



**Ministry of
Medical Services**

**Ministry of Public
Health and Sanitation**

Kenya Health Policy 2012 – 2030

Kenya Health Policy

2012 - 2030

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ACRONYMS

CSO	Civil Society Organization
DALY	Disability Adjusted Life Years
ESP	Economic Stimulus Program
FBO	Faith Based Organization
GDI	Gender Development Index
GDP	Gross Domestic Product
GOK	Government of Kenya
HMIS	Health Management Information System
HRH	Human Resources for Health
ICT	Information Communication Technology
IEC	Information Education Communication
KEMSA	Kenya Medical Supplies Agency
KHPF	Kenya Health Policy Framework
MDGs	Millennium Development Goals
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NACC	National AIDS Control Council
NCD	Non Communicable Disease
NGO	Non Governmental Organization
SACCO	Savings and Co-operative Organization
SAGA	Semi-Autonomous Government Agencies
SWAp	Sector-Wide Approach
TB	Tuberculosis
WHO	World Health Organization

FOREWORD

The Kenya Health Policy, 2012 – 2030 gives directions to ensure significant improvement in overall status health in Kenya in line with the country’s long term development agenda, Vision 2030, the Constitution of Kenya 2010 and global commitments. It demonstrates the health sector’s commitment, under government stewardship, to ensuring that the Country attains the highest possible standards of health, in a manner responsive to the needs of the population.

This Policy is designed to be comprehensive, balanced and coherent and focuses on the two key obligations of health: contribution to economic development as envisioned in the Vision 2030; and realization of fundamental human rights as enshrined in the Constitution of Kenya 2010. It focuses on ensuring equity, people centeredness and participatory approach, efficiency, multisectoral approach and social accountability in delivery of health care services.

The Policy focuses on six objectives, and seven orientations to attain the overall government’s goals in health. It takes into account the functional responsibilities between the two levels of government (county and national) with respective accountability, reporting and management lines. It proposes a comprehensive and innovative approach to harness and synergize health services delivery at all levels by engaging all actors, signaling a radical departure from past approaches in addressing the health agenda. This is demonstrated by the policy directions outlined in the Policy, particularly the right to the highest attainable standard of health. There is therefore an urgent need to raise awareness and ensure the necessary ownership of the Policy imperatives by the various stakeholders and implementing partners.

The Policy was developed through a participatory process involving all stakeholders in health including government ministries/agencies, development partners (multisectoral and bilateral) and implementing partners (Faith based, private sector and civil society).

It is our sincere hope that all the actors in health in Kenya will rally around these policy directions to ensure that we all steer the country towards the desired health status.

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PART 1:

BACKGROUND



CHAPTER 1: INTRODUCTION

1.1 Health Policy and the National Development Agenda

Kenya has over the years taken important steps aimed at laying a firm foundation to overcome the development obstacles and improve socio-economic status of her citizens including health. The development of Kenya Health Policy Framework (KHPF 1994-2010), launching of Vision 2030, enactment of the Constitution 2010, and fast tracking of actions to achieve the Millennium Development Goals (MDGs) by 2015 are some of the steps.

The implementation of KHPF 1994-2010 has led to significant improvement of health indicators such as infectious diseases and child health. The emerging trend of non-communicable diseases is however a threat to the gains made so far. This new health Policy provides the long term intent of government towards attaining its health goals. The Policy aims at consolidating the gains attained so far, while guiding achievement of further health gains in an equitable, responsive and efficient manner. It is envisioned that the ongoing government reforms, together with anticipated sustained economic growth, will facilitate the achievement of the health goals.

Vision 2030 details the long-term national development agenda- aiming to transform Kenya into a globally competitive and prosperous industrialized middle income country by 2030. Health is one of the components of delivering the Vision's Social Pillar given the key role it plays in maintaining a healthy and skilled workforce necessary to drive the economy. To realize this ambitious goal, the health sector defined priority reforms as well as flagship projects and programs including restructuring of the sector's leadership and governance mechanisms; improving procurement and availability of essential medicines and medical supplies; modernizing health information systems; accelerating health facility infrastructure development to improve access; human resource for health development and developing equitable financing mechanisms as well as establishment of social health insurance. This Policy aims to implement the priority health reforms envisaged in Vision 2030 with a view to ensure a healthy workforce capable of contributing towards the country's development agenda.

1.2 Health Policy and the Constitution of Kenya 2010

The Constitution of Kenya 2010 provides an overarching conducive legal framework for ensuring a more comprehensive and people driven health services delivery. It also seeks to ensure that a rights-based approach to health is adopted and applied in the delivery of health services. The Constitution provides that every person has the right to the highest attainable standard of health. It further outlines that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants. The Constitution introduces a devolved system of government which would enhance access to services by all Kenyans, especially those in rural and hard to reach areas. The Constitution also singles out health care for specific groups such as children and persons living with disabilities. The underlying determinants of the right to health, such as adequate housing, food, clean safe water, social security and education, are also guaranteed in the Constitution. The health Policy therefore seeks to make the realization of the right to health by all Kenyans a reality.

1.3 National, Regional and Global Health Challenges

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

declarations and commitments.

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

1.4 The Policy Development Process

The Policy was developed through an evidence-based and consultative process that was undertaken over a period of two years. Under the stewardship of the government, an extensive consultation process with stakeholders (government ministries/agencies development partners -multilateral and bilateral- and implementing partners -faith based, private sector, and civil society) was undertaken in order to gain consensus on divergent views. First, a comprehensive and critical analysis of the status, trends and achievement of health goals in the country and secondly the contribution of the previous policy framework and the sector actions towards achieving the health goals was undertaken. The outputs from these processes are available, as background information, for this Policy^{1,2} These informed the definition and development of this Policy's objectives and orientations.

1 Government of Kenya, 2010. *Health Situation trends and distribution, 1994 – 2010, and projections to 2030.*

2 Government of Kenya, 2010. *Review of the Kenya Health Policy Framework, 1994 – 2010.*

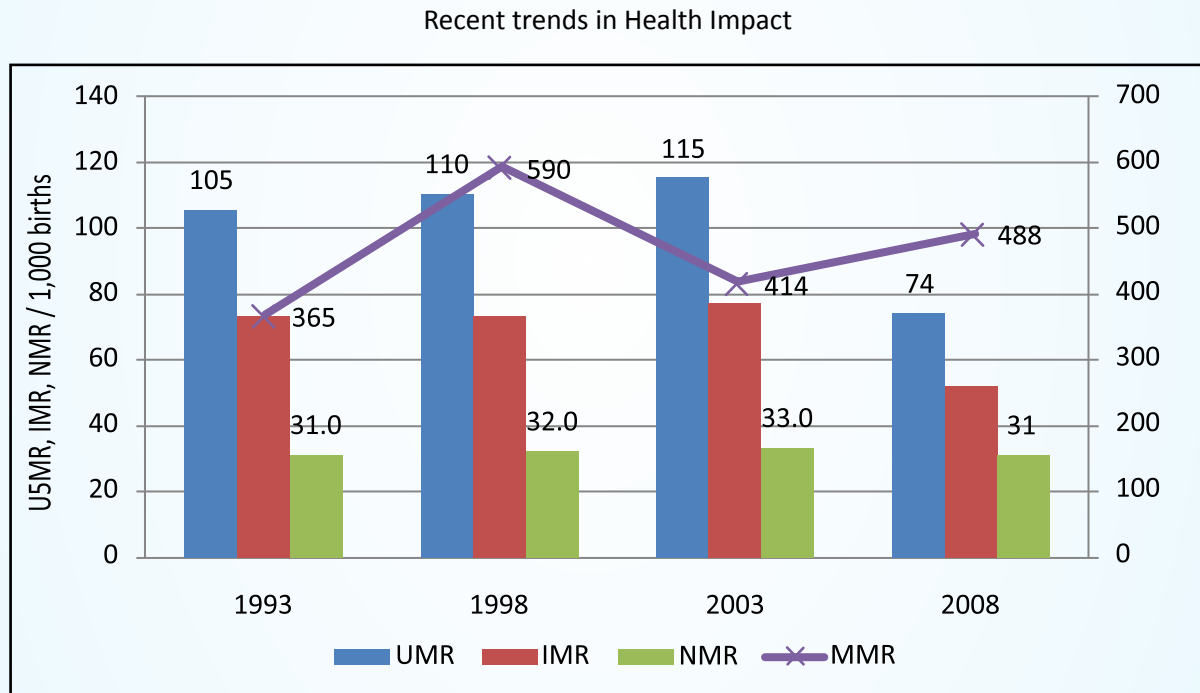
CHAPTER 2: SITUATION ANALYSIS

A comprehensive review of the 1994 – 2010 Kenya Health Policy framework was undertaken with a view to attain a deeper understanding of the challenges affecting the health sector, existing opportunities and define the necessary interventions.

This chapter highlights the progress made in the overall health of the country. To help in understanding the health patterns, it summarizes the situation regarding progress in (a) overall health status; (b) investment made in health and (c) Implementation of planned interventions. Based on these, the chapter paints a picture of future trends in disease burden in the Country up to 2030.

2.1 Overall Health Profile

Life expectancy (LE) at birth in Kenya reduced to a low of 45.2 years during the 1994-2010 policy period, but was estimated to have risen up to 60 years by 2009³- a trend that was reflected across all age groups. However, stagnation / worsening of the health situation was seen across all ages as demonstrated by poor performance of various health indicators as shown in the figure below. By the end of the last policy period, however, some evidence of improvements for specific age cohorts was emerging, particularly for adult, infant and child mortality.



Source: Respective Demographic and Health Surveys

Nevertheless, geographic and sex specific differences in health indicators among different age groups across the country persist. In addition, the country still faces a significant burden due to all disease domains – communicable conditions, non communicable conditions, and injuries / violence.

Leading causes of deaths, and disabilities in Kenya

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

(Source: GOK 2010. Review of the Kenya Health Policy Framework, 1994 – 2010)
 DALY's = Disability Adjusted Life Years – Time lost due to incapacity arising from ill health

This trend in health status has mainly been as a result of a number of contextual factors. The population growth rate has remained high (2.4% annual growth rate), with a high young and dependent population that is increasingly urbanized. Although the period under review showed improvements in GDP and reduction in population living in absolute poverty, especially in urban areas, absolute poverty levels still remained very high (46%). Literacy levels remained good at 78.1%, though inequities in age and geographical distribution persist. Gender disparities too were significant, though showed improvements particularly after 2003, a reflection of better opportunities for women. However, disparities between regions persist, with the GDI ranging from 0.628 (Central region) to 0.401 (North Eastern region). Finally, security concerns still persist in some areas of the country, making it difficult for communities to access and use existing services. Gender based crimes also continue to be reported in urban areas, particularly in the informal settlements.

2.2 Progress in Overall Health Status

2.2.1 Status of key health indicators

Many interventions have been introduced in the health sector to improve key health indicators- such as maternal and child health, HIV/AIDS and Tuberculosis (TB), Malaria, emerging threat of Non Communicable Diseases among others- and address age-specific health needs.

