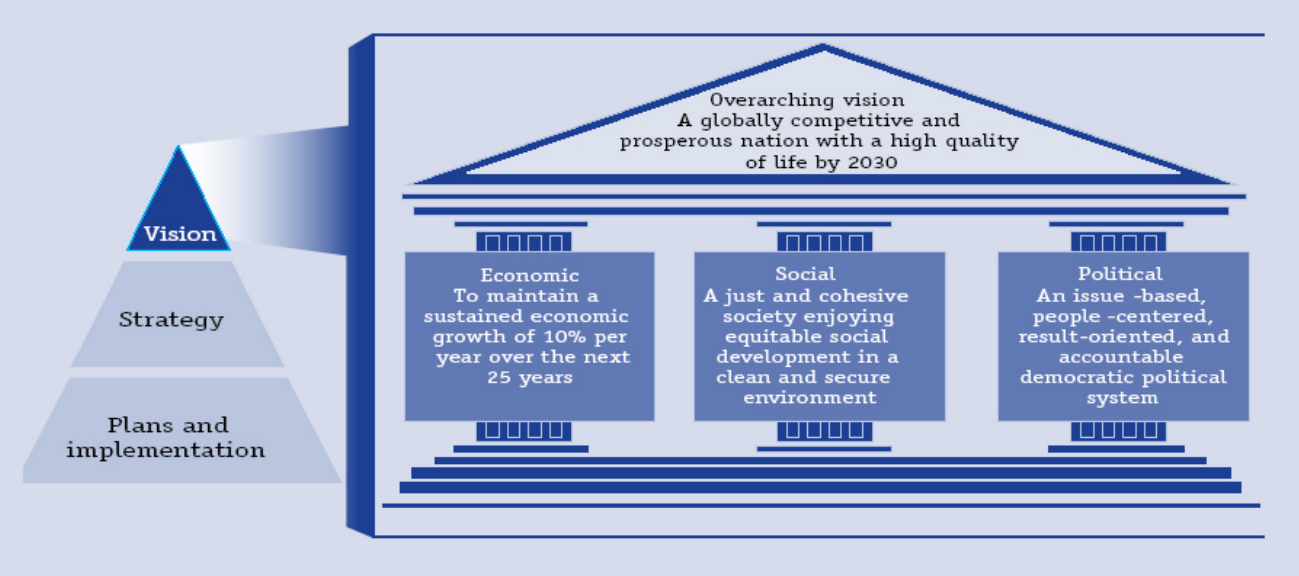
2.1 The National Development Agenda – Kenya Vision 2030

Vision 2030 details the Government of Kenya's long-term development aspirations for the country. The aim of Vision 2030 is to create "a globally competitive and prosperous country with a high quality of life by 2030" by transforming Kenya from a third world country into an industrialized, middle income country. The First Medium-Term Plan (MTP) for realizing the ambitions of the Vision outlines the key policy actions, reforms, programmes and projects that the Grand Coalition Government intends to implement between 2008 and 2012, the first stage in the push towards accomplishing the Vision.

As illustrated in Figure 2.1, Vision 2030 specifies strategies for reaching its economic, social and governance targets. Achieving the development goals outlined in Vision 2030 will require increasing the productivity of both people and processes. Thus the health sector is expected to play a critical supportive role in maintaining the healthy workforce necessary for the increased labour productivity that Kenya requires in order to match its global competitors.

> Vision 2030 aims to provide equitable and affordable health care at the highest affordable standard to all citizens, by restructuring health care delivery systems to shift the emphasis to preventive and promotive health care. The emphasis will be on access, equity, quality, capacity and institutional frameworks.

Figure 2.1: Pillars of Kenya's development framework – Vision 2030



Source: Kenya National Economic and Social Council.

Health is, therefore, one of the key components in delivering the Vision's social pillar, "Investing in the people of Kenya".

Kenya's vision for health is to provide equitable and affordable health care at the highest affordable standard to all citizens, involving (among other things) the restructuring of the health care delivery systems in order to shift the emphasis to preventive and promotive health care. Key focal areas of access, equity, quality, capacity and institutional framework will be achieved through a devolution approach that will allocate funds and responsibility for delivery of health care to hospitals, health centres and dispensaries, thereby empowering Kenyan households and social groups to take an active role in maintaining and managing their health care.

The health sector objectives stipulated in the MTP are to:

1. Reduce under-5 five mortality from 120 to 33 per 1,000 live births.
2. Reduce the maternal mortality ratio (MMR) from 410 to 147 per 100,000 live births.
3. Increase the proportion of deliveries by skilled personnel from the current 42% to 90%.
4. Increase the proportion of immunized children below one year from 71% to 95%.
5. Reduce the number of cases of TB from 888 to 444 per 100,000 persons.
6. Reduce the proportion of in-patient malaria fatality to 3%.
7. Reduce the national adult HIV prevalence to less than 2%.

The MTP flagship projects for health are rehabilitating health facilities, strengthening the Kenya Medical Supply Agency (KEMSA), fully implementing the Community Strategy,[1] de-linking the health ministries from service delivery, building the human resource capacity and developing equitable financing mechanisms.

2.2 National, Regional and Global Public Health Challenges

In today's world no country is immune from global health concerns, and numerous international initiatives have been taken to address health issues, both existing and emerging. Significant among these are the Alma-Ata Declaration and the Millennium Declaration, which articulated the MDGs, many of which deal directly with health. Thus any national health sector is part of a bigger picture that includes the immediate regional neighbourhood as well as the international concerns.

2.2.1 National Public Health Challenges

At the national level, maternal and child mortality remains a major public health problem for Kenya. Despite the Government's commitment to the international and regional health agenda, the country has lagged behind in meeting most of the targets set in the international and regional declarations. Besides communicable diseases, lifestyle related diseases such as hypertension, diabetes, heart disease and cancers are increasing, hence posing a threat to the health care system in terms of diverting resources from basic health care services to these diseases.

The huge burden of disease is due primarily to pervasive poverty, compounded by years of erratic application of policy, with the result that most of the population lacks the enabling environment for health, such as good nutrition, clean water, quality housing and a conducive living environment. Weak public health systems characterized by inadequate financial and human resources, inefficient support systems, and poorly coordinated responses to public health problems are responsible for the poor performance of the health care system.

The Government's budget allocation to health care, which is currently at 8%, is far short of the 15% target agreed in the Abuja Declaration.[2] For example, the number of nurses and doctors per population is 33/100,000 and 17/100,000, respectively, which is below the standard recommended by the World Health Organization (WHO). Kenya will, therefore, struggle to attain the health-related MDGs without increased resources to the sector.

Political instability is an additional threat to public health. As a result of the violence following the 2007 presidential elections, the delivery of basic health services to Kenyans and hence the performance of the health sector was seriously disrupted. Access to and availability of services were affected by the skirmishes. Similarly, the high incidence of gender-based violence during the period will have a serious impact on new HIV infections in the affected areas and among displaced persons. The government reorganization following the formation of the Grand Coalition Government resulted in the split of the Ministry of Health into two, a decision that poses a challenge to health sector stewardship and coordination.

> In today's world no country is immune from global health concerns.

2.2.2 Regional Public Health Challenges

Political instability in Kenya's neighbouring countries – especially Somalia and Sudan – with the subsequent influx of refugees into Kenya has imposed an increased demand for health services and at the same time heightened the risk of spreading communicable diseases. The latter threat includes a measles outbreak in 2007/08, as well as cases of polio – a disease not seen in Kenya in many years.

2.2.3 Global Public Health Challenges

Public health challenges globally have a bearing on the health situation in the country. New and emerging communicable diseases, especially Ebola, SARS (severe acute respiratory syndrome) and avian flu, along with HIV/AIDS, do not respect border crossings.

And in addition, geography and a high percentage of arid and semi-arid lands contribute to make Kenya particularly vulnerable to the impact of global warming and climate change. The effects of this phenomenon are, in fact, already being felt through prolonged drought and more intense flooding than have been known in the past. Over the next few decades increasing temperatures are expected to extend the areas of malaria endemicity to zones that are presently relatively free of the disease.[3] Climate change is also a factor in the increased prevalence of other diseases such as chikungunya, dengue fever, cholera and dysentery.

Drought induced food shortages, compounded by recent enormous fluctuations in the international commodity markets, also pose challenges to food security strategies, with negative implications for nutrition and the ability of people to maintain their health status.

Chapter Notes

[1] Ministry of Health, 2006, *Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE SERVICES,* Nairobi, Kenya.

[2] Commitment by the Heads of State and Government of the African Union, Abuja, Nigeria, 2001.

[3] United Nations Population Fund/AU Liaison Office, 2009, *State of the African Population Report 2008 – Population Dynamics and Climate Change: Implications for Africa's Sustainable Development*, Addis Ababa, Ethiopia.

3 Role of the Ministry of Public Health and Sanitation

Public health is about managing threats to the health of a community, paying special attention to the social context of disease and health. The concept is based on the premise that many diseases are preventable through simple, non-medical methods. It was defined in 1920 by Charles-Edward Amory Winslow (1877–1957) as the "science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations (private and health), communities and individuals". The goal of public health is to improve lives through a focus on the prevention or treatment of disease, surveillance of cases, and promotion of healthy behaviours.

3.1 MOPHS Core Functions

Defined roles and functions for MOPHS are stipulated in Presidential Circular No. 1/2008. The Ministry is central in providing a leadership role in ensuring that public health policy objectives are implemented to facilitate the attainment of the health sector objectives and targets set in the Strategy for National Transformation (SNT) 2008–2012 and the MDGs.

The mandate of MOPHS, as defined by Government, are as follows:

a. Public health and sanitation policy
b. Preventive and promotive health services
c. Community health services
d. Health education
e. Reproductive health
f. Food quality and hygiene
g. Health inspection and other public health services
h. Quarantine administration

MOPHS's core function is to provide primary care services at the community, dispensary and health centre levels. The Ministry is mandated to support the attainment of the health goals of the people of Kenya by implementing priority interventions in public health based on its mandate and guided by the strategic framework provided by the Strategy for National Transformation 2008–2012 and the wider health sector.

i. Oversight of all sanitation services
j. Preventive health programme including vector control
k. National public health laboratories
l. Government Chemist
m. Dispensaries and health centres (i.e., levels 2 and 3)
n. Kenya Medical Research Institute (KEMRI)
o. Radiation Protection Board
p. Member of KEMSA Board
q. Member of Kenya Medical Training College (KMTC) Board

The MOPHS presidential mandate translates into the core function of providing primary care services at the first three levels of the health care system – the community, dispensary and health centre – as outlined in Table 3.1.

3.2 Vision and Mission

From its mandate and core functions, grounded in the aspirations of NHSSP II and the development paradigm detailed in Vision 2030 and MTP, MOPHS has articulated the vision and mission illustrated in Figure 3.1.

Figure 3.1: Vision and mission of the Ministry of Public Health and Sanitation

The Vision
A nation free from preventable diseases and ill health

The Mission
To provide effective leadership and participate in the provision of quality public health and sanitation services that are equitable, responsive, accessible and accountable to Kenyans

3.3 Core Values Guiding Public Health and Sanitation Services

In providing services and public health guidance in the sector, the Ministry upholds the following principles and values:

- ***People first:*** Commitment to provide public health services that are responsive and sensitive to the socio-cultural values and needs of the various communities in Kenya.

Table 3.1: Primary care services of the Ministry of Pubic Health and Sanitation at the different levels of the health care system

Level 1	Levels 2 and 3
• Reproductive health – Community midwifery – Family planning • Child health – Community nutrition • Basic health care – Treatment of common ailments – Referral – Home based care • TB/HIV/malaria – Follow-up/defaulters – Case management • School health programme • Behaviour change communication • Environmental health – Water – Sanitation and hygiene – Food safety • Community surveillance	• Maternal health care – Antenatal care – Delivery – Postnatal care – Family planning • Child health care – Immunization – Growth monitoring • Basic health care/Treatment of minor ailments • HIV/AIDS/TB • Voluntary counselling and testing • Anti-retroviral therapy/Prevention of mother to child transmission • Malaria • Environmental health – Waste management • Health promotion (behaviour change communication/Health education) • Outreach • Surveillance

- ***Social justice and equity:*** Human rights approach and equitable access are fundamental guiding principles to inform delivery of public health services in the country.
- ***Partnership and collaboration:*** Close working relationship with all stakeholders to promote synergy.
- ***Result oriented:*** Results for Kenyans.
- ***Professionalism:*** Skills and competence of the highest standards.
- ***Accountability:*** Responsibility and answerability for our actions.
- ***Integrity:*** Moral excellence in service.
- ***Teamwork:*** Coordinated commitment to collaboration and working together to achieve a common goal.

These principles represent our commitment to the people of Kenya, as we strive to improve our social accountability to them. They form the basis of how we will monitor and review our progress against the priorities we will be implementing.

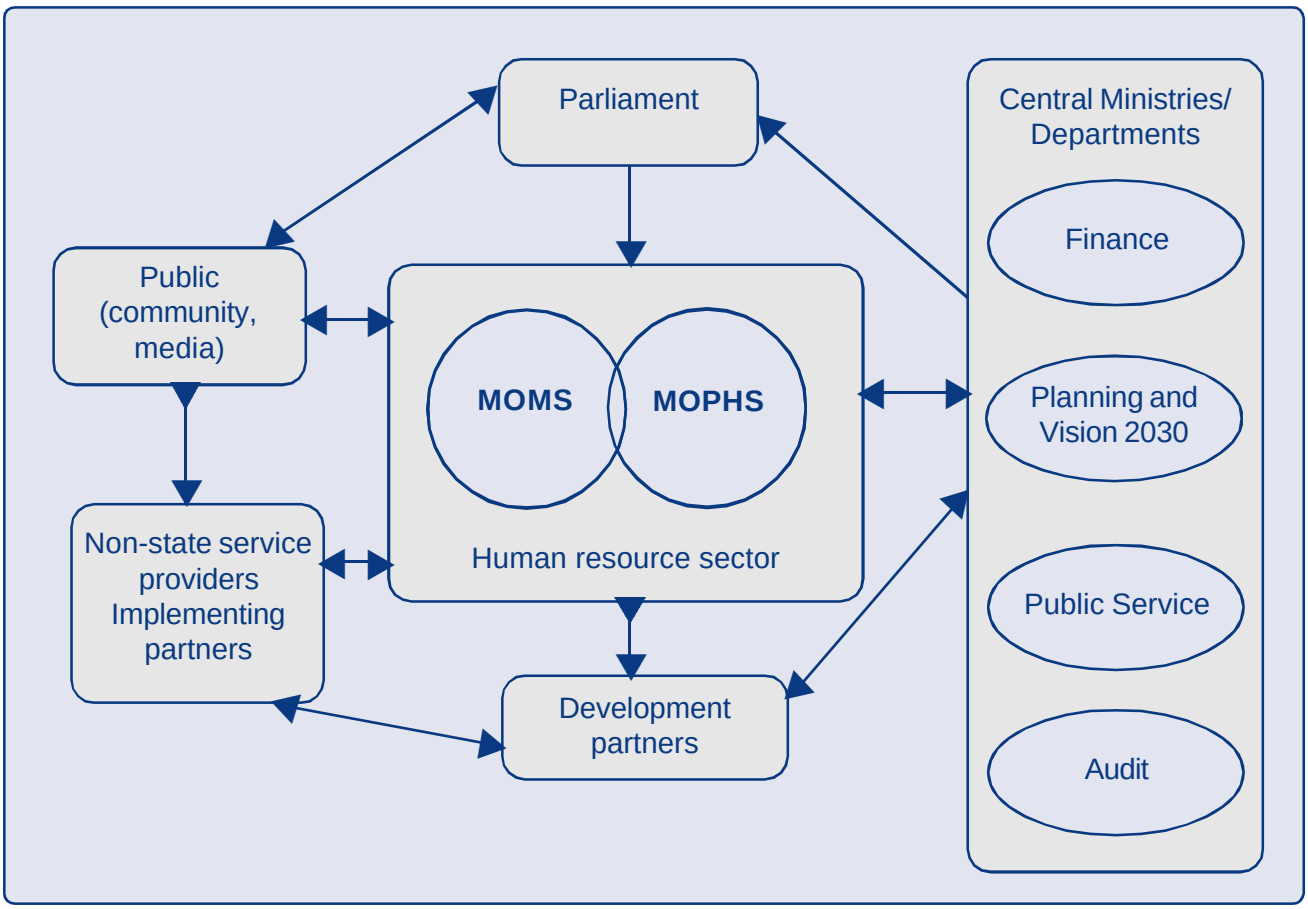
3.2 Linkages with Government and Health Sector

In the reorganization of government, MOPHS is grouped together with the ministries of Medical Services, Education, and Labour to form the Human Resource Development sector. It is through the human resource cluster that the Ministry plans, budgets and obtains its resources.

In addition, the Ministry interacts with other ministries outside the human resource sector, especially central ministries and departments (Finance, Vision 2030, Public Services, Audit), as well as Parliament, on policy development, strategic planning, resource mobilization and management, and monitoring and evaluation issues. Within the health sector, MOPHS, jointly with the Ministry of Medical Services (MOMS), provides stewardship to the health sector's development and implementing partners.

The linkages between MOPHS and other government ministries, departments and agencies are shown in Figure 3.2.

Figure 3.2: Linkages of MOPHS, government ministries/agencies and other health sector stakeholders



The nature of the interactions can be summarized as follows:

- Policy development, strategic planning, resource management, monitoring and evaluation
  - The Ministry of Medical Services
  - Development partners
  - Non-state health service providers (non-government organizations, private not-for-profit and private for-profit health care providers)
  - Quasi-formal working arrangements that guide the linkages defined in the Code of Conduct
- Implementation of programmes and interventions
  - Not-for-profit health care service providers (faith-based organizations – FBOs)
  - Community organizations
- Management of public health service delivery
  - MOMS at provincial and district levels in the coordination of health interventions
  - The Office of the President in financial management through the district treasury
  - The community in the management of health facilities and community programmes (the Health Sector Services Fund [HSSF] and the Community Strategy initiative)

4 Review of Health Sector Progress and Challenges

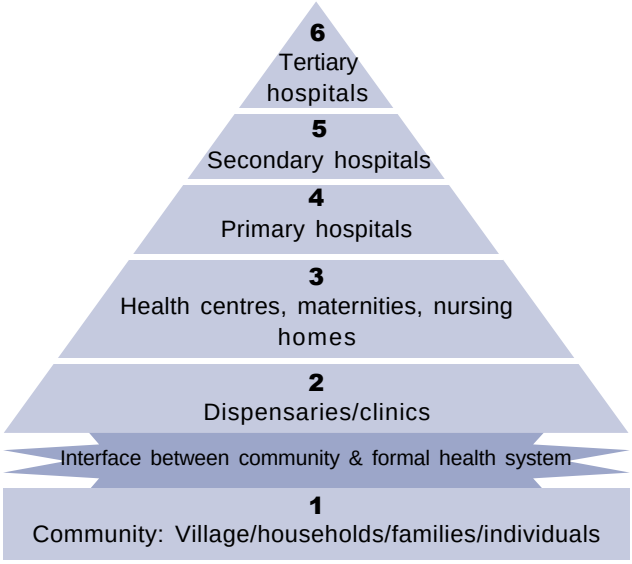
MOPHS health service delivery interventions at levels 1 to 3 of the health care system are based on the Kenya Essential Package for Health (KEPH) approach introduced in NHSSP II. The KEPH approach integrates health programmes into a single package that focuses on interventions to improve health in each of six defined cohorts of the human development cycle, and to organize the delivery of services around six well-defined levels of care (Figure 4.1). The idea is to develop synergy and mutually reinforce health care programmes.

The health sector has been reviewing its performance towards the achievement of NHSSP II targets and the MDGs through joint annual reviews and the midterm evaluation of NHSSP II. The review of the health sector progress and challenges presented here is derived from these review reports. NHSSP II and KEPH, for example, intended to take the health care system to a new dimension – moving away from the long-standing emphasis on curing disease to the promotion of programmes and actions to improve individual health. Significantly, the shift introduced a major focus at the community level (level 1).

4.1 Service Delivery Output Indicators

During the first two years of implementation of NHSSP II, performance assessments show that progress towards achieving the KEPH output targets (which mostly are related to public health interventions)

Figure 4.1: KEPH levels of care – Communities are the foundation of the pyramid



The NHSSP II/KEPH Life-Cycle Cohorts

- Pregnancy and the newborn (up to 2 weeks of age)
- Early childhood (2 weeks to 5 years)
- Late childhood (6–12 years)
- Youth and adolescence (13–24 years)
- Adulthood (25–59 years)
- Elderly (60+ years)

is good for cohorts 2–6, most notably in improved immunization rates. In other areas, however, interventions are not progressing as well as planned.

For cohort 1, performance has been poor and it is likely that the targets for this cohort will not be achieved by the end of the NHSSP II implementation period. Tables 4.1–4.3 summarize the annual achievements against the NHSSP II baseline and targets for the KEPH indicators for the different cohorts. Refer to Annex A, as well, for a summary of the priority health sector interventions recommended by the Midterm Review[1] of NHSSP II for acceleration in the medium term.

4.2 Service Delivery Impact Indicators

Kenya continues to be burdened with the double epidemics of communicable (especially HIV/AIDS, malaria, TB and pneumonia) and non-communicable diseases (cancer, hypertension, heart disease and diabetes). Maternal mortality and child morbidity and mortality remain a major public health problem. Despite the significant milestones that the country has attained, there have been few inroads in achieving the MDGs, as shown in Table 4.4.

