Republic of Kenya

Reversing the trends

The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

Ministry of Medical Services
STRATEGIC PLAN
2008–2012

Ministry of Medical Services
July 2008

Republic of Kenya

Reversing the trends

The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

Ministry of Medical Services
STRATEGIC PLAN
2008–2012

Ministry of Medical Services
1 July 2008

Ministry of Medical Services Strategic Plan, 2008–2012

Published by: Ministry of Medical Services
Afya House
PO Box 30016 GPO
Nairobi 00100, Kenya
Email: ps@health.go.ke
http://www.health.go.ke

Cover photos: Facilities courtesy Ministry of Medical Services staff; nurse at well-baby clinic courtesy National Coordinating Agency for Population and Development.

Message from the Minister for Medical Services

This strategic plan, covering the period 2008–2012, will guide the Ministry of Medical Services in the delivery of tangible results to all Kenyans for the next five years, as well as the continued pursuit of Kenya Vision 2030 and achievement of the Millennium Development Goals. A product of extensive collaboration and comprehensive feedback from our internal and external stakeholders, the plan establishes the strategic framework for the planning and delivery of health care services in Kenya as well as for monitoring performance.

In the plan, the Ministry defines its vision and mission, objectives and strategies, and sets out, as well, the outcomes and performance benchmarks envisaged for the next five years. The plan builds on the achievements realized under the second National Health Sector Strategic Plan (NHSSP II, 2005–2010) and the Economic Recovery Strategy (2003–2007) and anchors its strategic thrust on Kenya Vision 2030 and its first Medium-Term Plan.

Moreover, the plan takes cognisance of the fact that the objectives of NHSSP II have not been fully realized because of a number of challenges, including funding limitations, poverty levels in the country, and the prevailing unfavourable cross-sector environment such as roads, power and water supply.

The formation of the Grand Coalition Government and the subsequent split of the former Ministry of Health have provided an opportunity to focus specifically on the

Hon. Prof. Peter Anyang' Nyong'o, EGH, MP
Minister for Medical Services

delivery of health care services so as to achieve the goal of Vision 2030. The Ministry is well positioned to play its role and contribute towards ensuring that all Kenyans enjoy a high equality of life. To achieve this, the Ministry will endeavour to use available resources as efficiently as possible in order to maximize results and receive value for money.

More importantly, the plan will act as a guide for assessing performance and achievement of the results in the Ministry in the next five years. It provides clear strategies, objectives and outputs that will guide stakeholders in the implementation of projects and programmes so as to accomplish the health sector objectives. Further, the plan provides the coordination mechanism for collaboration among the different stakeholders in the sector.

It is my belief that all stakeholders will find this plan a useful tool for collaboration and implementation of the various strategies outlined herein, and that the plan will enable us to use our limited resources more efficiently as well as increase accountability.

Hon. Prof. Peter Anyang' Nyong'o, EGH, MP
Minister for Medical Services
1 July 2008

Foreword, by the Permanent Secretary

An elaborate consultative process involving key ministry stakeholders characterized the development of this strategic plan. Our special thanks go to the Minister for Medical Services, Hon. (Prof.) Peter Anyang' Nyong'o, and the Assistant Minister, Hon. Danson Mungatana, for their political leadership, guidance and support in the development of this plan. Their contribution, especially in the stakeholder meetings, provided the overall strategic direction upon which the strategy was developed. The meetings identified key strategic areas that facilitated the finalization of the plan.

The development process was coordinated jointly by the Head of the Planning Division, Elkana Ong'uti, and the Head of Technical Planning and Coordination, Dr. Harrison Kiambati. A core team of technical officers from the Ministry worked tirelessly to keep the preparation of the plan on track. These included Dr. Isabella Maina, Stephen Cheruiyot, Titus Kolongei, Douglas Ngaira, Fred Ombwori, Roline Njiru, Naomi Mathenge, Dr. J.N. Mbuva, Pepela Wanjala, Dr. D. Kiima, Dr. Wanjau Mbuthia, Dr. S.W. Mueke, Chaacha Marwa, Mercy Kasina, A.M. Njuguna and Samuel Obaga.

Other key players were Dr. R.I. Nyamai, Nelson Kariuki, Wycliffe Kisongoch, Joseph Mirech, Adan A. Adan, David Njuguna, Eric Owino, Judith Andia and A.M. Kiilu. From the Ministry of Planning, Florence Were also provided valuable input during the process. We also

Prof. James L. ole Kiyiapi, CBS
Permanent Secretary
Ministry of Medical Services

acknowledge the technical support from Dr. Humphrey Karamagi of the World Health Organization.

Several thematic teams worked hard to provide initial input into the plan: Decentralization; Commodity and Infrastructure; Planning, Monitoring and Evaluation and Partnerships, and Health Care Financing. Similarly, we express our appreciation to all the Heads of Department and other ministry staff as well as those of our semi-autonomous government agencies for their dedication and for sparing time to contribute towards the development of the plan.

We take this opportunity to thank all of our partners for their invaluable contribution, through either direct or indirect support. We particularly appreciate the role provided by the World Health Organization, Essential Health Services Programme of the Department for International Development (DFID) Kenya and the German Agency for Technical Cooperation (GTZ) for their support during the whole process of developing this plan. We appreciate the encouragement and support of all the other partners, including HENNET, that at different stages provided invaluable guidance and support.

It is my sincere conviction that together as a team we will remain focused on the implementation of this plan in order to achieve our vision of providing first class health care services to the people of Kenya and for the region and to meet the goals of Vision 2030.

Prof. James L. ole Kiyiapi, CBS
Permanent Secretary
Ministry of Medical Services
1 July 2008

Contents

List of Tables

List of Figures

List of Abbreviations

AIDS	Acquired immune deficiency syndrome
AIE	Authority to incur expenditure
ANC	Antenatal care
AOP	Annual operational plan
ART	Anti-retroviral therapy
BCC	Behaviour change communication
CFO	Chief Financing Officer
CHAK	Christian Health Association of Kenya
CHW	Community health worker
CHEW	Community health extension worker (being ECN and PHN)
CMA	Common management arrangement
CORP	Community-owned resource person
CPR	Contraceptive prevalence rate
DCH	Division of Child Health
DEH	Division of Environmental Health
DHP	District health plan
DHSF	District Health Stakeholder Forum
DHT	District Health Team
DHMB	District Health Management Board
DHMT	District Health Management Team
D/HRM	Department for Human Resource Management
DMOH	District Medical Officer of Health
DMS	Director of Medical Services
DMSO	District Medical Services Officer
DMSMT	District Medical Services Management Team
DOCL	Division of Clinical Services
DOMC	Division of Malaria Control
DOMH	Division of Mental Health
DON	Division of Nursing
DOPTH	Division of Ophthalmic Services
DPM	Directorate for Personnel Management
DRH	Division of Reproductive Health
DSRS	Department of Standards and Regulatory Services
ECN	Enrolled Community Nurse
EML	Essential Medicines List
ERS	Economic Recovery Strategy (shortened form of Economic Recovery Strategy for Wealth and Employment Creation – ERSWEC)
ERP	Enterprise resource person
FANC/MIP	Focused antenatal care/malaria in pregnancy
FBO	Faith-based organization
FMS	Financial management systems (=PFM)

FP	Family planning
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, TB and Malaria
GOK	Government of Kenya
HBC	Home-based care
HF	Health facility
HIV	Human immune-deficiency virus
HMC	Health management committee
HMIS	Health management information system
HRD	Human resources development
HRH	Human resources for health
HSRS	Health Sector Reform Secretariat
HSSF	Health Sector Services Fund
ICT	Information and communication technology
ICC	Interagency Coordinating Committee
IEC	Information, education and communication
IFMIS	Integrated financial management information system
IMCI	Integrated management of childhood illness
IPT	Intermittent prophylactic treatment (for malaria)
ITN	Insecticide treated bed net
JAR	Joint Annual Review
JICC	Joint Interagency Coordinating Committee
JPWF	Joint Programme of Work and Funding
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
KEMSA	Kenya Medical Supply Agency
KEPI	Kenyan Expanded Programme of Immunization
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
Ksh	Kenya shilling
LLITN	Long lasting insecticide treated bed net
MCH	Mother and child health
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MMR	Maternal mortality ratio
MMU	Ministerial Monitoring Unit
MOF	Ministry of Finance
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MOU	Memorandum of understanding
MTEF	Medium-term expenditure framework (three-year rolling plan)
MTPP	Medium-term procurement plan
MTRH	Moi Teaching and Referral Hospital
NA	Not available
NASCOP	National AIDS and STD Control Programme
NGO	Non-government organization
NHIF	National Hospital Insurance Fund
NHSSP II	Second National Health Sector Strategic Plan, 2005–2010
NS	Not stated
NSHIF	National Social Health Insurance Fund
PDMS	Provincial Director of Medical Services
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	Public finance and management
PHMT	Provincial Health Management Team
PHN	Public Health Nurse
PME	Performance-based monitoring and evaluation
PMSMT	Provincial Medical Services Management Team
PMTCT	Prevention of mother-to-child transmission (of HIV)
PMO	Provincial Medical Officer
PRO	Public Relations Office
PRM	Planning, review and monitoring
PS	Permanent Secretary
PU	Procurement Unit
RBM	Results-based management
RH	Reproductive health
RRI	Rapid results initiative
SCC	SWAp Coordinating Committee
SWAp	Sector-wide approach
SOP	Standard operating procedure
TB	Tuberculosis
TBD	To be determined
TOR	Terms of reference
TOT	Training of trainers
VCT	Voluntary counselling and testing
WG	Working group
WHO	World Health Organization
WIT	Work Improvement Teams
WRA	Women of reproductive age

Executive Summary

This Ministry of Medical Services strategic plan 2008–2012 is the Government's investment plan for Medical Services, specifying the outcomes and outputs that the Ministry will prioritize up to 2012. It guides the Ministry's efforts in supporting attainment of the Vision 2030, through guiding Medical Services implementation for the Government's 1st Medium Term Plan (MTP), and the Health Sector's second National Health Sector Strategic Plan (NHSSP II – 2005–2010).