During the period under review, interventions were undertaken aimed at improving maternal and child health indicators, albeit with mixed results. Coverage of critical interventions relating to maternal health stagnated or reduced, with improvements only seen with use of modern contraceptives (33% - 46%). On the other hand, child health interventions showed improvements in coverage during this period. However, reports indicate that ill health amongst children remains high, with no indications of improvement.

Specific interventions were also introduced to address the high burden due to specific diseases such as HIV/AIDS, Tuberculosis (TB) and Malaria. Notably, HIV/AIDS control showed progress with evidence of reducing incidence, prevalence and mortality. However, differences in coverage with regards to age, sex, and geographical location persist. Coverage regarding critical interventions for HIV prevention and management significantly improved during the previous policy period. Although TB control was challenged by the HIV epidemic, it also showed improvements, with key indicators such as Case Notification, Case Detection, and Treatment Successes all showing improvements. However, the emergence of drug resistant TB since 2005, particularly in males, is a key challenge. There was also evidence of reduction in malaria related mortality since coverage of effective interventions, such as Insecticide Treated Nets (ITN); Intermittent Prophylaxis Treatment; (IPTp) and Inside Residual Spraying (IRS), was scaled up. Although high coverage of interventions addressing Neglected Tropical Diseases has been achieved, they still exist among

different populations in the country.

Non communicable conditions represent an increasingly significant burden of ill health and death in the country and include cardiovascular diseases, cancers, respiratory diseases, digestive diseases, psychiatric conditions, congenital anomalies, amongst others. They represented 50 – 70% of all hospital admissions during the previous policy period and up to half of all inpatient mortality. There is no evidence of reductions in these trends. Finally, injuries and violence were high, mainly affecting the productive and young population, with mortality levels arising from this increasing over the years.

2.2.2 Risk factors to health

Risk factors to health in Kenya include unsafe sex⁴, suboptimal breastfeeding, alcohol and tobacco use, obesity and physical inactivity, amongst others.

Evidence points to improvements in unsafe sexual practices, with people increasingly embracing safe sex practices. This is attributed to steady improvements in knowledge and attitudes of communities regarding sexually transmitted infections and conditions. Breastfeeding practices have also changed, with exclusive breastfeeding for up to five (5) months showing significant improvements. Tobacco use remains high, particularly among productive populations in urban areas and among males. Evidence shows that one in five males between 18 – 29 years and one in two males between 40 – 49 years are using tobacco products. The same pattern is seen in the use of alcohol products, especially the impure alcohol products mainly found in the rural areas. Cases of alcohol poisoning continued to be reported during the previous policy period, with over 2% of all deaths in the country being attributed to alcohol use. Obesity appears to be on the rise, with an increasing population of Kenyans being overweight. It is estimated that 25% of all persons in Kenya are overweight or obese, with the prevalence being highest among women in their mid to late 40s and in urban areas.

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

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

2.2.3 Other determinants of health

Other health determinants include nutrition, maternal education, safe water, adequate sanitation, proper housing, among others.

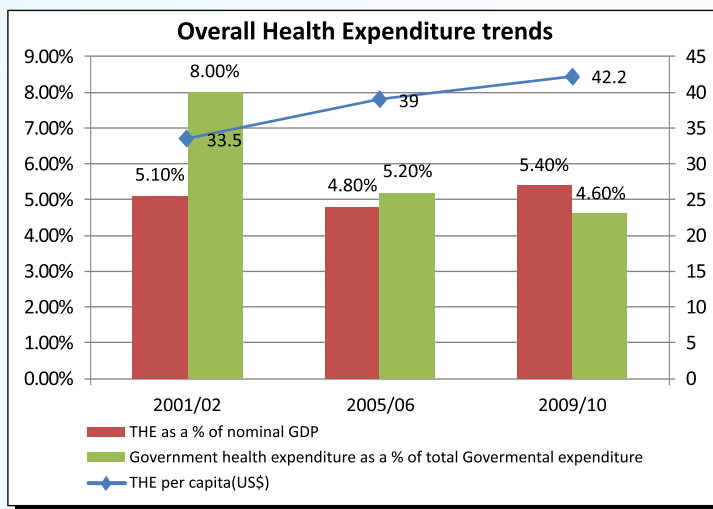
Maternal education has a strong correlation with child's health and survival. Improvements in maternal education have been noted over the years, with the numbers of women with no education reducing, while those with secondary or higher education increasing. Progress towards child nutrition has shown stagnating trends. Even though there have been improvements in acute nutrition deficiencies, such as underweight indicators in children under five (5), not much improvement is seen in prevalence of more chronic under nutrition variables, such as stunting and wasting. Additionally, undernourished children, both acute and chronic, are seen more in urban compared rural areas in the country. The nutrition status of women has also shown stagnating patterns, with up to 1%, and 12% of adult women being stunted and

⁴ Unsafe sex leads to many conditions affecting Health, such as HIV, reproductive tract cancers / conditions and other Sexually Transmitted Infections, unwanted pregnancies, psychosocial conditions, amongst others.

having unacceptably low body mass index (BMI) respectively. Under-nutrition is higher amongst women aged 15 – 19 years and in rural areas of the country. Obesity is higher in urban areas, currently affecting half of all women in Nairobi. There were improvements in availability of safe water sources and sanitation facilities particularly in rural areas. This however remains inequitable, with rural areas and some regions such as arid and semi arid areas still having poor services. Housing conditions have been improving, with a notable increase in households using permanent roofing, while households using earth floors reducing. The proportion of population in active employment has stagnated / reduced, with an associated increase in the proportion of inactive population. Finally, there has been a continued increase in urban population primarily driven by migration from rural to urban areas by those aged 20 – 34 years, both male and female. This increase is fueling an increase in urban informal settlements in the country, with their associated health risks.

2.3 Health Investments

Overall health system expenditure has significantly increased in nominal terms, from 17 US\$ per capita, to an estimated 40US\$ per capita during the period under review.



to an estimated 40US\$ per capita during the period under review. This increase was primarily driven by increases in government and donor resources, with proportion of household expenditures reducing as a proportion of the total expenditures.

However, there was no real increase in health system resources, with health expenditures as a proportion of GDP, and public expenditures as a proportion of general government expenditures remaining stagnant during the period. Additionally, health expenditures exhibited movement towards fairness in financing for health, with contribution to total

expenditures increasing by amount of wealth. Out of pocket spending was also highest in the better off provinces of the country. Financial risk protection also steadily increased to an estimated over 17% of the total population having some form of financial risk protection by the end of the policy period.

Evidence from the National Health Accounts, 2010 demonstrated improvements in allocative efficiencies, with more services being provided using the same amounts of resources in real terms. However, resources are increasingly being directed to management functions as opposed to service delivery.

Looking at actual expenditures, limited real improvements in human resources for health and infrastructure were noted during the previous policy period. While the actual numbers of these investments were improving, the numbers per person were stagnating / reducing. This is a reflection of the stagnation of real resources for health. Improvements in real terms are only notable in the last two (2) years of the policy period (2009 and 2010).

2.4 Progress in Implementation of Planned Interventions

The previous policy framework planned interventions in seven policy imperatives, plus a comprehensive reform agenda. Progress against planned interventions is mixed, as detailed below.

2.4.1 Ensure equitable allocation of government resources to reduce disparities in health status

A comprehensive bottom up planning process was instituted in the 2nd half of the policy period. However, other systemic issues, such as actual capacity to implement priorities, affected the prioritization process.

As such, interventions chosen did not necessarily lead to equitable access to essential curative as well as preventable services. Additionally, the poor information on resources available made it difficult to link the micro-economic framework with the epidemiological information for a rational planning framework. No criterion was established for geographic allocation of resources. Nevertheless, a standard resource allocation criterion for district hospitals and rural health facilities (health centers and dispensaries) was in use, though only for operations and maintenance. The norms and standards for health delivery which includes human resource; equipment and infrastructure norms, were in place though lacked in operationalization. Allocation for essential medicines and supplies based on facility type for lower level facilities was in place for most of the policy period. Experience with a pull system, with special drawing rights, was built in some provinces/regions in the country, with good results.

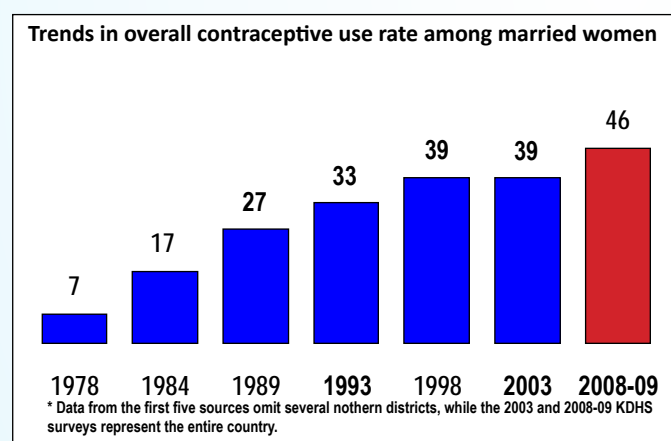
2.4.2 Increase the cost effectiveness and cost efficiency of resource allocation and use

Burden of disease and cost effectiveness were not comprehensively utilized in determining priority interventions. Prioritization was based not just on cost effectiveness, but also on feasibility of implementation, the system's capacity for implementation, and availability of resources to facilitate implementation. Data from the health management information system (HMIS) was used to determine the disease burden during the policy period. While norms and standards defining the appropriate mix of personnel and operations and maintenance inputs at all levels were in place, these were not utilized to ensure cost efficiency. Additionally, the Health Sector was not able to define and use unit costs for service delivery.

2.4.3 Continue to manage population growth

Reproductive Health services program interventions were strengthened across the country, with improvements in availability and range of modern contraceptives that increased the scope of choice for users.

Maternal education efforts improved, with advocacy efforts contributing to improvements in services



delivery, such as in family planning and its positive impact in family health. Information, education and communication (IEC) materials and processes were developed throughout the policy period, facilitating dissemination of the family planning messages. Community involvement in the advocacy and distribution was a key emphasis of the strategies, leading to increased access, availability and uptake of the commodities. This resulted in a drop in the fertility rates in most regions of the country for some time before stagnating.

Efforts to raise awareness on sexual and reproductive health amongst the youth were promoted, with a strategy available to roll out youth friendly services in health facilities. This aimed at managing unwanted teenage pregnancies.