Table 4.1: KEPH indicator targets for cohort 1

Indicators	NHSSP II baseline 2004/05	AOP 1 achievement (2005/06)	AOP 2 achievement (2006/07)	AOP 3 achievement (2007/08)	NHSSP II target 2010
% WRA receiving family planning commodities	10%	13%	43%	37%	60%
% ANC clients (4 visits) coverage	54%	56%	52%	39%	80%
% Deliveries conducted by skilled attendant in health facilities	42%	18%	37%	27%	90%
% Newborns with low birth weight (less than 2,500g)		2%	6%	4%	
% HIV+ pregnant women receiving nevirapine (PMTCT)	10%	90,985	29%	8%	50%
# Long-lasting insecticide treated bed nets (LLITNs) distributed to pregnant women	55,000	362,345	445,497	549,466	
% ANC clients receiving IPT 2	4%	44%	40%	33%	
# Health facilities providing basic emergency obstetric care (BEOC)	9	12	646	1,217	

Source: AOP 1, 2 and 3 reports.

Table 4.2: KEPH indicator targets for cohorts 2 and 3

Indicators	NHSSP II baseline 2004/05	AOP 1 achievement (2005/06)	AOP 2 achievement (2006/07)	AOP 3 achievement (2007/08)	NHSSP II target 2010
Early childhood 2 weeks – 5 years)					
% Children < 1 yr immunized against measles	74%	67%	80%	72%	95%
% Children < 1 yr fully immunized	58%	59%	80%	70%	100%
% Newborns receiving BCG	84%	96%	99%	78%	95%
% Children <5 attending CWC and found underweight		9%	11%	7%	
% Children <5 attending growth monitoring services (new visits)	20%		61%	54%	
% Children <5 receiving Vit A supplement	33%	15%	34%	44%	80%
# LLITN distributed to children under 5 yrs	250,000	1,739,675	2,773,293	620,898	
Late childhood (6 to 12 years)					
% School children correctly dewormed at least once in the planned period	25%	5%	43%	63%	80%

Source: AOP 1, 2 and 3 reports.

Table 4.3: KEPH indicator targets for cohorts 4, 5 and 6

Indicators	NHSSP II baseline 2004/05	AOP 1 achievement (2005/06)	AOP 2 achievement (2006/07)	AOP 3 achievement (2007/08)	NHSSP II target 2010
# HIV+ patients started on ART	8,000	65,502	164,827	13,198	
# VCT clients	200,000	474,899	780,261	1, 071, 391	
# New outpatient (curative) visits	0.08	0.4	22,572,807	22,516,265	
# Over five years treated for malaria			4,824,691	5, 392, 672	
# Condoms distributed (million)	80,000,000	43,950,000	46,122,511	25,727,361	
TB cure rate	67%	75%	80%	82%	75%
TB treatment completion rate (Sm+/DOTS)	80%	83%	81%	81%	88%
# Community health workers trained	0		5,294	9,445	
# Functioning community health units	0		129	91	
# Houses sprayed with IRS	2,500	443,575	514,714	413,333	

Source: AOP 1, 2 and 3 reports.

Table 4.4: Progress towards achievement of MDG targets

MDG objective / Proxy Indicators	Baseline 2003/04	Achieved 2004/05	Achieved 2005/06	Achieved 2006/07	Targets 2004/05	Targets 2005/06	Targets 2006/07
Reduce infant mortality							
Fully immunized <12 months (%)	57	57	61	72	65	67	70
Reduce maternal mortality							
Births attended by skilled personnel (%)	42	42	56	37	60	65	70
Reduce burden of disease							
Inpatient malaria mortality (%)	30	26	18	17	16	15	14
Reduce HIV prevalence							
HIV+ pregnant women 15–24 year attending ANC (%)	13	10	6.4	6.3	9.2	8.4	8

Adapted from Millennium Development Goals: Status Report for Kenya 2007.

4.3 Equitable Access to Quality Public Health Services

If people can't get to a health centre, or afford to pay for the service, they are not likely to seek health services. Access is thus a prerequisite to high utilization of health services as it brings the services closer to the people. Access is influenced by geographical, economic and socio-cultural factors

4.3.1 Geographical Access

Poor distribution of facilities, poor road network, weak referral systems, insufficient community health services and weak collaborations with other service providers all combine to reduce geographical access to health services. There are imbalances in geographical distribution of health facilities in different regions with under-served areas, such as North Eastern, North Rift Valley, Nyanza and Eastern provinces.

The Millennium Development Goals

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce infant mortality.
5. Improve maternal health.
6. Combat HIV/AIDS, malaria and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

Per the 2006 *Norms and Standards for Health Service Delivery*, the estimated infrastructure requirement is: 6,425 community units, 3,313 level 2 and 649 level 3 facilities to deliver KEPH. The gap for L1, L2 and L3 was 6,425, -169 and 422, respectively. As a result of inadequate funding, 86 health facility projects stalled and several others are not functional. In addition, 1,600 health facilities that were developed under Constituency Development Fund (CDF) programmes are not functional because of lack of equipment, health workers and drugs. This

Geographical access constraints:
- Mal-distribution of facilities
- Lack of funding
- Poor road network
- Poor coordination of infrastructure development

strategic plan envisions collaboration with the local communities, rehabilitation of the non-functional GOK facilities, operation of CDF facilities and construction of new facilities as possible interventions to increase access to health services.

4.3.2 Economic Access

Poor utilization of primary health care services at levels 2 and 3 is more often a result of economic barriers to accessing care because of low household income. High poverty levels (46% of Kenyans live below the poverty line) mean that most households cannot afford to pay for health services. Although government introduced the 10/20 policy and free services for childhood illnesses and maternity services at levels 2 and 3, current public expenditure tracking surveys have shown that the implementation of these initiatives is not adhered to and clients are still paying for the free services or paying higher fees rather than the 10/20 policy. However, piloting of an output-based approach (OBA), through provision of vouchers for delivery, has shown to be successful in improving access to maternity services.

4.3.3 Socio-Cultural Access

Socio-cultural barriers associated with low literacy levels, religious beliefs and gender bias hinder access to health services, especially by women, children, adolescents, the disabled and other vulnerable groups. Recognizing this problem, NHSSP II envisioned making the provision of health services more humane, compassionate and dignified.

Socio-cultural barriers:
- Low literacy
- Religious beliefs
- Gender bias

Targeted measures include ensuring privacy in the course of service delivery, especially for women. The human rights approach will be promoted in clinical settings, as well as establishing youth-friendly clinics and prioritizing gender issues.

4.4 Quality of Public Health Services

Service delivery faces quality constraints on many fronts: the low calibre of the human resource, deteriorating facilities and equipment, lack of drugs, and insufficient information on which to base both policy and targeted responses. Other factors that detract from service quality are insufficient standards and lack of enforcement of existing laws – which themselves need to be updated. Quality challenges are summarized in the following paragraphs; Annex B illustrates the root causes of the prevailing health problems and challenges.

4.4.1 Human Resources

Inadequate staffing levels, lack of appropriate skills, poor staff attitude, low morale and weak supervision undermine the quality of public health services provided at the rural health facilities. There are regional disparities in staff distribution.

Human resource constraints:
- Inadequate numbers
- Skills development
- Mal-distribution of human resource
- Staff attitude
- Low morale

The *Norms and Standards for Health Service Delivery* estimated that to deliver KEPH services, 321,253 community health workers (CHWs) and 12,500 community health extension workers (CHEWs) were required at level 1.

At level 2, requirements were set at 9,638 health workers (6,425 nurses and 3,213 public health officers) and a similar number of support staff. At level 3, the estimated workforce requirement was 21,418 health workers of various cadres and 8,567 support staff. A comparison with the existing staff reveals serious shortages. Most affected are the CHWs, CHEWs, nurses and clinical officers, with vacancy rates of 97%, 95%, 53% and 77%, respectively.

In the public sector there are 2,609 nurses at L3 and 2,913 nurses in L2, against a requirement

of 5,710 and 4,244 in L3 and L2, respectively. This translates to vacancy rates of 54% for L3 and 31% for L2. The number of clinical officers in post is 600 against a requirement of 930, a vacancy rate of 36%.

4.4.2 Health Facilities

The quality of service delivery is influenced by the quality of the service delivery environment – specifically, the availability of adequate and serviceable facilities such as surgical theatres, examination rooms, offices and staff houses. Inadequate facilities affect staff motivation and service quality. Poor preventive maintenance of existing facilities is a major obstacle to service quality.

Facility constraints:
- Inadequate space and room
- Poor maintenance
- Lack of privacy
- Poor planning
- Inadequate storage space
- Inadequate staff housing

Suitability of facilities and maintenance are a result of poor planning and lack of defined standards for facilities, with the result that there is a variety of different forms of facilities available around the country. Among other issues, inadequate water and electricity supplies jeopardize infection prevention and drug quality, while poor food storage threatens nutrition supplements. Facilities such as toilets for patients and incinerators for handling health facility waste (used dressings, tubings, placenta, etc.) affect the quality of services being offered.

4.4.3 Equipment

There is general lack of basic medical equipment to support service delivery in primary health facilities. Contributing to the lack of basic equipment are the absence of standard equipment guidelines developed in line with the expected functions and staffing requirements, inadequate security guidelines and maintenance procedures, and low budgetary provisions for procurement and maintenance.

Equipment constraints:
- Lack of basic equipment
- Lack of standard equipment guidelines
- Poor maintenance

4.4.4 Drugs and Supplies

Interruptions in the supply of essential medicines and medical and laboratory supplies negatively affect the quality of services offered at primary health facilities. Weaknesses have been identified in the organizational setting, structures, competencies, procedures for procurement, logistic system and prescribing practices.

4.4.5 Insufficient Evidence for Decision Making

An effective health management information system (HMIS) contributes to service quality by providing necessary information on health delivery for decision making. Unfortunately, surveillance and operation research is weak, especially at the district level, owing to lack of personnel, structures, systems and budgetary provisions. Moreover, at present the country lacks an integrated system to provide the required information.

4.4.6 Quality Standards and Guidelines

Constraints relating to quality standards and guidelines include insufficient standards and guidelines, non compliance with existing standards and guidelines, poor dissemination of the guidelines that do exist, and inadequate facilitative supervision. The Service Charter developed as one of the provisions of NHSSP II has not yet been fully disseminated and promoted among the general public so that clients are fully aware of their rights and obligations.

4.4.7 Public Health Legislation

Non compliance with public health legislation contributes to the poor quality of services. Because of budgetary constraints, inspection and enforcement of existing laws have been weak.

4.5 Human Resources Management System

Health care is a people-intensive activity. Effective management of the human resource for health (HRH) aims to ensure that adequate numbers of appropriately skilled and motivated workers are available to

deliver public health services. In order to meet the numerical staffing requirements and to ensure that staff are used optimally, a number of HR policies and practices need to be in place and operating effectively. These include HR information systems, recruitment, deployment, performance management, and training and development (including in-service training/ continuous professional development).

4.5.1 HR Information Systems

There is limited information available to inform decision making on HR planning, management and development. Currently, Kenya has no dedicated HR information system and the HMIS produces limited information on HRH. The quality of the information is also an issue; much of the HR information is paper-based and of an administrative/operational nature, which may make it inappropriate and irrelevant for strategic decision making. The HR information that is available is not utilized effectively and in some cases not at all. Even information generated from recent studies is not widely available, has not been updated and is not being used for HR planning. Unless health sector HR staff have adequate capacity and skills, however, even the best information will not be effectively used for strategic HR planning. The current HR staff do not have this capacity. There is therefore a need to improve the consolidation, quality, consistency and utilization of HR information.

4.5.2 Recruitment and Deployment

MOPHS is a new ministry, and many of the posts on the staff establishment are vacant. Currently, procedures and processes for recruitment and deployment are sparse if they exist at all. In 2006, the former Ministry of Health developed norms and standards based on 2003 population numbers (workforce projections). These did not take into consideration regional variations and disease burdens and were not disaggregated by type of provider.

The current authorized establishment for the health ministry has not been reviewed for over ten years and preceded the scale up of HIV services and the renewed commitment to achieving the MDGs. Thus it should be informed by the recommendations of the 2008 joint task force review, which looked at the current establishment and current needs. Moreover, the current establishment is an aggregate, hence does give a regional breakdown of different cadres nor does it take into account the level of education attained by the staff. One result is that regional distribution depends on administrative decisions, thus the mal-distribution. There is need for MOPHS to develop its recruitment and deployment policy, quantify the norms and standards, and revise the staff establishment. Of note is that an HRH strategic plan is currently under development as a joint effort of the two health ministries. (Refer to Annex C for a breakdown of the staff requirements and establishment.)

4.5.3 Staff Development

There will be a greater need for education, training and development initiatives to match the increased staff and to equip the staff with new and relevant skills (technical, leadership, management and supervisory) to deliver services. Currently, skill levels need strengthening to enable staff to do more than one job (multi-skill). Post-basic and in-service training opportunities are not well coordinated or managed. Individual health workers often seek training for their own personal development, and this may or may not conform with organizational needs to improve performance and address service requirements.

4.5.4 HR Planning and Management

The success of any plan to improve human resources will hinge on the capacity to plan for, manage and develop the workforce. Capacity is needed within MOPHS to develop a strategic approach for HRH issues in addition to the current functioning, which is basically administrative.

The current task of establishing a new ministry provides an ideal opportunity for defining the HR functions required by the Ministry and identifying the most appropriate structures, systems and capacity for carrying them out. But a strong case for a stronger, more strategic HR function needs to be made.

4.5.5 Staff Performance Systems

Given staff shortages, it is critical that performance and productivity of all available workforce be effectively managed and supported. The National Performance Framework (NPF) institutionalizes the results-based management

approach adopted by Kenya's public service and will hold institutions and individuals accountable for service delivery and achievement of targeted results. In addition, the Government has approved for implementation a new performance appraisal system (PAS) for the public service. This development will help to strengthen performance management systems, both facility and individual. Support will be required, however, for the effective introduction and institutionalization of the PAS at all levels.

4.5.6 Salaries, Attrition and Staff Distribution

Effective pay and compensation systems are required to attract and retain staff, especially critical staff for under-served and other hardship areas (for example, Tana Delta, North Eastern Province [NEP]).

4.6 The Health Infrastructure

Infrastructure in the health sector refers to three main components: buildings and equipment, both medical and non-medical; transport; and information and communication technology (ICT).

4.6.1 Buildings and Equipment

Currently, the quality of buildings and equipment at headquarters, some of the provincial and district health offices, and the primary health facilities is poor. The key issues affecting realization of the required infrastructure include:

- Lack of a defined standards for infrastructure and equipment in the Ministry, resulting in different forms of buildings and equipment, some of which are substandard.
- Poor maintenance of buildings and equipment, leading to malfunctioning of a large proportion of them.
- Poor maintenance of infrastructure as a result of lack of a comprehensive maintenance plan, absence of written guidelines or manuals on infrastructure maintenance, inadequate budget allocation for maintenance of infrastructure or security of equipment items, and inefficient disposal of non functioning equipment.
- Absence of a master plan on health facility construction and rehabilitation, which results in unequal distribution of health facilities and haphazard construction of new health facilities, especially through the CDF.

4.6.2 Transport System

An efficient transport system is very important in the delivery of health services. Reliable transportation enables patients, commodities and staff to be available at places of service delivery. The performance of the system depends on the availability of vehicles that are suitable for the intended purpose and the control mechanisms that are put in place.

With the split of MOH, all ambulance vehicles belong to MOMS. But most of these ambulances lack four-wheel drive, are low based and poorly equipped, and thus not suitable for the rural areas where most of the primary facilities (levels 2–3) are. There is need to have properly equipped and rural terrain friendly ambulances. For areas that are not accessible by vehicles, other forms of ambulances such as motor boat and "motorcycle ambulances" need to be provided. Currently there are three motor boat ambulances serving Lamu, Bondo and Suba. The use of motorcycle ambulances for referral of maternity cases is being piloted in Nyanza Province.

MOPHS has a total of 323 utility vehicles (12 at HQ, 221 at provincial and district levels, and 99 with national programmes). The gap is estimated to be 161 four-wheel drive vehicles and 2 seven-tonne lorries. There are 300 motorcycles and 3,000 bicycles. An additional 3,000 motorcycles and 140,000 bicycles will be required for the period of this plan. Annex D shows the overall transport needs at all levels.

In order to support the appropriate use of vehicles, there is need to have a transport policy in place that defines the rationale for the numbers, types and distribution of vehicles needed and guides the preventive maintenance and transport control systems throughout the Ministry.

4.6.3 Information and Communication Technology (ICT)

Increasingly in this communication era, the use of modern modes of communication is vital to any organization. The Government has

developed an ICT policy whose strategies will to be implemented by all Government departments. For MOPHS to implement the strategy of e-government, a health sector ICT policy, additional hardware and software, and capacity building of IT staff and users will be required. There will also be need to improve network connectivity, automation, inter-operability and integration of the different information systems in the Ministry. Areas with poor network coverage will need to have UHF radios and V-Sat and other new technologies in order to enhance connectivity. The number of staff required to run and maintain ICT systems needs to be reviewed and the gap filled.

4.7 Public Finance Management System (PFMS)

This system is responsible for efficient execution of the budget, ensuring that the funds available are timely, transparently accounted for and used for the purpose intended.

4.7.1 Budget

Currently, there are challenges in budgeting. There is no programme budget management system, and some budget items such as personnel and commodities are not disaggregated by levels of care. In an attempt to address this, a process of developing a "functional budget" has been adopted, but this basically duplicates work. To avoid this duplication, a review of the formal budget classifications and formats in order.

The feeling is that the current budgeting process is not very well linked to the planning process. There is therefore need to revise budgeting and planning formats and timeframes to ensure linkages of these two processes.

Moreover, budget release to districts is not efficient. Dispersal of funds to district health offices is done by the central Ministry office through the Treasury in the form of an authority to incur expenditure (AIE). The districts are usually not informed about the final approved budgets and have to operate on the basis of their quarterly AIEs. The AIEs are approved late and sometimes are not followed by availability of funds in the district accounts. The provincial and district health offices are not allocated funding in the current budget. Primary health facilities have been allocated financial resources for operation and maintenance, as is the case with levels 4 and 5. The facilities rely on handouts of supplies from the district level. It is important therefore to ensure that the new initiative to release funding from headquarters directly to provincial, district and primary health facilities is implemented.

4.7.2 Financial Information System

The Government-approved integrated financial management information system (IFMIS) has not been rolled out in MOPHS. As a result, management of the financial information that is critical for accountability and expenditure control remains a challenge. There is therefore need to accelerate the implementation of the IFMIS in the Ministry.

For the public financial system to work, it is necessary to address the current staff shortage in finance and accounting departments at headquarters, provincial and district levels. In addition, the capacity of existing staff needs to be enhanced with up-to-date knowledge, skills and tools of the trade.

4.8 Health Management Information System (HMIS)

HMIS serves the entire health sector and therefore strengthening of health information is a key priority for the two health ministries. NHSSP II provides policy and strategic directions for the development of a comprehensive national HMIS, and many assessment reports have been carried out on how to improve the HMIS. Despite the attention, however, there is currently no substantial financial allocation to support this system from the Ministry. Furthermore, the culture of information use is not fully embraced in the health sector.

On the other hand, some progress is being made in laying the groundwork for a useful system. Review, harmonization and adoption of health sector indicators have been finalized in line with the data requirements of the two health ministries with the aim of reducing the data

transaction costs. Data requirements, summary tools and data capture tools (registers) have been revised and distributed for use.

As for the human resource, 572 health records and information officers (428 HRIT and 144 HRIOs) with two-year (certificate) and three-year (diploma) training, respectively, are presently serving in the health system. Yet this number amounts to only 11% (572 against 4,882 staff complement), which is far below the requirement.

The key challenge is to beef up the current low investment levels to ensure full implementation and sustainability of strategies. Such investment is needed in the areas of financial, equipment and human resource capacity. There are equally many opportunities that can be maximized to improve the HMIS, especially utilization of ICT to improve communication and data transfer with most of the districts and service delivery points. These efforts should include rationalizing the different database management software and taking to scale a standard model for information management in the health sector. Such initiatives are ongoing to improve the performance of HMIS.

4.9 Procurement and Commodity Logistics Management Systems (General)

Since 1997, a series of reforms has been made to streamline public procurement in order to reduce corruption and improve value for money and efficiency in service delivery. The main weaknesses in the procurement system are:

- Poor procurement planning, stemming from the fact that there are no annual plans.
- Loose links with budgets.
- Delays in procurement processes often arising from poor documentation, flawed bids or proposed evaluations, and protracted decisions for contract award.
- Low capacity of procurement staff (both in numbers and in competence).
- Weak oversight.
- Lack of adequate equipment and working tools (computers, procurement manuals, guidelines).

In the *Roadmap for Acceleration of Implementation of Interventions to Achieve Objectives NHSSP II*, the main priorities in strengthening procurement systems included the establishment of functional procurement committees at all levels, development of the annual medium-term procurement plan, and capacity building of the procurement units with adequate and skilled staff including provision of appropriate tools of the trade. The Roadmap also emphasizes the development of procurement tracking systems that will show the efficiency and effectiveness of the procurement system.

To ensure proper management of procured goods, it is also important for efficient stores management systems to be put in place. This includes logistics management information systems for medical supplies.