This strategic plan is a roadmap for assessing Medical Services performance and achievement of the results in the next five years. It provides clear strategies, objectives and outputs to guide stakeholders to implement projects and programmes that realize the health sector medical services objectives. Furthermore, the plan provides the mechanism for coordinating collaboration among the stakeholders in the sector.

Medical Services are all about managing the implications of ill health, paying special attention to the social context of disease and health. They complement Public Health interventions by ensuring that essential medical care is made available as needed, when needed and in appropriate amounts. The aim is to improve lives by responding to the legitimate medical needs of the population in Kenya. The central leadership role of the Ministry of Medical Services (MOMS) is to ensure that Medical Services are provided to contribute to the attainment of the medium-term development goals as outlined in NHSSP II and the 1st Medium-Term Plan (MTP) 2008–2012. Its functions are derived from its core mandate, as defined in the Presidential Circular No. 1 2008.

Vision and Mission

The overall vision for Medical Services is to have "An efficient and cost-effective medical care system for a healthy nation". Its mission is "To promote and participate in the provision of

Four broad principles guide the operations of the Ministry of Medical Services and form the bedrock of this strategic plan:

- Efficiency
- Equity and human rights
- Effectiveness
- Partnership and collaboration

integrated and high quality curative and rehabilitative medical services to all Kenyans". It will attain this through direct provision of medical services, and building necessary linkages and partnerships with other service providers, and development partners as is needed.

Eight Strategic Thrusts

The priorities highlighted in this plan are based on an analysis of the challenges facing medical services in the country. The review of the NHSSP I, plus the NHSSP II Mid Term Review provided the basis for highlighting challenges that will be prioritized in medical services. The strategic model, therefore, is designed around eight key thrusts that capture the key deliverables that Medical Services is working to provide during the medium term. They elaborate the key areas of focus that the Ministry intends to prioritize to implement its mandate. These strategic thrusts, with the specific goals to be attained in each, are highlighted in the table below.

The coordination of the services is to be through three oversight structures, each of which are defined in detail. These are:

- ***The management structure:*** This guides internal Ministry coordination, to guide implementation of defined interventions and activities at the different levels.

- ***The governance structure:*** This looks at defining and the guiding strategic direction, and following up on the operation of interventions. It is largely defined through formal legislation, with members and functions formally gazetted by the Government.

- ***The partnership structure:*** This guides external coordination of service delivery by all stakeholders at the respective levels of care. All partners providing services at a given level of care engage with each other through this structure.

Medical Services Strategic Thrusts and 2012 Goals

Strategic thrust	2012 goals
Institute medical services reforms	▪ Capacity to offer adequate, quality cost efficient referral services in all hospitals. ▪ Adequate capacity for leadership and management to optimize health services delivery in Kenya. ▪ Functional governance and accountability systems at all levels of the Ministry. ▪ Application of ICT in the provision and management of information and services in all level 4–6 facilities. ▪ All level 5 and 6 facilities providing specialized level 6 services. ▪ Functional Health Service Commission.
Strengthen emergency preparedness and disaster management	▪ Set up functional emergency and disaster preparedness response teams in hospitals, and ▪ Ensure adequate support for emergency and disaster response in hospitals.
Institute and enforce appropriate policy and regulatory measures for the health sector	▪ Updated roles and responsibilities of boards and councils in line with current expectations. ▪ Kenya Quality Assurance Model for Health (KQAMH) implemented. ▪ Accreditation standards for the health sector developed. ▪ Public Health Act reviewed, amended and implemented to ensure efficient regulation of health research and professional practice. ▪ Kenya National Health Policy reviewed and implemented.
Institute structures and mechanisms for improved alignment, harmonization and government ownership of planned interventions	▪ Planning, monitoring and evaluation tools and mechanisms utilized at all levels of the sector. ▪ Common arrangements for alignment of planning, budgeting and monitoring systems in use across whole sector. ▪ Use of Government procedures and systems by at least 60% of donors. ▪ Inter ministerial coordinating process and structures in place and functional by 08/09 ▪ Framework in place to guide partnership with implementing partners (public private partnership) by 2009/10. ▪ Availability of quality health information from 90% of the reporting units for evidence-based decision making.
Development and management of the health workforce	▪ Institutionalized HRH planning and policy framework. ▪ Ensure the provision of adequate numbers of equitably distributed health workers. ▪ Enhanced development of HRH capacity to meet the health needs of the population. ▪ Improved retention of health workers at all levels. ▪ Institutionalized performance management systems. ▪ Improved human resource management systems and practices.

Continued

Medical Services Strategic Thrusts and 2012 Goals, *continued*

Strategic thrust	2012 goals
Provide a network of functional, efficient and sustainable health infrastructure for effective delivery of health care services	▪ Increase the percentage of level 4–6 facilities that meet the minimum norms and standards on hospital buildings and land from 37% to 70%. ▪ Increase the percentage of level 4–6 facilities equipped as per norms from 37% to 70%. ▪ Increase the percentage of level 4–6 hospitals with adequate utility and ambulance services vehicles. ▪ Provide appropriate ICT in 30% of the hospitals by 2012.
Ensure reliable access to quality, safe, and affordable essential medicines and medical supplies that are appropriately regulated, managed and utilized	▪ Revise/adopt KNDP and develop an implementation plan for its use. ▪ Provide KEMSA with the autonomy to perform its legal mandate as the agency to procure, warehouse and distribute medical commodities to the entire health sector in accordance with good distribution practices, ▪ Ensure secure institutional EMMS storage infrastructure with product quality assurance. ▪ Achieve optimal therapy through good prescribing and dispensing practices. ▪ Ensure the safe and environmentally-friendly disposal of EMMS waste. ▪ Educate the public to ensure that EMMS are appropriately utilized by clients. ▪ Mobilize adequate financial resources for procurement and distribution of EMMS. ▪ Ensure EMMS provided for public sector are of quality, safe, efficacious and in accordance with legal requirements and professional standards. ▪ Support operational research on EMMS and their use to address related health issues ▪ Rationalize EMMS donations.
Establish an equitable health care financing mechanism that ensures social protection, particularly for the poor and vulnerable	▪ Develop a financing strategy that ensures social health protection. ▪ Expand contributors to NHIF from 2.2 million to 9.6 million persons. ▪ Protect all households facing catastrophic health expenditures. ▪ Improve the efficiency and effectiveness of revenue collection and utilization. ▪ Develop resource allocation criteria that is based on outputs and disparities in the country. ▪ Increase predictable resources during the MTEF period by 50%.

Resources

Resource requirements for implementing the planned interventions are expected to increase annually, from Ksh39.7 billion in the first year of the plan to Ksh57.7 billion in the last year. The total amount for the four years is approximately Ksh197 billion, broken down by strategic thrust as shown in the following table.