2.4.4 Enhance the regulatory role of government in all aspects of health care provision

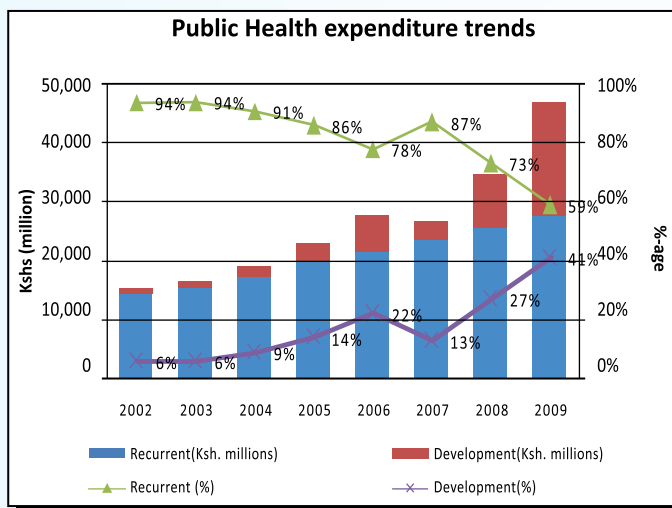
Measures were put in place to devolve management decision making to provinces and districts and leave central level in charge of policy functions, though their impact was limited due to lack of a legal framework and weak management capacity in the devolved units. The passing of the new Constitution in 2010 finally embedded this in law. The Public Health Act is however not attuned to the stewardship role of government in the current health delivery environment. Notably, the national level and sub-national level regulatory boards were strengthened to improve their capacity to deliver. Gradual decentralization of the management and control of resources to lower level institutions was initiated through the Health Sector Services Fund.

2.4.5 Create an enabling environment for increased private sector and community involvement in health services provision and finance

With the formalization of the Kenya Health SWAp process in 2006, a framework for sector coordination and partnership was established. Necessary instruments were defined based on Memoranda of Understanding to guide this dialogue and collaboration. In addition, service provision by non state actors has been facilitated by government, including through provision of public health commodities and medical supplies and tax exemptions for donations in some of the facilities and secondment of very critical staff in specific cases especially for underserved areas. However, the key beneficiaries of these have primarily been the faith based health services providers, and not the private for profit services providers. Collaboration with private for profit actors, and traditional practitioners is still weak. Government has also began facilitating provision of health promotion and targeted disease prevention / curative services through community based initiatives as defined in the 2007 Comprehensive Community Health Strategy.

2.4.6 Increase and diversify per capita financial flows to the health sector

The Sector was not able to expand the budgetary allocations, in real terms, to health. However, the Sector came up with strategies to influence resource allocation which included development and costing of sector plans, and active participation in resource allocation discussions. Nominal increases in allocations were achieved, particularly since 2006, and accelerated with the Economic Stimulus Package (ESP) in 2009.



These increases are nominal, not real, and represent a shift in total sector financing away from government and households, towards donors. There was also a relative increase in finances for preventive and promotive health care, as a proportion of recurrent versus development expenditures (see the figure above). The result of this weak sector financing means that the opportunity cost of new programs was high – with common programs having less financing. Similarly, a relative shift of resources towards preventive / promotive services implied less investment in real terms for medical care.

Nevertheless, the financing of health services has increasingly become progressive. The National Hospital Insurance Fund has been transformed into a state corporation mainly aimed at improving effectiveness and efficiency in health financing. It has expanded its benefit package to include more clinical services, preventive and promotive services.

Provision of insurance services has also expanded, with increased numbers of firms and persons covered. This has however remained limited to urban areas. In addition, the 10/20 Policy on cost sharing was introduced in 2004, reducing contributions of users of facilities to a token amount in dispensaries and health centers. Further, exemptions for user fees for some specific health services was introduced, including treatment of children less than 5 years, maternity services in dispensaries and health centers, TB treatment in public health facilities, and immunization services. Although this has significantly improved financial access to services, it has greatly reduced amounts of resources mobilized through user fees.

Community based health financing initiatives have not effectively been applied in the country in spite of the existence of a relatively strong community based Savings and Cooperative Organization (SACCO) that would have acted as a backbone for community based insurance initiatives.

2.4.7 Implementation of the reform agenda

A number of reform initiatives were undertaken albeit with mixed results:

- i. The capacity of the Ministry of Health was strengthened particularly in planning and monitoring, though limitations remain in other areas such as leadership / management;
- ii. An essential package of health has been available with each strategic plan, though its application to guide service delivery priorities has been limited;
- iii. Innovative service delivery strategies have been applied, such as mobile clinics, outreaches, or community based services, though their application has been limited to some areas and programs;
- iv. Sub-national management functions have been strengthened to allow them to better facilitate and supervise service delivery, though this mandate has been exercised differently in the various provinces/ regions, and districts;
- v. New statutes, laws, and policies guiding different aspects of the health sector have been introduced, though done in an uncoordinated manner and no update of existing laws undertaken;
- vi. The sector has made some efforts to develop a health financing strategy to guide its resource rationalization, and mobilization approaches;
- vii. Human resource component is being strengthened through redistribution; increase in numbers and review of management structures, although challenges still remain in terms investments; application of norms and standards, as well as motivation of existing staff. The sector does not also have an infrastructure investment plan to guide the distribution and improvement of health infrastructure, leading to low investments for both new and existing infrastructure.
- viii. Coordination of HIV/AIDS infection and other STIs control is being undertaken through a semi autonomous institution – the National AIDS Control Council (NACC) – managed through a different line ministry from the ministry responsible for health. However, financing of this approach, together with integrating the response into the overall health agenda, remains challenging;
- ix. While an explicit National Drug Policy was in place, its implementation was slow and only a fraction of the steps set out were realized. Some of the notable achievements include improvement in commodity management, particularly, harmonization of centralized procurement, warehousing and distribution mechanisms through Kenya Medical Supplies Agency (KEMSA). An Essential Medicines List has been available, though adherence to its use has been poor. Attempts to introduce a demand driven procurement system were instituted, with evidence of better availability of required commodities in public health facilities;
- x. Health Management and Information System architecture has continued to improve information completeness. However, information collected still remains limited to a few conditions, with completeness and quality weaknesses. Additionally, information analysis, dissemination and use is not well entrenched in the Sector. Use of information sources beyond routine health management information remains weak;
- xi. Cost containment and cost control strategies have not been wholly applied in the sector. Cost information is missing, and expenditure review data and recommendations are not applied. Contracting strategies for health services by providers were not employed as a means of cost control;
- xii. Amount and scope of systems, clinical and biomedical research being carried out has increased, with a number of operational decisions effected. There is however little collaboration amongst different research institutions, and poor linkage between research and policy;
- xiii. The decentralization of the central level Ministry of Health in line with devolution of its functions to the provinces/regions and districts hasn't happened yet. The central level has instead expanded significantly, as more programs are established, necessitating more program management units.

2.5 Overall Performance in Country Commitments

From the situation analysis, it is evident that progress towards attaining the overall health goals depicted mixed results. Notably, progress towards key commitments the country has made is still slow. The country is not on track to attain the commitments relating to health related Millennium Development Goals⁵, with no progress noted towards MDG's 5 (improve maternal health), and limited progress towards MDG's 1 (eradicate extreme poverty and hunger), 4 (reduce child mortality rates) and 6 (combat HIV, malaria, and other diseases). The lack of progress towards MDG 5 is also reflected in the limited progress towards attaining the obligations in the African Union Maputo Plan of Action⁶, which aimed to reduce poverty levels with an uncompromising evidence based approach to achieving the MDG's. Regarding investment in health, there have been limited increases in financing. Although the Paris Declaration on Aid Effectiveness⁷ was prioritized, the implementation of the principles remained poor. In addition, limited progress has been made towards the implementation of commitments of the Abuja Declaration, in which countries committed to spend at least 15% of their public expenditures on Health.

5 United Nations Millennium Summit, 2000

6 African Union Commission, 2006. *Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action)*

7 OECD, 2005. *Paris Declaration on Aid Effectiveness*

PART 2:

**POLICY
DIRECTIONS**



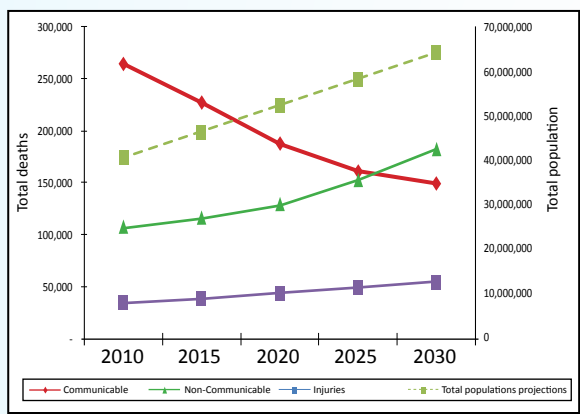
CHAPTER 3: POLICY FRAMEWORK

Emerging trends point to the fact that non communicable conditions and injuries/ violence related conditions will increasingly, in the foreseeable future, be the leading contributors to high burden of disease in the country, although the role of communicable diseases will remain significant. This implies that future country policies will be faced with a high disease burden arising from all the three conditions. Current total annual mortality is estimated at approximately 420,000 persons, out of which 270,000 (64%), 110,000 (26%) and 40,000 (10%) are due to communicable, non communicable, and injury conditions respectively. As interventions to address communicable conditions reach maturity and attain sustained universal coverage, projections show that there will be reductions in this category of disease burden, although these reductions will be slow due to the high populations facilitating communicable disease transmission.

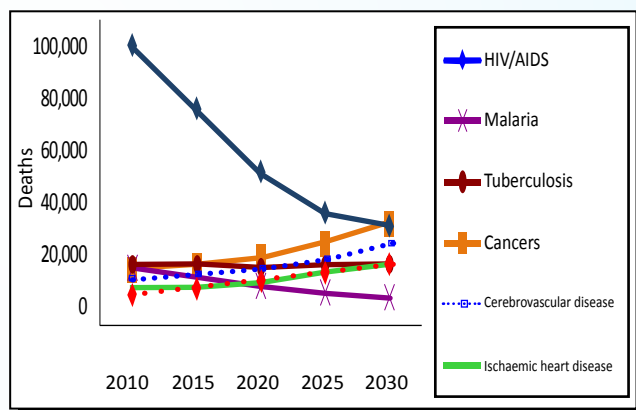
Future projections suggest that if the current policy directions and interventions⁸ are sustained, the overall mortality will reduce by only 14% (360,000 persons) annually by 2030. The contribution by disease domain would however be different, with communicable, non communicable, and injuries conditions contributing 140,000 (39%), 170,000 (47%), and 60,000 (14%) respectively. This represents a 48% reduction in absolute deaths due to communicable conditions, but a 55% increase in deaths due to non communicable conditions, and a 25% increase in deaths due to injuries / violence as shown in the figure below.

Health projections: 2011 – 2030

By disease domain



by disease condition



Source: Kenya Health Policy situation trends and distribution, 1994 – 2010, and projections to 2030

Current efforts to tackle malaria, TB and HIV should bear fruits in the short and medium term. Their contribution to the overall disease burden should reduce significantly. However, other quiescent or emerging conditions will continue to contribute immensely to the overall disease burden and thus negating the overall gains made through existing interventions on communicable diseases.