4.10 Policy Planning

Policy and planning have experienced, competent, innovative staff with capacities in results-based management. There are limitations, however, especially stemming from high staff turnover, lack of budgetary provision in the MTEF budget and inadequate staff numbers. But, there are opportunities such as deepening of public service reforms, existence of an evolving performance management and accountability framework, goodwill from development partners to establish monitoring and evaluation (M&E) systems and evolving budget processes towards programme and outcome-based budgets. Among the threats are inadequate financial and technical resources and weak sector-wide linkages, particularly with respect to ICT use in M&E.

4.11 Partnership

NHSSP II realizes that partnership is the main vehicle through which the plan's targets can be achieved as it allows all health sector stakeholders to collaborate and coordinate their actions, recognizing each one's specific responsibilities. Towards that end, since 2005, the following initiatives have been ongoing

in the sector to strengthen coordination and collaboration, as part of the sector-wide approach (SWAp) to the health sector reform agenda:

- Joint planning
- Joint performance monitoring and evaluation
- Joint financing
- Use of common management arrangements
- Strengthening sector leadership at all levels of the health system
- Institutionalization of partnership structures at all levels of the health system
- Institutionalization of governance structures at all levels

The main outputs that have been achieved since 2005 are:

- Joint sector planning and performance monitoring are now firmly in place.
- Partnership and governance structures are in place and functioning at all levels of the health system.
- The code of conduct (COC) for the SWAp was developed and signed by health sector stakeholders.
- Leadership and management capacity building for top and mid level managers is under way.

While there has been remarkable progress in the implementation of most of these initiatives, movement has been slow on implementing strategies aimed at joint financing and the use of common management arrangements.

Since Kenya has subscribed to the International Health Partnership, which is to ensure implementation of the Paris Declaration on Aid Effectiveness, MOPHS needs to foster partnership of all stakeholders involved in financing, implementing and utilizing public health and sanitation services.

As such, there is need for the Ministry to continue with strengthening of joint planning, performance monitoring and financing of public health and sanitation services; capacity building on leadership at all levels of the health system; and partnership and governance structures at all levels of the health system. Special attention and effort need to be given to implementing strategies or interventions that would enable joint financing and the use of common management arrangements for public health and sanitation services. There is also need to put in a place a mechanism for assessing compliance with the COC by all the signatories.

4.12 Financing Public Health Services

Mobilization of adequate resources for implementing the activities identified in the strategic plan is critical to our ability to achieve the overall goal of reducing preventable ill-health among the people of Kenya. This section of the plan assesses past trends in financing of preventive health services in the country and forecasts resource needs within the strategic plan period. The links among the three strategic thrusts and with the six sub-programmes in the MTEF budget for public health and sanitation are established.

An analysis of trends in MOH expenditures over the last three years indicates that public health expenditures increased from Ksh6.09 billion in 2005/06 to Ksh7.6 billion 2006/07, but declined to Ksh6.9 billion in 2007/08.

During the last four years, overall recurrent expenditures averaged slightly more than Ksh4 billion. Whereas budget estimates for development expenditure have been at around Ksh8 billion per year, actual absorption of those resources has been around Ksh3 billion annually. Recurrent spending has therefore been consistently higher than development expenditure.

The share of personnel emoluments has been at approximately 16.5% of total recurrent expenditure in the past three years. This percentage understates the amount of money used to pay workers in MOPHS, however, since around 2,000 workers – especially community health nurses – are still reflected as being paid from the Ministry of Medical Services. Procurement of drugs accounts for approximately 30% of the recurrent budget.

Cost-sharing revenue has varied between Ksh1 billion and 1.5 billion over the last three years and has provided a useful source of revenue for operating health facilities, especially levels 2 and 3.

Table 4.5 and Figure 4.1 summarize the trend of recurrent and development expenditures. These are disaggregated according to category in Table 4.6.

Table 4.5: Ministry of Public Health and Sanitation: Gross actual expenditure (Ksh million)

Original budget estimates				Actual expenditure		
	2005/06	2006/07	2007/08	2005/06	2006/07	2007/08
Recurrent (Ksh million)	4,350	4,726	4,018	4,013	4,191	4,182
Development (Ksh million)	7,166	7,232	9,170	2,076	3,360	2,753
Total (Ksh million)	11,517	11,958	13,187	6,088	7,551	6,935
Recurrent as % of total MOPHS expenditure	37.8	39.5	30.5	65.9	55.5	60.3
Development as % of total MOPHS expenditure	62.2	60.5	69.5	34.1	44.5	39.7
Total (%)	100.0	100.0	100.0	100.0	100.0	100.0

Figure 4.2: Public health expenditure trends, 2005/06–2007/08 (Ksh million)

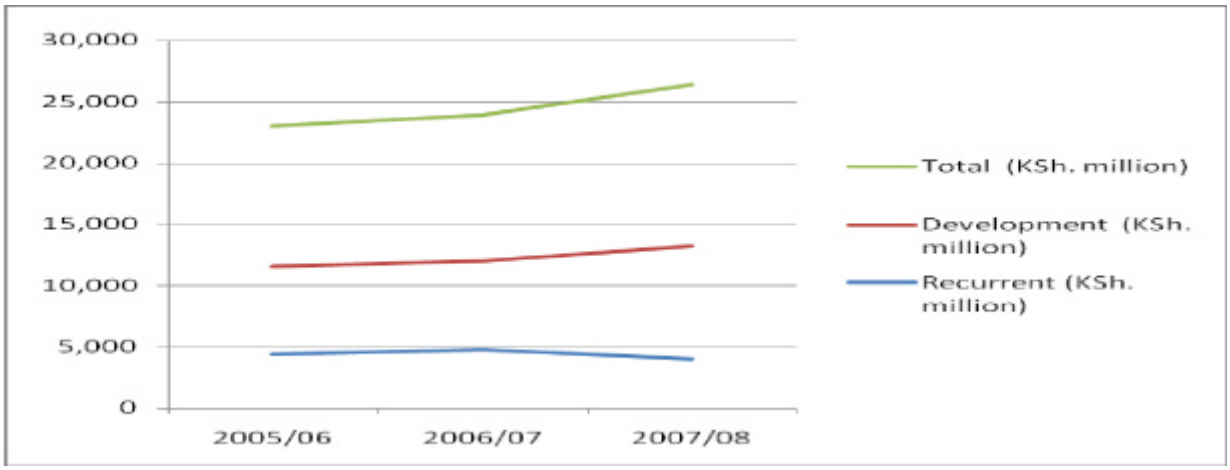


Table 4.6: Analysis of total recurrent MOPHS expenditures by category (Ksh million)

Category	Actual expenditure		
	2005/06	2006/07	2007/08
Salaries and other personnel	1,111	1,026	1,044
as % total recurrent	27.7	24.5	25.0
Transfers, subsidies and grants	854	881	967
as % total recurrent	21.3	21.0	23.1
Drugs and medical consumables	1,261	1,287	1,668
as % total recurrent	31.4	30.7	39.9
Other operations and maintenance	535	786	465
as % total recurrent	13.3	18.8	11.1
Purchase of plant and equipment	252	211	38
as % total recurrent	6.3	5.0	0.9
Total recurrent (gross)	4,013	4,191	4,182
%	100.0	100.0	100.0

4.13 Review of Public Health Expenditures, 2005/06–2007/08

Further breakdown of the expenditures in terms of public health programmes and those that provide a fundamental link to the operation of the strategic plan is shown in Table 4.7.

During the implementation of this strategic plan, health care financing is expected to be significantly and positively influenced by the MTEF, through which resources will continue being allocated to Ministries through MTEF sectors. To that extent, various initiatives are being implemented – especially the Health Sector Services Fund (HSSF), output-based approach (OBA) and the Joint Programme of Work and Funding (JPWF) – that are anticipated to enhance access to health financial resources by the poor and vulnerable. Full operation of a National Health Insurance Fund in the course of the plan period is expected to further ease households' expenditure shocks attributed to the burden of disease.

One of the major looming challenges for MOPHS is the prospect of low funding levels as a result of hard budget constraints. The shortage of necessary resources is likely to be aggravated by effects of the worldwide financial crisis, which is contributing to depressed economic performance as the global financial meltdown percolates into the country's systems. These challenges will be addressed through further austerity measures and a tightening of financial governance systems to enhance integrity and

Table 4.7: Core poverty programmes by expenditure category in the Ministry, 2005/06–2007/08 (Ksh million)

Priority programme	Expenditure by category (Ksh million)					
	Recurrent expenditure non-wage			Development expenditure		
	2005/06	2006/07	2007/08	2005/06	2006/07	2007/08
National AIDS/STD Control Programme	17.4	18.8	34.3	0.0	0.0	0.0
Environmental health services	188.4	279.9	312.4	3.4	30.7	0.0
Communicable and vector-borne diseases	127.7	94.7	41.8	8.2	3.7	0.0
Nutrition programme	14.4	13.7	13.2	0.4	0.0	0.0
Family planning, maternal/child health care	10.8	38.4	77.8	0.0	0.0	0.0
Rural health centres and dispensaries	2,796.8	2,688.2	2,712.6	522.1	1,770.2	655.8
Rural health training and demonstration centres	84.8	95.8	84.9	0.0	0.0	0.0
Drug control inspectorate	1.2	1.0	0.2	0.0	0.0	0.0
National leprosy and tuberculosis services	18.5	23.1	14.5	0.0	0.0	0.0
Integrated rural health services	0.0	0.0	0.0	197.7	5.8	0.0
KEPI	42.7	242.6	0.0	0.0	0.0	0.0
Specialized global fund – HIV/AIDS	0.0	0.0	0.0	706.6	198.1	382.0
Special global fund – TB	0.0	0.0	0.0	129.3	126.9	68.8
Special global fund – malaria	0.0	0.0	0.0	199.4	1,206.6	1,111.6

Past expenditure trends in the operation of public health activities show that financing of rural health centres and dispensaries, environmental health services, communicable and vector-borne diseases, and the Kenya Expanded Programme on Immunization (KEPI) have taken the lion's share of the overall MOPHS budget. This trend is not anticipated to change during the implementation of the MTP.

accountability in resource use throughout the public health system. To further this objective, work has commenced on the development of a health financing strategy.

Chapter Notes

[1] Ministry of Health, 2007, NHSSP II Midterm Review Report, and Roadmap for Acceleration of Implementation of Interventions to Achieve the Objectives of NHSSP II, Nairobi, Kenya.

5 Strategic Model

The model on which this plan was based provides for a series of broad strategic thrusts, each one with its own set of goals, objectives, and targets. Because the Ministry's mandate focuses on the community and the health services closest to the community, the emphasis is on public service.

5.1 Strategic Thrusts for Public Health and Sanitation

Five strategic thrusts define the priority areas MOPHS will address in the years 2008–2012. These priority areas are in line with the First Medium-Term Plan 2008–2012 and NHSSP II and are derived from the situational analysis presented above in Chapter 4 of this strategic plan. The five strategic thrusts are:

1. ***Strategic thrust 1:*** Improving equitable access to public health and sanitation services
2. ***Strategic thrust 2:*** Improving the quality and responsiveness of public health and sanitation services
3. ***Strategic thrust 3:*** Improving efficiency of public health and sanitation services
4. ***Strategic thrust 4:*** Fostering partnerships
5. ***Strategic thrust 5:*** Improving financing of public health and sanitation services

The linkages of these strategic thrusts with the health goals of NHSSP II, MTP and Vision 2030 are illustrated in Figure 5.1.

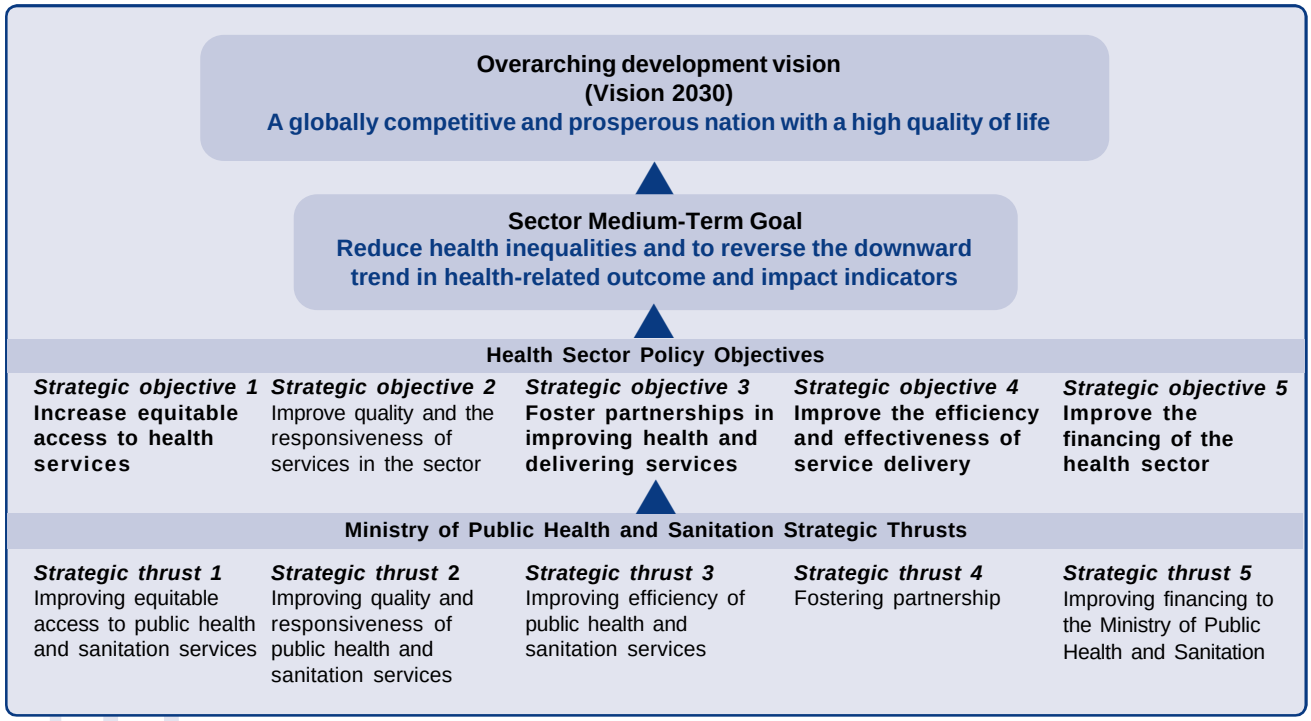
5.2 Implementation Framework for Achieving the Strategic Priorities

In what follows, each of the five broad strategic thrusts is broken down by specific goals and the strategies for achieving the

The plan's five strategic thrusts hinge on MOPHS principles and values:

- People first
- Social justice and equity
- Partnership and collaboration
- Result oriented
- Professionalism
- Accountability
- Integrity
- Teamwork

Figure 5.1: MOPHS strategic thrusts and links to Kenya Vision 2030, MTP and NHSSP II



goals. A brief explanation for the rationale for each thrust is given, while a series of tables summarizes the goals, strategies, yearly indicators and targets, and annual projected costs.

5.2.1 *Strategic Thrust 1:* Improving Equitable Access to Public Health and Sanitation Services

As noted earlier, geographical, economic and socio-cultural barriers can be formidable obstacles to people's ability to access public health and sanitation services. To improve access, this thrust outlines the specific goals and strategies itemized below.

1.1) Increase the proportion of communities that live within 5 km of a functional health facility from 52% to 62%, by:

1.1.1) Carrying out GIS mapping for development of a policy and strategy (norms and standards) for investing in health infrastructure,

1.1.2) Increasing the number of functional public health facilities by 480 for level 3 and 300 for level 2:

- Rehabilitation of 100 non-functional GOK and 100 CDF level 2 facilities.
- Construction of 100 new level 2 facilities.
- Rehabilitation of 160 non-functional GOK and 160 CDF level 3 health facilities.
- Construction of 160 additional new level 3 health facilities.

1.1.3) Designing and implementing innovative public health service approaches for special groups (e.g., pastoralist communities) at 120 nomadic, mobile and congregate settings,

1.1.4) Adding and operating 40 nomadic clinics, 40 mobile clinics and 40 stand-alone clinics, and

1.1.5) Implementing a comprehensive school health programme.

1.2) Increase the proportion of deliveries conducted by skilled attendants from 42% to 60%, by:

1.2.1) Implementing the Community Strategy by establishing 2,550 community units,

1.2.2) Strengthening the referral system,

1.2.3) Training CHWs and improving communication, e.g., using mobile phones, and

1.2.4) Scaling up strategies for demand creation by implementing two identified strategies annually (e.g., strengthening the capacity of CHWs including TBAs to play designated roles including promotion of skilled attendance at delivery; strengthen community level institutions such as Village Health Committees to increase demand for RH services at level 1, identifying and providing orientation for community midwives to create awareness and offer skilled attendance at delivery at level 1).

Table 5.1 summarizes goals, strategies, indicators and targets for thrust 1 on increasing access to public health services.

Table 5.1: Results framework for Strategic Thrust 1 – Increasing equitable access to public health services

Goals for 2012 (outcome indicators)	Strategies (including flagship projects)	Target description	Unit	Targets against each strategy (outputs)				Cost in Ksh '000			
				Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Increase the proportion of communities that live within 5 km of functional health facility from 52% to 62%	Carrying out GIS mapping for development of a policy and strategy for investing in health infrastructure	GIS mapping conducted		1				20,000	0	0	0
		investment policy and strategy developed	Doc	1				5,000	0	0	0
	Increasing number of functional public health facilities	Non functional GOK facilities operating	No	65	65	65	65	853,722	853,722	853,722	853,722
		CDF facilities operating	No	65	65	65	65	853,722	853,722	853,722	853,722
	Designing and implementing innovative approaches for special groups to access public health services	New facilities constructed	No	65	65	65	65	1,517,134	1,517,134	1,517,134	1,517,134
		Nomadic clinics	No	10	20	30	40	80,000	80,000	80,000	80,000
		Outreach/ mobile clinics	No	10	20	30	40	80,000	80,000	80,000	80,000
		Clinics in congregate settings	No	10	20	30	40	80,000	80,000	80,000	80,000
	Implementing comprehensive school health programme	Schools implementing comprehensive school health programme	No	300	800	1,300	1,800	90,000	165,000	180,000	195,000
Increase proportion of deliveries by skilled attendants from 42% to 60%	Scaling up Community Strategy nationally	Functional community units	No	300	1,050	1,800	2,550	1,029,534	2,573,835	2,573,835	2,573,835
	Strengthening level 1 and 2 referral system	Level 2 facilities with communication system	No	500	1,500	2,500	3,500	5,000	15,000	25,000	35,000
	Scaling up strategies for demand creation	Identified strategies in operation	Docs	2	2	2	2	20,000	20,000	20,000	20,000
				Total Strategic Thrust 1				**4,634,112**	**6,238,413**	**6,263,413**	**6,288,413**

5.2.2 *Strategic Thrust 2:* Improving the Quality and Responsiveness of MOPHS Services

A wide range of specific interventions for improving the quality and responsiveness of public health and sanitation services is proposed. As summarized in Table 5.2, the following goals, with corresponding strategies, are set for this thrust:

2.1) Reduce the vacancy rate of technical staff by 40%, by:

2.1.1) Recruiting 23,645 new health workers: 7,385 to fill existing vacancies and another 16,260 to fill vacancies arising from the rehabilitation of GOK and CDF facilities, and the addition of new facilities, and

2.1.2) Identifying 321,426 CHWs to provide services at the community units.

2.2) Increase the health workforce trained to 40,255 staff by 2012, by carrying out a training needs assessment and developing a training programme.

2.3) Rehabilitate and adequately equip 50% of level 2 and 3 and other public health facilities, by:

2.3.1) Renovating 2,262 health facilities (1,788 level 2 and 474 level 3) and procuring equipment, and

2.3.2) Conducting annual preventive maintenance in all level 2 and 3 health facilities.

2.4) Reduce proportion of facilities reporting no stock outs by 100%, by maintaining adequate stock levels of medicines, commodities and supplies through measures such as proper forecasting, timely procurement and efficient distribution.

2.5) Increase sanitation coverage from 46% to 66%, by:

2.5.1) Implementing the environmental and hygiene policy and strategy,

2.5.2) Constructing 32,000 demonstration pit latrines in public institutions annually, with an equal number of rural waste disposal methods (compost pits) for replication, and

2.5.3) Mobilizing 350,000 households to practise hand washing with soap in the same period.

2.6) Increase the number of households utilizing safe water by 20% by promoting use of treated water at household level, by:

2.6.1) Working with other sector partners to promote use of treated water by 1,700,000 households at the end of five years, and

2.6.2) Working with communities to identify and protect/treat communal water supply sources, e.g., springs, wells, catchment surfaces (roofs, rocks, dams, pans) and water treatment at household level using approved chlorine-based compounds.

2.7) Increase the number of facilities with health care waste management systems from 20% to 100%, by:

2.7.1) Identifying a central regional facility and providing an incinerator, as well as providing appropriate transport to collect waste from the satellite facilities, and

2.7.2) Implementing health care waste guidelines and training staff on same.

2.8) Increase client satisfaction by 50% in 2,408 health facilities, by:

2.8.1) Reviewing, developing and implementing standards and guidelines,

2.8.2) Implementing KQM model,

2.8.3) Implementing ISO 9001, and

2.8.4) Scaling up implementation of the Citizens' Charter in those facilities.

2.9) Reduce the incidence of food-borne diseases/illnesses by 5%, by:

2.9.1) Finalizing, disseminating and implementing food safety policy and strategy, and

2.9.2) Ensuring compliance with Cap 254 and 242.

2.10) Reduce mortality rate due to emergency to below 1/10,000 persons at risk per day.