NHSSP II objective	Strategic thrust	Resource requirements (Ksh million)				
		2008/09	2009/10	2010/11	2011/12	Total
Improve the quality and responsiveness of services in the sector	Institute medical services reforms that will ensure high quality services	590	590	693	866	2,739
	Strengthen emergency preparedness and disaster management	1,153	1,203	659	328	3,343
	Institute and enforce appropriate regulatory measures for medical services	40	44	30	27	141
Subtotal		*1,783*	*1,837*	*1,382*	*1,221*	*6,223*
Foster partnerships in improving health and delivering services	Institute structures and mechanisms for improved alignment, harmonization and Government ownership of planned interventions	190	275	220	205	890
Subtotal		*190*	*275*	*220*	*205*	*890*
Improve the efficiency and effectiveness of service delivery	Have reliable access to essential, safe and affordable medicines and medical supplies that are appropriately regulated, managed and utilized	9,148	10,183	11,298	11,912	42,541
	Improve infrastructure, equipment and ICT investment & preventive maintenance	2,183	5,245	5,360	4,850	17,638
	Develop and manage the health workforce	25,300	29,150	33,612	38,821	126,884
Subtotal		*36,631*	*44,578*	*50,270*	*55,583*	*187,063*
Improve financing of the health sector	Establish an equitable financing system that ensures social protection, particularly for the poor and vulnerable	1,110	785	665	665	3,225
Subtotal		*1,110*	*785*	*665*	*665*	*3,225*
Overall total		**39,714**	**47,475**	**52,537**	**57,674**	**197,401**

Key monitoring and reporting indicators for progress are structured to inform on and compare trends across the different outcomes, using a dashboard approach. This is an approach that takes into consideration that the respective indicators are not viewed in isolation, but rather are intricately linked to provide information on overall progress. Subanalyses of the selected indicators by sex, age, geographical distribution and contribution by different partners will also be monitored to ensure that the principles of equity, effectiveness partnership and efficiency are followed up. The indicators making up the dashboard are highlighted in the table below.

Indicators of achievement of the strategic thrusts

No	Outcome area	No	Indicator	Value			
				08/09	09/10	10/11	11/12
1	Hospital reforms	1a	% of clients satisfied with services	**65**	**70**	**75**	**80**
		1b	% of facilities with improved performance	**-**	**30**	**60**	**100**
2	Disaster preparedness and management	2a	% of hospitals with functional emergency response and disaster management teams in the country	**0**	**7**	**31**	**64**
		2b	% of hospitals with health workers trained on emergency and disaster response	**0**	**40**	**60**	**100**
3	Regulation	3	% of health facilities meeting accreditation standards	**20**	**40**	**60**	**60**
4	Partnership and governance	4a	Number of partners subscribing to COC	14	17	20	20
5	Human resources for health	5a	% of level 4–6 facilities that achieve at least 80% of the approved staff establishment				
		5b	% of facilities that meet minimum staffing norms	TBD		80	100
6	Infrastructure	6a	% of hospitals rehabilitated as per approved plans	37	45	56	70
		6b	Number of hospitals equipped as per minimum norms and standards	37	45	56	70
7	Commodity security	7a	% of public health facilities reporting no stock outs of tracer commodities all year round			**100**	**100**
		7b	% of health facilities with functional medicine and therapeutic committees	**10**	**30**	**50**	**60**
8	Social protection	8a	% population covered by public health insurance	**25**	**30**	**35**	**40**
		8b	% amount of public finances utilized at the facility level				

TBD: To be determined
Shaded cells: Ministerial national indicators

Chapter One

Introduction and Background

As the investment plan for Kenya's Ministry of Medical Services, this strategic plan specifies the outcomes and outputs that the Ministry will prioritize over the next five years. The plan guides the Ministry's efforts to support attainment of Vision 2030 through the first Medium-Term Plan (MTP), and to implement the recommendations of the Midterm Review (MTR) of the second National Health Sector Strategic Plan (NHSSP II – 2005–2010).[1]

The plan was developed in consultation with key stakeholders, and is anchored on the Kenya Health Policy Framework (1994–2010), which sets out the following policy imperatives in health during the period:

1. Ensure equitable allocation of Government resources to reduce disparities in health status;
2. Increase cost-effectiveness and efficiency of resource allocation and use;
3. Manage population growth;
4. Enhance the regulatory role of the government in health care provision;
5. Create an enabling environment for increased private sector and community involvement in service provision and financing; and
6. Increase and diversify per capita financial flows to the health sector.

To support the implementation of these strategic imperatives, the health sector developed two successive five-year strategic plans outlining the medium-term strategic objectives for the sector. The implementation of the first National Health Sector Strategic Plan (NHSSP I, 1999–2004) did not achieve the targeted improvements in health outcomes and impact. There was a downward trend in health indicators according to the 2003 Kenya Demographic and Health Survey (KDHS). Moreover, health and health

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

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

Table 1.1: Kenya's status with respect to the Millennium Development Goals (selected indicators)

MDG No Target	Baseline MDG 1990	Baseline NHSSP I 1999/00	Output NHSSP I 2003	Current estimates 2007*	Target MDG 2015
Kenyan population (millions)	21.4		28.7		NS
MDG 4: Child health					
Prevalence underweight children < 5 yrs (%)	32.5	33.1	28	11	16.2
Reduce IMR by 2/3 between 1990 and 2015	67.7	73.7	78	60	25
Reduce UFMR by 2/3 between 1990 and 2015	98.9	111.5	114	92	33
Proportion 1-year-olds immunized against measles (%)	48	76	74	80	90
Number of orphans due to AIDS	27,000	890,000	1.2 M	1.8 M	
MDG 5: Maternal, sexual-reproductive health					
Reduce MMR by 3/4 between 1990 and 2015	590	590	414		147
Proportion births attended by skilled health staff %	51	NA	42	37	90
Coverage of basic emergency obstetric care (BEOC)		24			100
% WRA receiving FP commodities	—	—	10	43	70
HIV prevalence among 15–24-yr-old pregnant women	5.1	13.4	10.6		NS
MDG 6: Disease control					
Malaria prevalence of persons five yrs and above	NA		30%		NA
Malaria inpatient case fatality rate*	NA		26%		NA
Pregnant women/children <5 sleeping under ITN (%)	NA		4/5	37/52	65/65
TB case detection rate (%)	NA		47		60
Treatment completion rate (TCR, smear+ cases) (%)	75		80		90
MDG 7: Access to safe water					
(National) (%)	48	55	48	57	74
Access to good sanitation (%)	84	81	50	85.2	NS

Key: IMR= Infant mortality rate; ITN= Insecticide treated net; MMR= Maternal mortality ratio; TB= Tuberculosis; TCR= Treatment completion rate: UFMR= Under-five mortality rate; WRA= Women of reproductive age

*This includes all fever cases treated as malaria. Malaria sentinel surveillance report of 2002 estimated it at less than 5%.
Source: Adapted from the National Health Sector Strategic Plan II (NHSSP II), 2005–2010, and the Midterm Review of NHSSP II (2007). Estimates for 2007 adopted from Ministry of Medical Services Facts & Figures on Health and Health Related Indicators, 2008.

related indicators for the Millennium Development Goals (MDGs) stagnated or declined (see Table 1.1).

NHSSP II was designed with the aim of reducing health inequalities and reversing the downward trends in health-related outcome and impact indicators that had been observed during the implementation of NHSSP I.

According to the Midterm Review, the implementation of NHSSP II has begun to turn around the downward slide in key indicators, particularly those related to MDGs 4 and 6. These efforts need to be complemented and scaled up for the sector to get on track towards its goals.

This strategic plan therefore aims to serve as a roadmap for assessing performance and achievement of the results in the Ministry in the next five years. It presents clear strategies, objectives and outputs that will guide stakeholders to implement projects and programmes so as to realize the health sector objectives. Furthermore, the plan provides the coordination mechanism for collaboration among the different stakeholders in the sector.

The Millennium Development Goals

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

Chapter Notes

[1] Ministry of Health, *Reversing the Trends – The Second National Health Sector Strategic Plan of Kenya: NHSSP II – 2005–2010*, September 2005.

Chapter Two

Kenya's Development Challenges: Global, Regional and National

Health, with all its socio-economic ramifications, remains one of the major global challenges and an important obstacle to human capital development. This is despite the intense resource investment in the sector and international policies and strategic efforts to improve the human condition. Numerous joint efforts as stipulated in various declarations and instruments underscore global concern and the belief that good health for all as a goal is attainable. The MDGs are a major element in a series of such initiatives to rally joint efforts and mobilize adequate resources for health. Kenya, like many other countries, is not only a signatory to the MDGs and other declarations, but also strives to devote an increasingly larger share of its gross domestic product (GDP) to investing in health.

Important international milestones in the struggle for health include the Alma Ata Declaration on Primary Health Care (September 1978), Roll Back Malaria, and the Abuja (2006) and Maputo (2006) declarations. These milestones provide not just the platform for sector planning and development in the country, they also serve as the international yardstick for assessing progress.

In April 2008, Africa region governments and their partners in health came together to review experiences and progress towards the primary health care (PHC) principles. Together, they reaffirmed the principles of the Alma Ata Declaration, particularly in regard to health as a fundamental human right and the responsibility that governments have for the health of their people. The need for accelerated action by African governments, partners and communities to improve health, particularly through a strengthened systems approach, was emphasized in the ensuing declaration.