This Health Policy therefore intends to ensure significant reduction in the overall ill health in the Kenyan population by guaranteeing reductions in deaths due to communicable diseases (by at least 48%) and containing the increases in deaths due to non communicable conditions and injuries below levels of public health importance without losing focus on emerging conditions. This would translate to a 31% reduction in the absolute numbers of deaths in the country, as opposed to only 14% reduction. This target corresponds well with current mortality trends in middle income countries. WHO 2008 Global Burden of Disease estimates suggest a 0.68% mortality rate in a representative group of middle income countries (Argentina, Brazil, Indonesia, and Egypt) as compared to the 0.94% mortality rate for Kenya (27% difference).

⁸ The existing policy directions and interventions that this Kenya Policy 2012-2030 aims to change

This level of mortality in 2030 represents a 50% reduction in overall deaths, per 1,000 persons, when the population estimates are taken into consideration, translating to a reduction of 62% for communicable conditions, 27% for non communicable conditions, and 27% for violence/injuries.

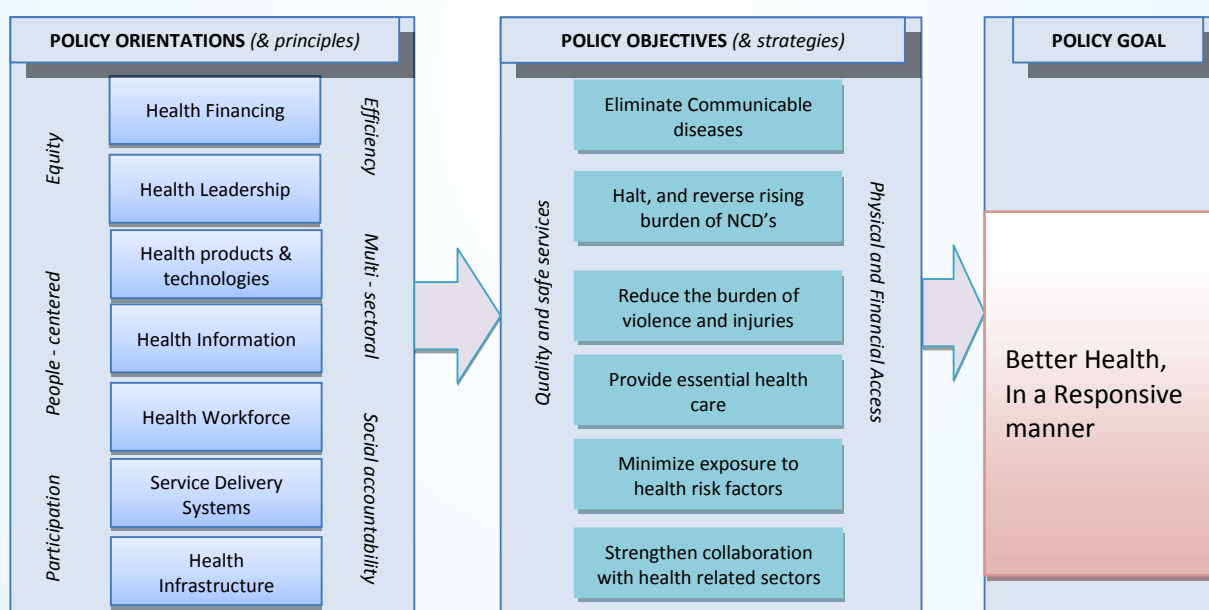
Absolute and relative mortality targets

	2010		2030	
	Absolute numbers of deaths	Deaths per 1,000 persons	Absolute numbers of deaths	Deaths per 1,000 persons
Total	420,000	10.6	290,000	5.4
Communicable conditions	270,000	6.8	140,000	2.6
Non communicable conditions	110,000	2.8	110,000	2.0
Violence / injuries	40,000	1.0	40,000	0.7
Population estimates	39,476,794		54,150,000	

Source: Projections

To achieve this, the policy is designed to be comprehensive, balanced, and coherent. By comprehensive, the policy shall provide guidance across the health spectrum for actions required to attain the country’s overall health goals. In being balanced, it shall cover all aspects of interventions in health that are needed to achieve the health goals, giving appropriate weight to their importance. In being coherent, it shall ensure different policy directions are mutually exclusive, but all contributing to a common overarching agenda. Based on this three-thronged framework (comprehensive, balanced, and coherent), policy directions are defined focusing on overall policy goal, objectives, principles, and orientations.

Framework for defining Policy directions



The **policy goal** is the overarching intent, and impact that the policy is designed to accomplish regarding health of Kenyans. This is elaborated qualitatively (aim of policy), and quantitatively (target of policy).

The **policy objectives** are the policy directions relating to the health service outcomes that need to be attained, to achieve the overall goal. These relate to health services (both population focused public health services and person focused - medical services), risk factors and behavior change objectives, and health related sector objectives.

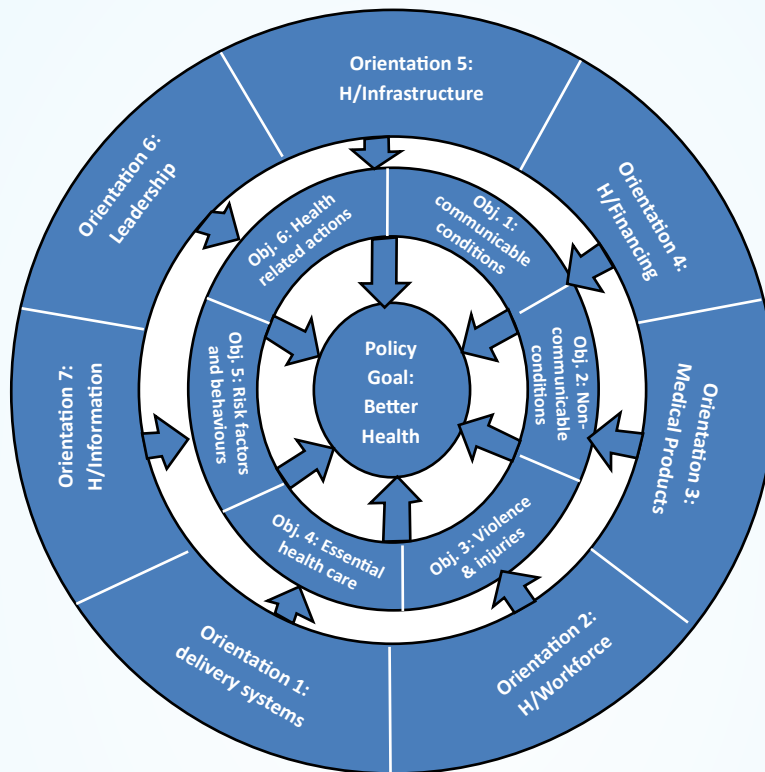
The **policy strategies** are the key areas of intervention that will be focused on to attain the policy objectives. These relate to health service access, and quality of care and service strategies.

The **policy principles** are the parameters for consideration that will guide future sector investments.

The **policy orientations** are the key policy directions the sector will strive to attain with regards to investments. This will enable the sector to organize and manage the delivery of interventions in a manner that facilitates attainment of the policy objectives. They relate to leadership / governance, health workforce, health products, health infrastructure, health financing, and service delivery systems.

The policy goal will be realized through a cascaded achievement of policy orientations and objectives. Each of the policy objectives and orientations are not mutually exclusive, and must be addressed from a synergistic viewpoint – investments in each are dependent on investments in others in order to support attainment of the policy goal.

Relationships of the different policy directions



CHAPTER 4: POLICY GOAL AND OBJECTIVES

4.1 Policy Goal

The goal of this Kenya Health Policy is ‘attaining the highest possible standard of health in a manner responsive to the needs of the population’.

The Policy aims to achieve this goal through supporting provision of *equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans*. It is designed to take the country beyond the current health services approach towards a focus on health, using a primary health care approach⁹ which remains the most efficient and cost-effective way to organize a health system¹⁰.

The **target** of the Policy is to attain a level and distribution of health that is commensurate with that of a middle income country¹¹. This would call for attainment of the following targets.

Kenya Health Policy targets

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

The **focus** of the Policy shall be on two obligations of health:

Realization of the right to health: The Policy aims to attain the right to health as outlined in the Constitution of Kenya 2010. To attain this, the Policy seeks to employ a human rights based approach in health care delivery. This means that the Policy will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programs. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all.

Contribution to development: The Policy will contribute to the attainment of the country’s long term development agenda outlined in Kenya’s Vision 2030. This will be through the provision of high quality health services with a view to maintain a healthy population able to deliver the development agenda.

4.2 Policy Objectives

The overall objective of this Policy is to **attain universal coverage of critical services that positively contribute to the realization of the overall policy goal**. Six policy objectives which address the current situation – each with specific strategies - are therefore defined.

Policy Objective 1: Eliminate communicable conditions

This aims to reduce the burden of communicable diseases, till they are not a major public health concern. The priority policy strategies include:

- i. Attain universal access to preventive health services addressing major causes of the disease burden due to communicable conditions;
- ii. Ensure quality of care in provision of the preventive and promotive services addressing major causes of the burden due to communicable conditions;

⁹ Primary Health Care approach aims to provide essential health care, based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

¹⁰ World Health Organization, 2008. Primary Health Care: Now, more than ever. World Health Report

¹¹ Average values for Argentina, Brazil, Egypt, and Indonesia taken as representative of Middle Income Countries, to provide the target Kenya will aim to achieve

- iii. Put in place interventions directly addressing marginalized and indigent populations affected by communicable conditions;
- iv. Enhance comprehensive control of communicable diseases by designing and applying integrated health service provision tools, mechanisms and processes.

Policy Objective 2: Halt and reverse the rising burden of non communicable conditions

This is to be achieved by implementing strategies to address all the identified non communicable conditions in the country. The priority policy strategies include the following:

- i. Ensure universal access to interventions addressing recognized non communicable conditions in the country;
- ii. Ensure that services relating to non-communicable conditions are of high quality standards with a view to maximize utilization of services the population has access to;
- iii. Strengthen advocacy for health promoting activities aimed at preventing increased burden due to non-communicable conditions;
- iv. Put in place programs for non-communicable diseases prevention and control;
- v. Put in place interventions directly addressing marginalized and indigent populations affected by non-communicable conditions;
- vi. Design and implement integrated health services provision tools, mechanisms and processes with a view to enhance comprehensive control of non communicable diseases;
- vii. Decentralize screening for non-communicable diseases to the lower levels to increase access.

Policy Objective 3: Reduce the burden of violence and injuries

This will be achieved by putting in place strategies to address the causes of injuries and violence. The priority policy strategies include the following:

- i. Make available corrective and inter-sectoral preventive interventions to address causes of injuries and violence;
- ii. Ensure universal access to quality emergency care (curative and rehabilitative) that mitigates effects of injuries and violence;
- iii. Put in place interventions directly addressing marginalized and indigent populations affected by injuries and violence;
- iv. Scale up physical and psychosocial rehabilitation services to address long term effects of violence and injuries.