2.11) Increase the utilization of cost-effective reproductive health services by 50%.

2.12) Increase the utilization of cost-effective child health care services by 50%, by:

2.12.1) Increasing the capacity of level 2 and 3 facilities to provide integrated management of childhood illness (IMCI) services, and

2.12.2) Increasing the proportion of children receiving immunization services.

2.13) Reduce new HIV infections by 50% by scaling up behaviour change initiatives at community/household level.

2.14) Increase TB case detection and treatment to 90% by increasing the capacity of level 2 and 3 to diagnose and treat.

2.15) Reduce malaria incidence to 15% by utilizing cost effective control measures such as LLITNs and indoor household spraying.

2.16) Reduce the incidence of malnutrition of children <5 years by 20% by providing Vitamin A supplements to 100% of all those eligible.

Table 5.2: Results framework for Strategic Thrust 2 – Improving quality and responsiveness of Public Health and Sanitation services

Goals for 2012 (outcome indicators)	Strategies (including flagship projects)	Target description	Unit	Targets against each strategy (outputs)				Cost in Ksh '000			
				Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/9	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Reduce the vacancy rate by 40%	Recruiting new staff	New staff recruits	No	5,911	11,822	17,733	23,645	2,277,240	5,238,131	8,789,100	12,986,512
Increase trained health workforce by 100%	Building staff capacity	Trained health workers	No	6,059	14,485	26,178	40,235	151,475	362,125	654,450	1,005,950
Rehabilitate and adequately equip 50% of level 2, 3 and other public health facilities	Renovating facilities and procure equipment	Rehabilitated facilities	No	529	1,058	1,660	2,262	4,441,697	4,761,843	5,081,988	5,402,134
	Carrying out preventive maintenance of facilities and equipment	Maintained facilities	No	529	1,058	1,660	2,262	418,109	874,302	1,369,043	1,901,866
Reduce proportion of facilities reporting stock outs by 100%	Maintaining adequate stock levels of medicines, commodities, and supplies	Facilities with no stock out	No	1,103	2,272	3,511	4,822	15,025,558	18,628,516	23,186,925	28,817,581
	Scaling up establishment of integrated surveillance and response system	Districts with functional system	No	10	20	35	50	253,540	253,540	380,311	380,311
		Districts with labs upgraded to perform tests on diseases of public health importance	No	10	20	35	50	45,000	46,000	46,000	46,000

Continued

Table 5.2, continued: Results framework for Strategic Thrust 2

Goals for 2012 (out-come indicators)	Strategies (including flagship projects)	Target description	Unit	Targets against each strategy (outputs)				Cost in Ksh '000			
				Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/9	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Reduce proportion of facilities reporting stock outs, continued	Scaling up establishment of integrated surveillance and response system, continued	Districts with capa-city to detect and respond to public health emer-gencies	No	10	20	35	50	189,000	173,000	177,200	179,300
	Improving HMIS and CHMIS capacity	Facilities with reporting capacity	No	500	100	1,500	2,000	50,000	50,000	50,000	50,000
	Strengthening operational research	Operations research activities	No	5	5	5	5	100,000	120,000	140,000	150,000
Increase sanitation coverage from 46% to 66%	Implementing the environ-mental and hygiene policy and strategy	Households with latrines	No	161,000	322,000	483,000	644,000	322,000	322,000	322,000	322,000
		Households with waste disposal system	No	161,000	322,000	483,000	644,000	322,000	322,000	322,000	322,000
		People practising hand-washing hygiene	No	350,000	700,000	1,050,000	1,400,000	35,000	35,000	35,000	35,000
		Provinces with mapped pollution sources	No	2	4	6	8	20,000	20,000	20,000	20,000
		Premises inspected for compliance	No	1,000	2,000	3,000	4,000	10,000	10,000	10,000	10,000
		Jigger infested households fumigated	No	1,000	2,000	3,000	4,000	20,000	20,000	20,000	20,000
		Vector and vermin breeding sites controlled	No	1,000	2,000	3,000	4,000	20,000	20,000	20,000	20,000
Increase the number of households utilizing safe water by 20% by promoting use of treated water at household level	Improving water safety at household level	Households using treated water	No	161,000	322,000	483,000	644,000	322,000	322,000	322,000	322,000
Increase the number of facilities with health care waste man-agement systems from 20% to 100%	Implementing health care waste guidelines	Facilities with proper health care waste systems	No	630	1,260	1,890	2,520	12,600	12,600	12,600	12,600

Continued

Table 5.2, continued: Results framework for Strategic Thrust 2

Goals for 2012 (out-come indicators)	Strategies (including flagship projects)	Target description	Unit	Targets against each strategy (outputs)				Cost in Ksh '000			
				Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/9	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Reduce the incidence of food-borne diseases/ illnesses by 5%	Finalizing and implementing food safety policy and strategy	Premises implementing HACCP and its prerequi-sites (SOPs and SSOPs)	No	1,000	2,000	3,000	4,000	10,000	10,000	10,000	10,000
	Ensuring compliance with Cap 254 and 242	Premises inspected for compliance	No	1,000	2,000	3,000	4,000	10,000	10,000	10,000	10,000
		Non compli-ance cases prosecuted	No	10	20	30	40	10,000	10,000	10,000	10,000
Increase the utiliza-tion of cost-effective RH services by 50%	Increasing capacity of level 2 and 3 facilities to provide RH services	Pregnant women attending at least four ANC visits	%	60	70	80	90	66,000	77,000	88,000	99,000
		Women delivering under skilled attendants	%	50	60	70	80	305,000	366,000	427,000	488,000
		Contracep-tive use	%	50	60	70	80	1,850,000	2,220,000	2,590,000	2,960,000
Increase the utiliza-tion of cost-effective child health care services by 50%	Increasing capacity of level 2 and 3 facilities to provide IMCI and other child health care services	Facilities providing treatment using IMCI guidelines	%	25	35	45	55	293,720	308,406	323,826	340,017
		Children <1 yr fully immu-nized	%	60	80	90	100	0	1,091,936	1,146,533	1,203,860
Reduce new HIV infections by 50%	Scaling up behaviour change and community/ household interventions	Communica-tion strategy in place	No	1				0			0
		HIV+ preg-nant women using PMTCT	%	40	50	60	70	0	61,238,130	183,714,390	0
	Scaling up coverage of core of HIV prevention interventions	Number of people counselled and tested for HIV	No		4,141,937	5,382,662	5,596,119	0	289,167	375,764	0
		Proportion of HIV+ preg-nant women receiving ARV for prophylaxis	%	66	70	75	80	0	57,717	95150	0
		Number of males cir-cumcised across all regions for HIV preven-tion	No	20,000	150,000	200,000	20,000	0	61,238	183,714	0
Increase TB case detection and treatment to 90%	Increasing capacity of level 2 and 3 facilities to diagnose and treat TB	MDR centre in place	No	1	2	5	5	60,000	60,000	300,000	300,000
		Cases detected	%	70	81	82	83	2,100	2,300	2,500	2,700

Continued

Table 5.2, continued: Results framework for Strategic Thrust 2

Goals for 2012 (outcome indicators)	Strategies (including flagship projects)	Target description	Unit	Targets against each strategy (outputs)				Cost in Ksh '000			
				Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/9	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Reduce the incidence of malnutrition in children <5 years by 30%	Increasing provision of supplements and therapeutic feeds	Children < 5 receiving Vitamin A supplement	%	60	80	90	100	163	164	167	170
	Reviewing, developing and implementing standard guidelines	Facilities implementing guidelines	No	602	1,204	1,806	2,408	150,500	150,500	150,500	150,500
Increase client satisfaction by 50% in 2,408 health facilities	Implementing KQM	Facilities implementing KQM		602	1,204	1,806	2,408	150,500	150,500	150,500	150,500
	Implementing ISO 22000	Facilities implementing ISO	No	602	1,204	1,806	2,408	150,500	150,500	150,500	150,500
	Scaling up implementation of Citizens Charter	Facilities implementing Citizen Charter	No	602	1,204	1,806	2,408	150,500	150,500	150,500	150,500
Create an efficient and effective emergency and disaster management mechanism	Finalizing development of disaster management policy	Policy in place	Doc	1				10,000	0	0	0
	Constituting and training disaster response teams	Disaster response teams	No	10	20	30	40	100,000	200,000	300,000	400,000
Ensure L2 and 3 have smooth operations and maintenance	Provide O&M funds to level L2 and 3	Primary health facilities (L2&3)	No	4,142	4,142	4,352	4,352	3,380,000	3,380,000	3,380,000	3,380,000
			Total Strategic Thrust 2					**28,219,482**	**35,926,759**	**45,756,998**	**56,718,124**

5.2.3 *Strategic Thrust 3:* Improve the Efficiency of Public Health and Sanitation Services

From the situation analysis, a number of cross cutting issues and challenges can be identified that thwart the efficiency of the public health support systems. These include:

- Inadequate support staff at provincial and district levels, as well as at levels 1 and 2 (maldistribution in some areas, e.g., Tana Delta).
- Inadequate ICT at all levels.
- Inadequate knowledge and skills of support staff.
- Inadequate transport for coordination/facilitation/supervision.
- Inadequate funds.
- Inadequate office equipment.
- Weak inventory management system/lack of planning/implementation.
- Poor attitude towards work/Motivation.

The following goals and strategies are proposed to counter these challenges and improve the workings of the support systems:

3.1) Reduce the staff vacancy rate by 60%, by:

3.1.1) Recruiting 43,965 support staff,
3.1.2) Developing recruitment and deployment policy,
3.1.3) Revising Ministry's staff establishment for new posts, and
3.1.4) Revising norms and standards to suit MOPHS needs.

3.2) Increase the proportion of staff trained as per government policy by 50%.

3.3) Increase the proportion of employee job satisfaction by 90%, by:

3.3.1) Decentralizing HR functions to provinces and districts,
3.3.2) Instituting incentives for staff retention,
3.3.3) Enhancing opportunities for staff promotions,
3.3.4) Providing office space and fittings, and
3.3.5) Developing human resource capacity.

ICT will be applied at all levels to support decision making and strengthen data management capacity – collection, analysis, computerization and use.

3.4) Increase the availability and utilization of ICT by 60%, by:

3.4.1) Improving capacity of staff in ICT,
3.4.2) Providing Internet connectivity and networking to all levels, and
3.4.3) Establishing linkages and data warehouses incorporating information from IFMIS, HRIS, LMIS, HMIS, etc.

3.5) Improve the utilization of transport services by 50%, by:

3.5.1) Developing a transport policy (improve the transport system),
3.5.2) Increasing the vehicle fleet – Automobiles, motorboats, motorbikes and bicycles, and
3.5.3) Improving the quality of automobiles.

3.6) Increase the availability of tracer drugs to 90% at SDPs.

3.7) Achieve 100% disposal of obsolete, unserviceable and surplus assets annually.

3.8) Increase the reporting rates of health facilities/districts providing quality health information by 30% at all levels for evidence-based decision making, by:

3.8.1) Providing data capture and summary tools at all health facilities,
3.8.2) Utilizing ICT in health information to strengthen data management capacity (collection, analysis, computerization and use) at all levels,
3.8.3) Scaling up establishment of integrated surveillance and response systems,
3.8.4) Establishing a community-based health management information system (CBHMIS),
3.8.5) Strengthening operational research, and
3.8.6) Coordinating PM&E, HMIS and IDSR information sources.

3.9) Strengthen the management and availability of general supplies, by:

3.9.1) Developing annual procurement plans, and
3.9.2) Decentralizing the procurement systems to provincial and district levels and facilities.

3.10) Strengthen the financial management systems, by:

3.10.1) Operating HSSF (to address the 25% policy issue),
3.10.2) Strengthening capacity in financial management at all levels,
3.10.3) Improving data capture on PFM, and
3.10.4) Introducing IFMIS at all levels.

Table 5.3 summarizes the goals, strategies, indicators and targets for thrust 3 on improving the efficiency of public health services.

Table 5.3: Results framework for Strategic Thrust 3 – Improving efficiency of public health and sanitation services

Goals for 2012 (outcome indicator)	Strategies (including flagship projects)	Target description	Unit	Base -line	Targets against each strategy (outputs)				Cost in Ksh '000			
					Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/9	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Reduce vacancy rate by 60%	Developing recruitment and deployment policy	Policy document	No			1			0	0	0	0
	Developing Ministry-specific staff establishment	Approved staff establishment	No			1			0	0	0	0

Continued

Table 5.3, continued: Results framework for Strategic Thrust 3

Goals for 2012 (out-come indicator)	Strategies (including flagship projects)	Target description	Unit	Base -line	Targets against each strategy (outputs)				Cost in Ksh '000			
					Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/9	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
	Revising norms and standards to suit MOPHS	Approved staff norms and standards	No			1			0	0	0	0
		Support staff employed (technical) employed	No	-	7,626	12,113	12, 113	12,113	3,453	5,000	5,200	5,400
Increase proportion of staff trained per gov-ernment training policy by 50%	Strengthening capacity of staff	Support staff trained		-	3948	5,061	6174	7287	98,700	126,525	154,350	182,175
		Technical staff trained		-	3,678	14,678	25,678	36,678	213,324	366,950	641,950	916,950
Increase the pro-portion of employee job satis-faction to 90%	Enhancing opportunities for staff promotions	Staff promotions		-	-	1,185	1,185	1,185	11,850	12,324	12,817	13,330
	Instituting incentive awards	Awards at HQ			3	3	3	3	60	60	60	60
		Awards at province			3	3	3	3	60	60	60	60
		Awards at district			3	3	3	3	100	100	100	100
		Awards at facility level			5	5	5	5	60	60	60	60
	Providing office space and fittings (improve the working environment)	Adequate office space at all levels			215	60	155	100	20,000	5,000	8,000	10,000
Increase availability and use of ICT by staff by 60%	Improving staff capacity in ICT	Support of staff trained on ICT	No		500	1,500	2,500	3,000	5,000	1,5000	2,500	3,000
		Technical staff trained on ICT	%		3	3	4	4	600	1,000	1,200	1,600
	Providing In-ternet connec-tivity and networking to all levels	Facilities with VSAT installed	%	8		10	20	45		2,000	4,100	5,100
		LAN set up	%			20	40	50		3,000	5,400	6,900
	Harmonizing linkages of automation systems (HRIS, HMIS, LMIS, IFMIS) at all levels	Systems automated		4	-	4	-	5	76,000	76,000	76,000	76,000
Improve provision and utili-zation of transport services by 50%	Developing and dissemi-nating trans-port policy	Policy in place	No	1	-	-	-	-		1,500	500	500
	Improving the transport system	Increase the vehicle fleet	No	632	150	30	30	30	50	50	50	0
		Motorboats	No	3	1	1	1	-	8,000	8,000	8,000	0
		Motorbikes	No	300	1500	400	400	400	20,000	20,000	20,000	20,000
		Bicycles	No	3,000	35,000	35,000	35,000	35,000	10,000	10,000	10,000	10,000
	Improving vehicle quality	Vehicles maintained	No	-	80	80	80	80	20,000	20,000	20,000	20,000
	Strengthening the referral system	Ambulance purchased	No	-	150		20	10	100,000	100,000	100,000	100,000

Continued

Table 5.3, continued: Results framework for Strategic Thrust 3

Goals for 2012 (out-come indicator)	Strategies (including flagship projects)	Target description	Unit	Base-line	Targets against each strategy (outputs)				Cost in Ksh '000			
					Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/9	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Reach 100% disposal of obsolete, unserviceable and surplus assets annually	Conducting an inventory of assets	Assets disposed of annually	No	5,600	5,600				3,000	1,000	1,000	0
	Decentralizing disposal	Districts disposing of assets			150	150	150	150	0	0	0	0
Increase reporting rates of health management information systems by 30% at all levels	Providing data capture and summary tools	Health facilities with data capture tools	No	4,500	4,600	4,700	4,700	4,700	50,000	52,000	55,000	60,000
	Utilizing ICT in health information	Districts reporting electronically	%	60	70	80	90	100	0	0	0	0
	Strengthening operational research	Operational research activities	No		5	5	5	5	200	120	140	150
	Improving the capacity of CHMIS	Community units with functional CBHMIS	No		100	200	300	400	50	50	50	50
					Total Strategic Thrust 3				**641,547**	**825,799**	**1,126,537**	**1,431,435**

5.2.4 *Strategic Thrust 4:* Fostering Partnerships

NHSSP II recognized that the Government health sector did not operate in a vacuum, and that strong collaboration with an array of partners was essential if the sector was to achieve its objectives. This strategic plan also acknowledges the value and strength of partnerships, and as summarized in Table 5.4, proposes the following goals and accompanying strategies to achieve this thrust:

4.1) Strengthen governance structures at levels 1, 2 and 3 by 2012, by putting governance structures into operation.

4.2) Improve stewardship and partnership arrangements at all levels, by:

4.2.1) Strengthening joint planning,
4.2.2) Strengthening joint performance monitoring,
4.2.3) Institutionalizing participatory planning, monitoring and evaluation,
4.2.4) Improving operational capacities,
4.2.5) Strengthening leadership and management,
4.2.6) Strengthening the legal regime governing MOPHS, and
4.2.7) Strengthening public private partnership.

Table 5.4: Results framework for Strategic Thrust 4: Fostering partnerships

Goals for 2012 (out-come indicator)	Strategies (incl flagship projects)	Target description	Unit	Target				Cost in Ksh '000			
				Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Strengthen governance structures at all levels by 2012	Putting governance structures into operation	Functional governance units	%	50	60	80	100	45,000	20,000	5,000	5,000

Continued

Table 5.4, continued: Results framework for Strategic Thrust 4

Goals for 2012 (outcome indicator)	Strategies (incl flagship projects)	Target description	Unit	Target				Cost in Ksh '000			
				Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Improve coordination, stewardship and partnership arrangements at all levels	Strengthening joint planning	Annual operational plan	No	1	1	1	1	52,500	55,125	57,881	60,775
		Ministerial strategic plan (2008–2012)	Doc	1	-	-	-	20,000	-	-	-
		Kenya Health Policy Framework (2010–2025)	Doc	-	1	-	-	5,000	17,500	-	-
		NHSSP III (2010–2015)	Doc	-	1	-		5,000	22,500	-	-
	Strengthening joint performance monitoring	Annual performance review reports	No	1	1	1	1	10,000	10,500	11,025	11,576
		COC monitored	No	1	1	1	1	500	500	500	500
		Ministerial strategic plan midterm and end term reviews	No		1		1	-	22,000	-	22,500
	Developing and institutionalizing joint financing	JFA	No	-	1	-	-	-	3,180	-	-
	Strengthening leadership and management	Capacity building for leadership and management at all levels	No	600	600	600	600	50,751	60,000	60,500	70,000
	Strengthening the legal regime governing MOPHS	Public Health Act reviewed	No			1				5,000	
	Strengthening public-private partnership	PPP policy	Doc	-	1	-	-	-	12,500	-	-
				Total Strategic Thrust 4				**188,751**	**223, 805**	**139, 906**	**170, 351**

5.2.5 *Strategic Thrust 5:* Improving Financing of Public Health and Sanitation Services

The strategic thrusts articulated in this plan are outstanding concerns identified by the Ministry with considerable effect on governance and finance. This component on improving financing of the public health and sanitation services has been broken down into three goals and various strategies to achieve the desired results. The goals and their corresponding strategies are:

5.1) Ensure all facilities receive financial resources based on needs by 2012, by:

5.1.1) Allocating financial resources based on needs, and

5.1.1) Fostering pro-poor financing mechanisms.

5.2) Increase efficiency in utilization of resources, by:

5.2.1) Improving budget management and efficient and equitable resource allocation and distribution,

5.2.2) Rolling out the operation of HSSF,

5.2.3) Institutionalizing OBA, and

5.2.4) Developing cost containment measures.

5.3) Increase financial resources to MOPHS by 20% over a period of five years, by:

5.3.1) Tapping into NHIF benefit package,

5.3.2) Increasing GOK allocation to the Ministry,
5.3.3) Mobilizing resources from development partners, and
5.3.4) Mobilizing resources from devolved funds.

Table 5.5 presents the results framework for strategic thrust 5 on improving financing of public health services. The table summarizes the goals, strategies, indicators and targets that are proposed.