Kenya faces a number of health challenges especially among children, including high mortality from immunizable diseases. Many people are also exposed to a heavy and wide-ranging disease burden partly because of the

Despite the challenges, the health sector in general, and Medical Services in particular, have had many successes that are presently leading to the emerging trends of reduced mortality.

country's unique geographical and climatic conditions. The difficult, disaster prone environment in the arid and semi-arid regions of the country, and the lush but malaria prone regions in the better endowed parts of the country, all have unique health risks associated with them. Political instability in the Eastern Africa region and subsequent displacement of people has the result of increasing the demand for health services in the country. Influxes of refugees from Somalia and Sudan contribute to the demand for services and at the same time increase the risk of spreading communicable diseases. These factors are compounded by the inability of the prevailing resources to adequately mitigate the impacts of these health risks.

At present, Kenya faces problems of emerging and re-emerging diseases. Tuberculosis has resurfaced as a major cause of ill health. While the HIV prevalence has been steadily reducing, current statistics show this reduction has stagnated. Conditions like Rift Valley fever, cholera and other epidemics continue to burden the population. In addition, the country faces an increasing health burden from injuries and non-communicable diseases. Again, these are exacerbated by the negative underlying social health determinants in the country. Poverty remains a major factor affecting people's ability to maintain health and to seek health services when needed. High inflation rates and now the economic slowdown occasioned by the global economic recession have worsened the poverty situation. The challenges have been accentuated by the negative events following the December 2007 elections, which led to the disruption of health services in affected parts of the country as some medical staff were displaced and health facilities destroyed. Patients with chronic diseases such as tuberculosis, hypertension, diabetes and HIV/AIDS, and those in need of reproductive and maternal and child health services, were seriously affected.

Moreover, limitations in resource capacity, investment plans and resource utilization have constrained the health sector's ability to fully harness existing technology to manage most of the direct causes of ill health and death. Every hospital should have at least the basic requirements such as a functional ambulance, adequate stocks of essential medicines and supplies, and a operating theatre. Even now this is not the case in Kenya and results-oriented management approaches are required to ensure the availability of such basic essentials.

Poverty remains a major factor affecting people's ability to maintain health and to seek health services when needed.

Weak regulatory structures and the liberalized market are additional roadblocks, as they have led to the proliferation of counterfeits. Substandard drugs, other medical supplies and equipment are dumped in the Kenyan market, thus undermining delivery of quality health services. And with overall resources already inadequate, the sector faces limited investment in operational research to guide the implementation of new innovations.

Existing efforts and support to respond efficiently and effectively to the health challenges are not yet ideal. Mechanisms for improved coordination and partnership have been defined; a Kenya Health Sector-wide Approach (SWAp), and its formal instrument, the Code of Conduct (COC), are place. However, adherence to the obligations of both the SWAp and the COC by all partners – including Government and donor partners – is still not adequate. The principles of the 2005 Paris Declaration on Aid Effectiveness are not fully inculcated into the thinking of the sector. Parallel financing continues, and not all funds are being channelled to the defined sector priority areas. This leads to inefficiencies in the use of available resources.

In spite of these challenges, however, the health sector in general, and Medical Services in particular, have had many successes that are presently leading to the emerging trends of reduced mortality. With accelerated focus on key areas, the health sector will be able to speed up the reversal of the downward trends in health indicators in the country.

Chapter Three

Kenya's Development Agenda

Kenya's Government is implementing an ambitious economic reform programme that has seen improved public sector management, including public procurement and financial management practices. The health sector has embraced and accelerated these reforms for improved service delivery.

The country has witnessed an increased growth of the economy, from stagnation in 2002, when it grew by only 0.5%, to a high rate of 7.0% in 2007. As a result, the per capita income increased from 2.5% in 2002 to 3.3% in 2006. According to the 2007 *Economic Survey*, the real GDP expanded by 6.1% in 2006, compared with a revised growth of 5.7% in 2005. GDP growth declined in 2008, however, as a result of the slowing in economic activity.

The Government is increasingly reorienting its budget to allocate a much larger share of expenditure to priority areas of health, infrastructure, education, agriculture and rural development. Allocations to these sectors increased from 56% to 66% of total government expenditure between 2004/05 and 2007/08. The allocation to the health sector increased from 5.3% in 2004/05 to 7.3% in 2007/08.

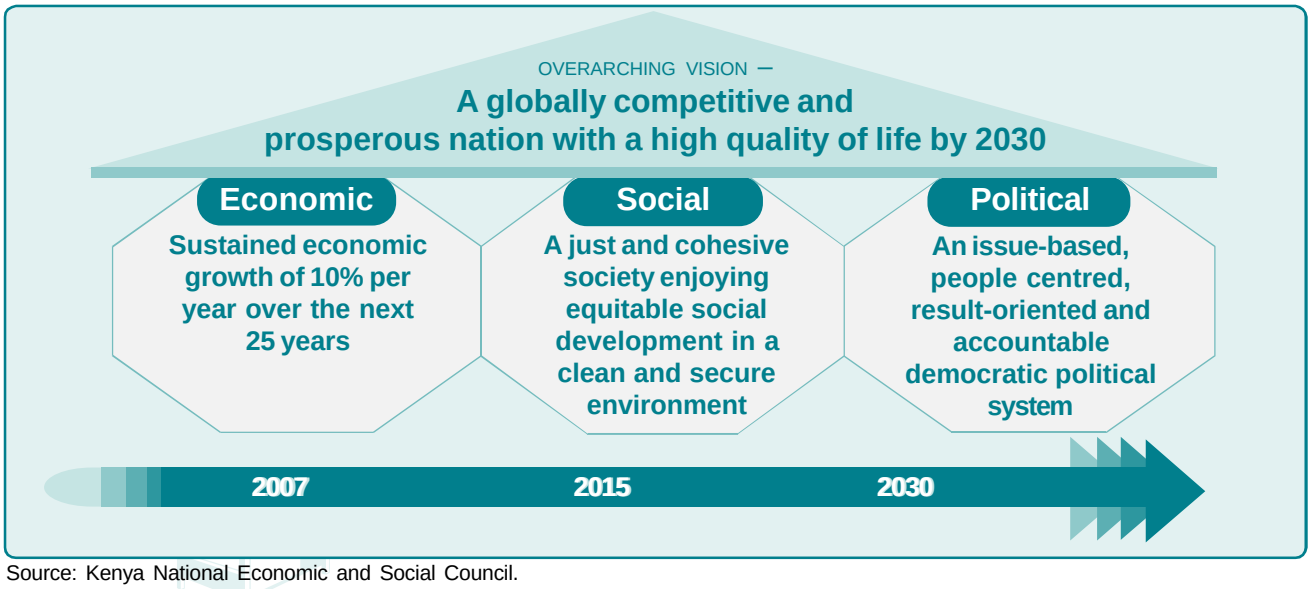
Guiding Kenya's overall development framework is *Kenya Vision 2030*, a long-term policy that aims to create a "globally competitive and prosperous country with a high quality of life by 2030". The Vision intends to transform Kenya into "a newly-industrialized, middle income country, providing a high quality of life to all its citizens in a clean and secure environment" as well as meeting the MDGs by 2015. It is based on the implementation of interventions in three pillars, as illustrated in Figure 3.1.

The country recognizes that achieving the development goals outlined in Vision 2030 will require a stable macroeconomic environment, supported by real time structural reforms. Such reforms would focus on accelerating the rehabilitation and expansion of infrastructure; developing

Vision 2030 has three main objectives for the health sector:

1. Revitalize the health care infrastructure.
2. Strengthen health care service delivery.
3. Develop equitable health care financing mechanisms.

Figure 3.1: Pillars of Kenya's development framework – Vision 2030



Source: Kenya National Economic and Social Council.

quality human capital to raise productivity and enhance global competitiveness; and maximizing economic opportunities for all Kenyans through targeted programmes to reduce inequality and poverty. They would also aim to encourage the growth of business through improved governance; reduce inequalities in economic and social improvements; and develop a more targeted approach to improving the overall welfare of the population.

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

The objective of the Vision in the health sector is thus to provide an equitable and affordable health care system of the highest possible quality. This will be achieved through three main strategies with the following flagship projects:

1. Revitalizing the health care infrastructure.
2. Strengthening health care service delivery.
3. Developing equitable health care financing mechanisms.

The health sector objectives will be delivered through a decentralized national health care system that involves devolution of funds to district and facility levels to enable the Ministry to concentrate on policy and research issues. With support from the private sector, Kenya also intends to become the regional provider of choice for highly specialized health care services, thus opening the country to "health tourism". Overall, the objectives are expected to be achieved by:

- Providing a robust countrywide health infrastructure network,
- Improving the quality of health care service delivery to the highest standards,
- Promoting partnerships with the private sector and development partners, and
- Providing access to those excluded from health care for financial or other reasons.

Vision 2030 is being implemented through medium-term plans (MTPs) that specify the Government's development for a given five-year period. In order to achieve the health care goals of Vision 2030, the health sector requires continued key reforms. Among these are an enhanced regulatory framework and the creation of an enabling environment to ensure increased private sector participation and greater community involvement in service management. This will be followed by increasing financial resources to the sector and ensuring efficient utilization of resources.