Policy Objective 4: Provide essential health care

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

- i. Scale up physical access to person-centered health care by prioritizing solutions targeting hard to reach, or vulnerable populations;
- ii. Ensure provision of quality health care, as defined in the norms and standards and guidelines , and by users;

- iii. Ensure free access to trauma care, critical care, emergency care and disaster care services;
- iv. Promote medical tourism as a means to ensure availability of high quality care in the country.

Policy Objective 5: Minimize exposure to health risk factors

This will be achieved by strengthening the health promoting interventions, which address risk factors to health, and facilitating use of products and services that lead to healthy behaviors in the population. At the beginning of the policy period, the key policy strategies that will be employed to achieve these include:

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

Policy Objective 6: Strengthen collaboration with other sectors that have an impact on health

This will be achieved by adopting a 'Health in all Policies' approach, which ensures the Health Sector interacts with and influences design, implementation and monitoring of interventions in all sectors that have an impact on health. As such, the social determinants of health that the Policy will seek to influence include: women literacy, access to safe water and adequate sanitation, nutrition, safe housing, occupational hazards, road safety, security, income among others. The level of involvement of the health sector shall depend on the level of impact on health. Key areas that the health sector will seek to influence in this regard include inter alia:

- i. Economic growth and employment: ensure that work and stable employment and entrepreneurship opportunities are available for all people;
- ii. Security and justice: ensure enhanced security and fair justice system important in managing access to food, water and sanitation, housing, employment opportunities, and other determinants of wellbeing;
- iii. Education and early life: enhance education of both women and men to promote their abilities to address challenges relating to health;
- iv. Agriculture and food: promote considerations of safety in food production systems, manufacturing, marketing and distribution;
- v. Nutrition: ensure adequate nutrition for the whole population through promotion of proper nutrition practices;
- vi. Infrastructure, planning and transport: encourage proper planning of roads, transport system and housing with a view to facilitate movements of people, goods and services;
- vii. Environments and sustainability: influence population consumption patterns of natural resources in a manner that minimizes adverse impact on health;
- viii. Housing: promote housing designs and infrastructure planning that take into account health and

wellbeing;

- ix. Land and culture: strengthen access to land and other culturally important resources by particularly women;
- x. Population: manage population growth and urbanization implications.

CHAPTER 5: POLICY GUIDING PRINCIPLES, AND ORIENTATIONS

5.1 Policy Principles

The principles aim to guide investments, interpretation of targets and performance of the sector as it moves towards attaining the overall Policy focus. These principles are based on an interpretation of primary health care principles. They include:

5.1.1 Equity in distribution of health services and interventions

This aims to ensure that there is no exclusion and social disparities in the provision of health care services. Services shall be provided equitably to all individuals in a community irrespective of their gender, age, caste, color, geographical location and socio-economic status. Focus shall be on inclusiveness, non discrimination, social accountability, and gender equality.

5.1.2 People – centered approach to health and health interventions

This aims to ensure that health care services and health interventions are premised on people’s legitimate needs and expectations. This necessitates community involvement and participation in deciding, implementing and monitoring of interventions.

5.1.3 Participatory approach to delivery of interventions

This will entail the involvement of the different actors in the design and delivery of interventions with a view to attain the best possible outcomes. Participatory approach should however not be viewed as an end in itself, but should always be encouraged, when potential for improved outcomes exists. Collaborative models of dialogue will continually be emphasized to achieve desired outcomes.

5.1.4 Multi – Sectoral approach to realizing health goals

A multi-sectoral approach is based on the recognition that health cannot be improved by focusing on interventions relating to health services alone, but that a focus on other related sectors are equally important in attaining the overall health goals. ‘Health in all Sectors’ approach will be applied in attaining the objectives of this Policy. Such related sectors include inter alia Agriculture – including food security; Education – secondary level female education; Roads – focusing on improving access amongst hard to reach populations; Housing – decent housing conditions especially in high density urban areas; Environmental factors – focusing on management of use of dirty fuels.

5.1.5 Efficiency in application of health technologies

This aims to maximize the use of existing resources. It entails the choice and application of technologies that are appropriate (accessible, affordable, feasible and culturally acceptable to the community) in addressing the health challenges.

5.1.6 Social accountability

This will entail reporting on performance, creation of public awareness, fostering transparency and public participations in decision making on health related matters.

5.2 Policy Orientations

The policy orientations define ‘how’ the health sector will organize itself to facilitate attainment of the above objectives. The orientations are organized around the following Health System Building Blocks:

- i. Service Delivery Systems: How health service delivery will be organized;
- ii. Leadership and Governance: How health service delivery will be managed;

- iii. Health Workforce: The Human Resources required for the provision of Health Services;
- iv. Health Financing: The systems needed to ensure adequate resources for service provision;
- v. Health products and Technologies: The essential medicines, medical supplies, vaccines, health technologies, and public health commodities required in provision of services;
- vi. Health Information: Systems for generation, analysis, dissemination, and utilization of health related information;
- vii. Health Infrastructure: The physical infrastructure, equipment, transport, and Information Communication Technology needed for delivery of health services.

5.2.1 Policy orientation 1: An efficient service delivery system that maximizes health outcomes.

Service delivery systems are broad, and include:

- i. Organization of service delivery;
- ii. Linkages across service delivery units (Referral);
- iii. Integrated systems for clinical management;
- iv. Emergency preparedness and response systems;
- v. Demand creation for service delivery;
- vi. Specialized systems for taking health services to marginalized populations;
- vii. Quality of delivery during provision of services.

These will be attained through the following strategies:

i. Organization of health service delivery around a four tiered health system.

The tiers of the system will be community, primary care, primary referral and tertiary referral services. Community services will focus on creating appropriate demand for services, while primary care and referral services will focus on responding to this demand.

- a. The *community services* will comprise of all community based demand creation activities organized around the Comprehensive Community Strategy defined by the Health Sector;
- b. The *primary care services* will comprise all dispensaries, health centers and maternity homes of both public and private providers. Their capacity will be upgraded to ensure they can all provide appropriate demanded services;
- c. The *county referral services* will include hospitals operating in, and managed by a given county. This is made up of all the former level 4 and district hospitals in the county – government, and private. Together, all these hospitals in a given county form the County Referral System, with specific services shared amongst the existing County Referral facilities to form a virtual network of comprehensive services;
- d. The *national referral services* will include the service units providing tertiary / highly specialized services including high level specialist medical care, laboratory support, blood product services, and research. The units include the former Provincial General Hospitals, and national level Semi Autonomous Agencies, and shall operate under a defined level of self autonomy from the National Health Ministry, allowing for self governance.

ii. Definition of an essential package of services to be provided and investments needed.

This will guarantee a clear set of essential services that are client focused and provider oriented with a view to ensure social accountability and guide investment priorities across the different building blocks.

iii. Putting in place a comprehensive referral system.

This will cover all tiers of the health system, with effective linkages across levels of care with the aim to ensure continuity of care. This includes referral of clients, samples, or information.

iv. Implementation of an integrated service delivery approach based on clients' needs.

This shall encompass preventive, curative and rehabilitative services, and shall bring together services aimed at satisfying the clients' needs as opposed to disease/program based services.

v. Provision of quality emergency health services at the point of need regardless of ability to pay.

Emergency conditions are those health conditions that are of sudden onset in nature; are beyond the capacity of the individual / community to manage; and are life threatening, or will lead to irreversible damage to the health of the individual / community if not addressed. The emergency treatment will be provided by the nearest health facility regardless of ownership (both public and private).

vi. Instituting emergency preparedness and response mechanisms at all levels of the health system.

This is to ensure adequate response to health effects of disasters and emergencies

vii. Scaling up demand creation for health services.

A community strategy that outlines demand creation and health services provision priorities in a given time / region shall be defined.

viii. Establishment of systems for provision of health services to marginalized and vulnerable populations.

Such marginalized populations include those in hard to reach areas of the country, those in informal settlements and most at risk populations.

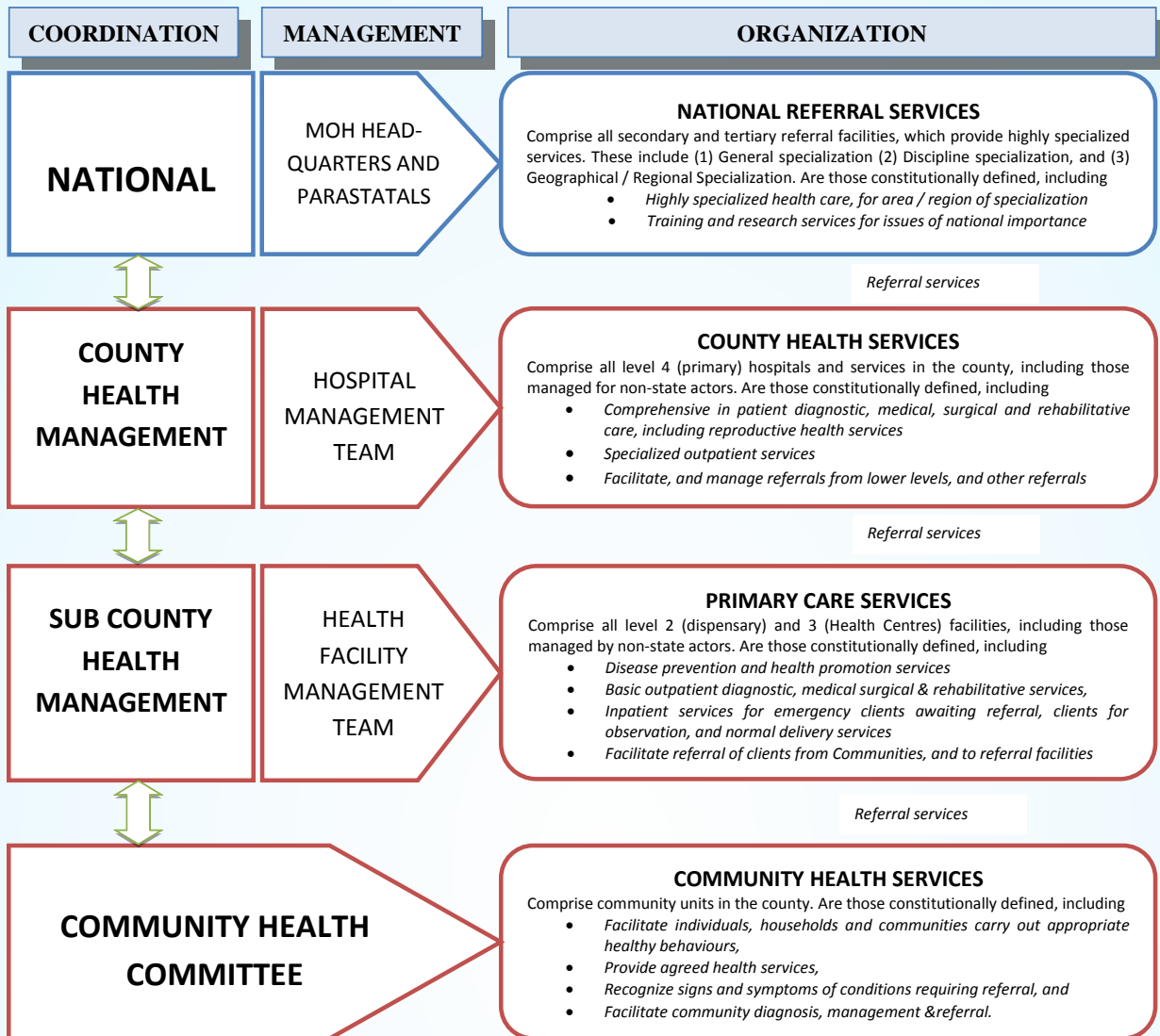
ix. Ensuring patient safety in provision of health services.