Table 5.5: Results framework for Strategic Thrust 5: Improving financing of public health and sanitation services

Goals for 2012 (outcome indicator)	Strategies (including flagship projects)	Target description	Unit	Targets against each strategy (outputs)				Cost in Ksh '000			
				Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 1 08/9	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12
Ensure that financial resources to all facilities are based on needs by 2012	Allocating resources based on needs	Facilities allocated resources according to needs	No	4,142	4,142	41,342	41,342	3,000	4,000	5,000	6,000
	Fostering pro-poor financing mechanisms	Financial resources allocated for pro-poor health care	%	100	100	100	100	5,000	6,000	6,000	7,000
Increase efficiency in utilization of resources	Improving budget compliance	Allocated funds used for intended purpose	%	100	100	100	100	2,500	3,000	4,000	5,000
	Operating HSSF	Health facilities receiving allocations through HSSF	%	0	20	20	30	0	150,000	10,000	12,000
	Institutionalizing OBA	Increased proportion of Ministry allocation to OBA	%	0	0	1	2	5,000	8,000	12,000	12,000
	Costing services	Service delivery levels using costing instrument	%	0	20	40	70	1,000	1,000	1,000	1,000
	Developing cost containment mechanisms and instruments	Compliance with budget requirements	%	100	1100	100	100	1,000	1,000	1,000	1,000
Increase financial resources to MOPHS by 20% over a period of five years	Tapping into NHIF benefit package	Health facilities receiving allocation through HSSF	No	50	70	80	99	1,000	1,000	1,000	1,000
		Resources from NHIF to Ministry PHS	%	10	20	30	40	0	0	0	0
	Increasing GOK budgetary allocation to the Ministry		%	1	4	6	10	0	0	0	0
	Enhancing resource mobilization	Resources mobilized from development partners	%	18	20	22	25	1,000	5,000	4,000	4,500
		Resources mobilized from devolved funds	%	5	20	40	50	100	200	400	500
			Total Strategic Thrust 5					**19,600**	**179,200**	**44,400**	**50,000**

6 Coordination Framework

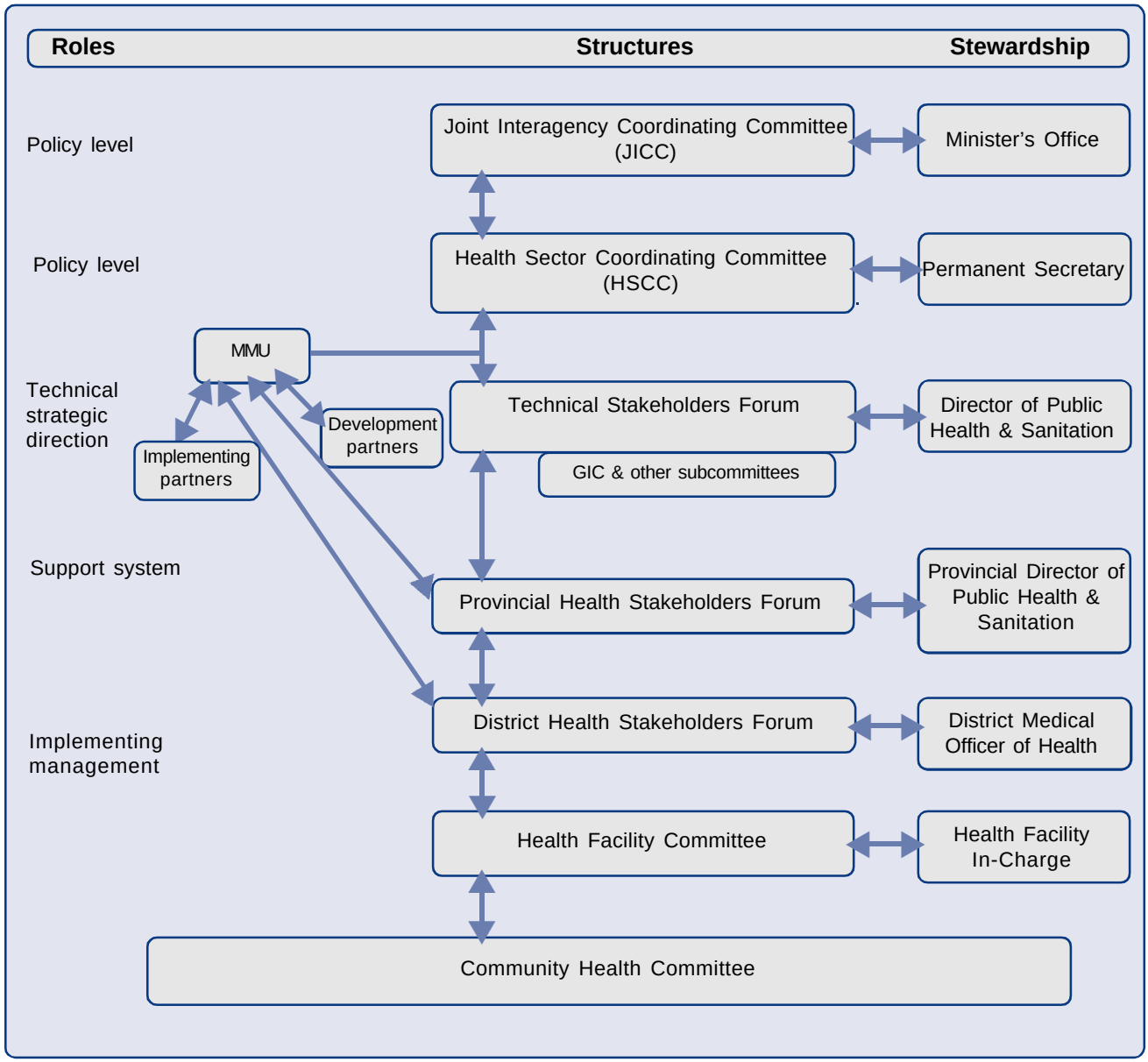
Effective coordination of health sector activities is recognized as key to efficient health care systems and to the provision of quality services. It is for this reason that NHSSP II clearly spelt out coordination structures at the different levels as a component of the SWAp. These structures have already been institutionalized and are functioning, and both MOPHS and MOMS have agreed to continue using them for coordinating all health sector stakeholders. The structures are described below and illustrated in Figure 6.1.

Nevertheless, several priority areas in governance and partnership structures require strengthening during the strategic plan period. To be addressed individually and jointly by the two ministries, these are:

- Ensuring that the partnership structures are functioning adequately at all the levels of care: national Health Sector Coordinating Committee (HSCC), Provincial Health Stakeholders Forum (PHSF), District Health Stakeholders Forum (DHSF), Divisional Health Stakeholders Forum (DIVHSF) and the community health committee (CHC).
- Defining the framework to guide pooled funding arrangements (Joint Financing Agreements) and commence implementation.
- Completing the framework for aligning funding from all partners (shadow budget).
- Strengthening the process of monitoring adherence to the Code of Conduct.
- Accelerating the articulation of public–private partnership policy.
- Undertaking comprehensive leadership and management training for all managers especially at subnational levels.
- Scaling up measures of social accountability towards clients of health services.

Structures and mechanisms for coordinating collaboration across the two ministries have been elaborated at all levels of the sector. Thus MOPHS will use the existing sector coordination framework to coordinate the implementation of this ministerial medium-term plan.

Figure 6.1: Ministry of Public Health and Sanitation coordination structure



6.1 Coordination Structures at the National Level

MOPHS will use the existing sector governance and coordination framework to facilitate the implementation of this strategic plan. Structures and mechanisms for coordinating collaboration across the two health ministries have been elaborated at all levels of the sector, and most are already in operation. The main coordination organs at national level comprise both joint activities by the two ministries and activities that are specific to MOPH, as described below.

6.1.1 Joint Inter Agency Coordinating Committee (JICC)

This is the cross-sector coordination structure whose key role is to provide political and policy direction, thereby ensuring that the sector is working towards achieving the policy objectives set out in Vision 2030 and the MTPs. The members of the committee meet under the leadership of the Minister of Medical Services and the Minister of Public Health and Sanitation as conveners. The Permanent Secretaries for both ministries serve as the secretariat.

6.1.2 Health Sector Coordinating Committee (HSCC)

The overall strategic coordination of the implementation of this strategic plan will be undertaken through the Health Sector Coordinating Committee (HSCC). The main role of this committee is to ensure that the ministerial strategic plan is implemented to achieve the health sector policy objectives. Meetings of the HSCC are co-chaired by the Permanent Secretaries of MOMS and MOPHS on a rotational basis. Sector partners will participate in both JICC and HSCC.

6.1.3 Technical Stakeholders Committee (TSC)

Technical coordination of the implementation of the ministerial strategic plan will be undertaken by the Technical Stakeholders Committee. Its role will be to ensure that the strategies being implemented are contributing towards the achievement of the specific strategic goals of this strategic plan. Two or more technical stakeholder committees may cooperate to address cross-cutting technical issues in both ministries. Meetings of the TSC will be co-chaired by the Directors of MOMS and MOPHS on a rotational basis.

6.1.4 Ministerial Management Unit (MMU)

This unit is the secretariat to the Ministerial Management Committee. The main task of this unit is to monitor the implementation of the ministerial strategic plan.

6.2 Coordination Structures at the Subnational Level

At subnational levels separate governance and coordination organs will facilitate provincial and district operations of the strategic plan. The various forums and committees will coordinate delivery of health care services for all partners within their areas of jurisdiction.

6.2.1 Provincial Health Stakeholder Forum (PHSF)

Provincial level coordination will be through the Provincial Health Stakeholders Forum. This structure will coordinate all issues within its contribution jurisdiction. It will be chaired by the Provincial Director of Public Health and Sanitation.

6.2.2 District Health Stakeholder Forum (DHSF)

The main role of this forum will be to manage the implementation of the plan and strengthen collaboration among all stakeholders in a district on health-related issues. The forum will be chaired by the District Medical Officer of Health.

6.2.3 Health Facility Committee (HFC)

The committee's main role will be to manage the implementation of priority public health interventions. It will be chaired by the health facility in-charge

6.2.4 Community Health Committee (CHC)

Greater ownership by the community will be achieved through the community health committee and the individual Health Facility Committee.

7 Capacity

MOPHS became fully operational in July 2008 following the definition of its structures and priorities. Being newly created, the Ministry will continue to work to improve its operations and functioning at all levels.

The immediate focus for improving operations of the Ministry will be:

1. Identifying competent persons to ***fill all the posts*** within the management structure in order to have the required management capacity needed to carry out the respective mandates of the different units in the structure.

2. Articulating ***performance targets*** for each unit in the management structure, in line with the Government's results-based management framework, to ensure that the units are clear about the performance expected of them in terms of their mandates.

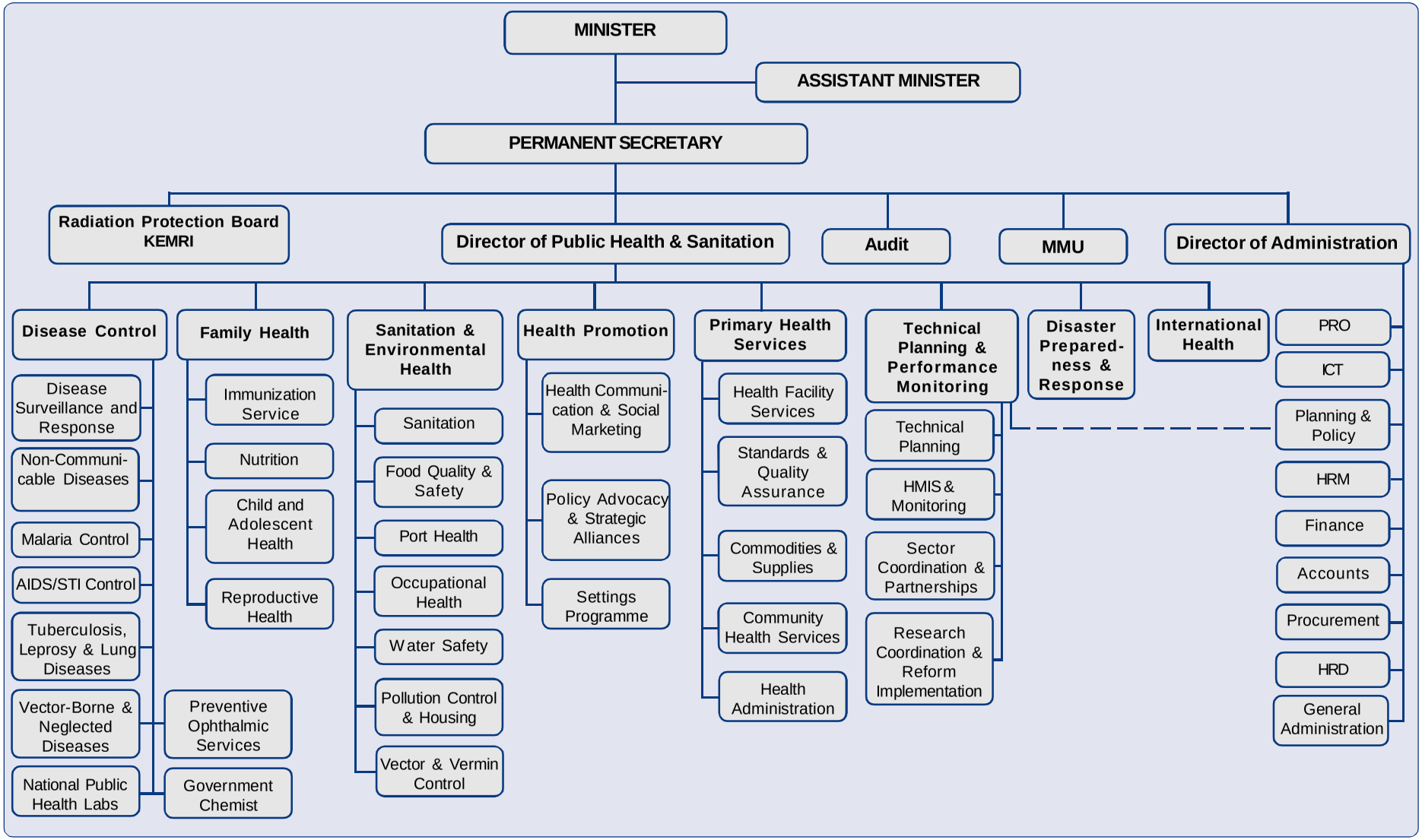
> Performance targets for each unit in the management structure, in line with the Government's results-based management framework, will help to ensure that the units are clear about the performance expected of them according to their mandates.

7.1 Management Structure and Functions at the National Level

The mandate assigned to MOPHS consists of public health and sanitation policy, preventive and promotive health services, and community health services. The particular focus is on service delivery at KEPH levels 1–3.

Among the specific functions are health education, reproductive health, food quality and hygiene, quarantine administration, vector control, health inspection, and other public health services. The parastatals and semi-autonomous government agencies under the Ministry include KEMRI and the Radiation Protection Board. All these functions are reflected in the organogram illustrated in Figure 7.1. The key management positions at national level are described below.

Figure 7.1: Ministerial structure at national level



Key: HMIS = Health management information system; HRD = Human resources development; HRM = Human resources management; ICT = Information and communications technology; KEMRI = Kenya Medical Research Institute; MMU = Ministerial Management Unit; PRO = Public Relations Office.

7.1.1 Office of the Permanent Secretary

The Permanent Secretary has the responsibility of oversight of the overall operations of the Ministry. In executing these functions he will be supported by the Director of Public Health and Sanitation, the Director of Administration, Principal Accounts Controller, Chief Finance Officer, and Director of Human Resources. Besides these, the Audit Department and the MMU provide additional support to the Permanent Secretary through their respective mandates.

7.1.2 Office of the Director of Public Health and Sanitation (DPHS)

The office of the DPHS is responsible for the technical operations of the Ministry. Seven departments provide support to and are directly under the supervision of the DPHS. The mandate and functions of the departments and divisions under the DPHS are shown in Table 7.1.

Table 7.1: Functions of departments and divisions under the office of the DPHS

Technical department	Divisions	Functions
Disease Prevention and Control	Non-Communicable Disease	Design and promote strategies that reduce risk of disease as a result of lifestyle or exposure to known health hazards.
	Malaria Control	Design and promote strategies for individual, family or community practices that prevent exposure to malaria infection, for ecological vector control and for early treatment for malaria.
	Tuberculosis and Leprosy Control	Design and implement strategies for reducing the risk of TB and leprosy infection; improve case detection and effective treatment as well as surveillance for drug resistance.
	Vector-Borne and Neglected Disease	Promote practices that prevent vector-borne infections, promote early case detection and effective treatment; advocate for and mobilize resources for neglected diseases and infections.
	National Public Health Laboratory	Develop laboratory services for public health investigations and disease diagnosis at levels 1, 2 and 3.
	Government Chemist	Support forensic services and toxicological investigations
	Preventive Ophthalmology	Design strategies for the prevention of eye infections, effective eye care and effective treatment of eye diseases.
	Disease Surveillance	Design disease surveillance systems, early warning systems and support to management of disease outbreaks.
Family Health	Reproductive Health	Develop policies, strategies and interventions that are responsive to sexual and reproductive health needs of individuals, adolescents, families and communities.
	Child and Adolescent Health	Develop policies, strategies and interventions for the promotion of child health, prevention of diseases affecting children and adolescents, and effective treatment and care for children and adolescents.
	Nutrition	Promote nutritional practices that maintain health and strategies for appropriate supplementation.
	Immunization	Promote strategies for high coverage in routine immunization and integration of new vaccines into the public health schedule.
Health Promotion	Health Communication	Develop the Community Strategy and its effective implementation; support other departments and programmes to effectively communicate health messages.
	Policy Advocacy	Develop and advocate for health polices that are responsive to the needs of individuals, families and communities; champion a rights approach to health.
	Settings programmes	Increase access to effective health promotion interventions within institutions; build capacity of institutions to respond to health challenges.
Environmental Health and Sanitation	Sanitation and Hygiene	Reduce health risks arising from inadequate sanitation.
	Food Quality	Protect consumers' health by ensuring that food produced, distributed, marketed and consumed meets required standards of food safety and quality.
	Water Safety	Protect consumers' health by ensuring water safety.
	Occupational Health	Protect people against ill health arising from daily activities in the workplace.
	Pollution Control and Housing	Reduce factors that contribute to poor housing and environmental pollution.
	Vector and Vermin Control	Ensure control of all disease vectors and vermin in vessels, households and the environment in line with Cap 242.
	Port Health	Reduce disease transmission through ports of entry including airports, seaports and frontier posts.

Continued

Table 7.1, continued

Technical department	Divisions	Functions
Primary Health	Provincial Health Services	Coordinate and oversee the delivery of public health and sanitation services in the country; support decentralization of service planning and provision; monitor and evaluate service delivery.
	Community Health Services	Scale up implementation of the Community Strategy; mobilize resources, monitor and evaluate quality of community-based health care services.
	Facility Health Services	Provide public health services at levels 1, 2 and 3, support the referral system, implement quality assurance strategies, assess quality of care and user satisfaction.
	Commodities and Supplies	Ensure availability of commodities (drugs, non-pharmaceuticals and medical equipment/devices) at primary health levels.
	Standards and Quality Assurance	Coordinate M&E and formulate standards
Disaster Preparedness and Response	Disaster Prevention and Risk Reduction	Establish early warning systems, coordinate response and resource mobilization; provide tools and guidelines for prediction; build capacity.
	Emergency Preparedness and Response	Carry out disaster mapping; database development and emergency coordination and management.
	Surveillance, Monitoring, Evaluation and Research	Develop and install surveillance systems, thresholds and evaluation systems; carry out surveillance and operations research.
International Health	International Health	Coordinate regional and international strategies and interventions, enhance implementation of international health protocols.
Technical Planning and Monitoring	Technical Planning	Provide technical guidance to other departments in the development of short-, medium- and long-term plans and performance monitoring reports; coordinate AOP planning, joint M&E, sector policy development.
	HIMS and Monitoring	Collect and collate all relevant information including research relevant for planning of service delivery and the supporting systems
	Sector Coordination and Partnership	Coordinate stakeholders to ensure that the delivery of public health and sanitation services is harmonized; develop the public health and sanitation reform agenda and ensure implementation of such reforms; support SWAp processes.
	Research Coordination and Research	Facilitate the development of research policies and agenda; ensure application of results from operations research.

7.1.3 Parastatals and Statutory Boards

The Ministry has one semi-autonomous agency, KEMRI, and one statutory board, the Radiation Protection Board. The core functions of these institutions are summarized in Table 7.2.

Table 7.2: Core functions of parastatal and statutory boards under MOPHS

Parastatal/Board	Mandate
KEMRI	Conduct research, surveys and surveillance programmes and disseminate results.
Radiation Protection Board	Oversee quality assurance and development of guidelines, rules and regulations, and enforce rules.

7.1.4 Support Services

The Director of Administration oversees nine departments/units. Their mandates and functions are summarized in Table 7.3.

7.1.5 Ministerial Support Units

There are two ministerial support units for the Ministry, Internal Audit and the Ministerial Management Unit (MMU). The core functions of the two units are outlined in Table 7.4.

Table 7.4: Core functions of ministerial support units

Unit	Mandate
Internal Audit	Ensure that effective systems for ensuring transparency, accountability and low fiduciary risk.
MMU	Coordinate performance contracting and to monitor performance.

7.2 Management Structures and Functions at the Subnational Levels

Provincial and district management structures are responsible for managing service delivery at their respective levels. The organizational structures for each level are illustrated in Figure 7.2 and their functions are summarized in Table 7.5.

The core functions and staff requirements for departments/units at the subnational levels are outlined in Table 7.6.

Table 7.3: Core functions of departments/units under the Director of Administration

Support services	Department/Division	Mandate
Finance and administration	General administration	Develop and institutionalize administrative systems to support the effective delivery of public health and sanitation services; manage logistics and develop systems.
	Finance	Ensure that the Ministry has efficient financial management and control systems that effectively support the delivery of quality public health and sanitation services.
	Accounts	Ensure that the Ministry has efficient accounting systems in support of the delivery of public health and sanitation services.
	Procurement	Ensure that procurement procedures are in place that ensure value-for-money, transparency and accountability of procurement of commodities, equipment and supplies for effective delivery of public health and sanitation services.
	ICT	Enable citizens to access Ministry services and information as efficiently and as effectively as possible through use of Internet and other channels of communication.
Human resource management	Human Resource Development	Ensure that an adequate, skilled and motivated workforce is available to provide quality public health and sanitation services; oversee personnel management, performance appraisal, personnel emoluments and budget.
	Human Resource Management	Ensure that the Ministry is staffed with the right people at the right places and at the right time; conduct strategic planning, build capacity.
Policy and planning		Ensure adequate financing of the Ministry in support of the delivery of quality public health and sanitation services; conduct long-term strategic planning; oversee performance management and accountability framework for results-based management, rapid results initiative, and monitoring and evaluation of implementation of MTP and Vision 2030.
PRO		Communicate with the public and the media.