Improved governance, decentralization, increased collaboration with stakeholders and granting autonomy to level 5 hospitals will thus be the hallmarks of the reform process in the sector.

Chapter Four

Role of the Ministry of Medical Services

Overall, the health sector aims to prevent ill health, and where this is not possible to address the medical and social implications of the resulting ill health. Medical Services are all about managing these implications of ill health, paying special attention to the social context of disease and health. They complement Public Health interventions by ensuring that essential medical care is made available as needed, when needed and in appropriate amounts. The aim is to improve lives by responding to the legitimate health care needs of the population of Kenya.

4.1 Responsibilities of the Ministry of Medical Services

MOMS's central leadership role is to ensure that Medical Services are provided to contribute to the attainment of the medium-term development goals as outlined in NHSSP II and the first Medium-Term Plan (MTP) 2008–2012. According to Presidential Circular No. 1 2008, the core functions of MOMS are:

1. Medical services policy
2. Curative services
3. HIV/AIDS and other sexually transmitted infections (STI) treatment and management
4. Maternal services
5. Rural medical services
6. Clinics and hospitals
7. Registration of doctors and paramedics
8. Nurses and midwives
9. National Hospital Insurance Fund
10. Clinical laboratory services
11. Kenya Medical Training College (KMTC)
12. Kenya Medical Supplies Agency (KEMSA)
13. Regulatory bodies for pharmacy and medicine
14. Member of KEMRI board

Medical Services aims to ensure that essential medical care is made available as needed, when needed and in appropriate amounts.

4.2 Vision, Mission and Structure for Medical Services

In line with the core functions listed above, MOMS has defined its vision and mission, as shown in Figure 4.1, which capture its responsibilities in fulfilling its role. The current organizational structure of the Ministry is illustrated in Figure 4.2.

Figure 4.1: Vision and mission of the Ministry of Medical Services

The Vision
An efficient and cost-effective medical care system for a healthy nation

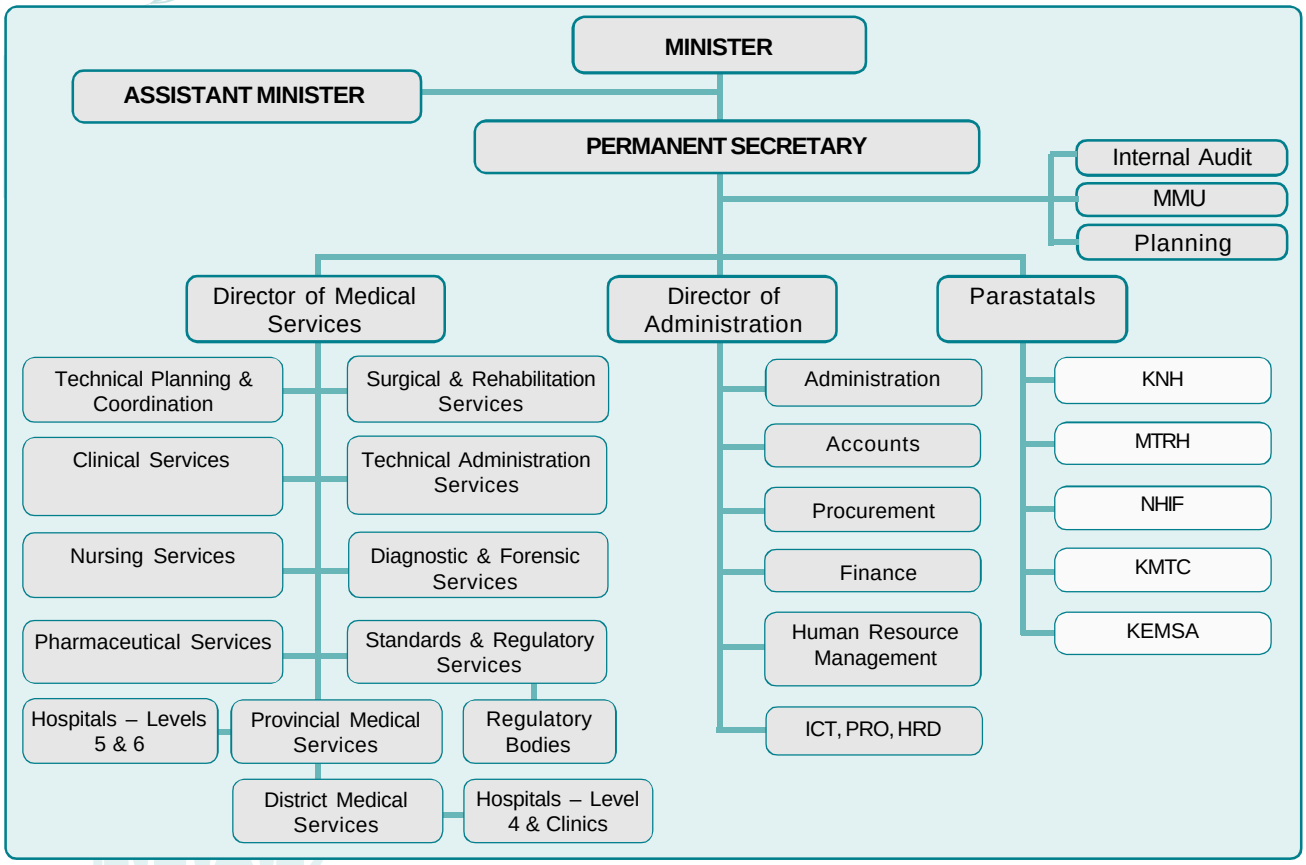
The Mission
To promote and participate in the provision of integrated and high quality curative and rehabilitative medical services to all Kenyans

4.3 Linkage with Government and the Health Sector

Ministry of Medical Services activities respond directly to two constituencies. The first is the ***Government of Kenya,*** for which it is mandated to provide Medical Services in a manner that supports attainment of the Government's first MTP, and therefore Vision 2030. Other Government functions in the health sector are mandated to other ministries. The second main constituency is the ***health sector*** as a whole. Here MOMS provides stewardship and coordinates delivery of medical services in the health sector in a manner that supports attainment of the overall NHSSP II objectives. The other aspects of health care services needed to attain the overall health sector objectives are carried out by other stakeholders. The stakeholders in the sector are defined in Box 4.1.

An analysis of the various stakeholders, conducted as part of the development of this strategic plan, is presented in Table 4.1.

Figure 4.2: Current organizational structure of the Ministry of Medical Services



Key: ICT = Information and communication technology; HRD = Human resources development; KEMSA = Kenya Medical Supply Agency; KMTC = Kenya Medical Training College; KNH = Kenyatta National Hospital; MMU = Ministerial Monitoring Unit; MTRH = Moi Teaching and Referral Hospital; NHIF = National Hospital Insurance Fund; PRO = Public Relations Office

Box 4.1: Health Sector Stakeholders

Government of Kenya, led by the Ministry of Medical Services and the Ministry of Public Health and Sanitation plus their parastatals. They also include other GOK ministries/institutions mandated to manage key determinants of health like the Ministry of Water, Ministry of Education, Ministry of Environment, Office of the President (disaster management, and nutrition). Additionally, other ministries/institutions support the sector such as the Ministry of Finance, Ministry of Planning and National Development, Office of the President (DPM) Cabinet Office (Public Service Reform and Development Secretariat), Ministry of Local Government (responsible for City Council health services), Public Service Commission, etc.

Implementing partners, who include all the actors supporting delivery of health care services to Kenyans. These are broadly categorized as private-for-profit organizations; private not-for-profit organizations (like faith-based organizations, non-government organizations and civil society organizations) and traditional practitioners (TP).

Development partners, who include all international partners supporting the health sector. These are broadly categorized as technical partners (focus is on provision of technical support for planned interventions) and funding partners (main focus of support is on provision of financing for planned interventions, either directly or indirectly through implementing partners).

Clients of health care services, who include the women, men, infants and children of Kenya seeking to improve or maintain their health status.