Quality of care and patient safety systems shall be prioritized.

x. Establishment of integrated supportive supervision and mentoring processes.

These should enable continuous learning, and capacity improvements at the implementation level.

Organization of health services delivery



5.2.2 Policy orientation 2: Comprehensive leadership that delivers on the health agenda.

Leadership and governance in health relate to the following:

- i. Management systems and functions;
- ii. Partnership and coordination of health care delivery;
- iii. Governance systems and functions;
- iv. Engaging of public and private services providers;
- v. Planning and monitoring systems and services;
- vi. Health regulatory framework and services.

The government will provide overall strategic leadership and stewardship aimed at defining the strategic vision of health agenda in Kenya. This will also aim to set the pace for good governance in delivery of health services. These will be attained by focusing on the following strategies:

- i. **Operationalization of a two tier management system corresponding with national and county governments.**

The national government functions shall be as defined in the Constitution of Kenya 2010. It shall operate through the national ministry responsible for health. The delivery of these functions will be through autonomous or semi-autonomous agencies, defined in each strategic plan. These will include specialized clinical support functions (national referral services including laboratory; national blood transfusion services; medical procurement; warehousing and distribution), and regulatory functions through professional councils and / or boards.

ii. Ensuring functional partnership and coordination mechanism at each tier of the health system.

This will be premised on the five principles of Aid Effectiveness: Ownership, Alignment, Harmonization, Mutual Accountability, and Managing for Results¹². This shall bring together all stakeholders in the health sector at the respective levels, representing the recognized Health Sector constituencies of:

- a. The government: Including the ministry responsible for health, and the other health related ministries functioning at the respective tiers of service delivery;
- b. Development partners supporting health, and health related interventions;
- c. Non state Implementing partners providing health services.

iii. Ensuring functional Health governance and coordination mechanism at each tier of the health system.

The structure and functioning shall be guided by a defined legal framework.

iv. Provision of oversight for implementation of functionally integrated, pluralistic health system.

This will enable optimization of equitable use of available resources and investing in comparative advantages of implementing partners in delivering this Policy's Objectives

v. Putting in place means for engaging with health related actors.

This aims to ensure that the health related sectors are prioritizing investments in outcomes that have an impact on health.

vi. Jointly develop operational and strategic plans and undertake review processes.

These will be linked to the overall planning and review framework of the health sector and shall apply to all entities in the health sector.

vii. Providing oversight to regulate and assess standards and quality of services.

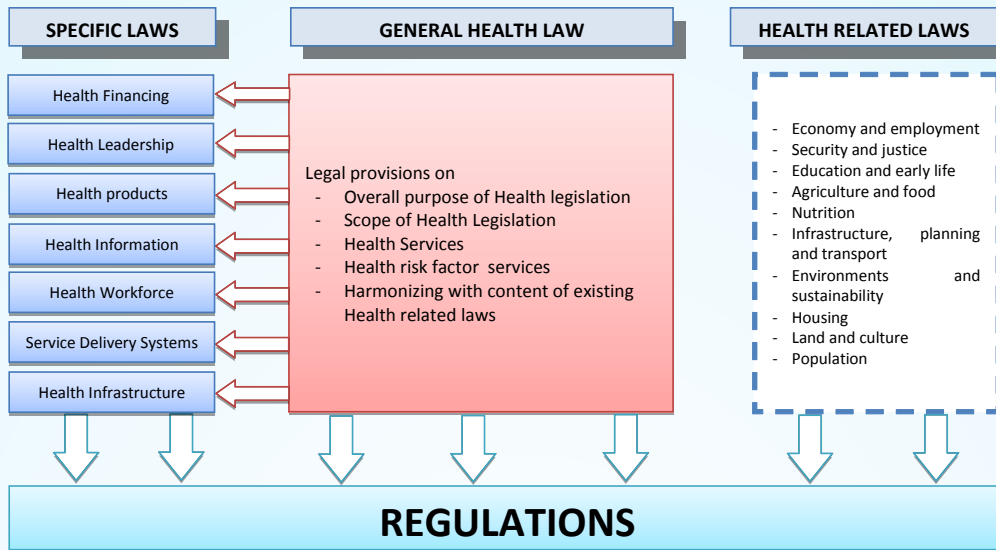
This will ensure that a defined level of quality of care is provided to the population

viii. Comprehensive legal and regulatory framework that guides sector actions.

The legal and regulatory framework shall bring together, in a comprehensive manner, all the health and health related legislations required to guide the implementation of the policy orientations. The ministry responsible for health will also put in place measures to regulate traditional and complementary medicines. The overall legal framework to guide health is shown in the figure below.

¹² 2005 Paris Declaration on Aid Effectiveness

Comprehensive Health Legal Framework



5.2.3 Policy orientation 3: Adequate and equitable distribution of human resources for health

Adequacy encompasses numbers, skills mix, competence, and attitudes of the health workforce required to deliver on the health goals. This, the sector will achieve through the following strategies:

- i. Review and application of evidence based health workforce norms and standards for the different tiers of services delivery;
- ii. Facilitation of rational capacity development of the health workforce through alignment of curricula and training to needs based on above-mentioned policy objectives. This will ensure that health personnel interact in a professional, accountable and culturally sensitive way with clients. Promotion of multi-skilling and multi-tasking of the health workforce will also be enhanced;
- iii. Improving management of the existing health workforce by putting in place attraction, retention and motivational mechanisms for the workforce especially in marginalized areas;
- iv. Putting in place systems to measure performance and competencies of health workforce, informed by clients/consumers of the services.

5.2.4 Policy orientation 4: Adequate finances mobilized, efficiently allocated and utilized, with social and financial risk protection assured.

This will be attained through ensuring equity, efficiency, transparency, and accountability in resource mobilization, allocation and use. This will be through:

- i. Establishing a national social health insurance mechanism that caters for employees, employers and the informal sector with a view to attain universal coverage;
- ii. Designing harmonized and progressive resource mobilization strategies targeting all sources of funds, both domestic and international;
- iii. Strengthening programming of external funding of health through improved harmonization and alignment to sector priorities and improved reporting;
- iv. Promoting community based health financing mechanisms;
- v. Ensuring efficient allocation and utilization of resources;
- vi. Progressively eliminating payment at the point of use of health services, especially by the marginalized

and indigent populations;

- vii. Periodically reviewing the criteria for resource allocation and purchasing mechanisms, taking into account national priorities and different sources of funds;
- viii. Advocating for increased financing for health, and related sectors, to meet agreed benchmarks (national and international) and to ensure required interventions are implemented;
- ix. Putting in place appropriate financing mechanisms for emergency health services;
- x. Developing mechanisms that promote public private partnership in financing of health;
- xi. Developing mechanisms that promote the role of private sector in financing of health.

5.2.5 Policy Orientation 5: Adequate health information, for evidence based decision making.

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

- i. Harmonization of data collection, analysis, and dissemination mechanisms of state and non state actors through a legal framework;
- ii. Continued strengthening of accuracy, timeliness, completeness of health information from population and health facilities;
- iii. Comprehensive analysis of health information to inform decision making;
- iv. Strengthening mechanisms for health information dissemination to ensure information is available where and when needed;
- v. Establishing mechanisms to promote, coordinate, regulate, and ensure sustainability of health research and development;
- vi. Putting in place health surveillance and response mechanisms.

5.2.6 Policy Orientation 6: Universal access to essential health products and technologies.

This is to ensure that effective, safe, good quality, and affordable health products and technologies are available and rationally used at all times. This, the sector will attain through implementation of the following strategies:

i. Defining and applying an evidence-based essential package of health products and technologies.

This shall be judiciously applied in the acquisition, financing and other access-enhancing interventions. It will incorporate national lists of essential medicines, health products and diagnostics; treatment protocols, and standardized equipment.

ii. Establishing a national appraisal mechanism for health products and technologies.

This will provide guidance on the clinical and cost-effectiveness of new health products, technologies, clinical practices and interventional procedures.

iii. Putting in place a harmonized national regulatory framework for health products and technologies.

This shall advance the quality, safety and efficacy/effectiveness based on sound science and evidence. The regulatory framework shall be autonomous in its operations and shall encompass human drugs; vaccines, blood and its products; diagnostics, medical devices and technologies; animal and veterinary

drugs; food products, tobacco products, cosmetics and emerging health technologies.

iv. Rational investment in and efficient management of health products and technologies.

This aims to ensure the most effective management of patients in line with established standards. This will incorporate cost-effective prescribing and other interventions to improve rational use of drugs and other health products.

v. Have in place effective and reliable procurement and supply systems.

These shall leverage public and private investments to advance patient access to essential health products and technologies and deliver value-for money across the system.

vi. Promoting local production, research and innovations of essential health products and technologies.

This shall be in a manner that advances universal access and promotes national competitiveness.

vii. Ensuring availability of affordable, good quality health products and technologies.

This shall be through full application of all options (e.g. promoting use of generics and exploiting all provisions in the trade-related aspects of intellectual property rights) and public health safeguards relating to health products and technologies, through multi-sector interventions on trade, agriculture, food and related sectors.

5.2.7 Policy Orientation 7: Adequate and appropriate health infrastructure

Health infrastructure shall relate to all the physical infrastructure, equipment, transport, and technology (including ICT) required to support effective delivery of services. This shall be a network of functional, efficient, safe, and sustainable health infrastructure based on the needs of the consumers. This, the sector will attain through focusing on the following strategies:

- i. Adopting evidence based health infrastructure investments, maintenance and replacement through utilization of norms and standards in line with government/institutions policies;
- ii. Development of health infrastructure and maintenance master plans for all planning units in the sector;
- iii. Investment in health infrastructure to increase access to health services;
- iv. Providing the necessary logistical support, including transport, communication and IT, e-health, and medical devices to establish an appropriate and efficiently functioning referral system;
- v. Promoting and increasing private sector investments in the provision of health services through infrastructure development;
- vi. Development of guidelines for donations and purchase of vehicles, medical equipment and the disposal of the same;
- vii. Strengthening the regulatory bodies to enforce health infrastructure standards;
- viii. Development of specific policies for buildings, civil works and medical devices.