Figure 7.2: Organization structure for subnational management levels and reporting offices at headquarters level

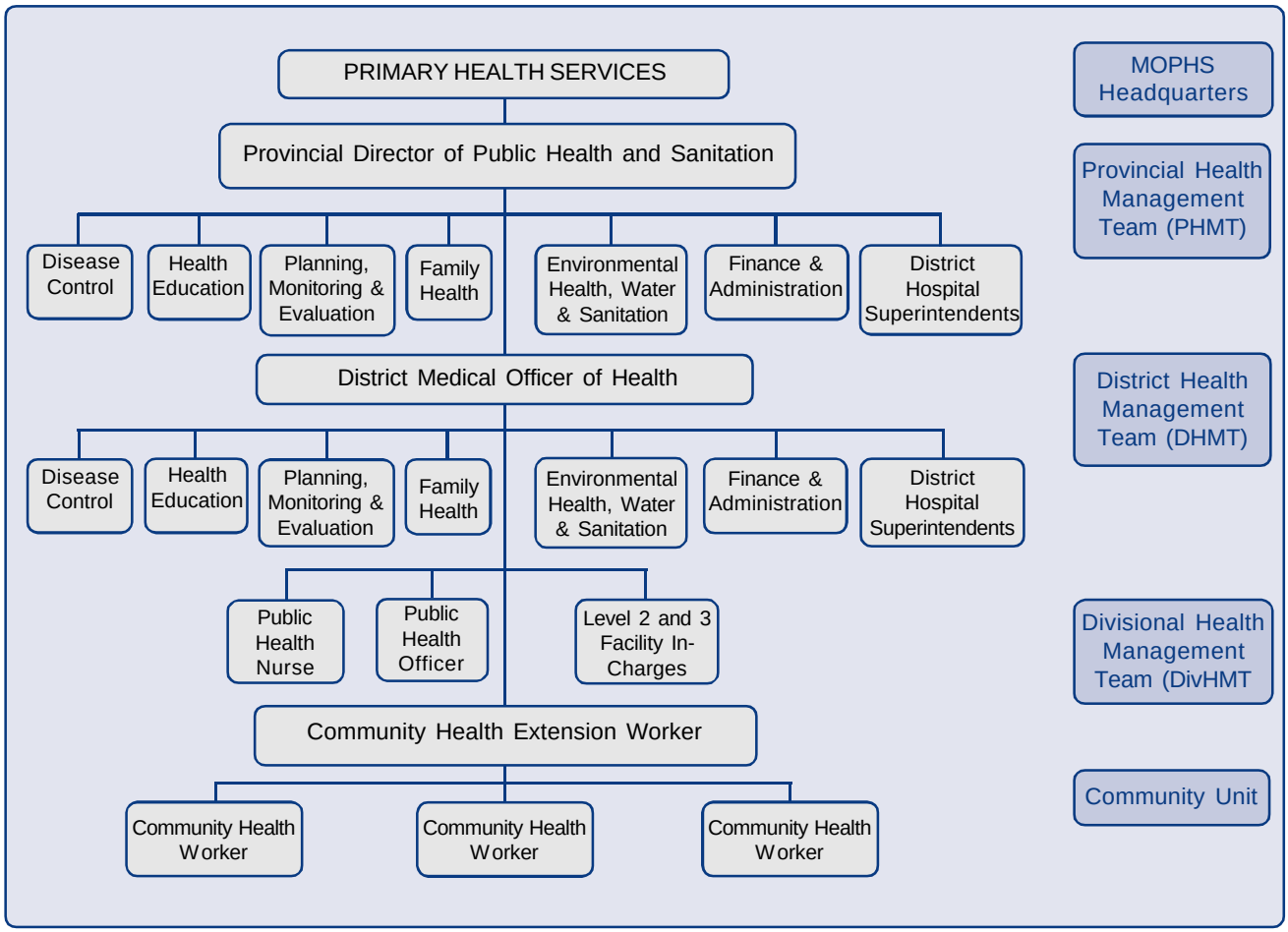


Table 7.5: Core functions of subnational management structures

Level	Core functions/Mandate
Province	• Overall coordination and management of health services in the province • Strategic, and operational planning for public health services in the province • Performance monitoring, evaluation and supervision • Capacity building and support to districts and local authorities • Quality assurance • Disease surveillance and control • Emergency response • Governance and linkages with other sectors • Infrastructure development • Logistics support and commodity security • Resource mobilization • Environmental protection and sanitation
District	• Overall coordination and management of health services in the district • Strategic and operational planning for public health services in the district • Performance monitoring, evaluation and supervision • Capacity building and support to divisions, community and local authorities • Quality assurance • Disease surveillance and control • Emergency response • Governance and linkages with other sectors • Infrastructure development • Logistics support and commodity security • Resource mobilization • Environmental protection and sanitation
Division	• Planning for health services in the division • Coordination of monitoring and reporting (for public health services) in division • Provision of preventive services • Logistics management • Resource mobilization • Supervision of community health care services
Community	• Coordination of implementation of the comprehensive community health services • Participatory planning and action • Targeted health promotion • Water and sanitation activities • Vector control • Home-based care • Delivery of defined health programme interventions • Monitoring and reporting on community actions

Table 7.6: Core responsibilities and staff requirements for units at the subnational level

Management team	Unit	Minimum officers	Core responsibilities
Provincial and District Health Management Teams	Medical Officer of Health		Overall management and coordination of services in the province.
	Disease control	Overall coordinator 1 HIV coordinator 1 TB coordinator	Planning and coordination of public health interventions targeting specific diseases NCDs, infectious diseases, etc.); epidemic (malaria, TB, HIV, preparedness and response.
	Health education	1	Design and implementation of health promotion interventions.
	Environmental health, water and sanitation	1	Environmental health, food and water safety and hygiene, vector control, and enforcement of Public Health Act.
	Family health	1	Coordination and planning for reproductive and child health services.
	Planning, monitoring and evaluation officer	1	Planning, M&E, surveillance, mapping resources and services, HMIS, quality assurance.
	Medical superintendent	1	Ex-officio member, responsible for ensuring harmony with medical services.
	Finance and administration	1	General administration, logistics support, personnel and finance.
Divisional Health Management Team	Public health nurse	1	Coordination of disease control and family health services.
	Public health officer	1	Coordination of health education, environmental health, water and sanitation services.
	Facility in charges	3	Coordination of planning, monitoring, surveillance, resource and service mapping, information management, quality assurance, and finance and administration for public health in the division.
Community Unit	CHEWs (PHTs, etc.)	2	Planning, coordination of implementation, monitoring and supervision of all public health services in the community unit.
	CHWs	50	Implementation of defined health services.

8 Resource Flows

Consistent with the programme-based approach adopted in developing this plan, the cost estimates for its implementation have been organized along the five strategic thrusts: improving equitable access; improving service quality and responsiveness; improving the efficiency of public health system; fostering partnerships; and improving financing.

8.1 Costing of Public Health Interventions

Estimated cost of the public health interventions proposed here has been aligned with the expenditure ceilings of the MTEF for 2008/09–2011/12, and broken down into specific expenditure categories – personnel emoluments, infrastructure and equipment, operations and maintenance O&M), and medical commodities.

8.1.1 Overall Cost of the Plan

Table 8.1 presents the cost estimates for the five strategic thrusts. The annual cost of the plan increases from Ksh33.7 billion in 2008/09 to Ksh64.6 billion in 2011/12, bringing the total cost of the plan to Ksh195.2 billion over the four years. (See Figure 8.1.)

Strategic thrust 2, on improving the quality and responsiveness of public health and sanitation services, constitutes the core of the plan – accounting for about 85% of the resource requirements for the period 2008/09–2011/12.

The main cost drivers are medical commodities, personnel emoluments, equipment, construction of latrines and establishment of modern waste disposal technologies in target communities.

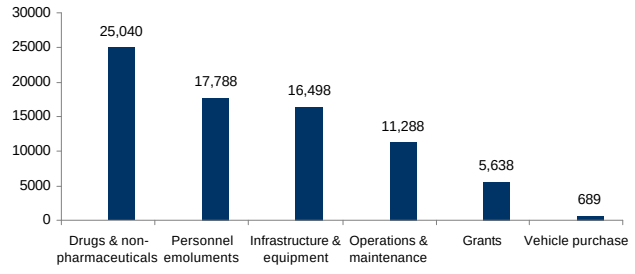
Financial projections made for allocating resources are aligned to the five strategic thrusts of this strategic plan:

- Improving equitable access
- Improving service quality and responsiveness
- Improving the efficiency of public health systems
- Fostering partnerships
- Improving financing

Table 8.1: Summary resource requirements by thrusts, 2009/10–2011/12 (Ksh 000,000 and percentage)

Thrust	2008/09		2009/10		2010/11		2011/12	
	Ksh 000	%	Ksh 000	%	Ksh 000	%	Ksh 000	%
Improving equitable access to public health services	4,634,112	14	6,238,413	14	6,263,413	12	6,288,413	10
Improving service quality and responsiveness public health services	28,219,482	84	35,926,759	82	45,756,998	86	56,718,124	88
Improving efficiency of public health services	640,507	2	825,799	2	1,126,537	2	1,431,435	2
Fostering partnerships	188,751	1	223,805	1	139,906	0	170,351	0
Improving financing of public health services	19,600	0	179,200	0	44,400	0	51,000	0
Total	**33,702,452**	**100**	**43,393,976**	**100**	**53,331,254**	**100**	**64,659,323**	**100**

Figure 8.1: Summary resource requirements by strategic thrusts (Ksh 000,000)



This is followed by thrust 1 on improving equitable access to health services, which represents about 11.9% of the estimated resource requirements. For instance, the plan is to increase the number of health facilities with functional infrastructure and equipment from 1,058 in 2008/09 to about 2,262 in 2011/12, and to increase the number of nomadic clinics from 10 in 2009/10 to 40 clinics by 2011/12.

To improve equitable access to public health and sanitation services, the plan will develop the health infrastructure and beef up equipment maintenance to support service provision. A particular emphasis is on the construction of new health facilities especially in nomadic communities.

8.1.2 Distribution of Costs by Input Categories

A breakdown of the costs by specific input categories shows that medical commodities, personnel emoluments and infrastructure requirements are the main cost drivers. Table 8.2 shows the costs by category in Kenya shillings and the percentage share of the total costs.

From Table 8.2, it can be seen that the main cost drivers for this strategic plan are: drugs and non-pharmaceuticals; personnel emoluments; and infrastructure.

Table 8.2: Distribution of costs by budget category, 2009/10–2011/12 (Ksh 000 and percentage)

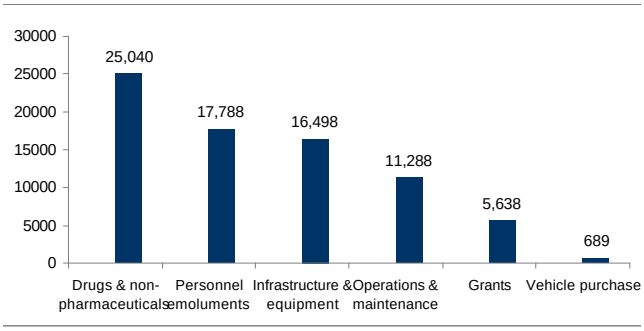
Input category	2008/09		2009/10		2010/11		2011/12	
	Ksh 000	%	Ksh 000	%	Ksh 000	%	Ksh 000	%
Personnel emoluments	2,428,715	7	5,600,256	12.9	9,443,550	17.5	13,992,462	21.3
Drugs and non-pharmaceuticals	15,025,721	45	18,628,680	42.9	23,187,092	42.9	28,817,751	43.9
Operations & maintenance	7,865,304	23	10,009,989	23.1	10,477,675	19	10,769,254	16.1
Vehicles/motorboats	138,050	0	138,050	0.3	138,050	1	130,000	1.2
Infrastructure	8,239,662	24	9,002,001	20.7	10,059,887	19.6	10,914,856	17.4
Equipment	5,000	0	15,000		25,000		35,000	
Total	33,702,452	100	43,393,976	100.0	53,331,254	100	64,659,323	100

8.2 Available Financing

Budgetary allocations complemented with cost sharing revenues collected and retained by health facilities are expected to form the main sources of finance for MOPHS over the current MTEF period. The level of cost sharing revenues has been kept constant over the period at the amount reported in 2007/08.

On the other hand, as indicated in Table 8.3 and summarized in Figure 8.2, budgetary allocations to the Ministry are expected to increase, from Ksh10 billion in 2008/09 to Ksh25 billion in 2011/12. This estimated available resources excludes off-budget financing to public health and sanitation services from the development resources. Table 8.4 shows the trend in expected expenditures (including cost sharing revenues) 2008/09 to 2011/12.

Figure 8.2: Total estimated available resources by main budget categories (Ksh 000,000)



8.3 Resource Gap

Table 8.5 distributes the estimates from Table 8.4 by the main thrusts and compares the MTEF allocations (including cost sharing resources) with the MTP budget estimates. The overall financing gap is Ksh103.6 billion over the four years. This is distributed by year as follows: Ksh256 billion in 2008/09; Ksh23.8 billion in 2009/10; Ksh32.2 billion in 2010/11; and Ksh42.0 billion in 2011/12.

The gap is further distributed by each of the five thrusts as follows: Thrust 1, Ksh15.2 billion; Thrust 2, Ksh105.4 billion; Thrust 3, Ksh2.3 billion; Thrust 4, Ksh0.5 billion; and Thrust 5, Ksh0.02 billion. As shown in Table 8.5, the largest financing gap is in thrust 2 (improving the quality and responsiveness of public health services), which accounts for about 85% of the total gap. Large financing gaps by input categories are on drugs and non-pharmaceuticals, infrastructure including equipment and personnel emoluments.

The main cost drivers for this strategic plan are: drugs and non-pharmaceuticals; personnel emoluments; and infrastructure.

Table 8.3: Estimated financing for MOPHS 2008/09–2011/12, budgetary and cost sharing (Ksh 000,000)

Category	2008/09	2009/10	2010/11	2011/12
Budgetary allocations	8,627	20,309	21,961	23,873
Cost sharing revenues	1,572	1,572	1,572	1,572
Budgetary + cost sharing	10,199	21,881	23,533	25,445

Source: Medium-Term Expenditure Framework (MTEF); MOPHS 2009.

Table 8.4: Distribution of estimated available resources by main budget categories, 2008/09–2011/12 (Ksh 000,000)

	2008/09	2009/10	2010/11	2011/12
Drugs & non-pharmaceuticals	2,370	6,403	7,431	8,836
Infrastructure & equipment	309	5,211	5,420	5,558
Operations & maintenance	2,448	2,760	2,963	3,117
Personnel emoluments	2,875	4,991	4,999	4,923
Vehicle purchase	100	194	196	199
Grants	1,313	1,360	1,413	1,552
Total	**9,418**	**20,920**	**22,424**	**24,187**

Source: MTEF estimates.

Table 8.5: Comparison: Budget, MTEF allocations; and funding gap

	MTP cost estimates				MTEF budget (Ksh 000)				Funding gap				
	2008/09	2009/10	2010/11	2011/12	2008/09	2009/10	2010/11	2011/12	2008/09	2009/10	2010/11	2011/12	Total
Strategic thrust 1: Increase equitable access to public health													
Infrastructure development	2,615,856	2,625,856	2,635,856	2,645,856	98,147	1,517,663	1,584,394	1,343,066	-2,517,709	-1,108,193	-1,051,462	-1,302,790	-5,980,153
Community health services (O&M)	2,018,256	3,612,557	3,627,557	3,642,557	628,274	996,280	1,026,134	1,054,433	-1,389,982	-2,616,277	-2,601,423	-2,588,124	-9,195,805
Subtotal	*4,634,112*	*6,238,413*	*6,263,413*	*6,288,413*	*726,421*	*2,513,944*	*2,610,529*	*2,397,499*	*-3,907,691*	*-3,724,469*	*-3,652,884*	*-3,890,914*	*-15,175,958*
Strategic thrust 2: Improve quality and responsiveness of public health and sanitation services													
O&M for L2 &3 facilities	3,380,000	3,380,000	3,380,000	3,380,000	1,052,179	932,145	956,107	978,429	-2,327,821	-2,447,855	-2,423,893	-2,401,571	-9,601,139
PE (technical)	2,428,715	5,600,256	9,443,550	13,992,462	2,875,983	4,991,002	4,999,132	4,923,894	447,268	-609,254	-4,444,418	-9,068,568	-13,674,972
Medicines and public health commodities	15,025,721	18,628,680	23,187,092	28,817,751	2,370,719	6,403,510	7,431,722	8,836,322	-12,655,002	-12,225,170	-15,755,370	-19,981,429	-60,616,971
O&M for central programmes	1,776,240	1,931,678	2,305,325	2,233,911	552,936	532,723	652,112	646,664	-1,223,304	-1,398,955	-1,653,213	-1,587,247	-5,862,719
Infrastructure/Equip.	5,608,806	6,386,145	7,441,031	8,294,000	210,442	3,690,994	3,999,132	4,210,128	-5,398,364	-2,695,151	-3,441,899	-4,083,872	-15,619,286
Subtotal	*28,219,482*	*35,926,759*	*45,756,998*	*56,718,124*	*7,062,259*	*16,550,374*	*18,038,206*	*19,595,437*	*-21,157,223*	*-19,376,385*	*-27,718,792*	*-37,122,687*	*-105,375,087*
Strategic thrust 3: Improve efficiency													
O&M for administration/management/province and district	482,457	682,749	980,487	1,291,435	150,187	188,290	277,352	373,839	-332,270	-494,459	-703,135	-917,596	-2,447,459
Infrastructure	20,000	5,000	8,000	10,000	750	2,890	4,300	5,076	-19,250	-2,110	-3,700	-4,924	-29,984
Vehicles/Motorboats, etc.	138,050	138,050	138,050	130,000	100,450	194,342	196,450	199,550	-37,600	56,292	58,400	69,550	146,642
Subtotal	*640,507*	*825,799*	*1,126,537*	*1,431,435*	*251,387*	*385,522*	*478,102*	*578,466*	*-389,120*	*-440,277*	*-648,435*	*-852,969*	*-2,330,801*
Strategic thrust 4: Foster partnerships													
O&M	188,751	223,805	139,906	170,351	58,757	61,722	39,575	49,313	-129,994	-162,083	-100,331	-121,038	-513,446
Subtotal	*188,751*	*223,805*	*139,906*	*170,351*	*58,757*	*61,722*	*39,575*	*49,313*	*-129,994*	*-162,083*	*-100,331*	*-121,038*	*-513,446*
Strategic Thrust 5: Improve financing													
O&M	19,600	179,200	44,400	51,000	6,101	49,420	12,560	14,763	-13,499	-129,780	-31,840	-36,237	-211,356
Subtotal	*19,600*	*179,200*	*44,400*	*51,000*	*6,101*	*49,420*	*12,560*	*14,763*	*-13,499*	*-129,780*	*-31,840*	*-36,237*	*-211,356*
Grand total	**33,702,452**	**43,393,976**	**53,331,254**	**64,659,323**	**8,104,926**	**19,560,982**	**21,178,971**	**22,635,478**	**-25,597,526**	**-23,832,994**	**-32,152,283**	**-42,023,845**	**-123,606,648**

9 Accountability and Risk

Development of this strategic plan entailed a formal risk assessment, as well as the identification or assignment of the parties responsible for ensuring the delivery of the proposed activities. The section presents, first, the responsible units for accountability purposes for each of the goals of the plan and then an itemized tracking of the identified risks with suggestions for possible mitigation of their impact. The risks are keyed to the risk–impact matrix summarized in Table 9.1.

Table 9.1: Summary risk–impact matrix

Probability↓ Impact→	Low	Medium	High
Low			E,I
Medium		A,F,G	H
High	J	B	C,D

9.1 Goals and Responsibilities

The responsibility for successful execution of the plan lies with the various divisions, districts, facilities and community health workers. The responsible institutions for each of the goals is detailed in Table 9.2.

9.2 Risk Assessment

The plan will be implemented during a period of unprecedented global recession. In Kenya, the plan coincides with an inflationary trend that has affected all segments of consumers. The world's leading economies, which are also the principal contributors to public health interventions, are under siege with a potential knock-on effect to official development assistance (ODA). Without Government intervention, Kenya's low and middle income groups are facing the threat of unaffordable basics of life, including adequate access to food. In view of these circumstances and in the light of the transition from one sector and one ministry, the overall risk to this plan is assessed at medium to high. Some key risks that may hinder the ability of MOPHS to implement the

> Unprecedented global recession, high inflation and pervasive poverty in Kenya, as well as the transition from one sector and one ministry, mean that the overall risk to this plan is assessed at medium to high.