Table 4.1: Stakeholder analysis

Category	Stakeholder	Stakeholder expectations	Stakeholder strengths	Stakeholder weaknesses
Government	Related ministries	▪ Provide service in terms of information, particularly data on development projects and programmes ▪ Understand their policy and planning needs	▪ Technical expertise	▪ Coordination mechanisms ▪ Weak governance systems
		▪ Undertake effective monitoring and evaluation of the development projects and programmes undertaken ▪ Practise good governance	▪	▪
	Ministry of Medical Services staff	▪ Exhibit commitment to their welfare ▪ Maintain conducive work environment where individuals are trusted, respected and appreciated ▪ Maintain favourable terms and conditions of service ▪ Maintain favourable schemes of service ▪ Provide training and development ▪ Practise the principles of good governance	▪ Technical expertise ▪ Capacity ▪ Commitment to work and productivity ▪ Portray the right image of the Ministry	▪ Portray the right image of the Ministry ▪ Adherence to Ministry policies, rules and regulations
	Professional bodies (medical practitioners)	▪ Provide reliable data and information ▪ Practise the principles of good governance ▪ Maintain favourable policies and guidelines	▪ Technical expertise ▪ Coordination and supervision	▪ Standards and ethics ▪ Administration of penalties
	Parliament/ National Assembly	▪ Practise principles of good governance ▪ Adhere to rules and regulations of the government	▪	▪ Enactment of necessary bills ▪ Professional integrity

Continued

Table 4.1, *continued:* Stakeholder analysis

Category	Stakeholder	Stakeholder expectations	Stakeholder strengths	Stakeholder weaknesses
	Political leadership	▪ Develop strong institutional capacity that enhances service delivery and achievement of health goals ▪ Support competent and skilled personnel ▪ Implement viable health policies ▪ Practise the principles of good governance		▪ Political goodwill ▪ Professional integrity
	Ministry of Finance	▪ Practise the principles of good governance ▪ Set clear policy agenda and ministry priorities ▪ Participate in the budgeting process ▪ Use resources efficiently ▪ Practise participatory approach in policy formulation, planning and management	▪ Resource mobilization	▪ Reliability of resource allocation ▪ Participation in key meetings
Development partners	Development partners	▪ Provide timely reports and reviews ▪ Support effective and efficient resource utilization ▪ Support achievement of project goals and outcomes ▪ Involve stakeholders in the various aspects ▪ Adhere to project regulations and philosophies ▪ Ensure project sustainability ▪ Practise the principles of good governance ▪ Conduct continuous monitoring and evaluation	▪ Technical expertise ▪ Support in the implementation of development projects and programmes ▪ Collaboration and synergy building	▪ Disbursement of resources ▪ Consistency and commitment ▪ Dependency on their governments' policies and priority areas ▪ Understanding and responding to Ministry's challenges, needs and expectations ▪ Poor/non-transparent reporting systems
Implementing partners	Suppliers/ Merchants	▪ Disburse payments for goods and services supplied on time ▪ Practise the principles of good governance ▪ Issue purchase orders on time	▪ Linkage network to high quality goods and services ▪ Capacity	▪ Timely supply of procured goods and services
	Private sector (pharmaceuticals)	▪ Provide clear policies and guidelines ▪ Protect against unfair competition by quacks ▪ Deliver services effectively and efficiently ▪ Practise principles of good governance	▪ Capacity ▪ Technical expertise	▪ Credibility (drugs) ▪ Credibility (personnel) ▪ Price regulations ▪ Over the counter prescriptions

Continued

Table 4.1, *continued:* Stakeholder analysis

Category	Stakeholder	Stakeholder expectations	Stakeholder strengths	Stakeholder weaknesses
Implementing partners, continued	Non-state actors (NGOs, CBOs, FBOs, etc.)	▪ Provide reliable information on health indicators ▪ Deploy qualified medical officers ▪ Practise participatory approach in policy formulation, planning and management ▪ Access direct funding ▪ Build capacity ▪ Provide tax exemptions for key commodities ▪ Practise the principles of good governance ▪ Protect against unfair competition	▪ Capacity ▪ Complement the Ministry in implementation of health projects and programmes ▪ Technical expertise ▪ Understanding of community needs and expectations and plan for them ▪ Funding	▪ Coordination ▪ Adherence to Ministry priorities of different areas ▪ High expectations ▪ Frequent lack of resources
	Private-for-profit	▪ Practise the principles of good governance ▪ Protect against unfair competition ▪ Provide reliable information on health indicators ▪ Provide clear policies and guidelines ▪ Practise participatory approach in policy formulation, planning and management	▪ Capacity ▪ Complement the Ministry in implementation of health projects and programmes ▪ Technical expertise ▪ Funding	▪ Coordination ▪ Adherence to Ministry priorities of different areas ▪ Cost of services
Clients	Community	▪ Demonstrate understanding of their needs and expectations and plan for them ▪ Initiate sustainable projects and policies for better health ▪ Achieve national and international health outcomes ▪ Ensure good governance and ethical behaviour ▪ Provide quality health services ▪ Practise participatory approach to planning and management	▪ Participate in project monitoring and evaluation ▪ Understanding their needs ▪ Participate in local development projects and decision making	▪ Provide local support to Ministry's policies and initiatives ▪ Internal/community politics ▪ Customs and traditions
	Media	▪ Receive timely information ▪ Access facts/information	▪ Medium of communication to the community ▪ Capacity ▪ Technical expertise	▪ Good news is no news

These different expectations and stakeholders are described below. Figure 4.3 illustrates the linkages.

- ***Medium-term plans (MTRs):*** Five-year rolling plans specifying Government's medium-term benchmarks as it moves towards attainment of Vision 2030.

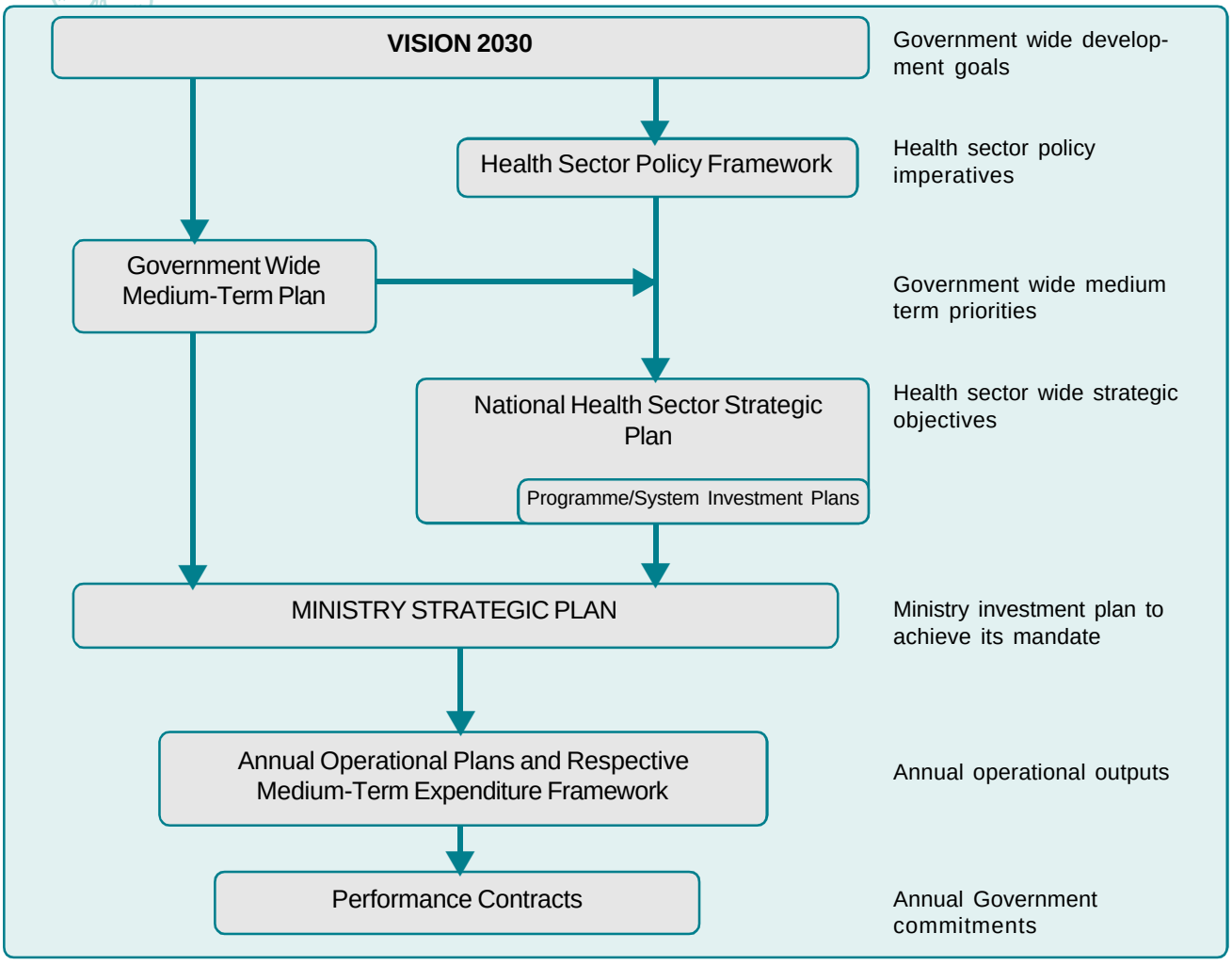
- ***Health policy framework:*** Overall policy direction for the health sector outlining its long-term objectives and the policy imperatives guiding it. The framework ensures that the sector's long-term direction is in line with supporting Vision 2030.