PART 3: POLICY IMPLEMENTATION



CHAPTER 6: IMPLEMENTATION FRAMEWORK

6.1 Stakeholder Roles

The policy implementation process will adopt a multisectoral approach, involving different stakeholders—consumers (individuals, Households, communities), non state actors (CSOs, FBOs/NGOs, private sector, and development partners), and state actors (government ministries and agencies) at the national and county levels.

6.1.1 Clients/Consumers

Individual: This Policy recognizes the role an individual plays through adoption of appropriate health practices and health care seeking behaviors as key in realization of the country’s health goals. The Policy shall therefore seek to enhance the capacity of the individual to effectively play this role.

Household: The sector shall ensure that households are empowered to take responsibility for their own health and well being and are facilitated and capacitated to participate actively in the management of their local health care systems.

Communities: This Policy recognizes the significant role that communities have traditionally played in contributing to the achievement of national, community and family health goals through various innovative interventions. These have ranged from informal community programmes to home-based interventions. These will continue to be encouraged.

6.1.2 Non State Actors

Implementing Partners: Traditionally, implementing partners have played a significant role in ensuring that health services are available to the community. This Policy recognizes the strengths of these actors in designing and implementing development programs as well as organizing and interacting with community groups. The implementing partners have also been a critical source of much needed human and monetary resources that are critical in the implementation of this Policy. In addition, this Policy acknowledges the range of interventions implemented by implementing partners in addressing risk factors to health and in the areas of education, health, food security and water sectors, among others.

The Private Sector: This Policy recognizes the important role and participation of the private sector in all areas of health delivery – primary, secondary and tertiary. Drawing from past experiences, the private sector can be expected to contribute substantially to the urban primary and tertiary levels and to some extent the secondary levels of health care. The private sector has resources and expertise that can foster the design and implementation of Health interventions in the country. It has comparative advantage in being efficient and cost-effective. The government sees the private sector as a crucial partner, both as a source of financial resources for the health sector and in ensuring program delivery competencies.

Development partners: This Policy recognizes that health services require significant financial and technical investment in a context of limited domestic resources. Donors and international non-governmental organizations have traditionally played a key role in providing resources for the health sector. This role has been structured around principles of Aid Effectiveness, which place emphasis on government ownership, alignment, harmonization, mutual accountability and managing for results of programs in the health sector. The implementation of this Policy will require the continued support of development partners in health, especially given the devolved system of government.

6.1.3 State Actors - including Semi-Autonomous Government Agencies

Inter-sectoral and inter-ministerial actors: It is well recognized that improving the overall health status and well-being of the public depends on the synergistic functioning of the various sectors in the economy. For instance, the health status of the public would be dependent inter alia on adequate nutrition, safe drinking water, basic sanitation, a clean environment and primary education, especially for the vulnerable

populations. The policies and the modes of functioning of these interdependent areas would necessarily interlink with each other to contribute to the health status of the individuals, communities and the general public. From the Policy perspective, it is therefore imperative that the independent policies of each of these inter-connected sectors be harmonized and the interface between the policies of the various sectors be smooth. To attain this, the ministry and county departments responsible for health shall take a lead role in advising, mobilizing and collaborating with other government ministries, departments and agencies.

6.2 Institutional Framework

This Policy recognizes that coordination of service delivery in the health sector has in the previous policy period been done through a sector wide approach (SWAp), the Kenya Health SWAp (KHSWAp)¹³ that brings together all health stakeholders and is managed through partnership instrument, the Code of Conduct¹⁴. Governance structures and systems have also existed, through boards, at the respective service delivery levels (hospitals, and districts), including a common framework for planning and implementation.

The management of the health sector under a devolved system necessitates new institutional and management arrangements. This Policy is also alive to the functional assignments between the two levels of government with respective accountability, reporting and management lines. This Policy therefore provides a structure that harnesses and synergizes health service delivery at all levels of this devolved system and seeks to meet the following objectives:

- i. Delivery of efficient, cost-effective and equitable health services;
- ii. Devolution of health service delivery, administration and management to the community level;
- iii. Stakeholder participation and accountability in health services delivery, administration and management;
- iv. Operational autonomy;
- v. Efficient and cost-effective monitoring, evaluation, reviewing and reporting systems;
- vi. Smooth transition from the current to the proposed devolved arrangements; and
- vii. Complementarity of efforts and interventions.

6.2.1 National ministry responsible for health

The National Ministry shall establish and facilitate an institutional and management structure to coordinate and manage delivery of the constitutionally defined health mandates and services at the national level while championing the implementation of this Policy. Its principle mandates shall be:

- i. Developing national policy and legislation, standard setting, national reporting, supervision, sector coordination and resource mobilization;
- ii. Offering technical support with emphasis on planning, development and monitoring of health services and delivery standards throughout the country;
- iii. Monitoring quality and standards of performance of county governments and community organizations in the provision of health services;
- iv. Providing guidelines on tariffs chargeable for the provisions of health services;
- v. Conducting studies required for administrative or management purposes.

During the transition period (NHSSP 2012-2017), the national government shall directly support establishment of required capacities at the county level.

¹³ Government of Kenya, 2005. Kenya Health SWAp concept paper, October 2005. Ministry of Health

¹⁴ Government of Kenya, 2007. Health Sector Code of Conduct, August 2007. Ministry of Health

6.2.2 County department responsible for health

The Constitution of Kenya 2010 has assigned the larger portion of delivery of health services to the counties with exception of national referral services. This Policy therefore provides a structure that harnesses competencies at the county level and synergizes health service delivery across counties and between the two levels of government. In this regard, the County Health Department shall establish and facilitate an institutional and management structure to coordinate and manage delivery of the constitutionally defined health mandates and services at the county level. Its overall roles and responsibilities shall be:

- i. Delivering county level health services;
- ii. Licensing and accrediting non state health services providers;
- iii. Financing of county level health services;
- iv. Maintaining, enhancing and regulating asset development and health services providers' operations;
- v. Approving county special partnership agreements for county health services providers;
- vi. In collaboration with national government, gazetting regulations for community managed health supplies to be implemented at county level;
- vii. Undertaking planning, investment and asset ownership function of public health facilities;
- viii. Developing an investment plan to enable fulfillment of the highest attainable right to health and document annual progress on fulfillment as required by the Constitution;
- ix. Asset financing and ownership;
- x. Channeling public and other funds to develop health facilities;
- xi. Collecting and aggregating information at county level on implementation of projects in order to document value for money and progress in attainment of the rights;
- xii. Providing a legal framework for lending arrangements to facilitate loan repayments and fees for use of assets by licensed health services providers.

6.2.3 Technical management of health at the county level:

A professional and technical management structure shall be established in each county to coordinate delivery of the constitutionally defined county level health services through the network of health facilities in the county. In order to achieve this, county governments shall establish a county health management team. The Management Team will be required to perform the following county level health management functions:

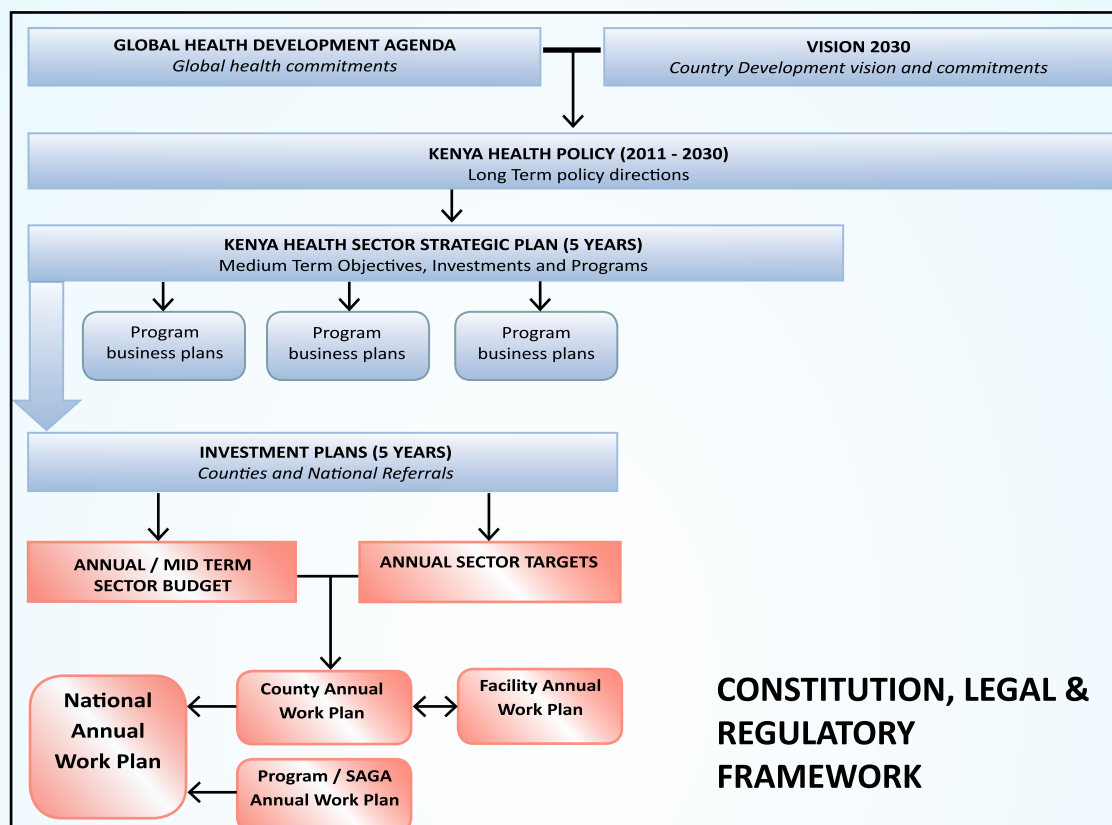
- i. Strategic and operational planning, supportive supervision, monitoring and review of health service delivery in the county;
- ii. Coordinate delivery of health services in the county;
- iii. Provide a linkage with the County Executive Committee and other actors to facilitate health sector dialogue at the county level;
- iv. Provide leadership and stewardship for overall health management in the county, through building linkages with, and putting in place strategies to influence health related sectors in the county, such as education, roads, gender, nutrition, and others. This will ensure that the interventions of these sectors have positive health outcomes;
- v. Mobilize resources for county health services;
- vi. Coordinate the referral function across the level 3 facilities in the county, and between the different levels of the health system in line with the Sector Referral Strategy.

CHAPTER 7: MONITORING AND EVALUATION

7.1 Monitoring and Evaluation Framework

This comprehensive Kenya Health Policy is an integral part of the overall Kenya Health Policy, Strategy and Planning Framework, as shown below.

Overarching planning and review framework



The Kenya Health Policy is the primary policy document providing long term direction for health in Kenya for the period 2012 – 2030. The Policy outlines the intent of the country towards attaining the overall health aspirations of the people of Kenya. The Policy is informed by the Kenya’s Vision 2030, the Constitution of Kenya 2010 and the global health commitments.