Table 9.2: Objectives, goals and responsible parties

NHHSP II Objective	Strategic thrust – MOPHS	Goal for 2012	Responsible unit
Increase equitable access to health services	Improve equitable access to public health and sanitation services	Increase the proportion of communities that live within 5 km of functional health facility from 52% to 62%	Division of Community Strategy
		Increase financial access to health care services	DFA /DPP /NHIF
		Increase proportion of deliveries by skilled attendant from 42% to 60%	Div. RH /DHP
Improve the quality and responsiveness of health services in the sector	Improve the quality and responsiveness of public health and sanitation services	Reduce the staff vacancy rate by 40%	DHRM
		Increase proportion of health workforce trained by 100%	DHRM
		Rehabilitate and adequately equip 50% of level 2 and 3 and other public health facilities	DCH
		Reduce proportion of facilities reporting stock outs by 100%	DCH
		Increase number of districts with functional surveillance systems by 30%	Div. HMIS
		Increase number of facilities with health care waste management system from 20% to 100%	DEH&S/DHP
		Increase sanitation coverage from 46% to 66%	DEH&S/DHP
		Increase the proportion of households utilizing safe water by 20%	DEH&S /DHP
		Increase client satisfaction by 50%	DPHS
		Reduce the incidence of food-borne diseases/illnesses by 5%	DEH&S /DHP
		Reduce mortality rate due to emergency to below 1/10000 persons	DEPR
		Increase the utilization of cost-effective RH services by 50%	DFH
		Increase the utilization of cost-effective child health care services by 50%	DCAH
		Reduce new HIV infections by 50%	NASCOP/DDPC
		Increase TB case detection and treatment to 90%	NASCOP
		Reduce malaria incidence to 15% through utilization of cost-effective control measures	DDPC/M
		Reduce the incidence of malnutrition in children <5 years by 30%	Div. N
Improve efficiency and effectiveness of service delivery	Improve efficiency of the public health system	Reduce vacancy rate by 60%	DHRMD
		Increase the proportion of staff who are trained as per the Government training policy by 50%	DHRMD
		Increase the proportion of employee job satisfaction to 90%	DPHS
		Increase the availability and utilization of ICT by staff by 60%	DICT
		Improve provision and utilization of transport services by 50%	DFA
		Achieve 100% disposal of obsolete, unserviceable and surplus assets annually	DFA
Improve financing of the health sector	Improve financing of the public health and sanitation services	Ensure all facilities receive financial resources based on needs by 2012	DPP/DTP
		Increase efficiency in utilization of resources	DPP/DTP
		Increase financial resources to MOPHS by 20% over a period of five years	DPP/DTP
Foster partnership in improving health and service delivery	Foster partner-ships in improving public health service delivery	Strengthen governance structures at levels 1–3 by 2012	DCH
		Improve coordination and partnership arrangements at all levels	Department of Technical Planning

planned strategies are discussed in the following sections.

9.2.1 *Risk A:* Government Funding Does Not Increase

The trend in government allocation to the health sector has stagnated at around 7%. Historically, public health has received comparatively insignificant government allocations. During this year's budget, the allocation to the Ministry remained low but was an improvement from past allocations. This is paradoxical in the fiscal planning of the country, as preventive and health promotion services are considered to be public goods.

Mitigation: MOPHS engaged in the MTEF process for the first time, and public health and sanitation costs are reflected in the framework. It is expected that this will lead to Government commitment to preventive and health promotion services through support to the Community Strategy and to life saving procedures such as immunization and vaccination, provision of ART, and free LLITNs.

9.2.2 *Risk B:* Development Partners Reduce Funding to the Health Sector

Despite the bleak economic outlook among the countries providing most aid to public health interventions, particularly for HIV/AIDS,

tuberculosis and malaria, the commitment to the sector remains high. However, as partner countries sink deeper into recession, the risk is real that they may be forced to re-programme or even reduce their aid. This will be in response to pressing domestic needs and the need to inject more money into the markets.

Mitigation: The external political commitment towards Kenya is not likely to change, particularly if the country continues with the post-election violence reform agenda. The growing advocacy in support of the MDGs, for example through International Health Partnerships (IHP), Providing for Health (P4H) and other initiatives, will rally support to public health programmes in Kenya and similar countries. The Kenya Health SWAp and public–private partnerships (PPP) will be expected to contribute to aid effectiveness and efficiency in public health and sanitation.

9.2.3 *Risk C:* Corruption in the Country Remains Unchanged

Kenya continues to be on the list of countries with a high corruption index. The negative impact and corrosion affects all the sectors of the country including health. Corruption in the health sector has the outcome of reducing the availability of resources through actual haemorrhaging, inefficiency and poor quality of care, leading to low utilization. This will be accentuated by the concerns about Global Fund support.

Mitigation: Government has put in place public service reforms that include streamlining procurement, recruitment and performance contracts. In addition, Government is planning to re-think the civil service salary structure. These initiatives, together with efforts of the Kenya Anti-Corruption Council, are expected to provide strong disincentives to corruption. Efforts by civil society groups and the media to educate the public should also help to reduce corruption.

The scaling up of the Community Strategy will improve people's participation in and ownership of their health care services.

9.2.4 *Risk D:* Further Increase in Poverty Levels

In view of the bleak economic outlook, more Kenyans may slip through the gaps and an increasing number fall below the poverty line. Poor people are sick more often and less productive than those who are better off financially. Most sick and poor people suffer from preventable disease, thus putting greater demand on the services of MOPHS. The poor also often live in substandard housing in marginalized areas, whether in rural or urban settings, predisposing them to poor access to health care.

Mitigation: The Government has embarked on the implementation of the MTP, which is the guide for the first phase in transforming the country into a middle income economy by 2030. The plan proposes more investment in areas of production including manufacturing, tourism and services. Better market regulation measures are also envisaged.

9.2.5 *Risk E:* The Imminent Collapse of Faith-Based Health Care Services Becomes Real

Faith-based organizations are an integral part of Kenya's health services as they often target the poor and marginalized in rural areas, arid and semiarid areas, as well as urban slums. In the recent past these services have come under intense pressure from the highly subsidized and tax-based Government health services. Government and donor grants to these groups have continued to trickle away and may dry altogether. Weak systems aggravate the prevailing unhealthy conditions. One response has been to raise user fees, which are the principal source of funding for the FBOs, but this only contributes to lower utilization rates, leading to even greater reduction in revenue.

Mitigation: The FBOs have drawn a memorandum of understanding that will for the first time provide security to Government contributions to these services. Already Government is providing drug kits and public health drugs to the FBOs. In the proposed Health Sector Services Fund, FBO facilities will also receive public allocations and development partner funds will increasingly be channelled through the HSSF. Reforms to the National Hospital Insurance Fund will contribute to increasing the patronage of FBO facilities. Lastly, through the PPP policy and strategy as an integral element of the Kenya health SWAp, pooled funds will support FBOs and NGOs.

9.2.6 *Risk F:* Insufficient Improvement of the Weak Management and Coordination Systems

The health sector suffers the ill effects of weak human resource, financial management and planning systems. The net effect is out-migration by the health workforce, reduced value for money, and erratic development of health care infrastructure and services. The mushrooming of CDF facilities constructed without regard to sector standards is an example of these inefficiencies in the system.

Mitigation: The development of Ministry-specific plans modelled on MTP and Vision 2030, as well as the commitment to "one sector plan/one AOP, one Joint Programme of Work and one Joint Financing Framework", are all strategies for redressing fragmentation and weak coordination and planning. A review of institutional structures and strengthening of the management of the HSCC, internal management and coordination are other strategies forming part of this plan.

9.2.7 *Risk G:* The Expanded Sector Will Lead to Relative Reduction of Resources to Public Health

The Ministry of Finance has for the first time added two big ministries to the traditional health sector cluster, to form a new sector – human resource development. This means that the ministries have to fight for MTEF allocations in the face of ring-fenced resources to personnel emoluments. The Ministry of Education has by far the highest proportion of the ring-fenced funds in this new sector. With the expanded cluster, resources to the other economic categories in the MTEF budget will receive proportionately lower allocations, which will have a deleterious impact on service delivery.

The net effect of existing weak human resources, financial management and planning systems is out-migration by the health workforce, reduced value for money, and erratic development of health care infrastructure and services

Mitigation: The MTEF process, which includes public hearings, is expected to redress any imbalances. The signing of the JFA will form a further instrument for rational resource allocation. Increase in development partner funds that are on-budget and on-account will improve predictability of funding and therefore yield better planning.

9.2.8 *Risk H:* Food Security and Nutrition May Get Worse if Food Production Falls

The current high cost of farm inputs has affected food production and the willingness of farmers to sell produce to the government stores at the government set prices. The situation favours increased export of foodstuffs to neighbouring countries. The consequence will be increased rates of malnutrition and ill-health, particularly among children, women and HIV/AIDS patients. This is happening against the absence of a food security policy in the country.

Mitigation: The Ministry of Agriculture and Ministry of Finance are constantly reviewing prices of farm produce vis-à-vis the inputs. Recently there have been instances of government subsidy to consumers covering maize meal. There are plans to subsidize farm inputs.

9.2.9 *Risk I:* The Insecurity in Commodity Management Will Persist

Deficiencies in drug supply chain management may continue to dog the public health sector, in that KEMSA may not deliver. Moreover, the procurement and distribution functions are largely outside the purview of MOPHS. The result will be persistent drug shortages and frequent stock outs.

> ***Mitigation:*** The Minister for Medical Services plans to implement the recommendations of the Task Force on KEMSA. One of these is to allow KEMSA its legally mandated management autonomy in drugs and supplies management.

9.2.10 *Risk J:* Negative Public Perception of Government Health Care Services

The public may continue to harbour negative views of the quality and management of public services, and more so services for the poor. For example, this perception is thought to be the root cause for women not delivering under the care of trained health professionals. This will affect utilization and unfavourable health seeking behaviour among the people.

> ***Mitigation:*** The scaling up of the Community Strategy will improve people's participation and ownership of the services. Moreover, the human factors that affect user satisfaction and utilization are central in this strategic plan.

10 Monitoring, Evaluation and Reporting

A robust monitoring and review mechanism is essential to achieving the Ministry's strategic priorities. To enable adequate follow up and implementation of its priorities, the Ministry will have a clear review and monitoring mechanism to ensure that commitment to achieving the strategic priorities is maintained. The process will focus on ensuring appropriate linkages to health sector and wider Government monitoring and review processes.

10.1 Framework for Monitoring and Reporting

The monitoring and review process defined here is at both the operational and the strategic level. At the strategic level, the monitoring process will be in line with monitoring support towards the strategic objectives of the overall health sector. On the other hand, the operational monitoring will focus on monitoring progress towards the strategic priorities of the Ministry.

Strategic monitoring will be done at the midterm and end term of this plan period. The midterm review will coincide with the formal articulation of a new policy direction for the health sector. As such, it will focus on:

- Reviewing progress made and identifying challenges and strategies for acceleration, and
- Incorporating any realignment of the strategic priorities of the Ministry, in line with the new policy framework.

All levels of the Ministry will be involved in the process of strategic monitoring, as will its partners, including the Ministry of Medical Services. Each level of service delivery will carry out its own monitoring and evaluation.

Operational monitoring will be carried out monthly, quarterly and annually. This will focus on monitoring progress against interventions and activities set out in the operational plans. Each planning unit at all levels in the Ministry will be involved.

> The performance appraisal system will be part of the sector monitoring. Indicators will be utilized to measure progress against set targets.

The performance monitoring process will be the cornerstone of the sector monitoring. Indicators will be utilized to measure progress against set targets. The indicators will be used in two ways:

1. ***Sector-wide indicators:*** The set of indicators the sector will use to inform on progress at the strategic level. One or at most two indicators will be utilized for each result area (service delivery and systems) the sector is working towards. Collection and monitoring of progress will be the responsibility of the sector.
2. ***Programme indicators:*** Indicators that the respective programme areas will use to inform on progress towards programme objectives. The number will depend on the particular programme area. Monitoring of progress will be the responsibility of the respective programme area.

10.2 Indicators for Monitoring Progress

Several specific indicators have been selected for use in monitoring the performance of the plan. Most of the indicators will be collected as part of routine reporting and captured in the HMIS. A few of them, such as user satisfaction, will be obtained through annual surveys. The core indicators are described in Table 10.1, and Table 10.2 gives the midterm and end of term benchmarks.

Table 10.1: Core indicators for monitoring outcomes

No	Outcome area	No	Indicator	Indicator calculation: N/D*100	Frequency of collection
1	Service delivery	1a	% Women in reproductive age receiving family planning commodities	**Numerator:** Number of WRA who received FP commodity **Denominator:** Estimated total WRA	Annually, part of AOP monitoring
		1b	% Pregnant women attending at least 4 ANC visits	***Numerator:*** Number of ANC clients who have made 4 clinic visits ***Denominator:*** Estimated number of pregnant women	Annual – MOH register
		1c	% Deliveries conducted by skilled attendants	***Numerator:*** # deliveries conducted by trained health staff ***Denominator:*** Estimated number of expected deliveries	Annual
		1d	% HIV+ mothers receiving preventive ARV to prevent PMTCT	***Numerator:*** # of HIV+ pregnant women who received preventive ARVs ***Denominator:*** # HIV+ pregnant women	Annual
		1e	% Pregnant women receiving LLITN	***Numerator:*** # pregnant women who receive LLITNs during current pregnancy ***Denominator:*** # pregnant women in catchment area	Annual
		1f	% Newborns receiving BCG (TB vaccination)	***Numerator:*** # of children <1 yr receiving vaccination against TB ***Denominator:*** Estimated number of live births in catchment	Annual
		1g	% Children <1 year receiving measles immunization	***Numerator:*** # of children <1 yr receiving vaccination against measles ***Denominator:*** Estimated number of surviving children <1 year	Annual
		1h	% Children <1 year fully immunized	***Numerator:*** # of children <1 receiving all antigens ***Denominator:*** Estimated number of surviving children <1 year	Annual
		1i	% New cases of children under 5 years old attending CWC	**Numerator:** # of children <5 yrs new cases child welfare clinic ***Denominator:*** Estimated number of children <5 years in catchment	Annual
		1j	% Children < 5 years old receiving LLITNs	***Numerator:*** # children <5 years receiving LLITNs ***Denominator:*** Estimated number of children <5 years in catchment	Annual

Continued

Table 10.1, continued

No	Outcome area	No	Indicator	Indicator calculation: N/D*100	Frequency of collection
	Service delivery, continued	1k	Infant mortality rate	***Numerator:*** # of deaths of children <1 yr in catchment area ***Denominator:*** # of live births in catchment area	Annual, survey
		1l	Under 5 years mortality rate	***Numerator:*** # of deaths of children <5 yrs in catchment area ***Denominator:*** # of children <5 years in catchment area	Annual, survey
		1m	% School children correctly de-wormed	***Numerator:*** # of school children de-wormed during the year ***Denominator:*** # school children in the catchment area during the year	Annual
		1n	% Population counselled and tested for HIV	***Numerator:*** # of persons counselled and tested in specified period ***Denominator:*** # of population in catchment area	Quarterly, annual
		1o	# Condoms distributed	***Numerator:*** # of condoms distributed ***Denominator:*** None	Quarterly, Annual
		1p	TB Case detection rate	***Numerator:*** # of new TB cases detected ***Denominator:*** Estimated number of new Tb cases in the catchment area	Annual
		1q	% Households sprayed with IRS	***Numerator:*** # of households sprayed with IRS ***Denominator:*** # of households in catchment area	Quarterly, annual
		1r	% Functioning community health units (CHUs)	***Numerator:*** # CHUs with trained CHCs, CHWs and have kits ***Denominator:*** # of expected CHU	Quarterly, annual
2	Support systems	2a	% Clients satisfied with services	**Numerator:** # clients satisfied with services **Denominator:** # Interviewed	Survey
		2b	% Facilities without all 14 tracer drugs for more than 2 weeks.	**Numerator:** # of facilities without tracer drugs >2 weeks **Denominator:** # of facilities in catchment area	Survey
		2c	% Facilities that submit timely accurate reports to the national level	***Numerator:*** # facilities submit accurate reports on time to national level ***Denominator:*** # facilities in catchment area	Quarterly, Annual
		2d	% Facilities that submit complete and accurate reports to the national level	***Numerator:*** # facilities submit accurate reports on time to district level ***Denominator:*** : # facilities in catchment area	Quarterly, annual
3	Governance and financing	3a	% Districts with functional district stakeholder forum	***Numerator:*** # districts with functional stakeholder forum ***Denominator:*** # of districts in catchment area	Quarterly, annual

Table 10.2: End of term and midterm measure indicators

Indicator	Baseline	Midterm target	End of term target
1 Under-5 mortality rate	120	80	33
2 Maternal mortality ratio	414	284	147
3 Proportion of deliveries by skilled attendants	28	62	95
4 Proportion of fully immunized children	70	82	95
5 Proportion of pregnant receiving nevirapine (%)	21	50	70
6 HIV prevalence rate (%)	7.4	5.0	2.0
7 TB cases/100,000 population	888	650	444

Source of baseline data: KDHS 2003 and AOP 3 report (HMIS).

10.3 Interpretation of Performance

We will use what is known as a "dashboard" approach to measure our progress towards the goals of this strategic plan. This means that rather than assessing each target individually, we will be looking at our achievements in the aggregate – forward (ideally) movement on all or most of the indicators together. (See Table 10.3 for the mechanism.) This is really the only way to make substantive progress in public health and sanitation services.

Table 10.3: Interpretation of indicators against dashboard

Interpretation of dashboard	Interpretation	Implications for Government and partners
Excellent progress	Over 80% of dashboard indicators with performance of 120% or more than targeted achievement	Performance warrants additional resources above what is already committed to be provided, particularly for targeted areas based on sub analyses.
Significant progress	Over 80% of dashboard indicators with performance of at least 80–120% of targeted achievement	Performance adequate to maintain planned resources, with additional commitments individually determined for areas with poor performance.
Adequate progress	Over 50% of dashboard indicators with performance of at least 80–120%	Performance adequate to maintain planned resources.
Inadequate progress	50–80% of dashboard indicators with performance under 80% of targeted achievement	Performance inadequate to warrant additional resources. Committed resources at risk.
Poor progress	Over 80% of dashboard indicators with performance of under 80% of targeted achievement	Performance inadequate, committed resources seriously under threat.

10.4 Monitoring and Reporting Process

Monitoring will be conducted jointly with the Ministry of Medical Services as they share sector-specific outputs and outcomes. Monthly reviews, however, will be Ministry specific. The time plan for the monitoring and reporting is given in Table 10.4

The plan proposes the use of what is known as a "dashboard" approach to measure progress towards goals. This means that rather than assessing each target individually, achievements will be reviewed in the aggregate – forward (ideally) movement on all or most of the indicators together.

Table 10.4: Monitoring and review framework

Frequency	Target	Focus	Level of monitoring and review
Monthly	Monthly activity reports	Identify activities whose implementation is delaying delivery of outputs, and plan to address challenges	Activity level
Quarterly	Quarterly progress reports	Identify outputs whose achievement during the year is threatened, and plan to address challenges affecting them	Output level
Annually	Annual progress reports	Identify progress, issues and challenges affecting implementation of outputs, and make recommendations of priorities for coming year	Output level
Mid term	Midterm review	Identify progress, issues and challenges affecting implementation of outcomes towards supporting the achievement of the overall goal, and make recommendations for the remaining half of the strategic plan	Outcome level
End term	End term review	Identify progress, issues and challenges that affected achievement of the overall goal, and make recommendations for the next strategic plan focus to enable it to support achievement of overall sector policy	Goal level

References

CBS, MOH and ORC Macro. 2004. *Kenya Demographic and Health Survey, 2003.* Calverton, Maryland: Central Bureau of Statistics, Kenya Ministry of Health and ORC Macro.

KNBS. 2007. *Kenya Integrated Household Budget Survey, 2007*. Kenya National Bureau of Statistics, Nairobi, Kenya.

KNBS. 2008. *Economic Survey 2008.* Kenya National Bureau of Statistics. Government Printer, Nairobi, Kenya.

MOH. 1994. *Kenya's Health Policy Framework 1994–2010.* Nairobi: Government Printer.

MOH. 1999. *The National Health Sector Strategic Plan: 1999–2004*. Nairobi: Government Printer.

MOH. June 2004. "Report on an Inter-Sectoral Workshop on Traditional Medicine, HIV/AIDS, Research and Sustainable Development in Kenya". Ministry of Health, Nairobi.

MOH. 2005. *Reversing the Trends – The Second National Health Sector Strategic Plan of Kenya: NHSSP II – 2005–2010.* Ministry of Health, Nairobi.

MOH. 2006a. *Joint Programme of Work and Funding 2006/07–2009/10 for the Kenya Health Sector.* Health Sector Reform Secretariat, Ministry of Health, Nairobi

MOH. 2006b. *Norms and Standards for Health Service Delivery in Kenya*. Ministry of Health, Nairobi.

MOH. 2007a. *Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya – The Kenya Essential Package for Health.* Ministry of Health. Nairobi.

MOH. 2007b. *Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya – NHSSP II: Midterm Review Report*. Sector Planning and Monitoring Department, Ministry of Health, Nairobi.

MPND. 2003. *Economic Recovery Strategy for Wealth and Employment Creation 2003–2007 (ERSWEC)*. Ministry of Planning and National Development, Nairobi.

NCAPD, MOH, CBS and Macro International. 2005. *Kenya Service Provision Assessment Survey 2004.* Nairobi: National Coordinating Agency for Population and Development, Ministry of Health, Central Bureau of Statistics, and Macro International.

Office of the Prime Minister, Ministry of State for Planning, National Development and Vision 2030. 2008. *First Medium-Term Plan (2008–2012)*. Nairobi.