- ***National Health Sector Strategic Plan:*** Overall health sector medium-term plan, outlining the strategic objectives that ALL constituent actors in the sector are working towards. Programme and system strategic

plans are specified to provide more information on strategic objectives for a given area/need. These are institutionally a part of the NHSSP.

- ***Ministry strategic plan:*** Medium-term investment plan for Medical Services, outlining strategic thrusts and priority interventions the Ministry will focus on, resource implications, available financing and, therefore, financing gaps. It responds to expectations of the Ministry by the MTP, and the NHSSP. It forms the basis for resource mobilization and allocation by Government and funding partners in the health sector.
- ***Annual operational plans (AOPs) and respective medium-term expenditure frameworks:*** Operational plan and expenditure frameworks for the health sector, outlining the key outputs the sector will focus on during a defined year, to enable the sector to attain the priorities outlined by the respective Ministries' strategic plans. The MTEF represents the budgeting tool for the Government and on-budget partners, illustrating how their funds will be distributed across the planned outputs. The sector MTEF (shadow budget) specifies how all the other partners in addition to Government and on-budget partners will allocate resources across the priority outputs. Actual activities being implemented are specified in the respective planning units that make up the Ministry.
- ***Performance contract:*** Obligations made at the different levels of the sector that will be achieved during the given year. These are derived from the AOP.
- ***Vision 2030:*** The long-term development blueprint for the whole country.

Figure 4.3: Linkage between Government-specific and health sector planning processes



Chapter Five

Review of Health Sector Progress and Challenges

Reviews and appraisals to assess the progress the health sector has made towards its objectives include two main independent evaluations between 2005 and 2007, plus annual evaluations since 2005. The first independent review was the external evaluation of NHSSP I, while the second was the Midterm Review of NHSSP II.

5.1 Review of NHSSP I

Well-focused national health policies were among the positive aspects identified by the NHSSP I review. The review also lauded a reform agenda whose overriding strategies intended to improve health care delivery services and systems through efficient and effective management systems and reform. Despite these good qualities, however, the overall implementation of NHSSP I did not manage to make a breakthrough in terms of transforming critical health sector interventions and operations into concrete improvements in meeting the most significant targets and indicators of health and socio-economic development envisioned in the plan. The shortcomings of NHSSP I may be attributed to a set of factors, most of which are inter-related, such as:

- Absence of a legislative framework to support decentralization;
- Lack of well-articulated, prioritized and costed strategies;
- Inadequate consultation amongst MOH staff themselves and other key stakeholders involved in the provision of health care services;

NHSSP II has five broad **policy objectives**:

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

The NHSSP II – KEPH Life-Cycle Cohorts

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

- Lack of institutional coordination and ownership of the strategic plan, leading to inadequate monitoring of activities;
- Weak management systems;
- Low personnel morale at all levels; and
- Inadequate funding and low level of resource accountability.

As a result, efforts made during NHSSP I did not contribute to the improved health status of Kenyans. Rather, health indicators showed a stagnating, even downward, trend. The following lessons/recommendations can be drawn:

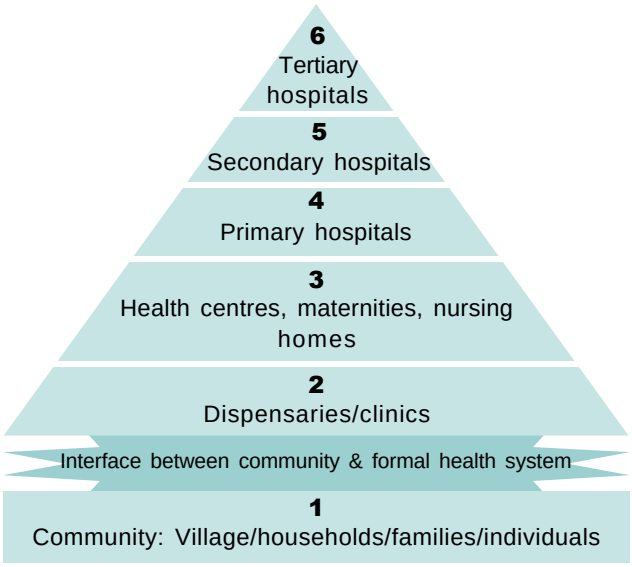
1. The next strategic plan should strengthen the implementation of a sector-wide approach including a clear resource envelope needed to implement it.
2. The next strategic plan should provide a specific time frame for reviews and monitoring, as well as midterm and final evaluations, to ensure adherence to the strategic plan according to the agreed benchmarks.
3. All MOH departments should prepare individual departmental medium-term strategic plans based on the next strategic plan targets and objectives.
4. An institutional review is necessary to realign the current organizational structure and (re-) position new and emerging core functions.
5. The next strategic plan should explicitly address the issue of coordination and come out with improved internal and external coordination mechanisms.
6. A national training policy is needed to guide and integrate training and capacity building on the basis of needs.
7. A national policy for health infrastructure, equipment and waste management should be developed. Capital budgets need to have adequate provision for operations and maintenance (O&M).
8. The preparation of the next strategic plan should involve a participatory process at all levels of MOH and stakeholders.

5.2 Review of NHSSP II

The current sector strategic plan – NHSSP II – was designed on the basis of these lessons learnt and had five strategic objectives: Increase equitable access to health services; improve the quality and responsiveness of services; foster partnerships in improving health and delivering services; improve the efficiency and effectiveness of service delivery; and improve the financing of the health sector. The plan also introduced the Kenya Essential Package for Health (KEPH),[1] which defined six life-cycle cohorts and six service delivery levels that would be the core focus of activities (Figure 5.1).

Progress towards the objectives was reviewed by the sector in October 2007 (at its midterm). Key achievements and challenges for the respective strategic objectives in NHSSP II are detailed in Table 5.1. The resultant recommendations were consolidated into a *Roadmap for Acceleration of Implementation of the NHSSP II Objectives*. These have informed the strategic thrusts and priorities for investment in Medical Services, in line with the Ministry's mandate.

Figure 5.1: KEPH levels of care



Chapter Notes

[1]Ministry of Health, *Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya – The Kenya Essential Package for Health,* Nairobi, 2007.

Table 5.1: Midterm key achievements, challenges and recommendations for sectoral action

Strategic objective	Achievements	Challenges/Constraints	Recommendations
Increase equitable access to health services	▪ 1,600 health facilities built using Constituency Development Funds (CDF). CDF-MOH planning mechanism now established. ▪ Inputs to strengthen referral such as mobile phones, equipment, ambulances provided. Drafting of referral strategy has begun. ▪ 3,649 health workers recruited and working in under served areas ▪ National Social Insurance Scheme designed and debated.	▪ Coordinating the investment to ensure facilities are built according to priorities and commensurate with available operational resources. ▪ Accelerating the drafting process to guide investments in other health systems. ▪ Inequitable distribution of health workers remains significant. ▪ Insufficient consultation during development of NSHIF resulted in legislation not being passed.	▪ Provide support to ensure universal access to maternal and neonatal health services for cohort 1, involving demand creation and supply side interventions such as free delivery, skilled attendants, effective referral and other emergency obstetric care components. ▪ Support the comprehensive implementation of guides and frameworks for cohorts 4 and 6. ▪ Strengthen implementation of existing service delivery efforts for child health for cohorts 2 and 3, with a particular focus on coordination. ▪ Accelerate Kenya Essential Package for Health (KEPH) dissemination throughout the sector.
Increase equitable access to health services, continued	▪ Reduction in user fees (20/10 policy) consolidated. Free deliveries at levels 2 and 3. ▪ Pro-poor resource allocation defined and in use. ▪ Surveys suggest client satisfaction is rising. Waiting times reduced. ▪ Annual client satisfaction reviews inform AOPs. ▪ Service Charter in place defining rights and obligations.	▪ Dissemination of KEPH incomplete and implications not fully institutionalized (development partner support not fully aligned; implementation guides not completed; staff not oriented/trained; some services not yet scaled up) ▪ Geographical dimension of poverty not sufficiently incorporated into allocation criteria.	▪ Develop a strategy to influence the implementation of KEPH outside the health sector. ▪ Strengthen public-private partnerships in delivery of services, particularly in underserved areas, by improving formal frameworks and facilitating access to the HSSF.
Improve the quality and responsiveness of services	▪ Introduction of target based performance appraisal system. ▪ Supervisory checklists developed and used. ▪ Growing use of clinical audits, including for maternal mortality (no. of MM audits year on year) ▪ Availability of drugs substantially improved (extent of improvement)	▪ Reaching targets through efficiency gains without increased resources is proving a challenge. ▪ Transport is constraining regular supervision. ▪ Supply chain management has improved, but periodic stock outs continue.	▪ Roll out service charter, to be displayed publicly containing information on services, standards, complaints, and the mechanisms to redress. ▪ Develop and implement country-specific hospital reforms to support and complement services at the primary care level. ▪ Re-categorize and accredit health facilities in line with KEPH to guide the identification of inputs required in the context of KEPH Norms and Standards. ▪ Update and implement service delivery clinical and management guidelines. ▪ Create facility-based incentives to improve quality of services such as institutionalizing processes for recognition and reward. ▪ Put in place national strategy for integrated supportive supervision, involving clear definitions and implementation arrangements and linkages to AOPs and performance appraisal, and incorporating new service delivery guidelines ▪ Fast track leadership and management capacity strengthening initiatives in accordance with the decentralization of management in the sector, including in-service training and patient centred accountability.