The Policy is to be implemented through Medium Term Strategic Plans. These will elaborate the comprehensive medium term strategic and investment approaches, with two key elements:

- Medium term health and related services objectives and outcome (coverage) indicator targets for each of the six policy objectives, defined by the national government;
- Priority investments across the seven policy orientations required to attain the above-mentioned medium term health and related services objectives. Priority investments would be defined by the respective planning units (counties, SAGAs), to enable attainment of defined objectives and targets for the sector.

The Health Policy principles are applied here as they form the basis for defining the resource allocation criteria across the various health system building blocks and counties. This enables a shift in the basis for prioritization of investments from diseases, to areas in the building blocks.

The program business plans reiterate these sector wide objectives around specific services (e.g. HIV, or Malaria), or systems (e.g. HRH, or health financing Strategy) areas. As such, they are part of the National

Health Sector Strategic Plan – their use is in laying particular emphasis on a given area. These program business plans at the national level are important in mobilizing resources for a given agenda, and as such focus efforts on accelerating its attainment.

Specific investment plans are elaborated for decision making units in the health sector. These decision making Units represent the major units of service delivery in the health sector around which investments can be made and targets delivered. They are:

- i. Counties: as autonomous, decentralized management units that are able to plan and raise resources for defined services;
- ii. Referral facilities: as critical service delivery units in counties and the national level (national referral facilities);
- iii. Semi-Autonomous Government Agencies: as units defined to deliver specified services, with independent budgets.

Investment plans provide information and guidance on the annual targets, and budgeting processes.

The budgeting process and framework therefore will be based on agreed priority investments in the respective investment plans. During the budgeting process, the priorities for investment should be directly derived from the building block investments. The seven policy orientations form the sector programs in the budget, around which priorities and budgets are defined.

The defined priorities and budgets form the guide for the elaboration of annual work plans – the priority activities for implementation in the short term, based on the resources available.

7.2 Progress indicators

These are based on the respective domain areas. Indicators that will be used are shown in the table below. Targets are based on the WHO statistics of the average value of four middle income countries – Argentina, Brazil, Egypt, and Indonesia.

Policy Area	Domain	Impact level Indicators	2010 estimates	2030 target	% change
Policy Goal	Level and distribution of health	Life Expectancy at birth (years)	60	72	16% improvement
		Annual deaths (per 1,000 persons)	10.6	5.4	50% reduction
		Years Lived with Disability	12	8	25% improvement
	Responsiveness of services	Client satisfaction	84.87	95	11% improvement
Policy Objectives	Communicable conditions	Annual deaths due to communicable conditions (per 1,000 persons)	6.8	2.6	62% reduction
	Non communicable conditions	Annual deaths due to non communicable conditions (per 1,000 persons)	2.8	2.0	27% reduction
	Violence & Injuries	Annual deaths due to violence / injuries (per 1,000 persons)	1.0	0.7	27% reduction
	Essential health care	Neonatal Mortality Rate (per 1,000 births)	31	13	59% reduction
		Infant Mortality Rate (per 1,000 births)	52	20	63% reduction
		Under 5 Mortality Rate (per 1,000 births)	74	24	68% reduction
		Maternal Mortality Rate (per 100,000 births)	488	113	77% reduction
	Risk factors, and healthy behaviors	Adult Mortality Rate (per 100,000 births)	358	204	43% reduction
		Deaths due to top 10 risk factors	55.50%	36.60%	34% reduction
	Health Related Sector services	Disabilities due to top 10 risk factors	47.30%	31.20%	34% reduction
		Coverage levels of health related sectors outcomes		???	Two thirds (2/3) reduction

Targets shall be measured in terms of absolute achievement; and variation in achievement across counties in the country (Standard Deviation).

CHAPTER 8: CONCLUSION

This Comprehensive Kenya Health Policy represents a commitment towards improving the Health of the people of Kenya by significantly reducing ill health to levels similar to those of middle income countries like Argentina, Brazil, Egypt and Indonesia. In proposing a comprehensive and innovative approach to addressing the health agenda, the government and the people of Kenya are signaling a radical departure from the past approaches to addressing the health challenges. The Policy is premised on the Constitution of Kenya 2010, Vision 2030 and global health commitments.

This Policy was developed through an inclusive and participatory process involving all stakeholders in the health sector and related sectors over a period of two years. A situation analysis, based on review of progress made in implementation of the previous policy framework (1994-2010) was undertaken with a view to attain a deeper understanding of the challenges affecting the health sector, existing opportunities and define the necessary interventions.

The Policy defines the health goal, objectives – including strategies- guiding principles and orientations aimed at achieving the health agenda in Kenya. The Policy also outlines comprehensive implementation framework to achieve the goal and objectives. The implementation framework is comprehensive and takes into account the role of all stakeholders in the health sector in delivering the health agenda. It also details the institutional management arrangements under the devolved system of government- taking into account the varied roles of national and county levels of government. It therefore provides a structure that harnesses and synergizes health service delivery at all levels of this devolved system of government.

Finally, the Policy spells out the monitoring and evaluation framework with a view to track progress made in achieving the Policy objectives. The monitoring of progress will be based on level of distribution of health services; responsiveness of health services to the needs of the people; progress in respective disease domain areas including communicable, non-communicable and injury/violence conditions; risk factors; and the interventions of health related sectors.

It is hoped that all the actors in health in Kenya will effectively play their respective roles, guided by the Policy directions, to ensure that Kenya achieves her health agenda.

GLOSSARY OF TERMS

Abortion: Termination of a pregnancy before it is viable as an independent life outside of the womb. This can occur spontaneously, or be induced by external actions. Current medical expertise in the country can sustain a viable life outside the womb from 24 weeks of gestation. As medical expertise improves, this should reduce further. Unsafe abortion remains a major cause of maternal mortality.

Ambulatory: A condition or a procedure, not requiring admission to a hospital. These are managed on an outpatient basis.

Disease: Any condition that causes pain, dysfunction, distress, social problems, and / or death to the person afflicted, or similar problems for those in contact with the person. It may be caused by external factors, such as infectious diseases, or by internal dysfunctions, such as cancers. Diseases usually affect people not only physically, but also emotionally, as contracting and living with many diseases can alter one's perspective on life, and their personality.

E-Health: the use, in the health sector, of digital data -transmitted, stored and retrieved electronically - in support of health care, both at the local site and at a distance."

Emergency: Any event / crisis that exceeds the community's or an individual's ability to respond

Emergency treatment: Health care services necessary to prevent and manage the damaging health effects from an emergency situation. It involves services across all aspects of health care services and includes first aid treatment of ambulatory patients and those with minor injuries; public health information on emergency treatment, prevention, and control; and administrative support including maintenance of vital records and providing for a conduit of emergency health funds across Government.

Emergency care involves arrangements for transfer of clients once the emergency nature of the service is stabilized. Execution of these transfer arrangements ends the emergency phase of health care.

Essential Health Products and Technologies: those products that, "... satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. EHPTs are intended to be available within the context of a functioning health system at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford". The implementation of the concept of essential health products is intended to be flexible and adaptable to many different situations; exactly which health products are regarded as essential remains a national responsibility.

Health: A state of complete physical, mental and social well-being and not merely the absence of *disease* or infirmity.

Health care professionals: The workforce that delivers the defined Health care services. The workforce includes all those whose prime responsibility is the provision of health care services, irrespective of their organizational base (public, or non-public).

Health Care Services: The prevention and management of disease, illness, injury, and other physical and mental impairments in individuals delivered by health care professionals through the health care system and can either be routine health services, or emergency health services.

Health System: The mechanism to deliver quality health care services to all people, when and where they need them.

Humanitarian actions: All actions to mitigate effects of an emergency. These include *emergency health services*.

Human Resource for Health: The stock of all individuals engaged primarily in the improvement of the

health of populations. The public health workforce includes those primarily involved in protecting and promoting the health of whole or specific populations, as distinct from activities directed to the care of individuals.

Illness: A state of poor health or when conditions of health are not fulfilled.

Injury: Physical damage to a person.

Medical Care Services: The management of disease, illness, injury, and other physical and mental impairments in humans. This involves diagnosis, treatment and rehabilitation of persons, following a disease, illness, injury or other impairment.

Medicine: Any substance or product for human or veterinary use that is intended to modify or explore physiological systems or pathological states for the benefit of the recipient. The terms drug, medicine and pharmaceutical may be used interchangeably, depending on context.

Non-State Actors: Individuals, or institutions whose primary purpose are in provision of Health Services, but are not a part of the State. They include service providers (for profit and not for profit), Health Civil Society organizations, NGO's and their related management systems.

Post delivery period: This represents the 6 weeks following delivery. It corresponds with the post partum period.

Public Health Services: The health care services concerned with the science and art of preventing disease, prolonging life and promoting health through organized efforts and informed choices of society, organizations, public and private, communities and individuals and are concerned with threats to the overall health of a community.

Referral: The process by which a given level of health services that has inadequate capacity to manage a given health condition or event, seeks the assistance of a higher level of health care delivery to guide, or take over the management of the condition. It ensures establishment of efficient health service delivery system linkages across *levels of care* that ensure continuity of care, for effective management of health needs of the population in Kenya. It involves movement of clients, expertise, specimens, or client information.

Referral health services: The health care services whose function is specifically to manage, or facilitate the *referral process*.

Reproductive health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It includes the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Routine Health Services: Health care services necessary to prevent and manage the damaging health effects from non emergency situations. It involves services across ALL aspects of health care services.

Trained Health professional (in the context of provision of legal termination of pregnancy): A health professional, with formal medical training at proficiency level of a Medical Officer (doctor), nurse midwife, or clinical officer who has been educated and trained to proficiency in the skills needed to manage uncomplicated abortion and post abortion care and in the identification, management and referral of abortion related complications in women and family. Such a health professional should have a valid license from the Medical and Dental practitioners Council to practice, and providing the service from a legally recognized health facility with an enabling environment consisting of the minimum human resources,

infrastructure, commodities and supplies for the facility as defined in the health sector norms and standards.

Unsafe abortion: A procedure carried out by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both¹⁵

Universal access: The effective physical and financial access to health services.

Universal health care: is a term referring to organized health care systems built around the principle of universal coverage for all members of society, combining mechanisms for health financing and service provision.

Health products and technologies: The application of organized knowledge and skills in the form of medicines, devices, vaccines, procedures and systems developed to solve a health problem and improve quality of lives". Essential health technologies encompass medical devices, biological products, diagnostics and medical laboratory technologies, transplantation of human cells, tissues or organs; emergency, surgical and e-health technologies. Their regulatory scope encompasses human drugs; vaccines, blood and biologics; medical devices and technologies; animal and veterinary drugs; food products, tobacco products, cosmetics and emerging health technologies; Regulatory framework to be de-linked from healthcare service structures, in line with Leadership and Governance systems anticipated in this Policy

¹⁵ World Health Organization. (2004). "Unsafe abortion: global and regional estimates of unsafe abortion and associated mortality in 2000"



Ministry of Medical Services
Ministry of Public Health and Sanitation