Annex A
Priority Health Sector Interventions for Acceleration in the Medium Term, arising from the Midterm Review of NHSSP II

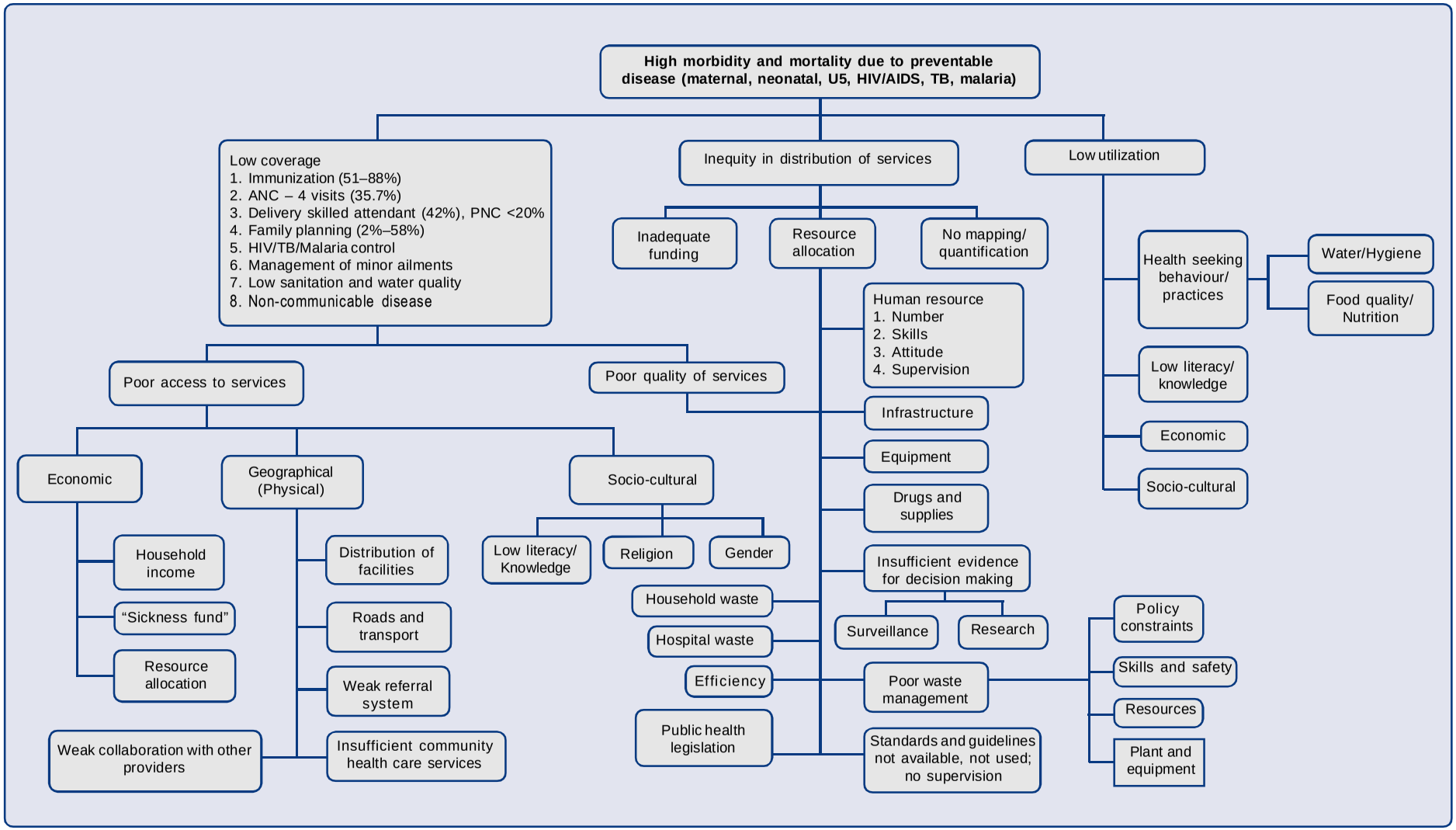
NHSSP II objective	Priority interventions
Objective 1: Increase equitable access to health services	▪ Provide support to ensure universal access to maternal and neonatal health services for cohort 1, involving demand creation and supply-side interventions such as free delivery, skilled attendants, effective referral and other emergency obstetric care components. ▪ Comprehensively implement guides and frameworks for cohorts 4 and 6. ▪ Develop a policy, strategic approach and implementation framework for NCDs to address healthy lifestyles and provision of direct medical care for individuals in a clinical setting (all cohorts). ▪ Reduce morbidity and mortality from malaria by accelerating implementation of the national malaria strategy, which has been revised in line with NHSSP II, particularly targeting cohorts 2, 3 and 5. ▪ Strengthen implementation of existing service delivery efforts for child health for cohorts 2 and 3, with a particular focus on coordination. ▪ Accelerate implementation of TB control initiatives (cohort 5). ▪ Accelerate Community Strategy implementation (level 1), by rolling out the community health worker structure, providing behaviour change communication, scaling up outreach services, etc. ▪ Accelerate dissemination of the Kenya Essential Package for Health (KEPH) throughout the sector. ▪ Develop a strategy to influence the implementation of KEPH outside the health sector. ▪ Strengthen public-private partnerships in delivery of services, particularly in under-served areas, by improving formal frameworks and facilitating access to the HSSF.
Objective 2: Improve the quality and responsiveness of services	▪ Roll out service charter – to be displayed publicly – containing information on services, standards, complaints and the mechanisms to redress. ▪ Develop and implement country-specific hospital reforms to support and complement services at the primary care level. ▪ Re-categorize and accredit health facilities in line with KEPH to guide the identification of inputs required within the context of existing KEPH Norms and Standards. ▪ Update and implement clinical and management guidelines for service delivery. ▪ Creating facility-based incentives to improve quality of services, such as institutionalizing processes for recognition and reward. ▪ Put in place national strategy for integrated supportive supervision, involving clear definitions and implementation arrangements and linkages to annual plans and performance appraisal, as well as incorporating new service delivery guidelines. ▪ Fast track leadership and management capacity strengthening initiatives in accordance with the decentralization of management in the sector, including in-service training and patient centred accountability.
Objective 3: Foster partnerships in improving health and delivery services	▪ Strengthen sector coordination and participation structures at all levels. ▪ Monitor adherence to COC principles and obligations, including the development of aid effectiveness indicators and targets, and integrate their measurement in sector annual reviews. ▪ Provide joint support and responsibility to strengthen common management arrangements, so as to ensure use of country systems for support. ▪ Ensure partners are providing coordinated and demand driven technical assistance and cooperation. ▪ Support implementation of common monitoring tools and systems including utilization of the Joint Review Missions for review and planning of sector interventions. ▪ Develop mechanisms for generating, sharing and using information with implementing partners. ▪ Build the capacity of coordinating secretariats for partnership (HENNET and private sector). ▪ Encourage development partners to increasingly channel funds through joint financing arrangements and use in-country systems ▪ Establish and implement coordination mechanism for partner missions to the country. ▪ Coordinate and pool capacity development support, particularly for systems strengthening.

Continued

NHSSP II objective	Priority interventions
Objective 4: Improve efficiency and effectiveness	▪ Fast track implementation of HRH initiatives. ▪ Strengthen the management and availability of commodities and supplies. ▪ Align infrastructure, communication & ICT strategies to ensure they support service delivery effectively. ▪ Strengthen the public financial management systems. ▪ Strengthen use of strategies for bottom up planning and budgeting. ▪ Scale up use of performance monitoring mechanism (including HMIS).
Objective 5: Improve financing of the health sector	▪ Establish mechanisms to increase availability of resources. ▪ Improve budget management and the efficiency and equitability of resource allocation and utilization, particularly by developing costing frameworks, improving pro-poor resource allocation formulas, instituting cost-effectiveness analysis to aid prioritization, availing finance/cost information to the public, and incorporating all income sources for expenditure tracking. ▪ Complete and implement health care financing strategy. ▪ Implement HSSF, through more comprehensive district budgeting, finalization of guidelines, training, and ensuring that fiduciary risk is low. ▪ Implement the shadow budget as a means to link planning and budgeting processes for the entire sector. ▪ Improve predictability of resources by holding partners accountable to provide information on their frameworks and budgets, and quarterly disbursement data.

Causes of Prevailing Health Problems and Challenges

Annex B



Annex C
MOPHS Staff Requirements, Establishment and Gaps

Cadre	Abbreviation	Staff requirement	Estab-lishment	No. in place	Gap	60% of gap
Minister		1	1	1	0	0
Assistant Minister		1	1	1	0	0
Permanent secretary		1	1	1	0	0
Director of administration		1	1	0	1	0.6
SDS		1	1	0	1	0.6
DS		3	3	2	1	0.6
Under secretary		5	5	0	5	3
Senior asst sec		5	5	0	5	3
Assistant sec III/II/I		8	8	2	6	3.6
					0	
Planning						
Chief economist/Statistician	CE	1	1	1	0	0
Snr dep chief Economist	SDCE	1	1	0	1	0.6
Deputy chief Economist	DCE	1	1	0	1	0.6
Principal econ/Statistician	PE/Senior	2	2	0	2	1.2
Snr econ/Statistician	SE/Senior	3	3	2	1	0.6
Economist/Statistician II/I	E/Stat II	6	6	0	6	3.6
Senior statistical officer	SSO	1	1	0	1	0.6
Statically officer I	SO I	2	2	0	2	1.2
Statically officer II	SO II	5	5	0	5	3
Statistical assistant II/I/Snr	SA	7	7	0	7	4.2
					0	
ICT officers	PICT	1	1	0	1	0.6
	SICTO	1	1	0	1	0.6
	CICTO	1	1	0	1	0.6
	ICTO III	2	2	0	2	1.2
	ICTO	10	10	1	9	5.4
	SA/P I/II	5	5	0	5	3
Record management officers (RM)	SRMO	10	10	0	10	6
	RMO	50	50	0	50	30
	RMO II/I	170	170	1	169	101.4
	RMOIII	28		21	7	4.2
Secretary	ES II		2	0		0
	SPS		17	0		0
	PS		4	4		-2.4
	PS I/II		21	10		-6
	SHT I/II		100	16		-9.6
	CT I/II		80	13		-7.8
Public relations	PIO		1	0	1	0
	CIO		1	1	0	-0.6
	SIO		3	0	3	0
	IO I		1	1	0	-0.6
	IO II		1	0		0
	IA		1	0		0
					0	

Continued

Cadre	Abbreviation	Staff requirement	Estab-lishment	No. in place	Gap	60% of gap
Security services	SSO		1	0		0
	SO II		3	0		0
Assist security officer	ASO		6	0	6	0
S. security warden	SSW		5	0		0
Procurement officers	SPPO	1	1	0	1	0.6
	PPO	1	1	0	1	0.6
	CPO	1	1	1	0	0
	SPO		3	1	2	-0.6
	PO I		3	2	1	-1.2
	PO II		5	3	2	-1.8
	P Asst		12	4	8	-2.4
	Senior storekeeper		1	0	1	0
	Storekeeper		53	2	51	-1.2
Telephone supervisors	TS II		1	1	0	-0.6
	TO I/II /Senior		1	1	0	-0.6
Finance officers	CFO		1	0	1	0
	DCFO		1	0	1	0
	SPFO		1	0	1	0
	FO I		4	1	3	-0.6
	FO III/II		3	0	3	0
Accounting officers	PAC		1	0	1	0
	AC		1	0	1	0
	CA		1	1	0	-0.6
	SA		7	3	4	-1.8
	AC I		19	7	12	-4.2
	AC II		64	2	62	-1.2
	AA II/I		90	6	84	-3.6
Human resource management officers	DD HRM		1	0	1	0
	SAD(HRM)		1	0	1	0
	ADHRM		1	1	0	-0.6
	PHRMO		1	1	0	-0.6
	CHRMO		1	0	1	0
	SHRMO		3	0	3	0
	HRMO I		1	0	1	0
	HRMO II		9	4	5	-2.4
	HRM Asst III/ II/I		39	4	35	-2.4
Human resource development officers (HRDO)	ADHRMO		1	0		0
	CHRDO		1	0	1	0
	CTO		1	0		0
Clerical officers			645	15	630	-9
Drivers	Driver III/II/I/Senior	498	383			298.8
Librarian	Library I		1	0	1	0
	Library II		4	0	4	0
	Library asst		1	0	1	0
Audio visual aids officer			6	0		0
Audio visual aid asst	III/IIB/IIA/I		1	0		0
Chief training officer (mass media)			1	0		0
Chief supp printer			1	0		0
Designer II			3	0		0
Photographer II			2	0		0
Photographer III			1	0		0
Photo lithographer			1	0		0
Cameraman III			1	0		0

Continued

Cadre	Abbreviation	Staff requirement	Estab-lishment	No. in place	Gap	60% of gap
Printing assistant II/IIB/IIA/I			2	0		0
Office machine operator III/II/I			6	0		0
Cinema operator III/IIB/IIA/I			1	0		0
Subordinate staff			2,000			0
Subtotal			3,312	3,810		-2,286
Technical administration						
Secretary/Director public health		1	1	1	0	0
Doctors		250	175	175	75	45
Pharmacist		15	15	15	0	0
Chief public health officer		1	1	1	0	0
SDCPHO			20	2	18	-1.2
DCPHO		45	5		40	27
PHOII/1/Asst chief/Senior asst chief		184	170		14	110.4
Asst CPO		159	20		139	95.4
PHO III/II/I/SNR		2,677	2,124		553	1,606.2
PHT III/II/I/SNR		2,726	2,176		550	1,635.6
Pharmaceutical technologists		150	150	0	150	90
Radiation protection services						0
CRPO		1	1	1	0	0
SDCRPO		1	0	0	0	0.6
DCRPO		4	1		3	2.4
ACRPO		16	0		16	9.6
RPO II/I/SNR/PRINC		79	25		54	47.4
Princ radiation protec tech		1	0	0	1	0.6
Chief radiation protec tech		4	0	0	4	2.4
Radiation protec tech III/II/I/Snr		33	0	0	33	19.8
					0	
Government Chemist						
Government Chemist		1	1	0	1	0.6
Chief principal chemist/						
Snr dep govt chemist		3	1	0	3	1.8
Deputy govt chemist		4	2	0	4	2.4
Asst govt chemist		7	0	0	7	4.2
Principal chemist		10	4		6	6
Chemist II/I/Snr/Analyst		95	81		14	57
Principal lab tech		1	0	0	1	0.6
Chief lab technologist		3	2		1	1.8
Lab technologist		54	51		1	32.4
Lab technician IV		2	2		2	1.2
Lab technician III/II		8	0		8	4.8
					0	
Nutrition personnel						***0***
Chief nutrition officer		1	1	1	0	0
Snr DCNO		4	0	0	4	2.4
DCNO		7	2	0	5	4.2
Nutrition officer I/Snr/Asst chief /						
Snr asst chief/Graduate		500	0	101	399	239.4
Snr asst CNO		12	1		11	7.2
Asst chief nutri officer		25	1	0	24	15
Nutrition officer III/II/I/Snr		1,490	87		1,403	894
Nutrition asst III/II/I/Snr		603	603	603	0	0
Catering						
Housekeeper/Cateress III		10	9	9	1	0.6
Asst housekeeper/Cateress II		12	0	5	7	4.2
Laundry assistant		8	0	0	8	4.8
Housekeeping assistant III/II/I		121	121	121	0	0
Cook III/II/I/Snr		159	159	85	74	44.4

Continued

Cadre	Abbreviation	Staff requirement	Estab-lishment	No. in place	Gap	60% of gap
Vector-borne disease staff						
Chief medical parasitologist/Entomologist		0	0	1	1	-0.6
Snr deputy chief parasitologist/ Entomologist		2	0		2	1.2
Deputy chief parasitologist/Entomologist		10	0	0	10	6
Asst chief medical parasitologist/ Entomologist		30	1	1	29	17.4
Medical parasitologist/ Entomologist II/I/ Snr/Principal		200	17	17	183	109.8
Mortuary attendant III/II		856	40		816	513.6
Ent field lab tech III/II/I/Snr		369	67		302	221.4
Ent field tech III/II/I/Snr		359	359	359	0	0
Chief medical biochemist		1	0	0	1	0.6
Snr deputy chief medical biochemist		4	0	0	4	2.4
Deputy chief medical biochemist		6	6	0	6	3.6
Asst deputy chief medical biochemist		18	0	0	18	10.8
Medical biochemist II/I/Snr/Chief		94	11	0	83	56.4
Snr biochemist		3	3	0	3	1.8
Biochemist II/I		10	10	2	8	4.8
Biologist II		1	1	1	0	0
Asst. livestock officer			0	1	1	-0.6
Livestock health assistant		1	1	1	1	0
Junior animal house asst		2	2	0	2	1.2
Leprosy asst II B		2	2	0	2	1.2
National Public Health Lab Services						
Chief medical lab technologist		1	1	0	1	0.6
Snr deputy chief medical lab. technologist		3	0	0	3	1.8
Deputy chief medical lab tech		10	1	0	9	6
Snr asst chief medical lab technologist		100	1		99	60
Asst chief medical lab tech.		214	0	1	213	127.8
Medical lab. tech I/Snr./asst. chief/ Snr asst chief (Graduates)		900	11	14	3	531.6
Medical lab technologist III/II/I/Snr (Dip)		3,196	638	720	82	1,485.6
Chief medical lab technician						0
Deputy chief medical lab technician						0
Snr medical lab technician						0
Medical lab technician III/II/I		736	1,106	918	188	-109.2
Health promotion						
Chief health education officer			3	0	3	0
Deputy chief health education officer			4	0	4	0
Snr health educ officer			1	0	1	0
Education officer III/II/I			30	0	30	0
Snr family planning field educator			1	0	1	0
Family planning filed officer II			40	0	40	0
Family planning field officer II/IIB/IIA			171	0	171	0
Lecturer I			0	0	-1	0
Khadi I			0	1	-1	-0.6
Pricing officer			0	1	-1	-0.6
Licensing officer II			0	1	-1	-0.6
Mental health services						
Prin social welfare officer		1	1	1	1	0
Chief social welfare officer		1	1	0	1	0.6
Snr social welfare officer		2	2	1	1	0.6
Social welfare officer I		9	9	2	7	4.2
Social welfare officer II		21	21	0	21	12.6
Social welfare officer III		37	37	4	33	19.8
Social welfare asst. III/IIB/IIA/I		27	27	0	27	16.2

Continued

Cadre	Abbreviation	Staff requirement	Estab-lishment	No. in place	Gap	60% of gap
Health administration services						
Chief health administrative officer		1	1	0	1	0.6
Snr dep chief health administrative officer						0
Deputy chief health administrative officer		2	2	1	1	0.6
Asst chief health administrative officer		10	10	10	0	0
Snr health administrative officer		165	165			99
Health administrative officer I		790	790			474
Health administrative officer II		511	511			306.6
Nursing						
Chief nursing officer		1	1	0	1	0.6
Snr dep chief nursing officer						0
Dept chief nursing officer						0
Asst chief nursing officer		200				120
Snr nursing officer		6,383				3,829.8
Nursing office III/II		8,305				4,983
Enrolled nurse III/II/I		16,370				9,822
					0	
Clinical officers		1,300	500	500	800	480
					0	
Community oral health officers		806				483.6
Laboratory technicians		806				483.6
Pharmaceutical technologist		806				483.6
Statistical clerks		1,612				967.2
Clerks/cashiers		806				483.6
General attendants		1,612				967.2
Cooks		806				483.6
Watchmen		1,612				967.2
General attendants		5,344				3,206.4
Watchmen		2,672				1,603.2
					0	
Total		**68,467**	**17,877**	**7,626**	**8,078**	**36,504.6**

Annex D Transport Requirements

Table C1: Vehicles per level and units

	Region									Programmes				
	HQ	NBI	Nyanza	R/V Western		Eastern	Central	Coast	NEP	HQ	NASCOP	NTLB	KEPI	Malaria
Available	16	27	4	18	47	35	40	30	20	12	27	9	20	4
Required	28								23					
Gap	12								3					
Drivers		6		59	20	37	20		15					
Ambulances				34										

Table C2: Transport requirements by province, district and location

	Category	Requirement	Available	Gap
Minister	1 4WD, 2 others	3	3	-
Asst Minister	Prado	1	1	0
PS	PradoPGT	2	2	0
HQ	4WD double cabin (4)4WD Prado (4)	25	15	10
HQ – Pool	D/Cain/Prado Nissan XTrail (2)	22	12	10
Programmes	4WD (60)	109	99	4
	Lorry (7)	9	7	2
Provinces (8)	4WD double cab (2)	16		-2
	Utility vehicle, 4WD (2)	16	-	
	10 seater (2)	16	-	
Districts (150)	4WD (1)	150	-	
	10 seater (1)	150	-	
	4WD Ambulance (1)	150	0	150
	Motorboat (2):			
	Bondo, Lamu, Busia, Suba	6	3	3
Locations (7,100)	Bicycles (20)	142,0000	3,000	139,000
	Motorbikes (1)	3,000	300	2,700

Notes:
1. The information for the vehicles available was difficult to get and inconsistent in nature.
2. On requirements, it is assumed that each PHMT and DHMT will require two 4WD utility vehicles and one 4WD ambulance for each district and there are currently 170 districts.
3. The following are the cost estimates used for the various vehicles
   - Purchase of new fully equipped ambulances @ Ksh4M
   - Utility vehicles @ Ksh3M
   - 7-tonne Lorry @ Ksh8M (or equivalent to three utility vehicles)
   - Motor boats - 3M
   - Motorbikes @ Ksh350,00
   - Bicycles @ Ksh6,000
   - Regular maintenance programmes @ Ksh500,000 per vehicle per year.

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