Continued

Table 5.1, *continued*: Midterm key achievements, challenges and recommendations for sectoral action

Strategic objective	Achievements	Challenges/Constraints	Recommendations
Foster partnerships in improving health and delivering services	▪ JPWF, MTEF and AOPs are established framework documents and processes. ▪ Decentralized planning implemented; participation steadily improved. ▪ Code of Conduct (COC) signed and inclusive of implementing partners (NGOs). ▪ Joint Financing Arrangement (JFA) being developed. ▪ Quarterly reviews of progress initiated.	▪ Planning and budgeting processes at national level are disjointed. ▪ Significant activity not aligned to existing plans. ▪ Capacity of implementing partners to fully engage in sector is limited. ▪ Significant external funding still not captured in government budget. ▪ Transparency of resource allocation decisions and predictability of funding remain a challenge. ▪ Quarterly reviews not yet institutionalized at every level. ▪ MOH still not fully adapted to carry out SWAp stewardship, with structure and functions based on vertical programme approach. ▪ Mechanisms for implementing partner and development partner accountability not yet in place.	▪ Strengthen sector coordination and participation structures at all levels. ▪ Monitor adherence to COC principles and obligations, including the development of aid effectiveness indicators and targets and integrate their measurement into sector annual reviews. ▪ Promote joint support and responsibility to strengthen common management arrangements, to ensure use of country systems for support. ▪ Ensure partners are providing coordinated and demand driven technical assistance and cooperation. ▪ Support implementation of common monitoring tools and systems including using the JRMs for review and planning of sector interventions. ▪ Develop mechanisms for generation, sharing and use of information with implementing partners. ▪ Build the capacity of coordinating secretariats for partnership (HENNET and private sector). ▪ Encourage development partners to increasingly channel funds through joint financing arrangements and use in-country systems. ▪ Establish/implement coordination mechanism for partner missions to Kenya. ▪ Coordinate and pool capacity development support, particularly for systems strengthening.
Improve efficiency and effectiveness of service delivery	▪ A mechanism to direct funds to health facilities (HSSF) was successfully piloted; national arrangements are being gazetted; roll-out is being planned. ▪ A shadow/functional budget exercise has been initiated to establish operational linkages between government budget and sector planning formats. ▪ Harmonization of HMIS indicators was initiated. ▪ Plans to strengthen financial management, human resources and supply chain management (including procurement) have been developed. Annual procurement planning process has been introduced. ▪ Transport assessments conducted in two provinces.	▪ Finalization of JFA is experiencing delays due to GOK capacity constraints and challenges in harmonizing development partners. ▪ Capacity at implementation level for planning and monitoring remains weak. Not all development partners follow the planning calendar. ▪ Data collection and use remains inefficient and sporadic. Findings from operational research not fully incorporated into decision making. ▪ Internal controls remain weak, and fiduciary risk is perceived to be high. ▪ A strategic approach to management of infrastructure, communication and ICT is lacking.	▪ Fast track implementation of HRH initiatives. ▪ Strengthen the management and availability of commodities and supplies. ▪ Align infrastructure, communication and ICT strategies to ensure they support service delivery effectively. ▪ Strengthen the public financial management systems. ▪ Strengthen use of strategies for bottom up planning and budgeting. ▪ Scale up use of performance monitoring mechanism (including HMIS).

Continued

Table 5.1, *continued*: Midterm key achievements, challenges and recommendations for sectoral action

Strategic objective	Achievements	Challenges/Constraints	Recommendations
Improve efficiency and effectiveness of service delivery, continued	▪ A national communication strategy has been drafted. ▪ Government-wide ICT policy is being implemented by the MOH.	▪	▪
Improve financing of the health sector	▪ Increase in allocation and per capita spent on health. ▪ Increased development partner funding, especially for scale up of priority public health interventions such as for malaria and HIV. ▪ National Hospital Insurance Fund increased benefits package to include vulnerable populations. ▪ Resource allocation has been reduced at higher levels and increased at lower levels of the system (15.6% of the MOH budget allocated to tertiary level). ▪ Expenditure reviews and expenditure tracking surveys conducted to rectify expenditure bottlenecks.	▪ Percentage of budget spent has decreased from 87% to 69% 2004/05–2006/07. ▪ Difficult to make strategic resource allocation decisions with only partial knowledge of resource flows to the sector. Donor conditionality further fragments information systems.	▪ Establish mechanisms to increase availability of resources. ▪ Improve budget management and efficient and equitable resource allocation and utilization, particularly by developing costing frameworks, improving pro-poor resource allocation formulas, instituting cost-effectiveness analysis to aid prioritization, availing finance/cost information to the public, and incorporating all sources for expenditure tracking. ▪ Complete and implement health care financing strategy. ▪ Implement HSSF, through more comprehensive district budgeting, finalization of guidelines, training and ensuring fiduciary risk is low. ▪ Implement the shadow budget as a means to link planning and budgeting processes for entire sector. ▪ Improve predictability of resources by holding partners accountable to provide information on their frameworks and budgets, and quarterly disbursement data.

Chapter Six

Strategic Model

Over the years the role of medical services in Kenya's health sector has evolved considerably. In the immediate post independence period, the sector aimed to ensure widespread provision of medical services. A number of hospitals were established and a network of public health officers put in place to coordinate provision of pubic health interventions. The advent of the primary health care (PHC) approach shifted the focus of the sector to prioritizing disease prevention and health promotion interventions provided through a network of health centres and dispensaries rather than hospitals.

One result of a skewed interpretation of the PHC approach in the country, was that investments in medical care were not prioritized in planning and financing. This has resulted in the sector's inability to adequately address the medical needs of the population, leading to unnecessary morbidity and mortality.

An effective PHC approach, in contrast, calls for adequate investments in all aspects of the system, including hospitals, based on their expected role. Medical services are often costly but have their critical role to play. There is therefore need to rehabilitate and expand our ability to provide medical care complementary to and in close collaboration with the public health interventions to ensure a complete package of services to the growing population in Kenya.

The strategic model for Medical Services is therefore driven by the need to ensure the availability of key Medical Services for the population, so as to address their legitimate medical care needs. Priorities are informed by the Ministry mandate, and respond to priorities from the first MTP and the recommendations from the previous reviews in the sector.

Four broad principles guide the operations of the Ministry of Medical Services:

- ***Efficiency:*** Best output from available resources
- ***Equity and human rights:*** Fairness in the distribution and use of resources.
- ***Quality:*** Highest feasible standard of care
- ***Effectiveness:*** Interventions give clients the best possible health outcomes.
- ***Partnership and collaboration:*** Working with others in the provision of Medical Services

6.1 Key Principles Guiding Medical Services

NHSSP II clearly elaborated the principles guiding the sector. In the delivery of Medical Services, we will put special emphasis on the following principles.

- ***Efficiency:*** Through this, we aim to get the best outputs from the available resource inputs we have at our disposal. Or, in the same manner, we aim to get our outputs using the least possible resource inputs.
- ***Equity and human rights:*** This denotes fairness in the way we distribute and use our available resources. We relate equity and human rights, as we intend to use a human rights-based approach to ensure we share resources fairly. We look at equity in all its dimensions, including geographic, gender, age, vulnerability and others.
- ***Quality:*** We intend to provide the highest feasible level of standards of care for the clients of our services. Our service charter articulates the quality we strive to achieve.
- ***Effectiveness:*** The aim here is to ensure that the interventions we prioritize are the ones that give our clients the best possible health outcomes. Our focus is on those that are able to restore the health of the client to as near a normal position as is feasible.
- ***Partnership and collaboration:*** We intend to cultivate the collegial atmosphere needed to harness the benefits of working jointly with others supporting or potentially supporting the provision of Medical Services in Kenya. These include both our implementing partners and our funding partners.

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

6.2 Strategic Thrusts in Medical Services

Eight key strategies are defined in this plan, with the intention of capturing the key deliverables Medical Services is working to provide during the medium term. They define the primary areas of focus the Ministry will prioritize to implement its mandate. These strategic thrusts are illustrated in Figure 6.1 and elaborated in the sections and tables that follow.

Figure 6.1: Ministry strategic thrusts in the medium term

Overarching development vision (Vision 2030)
A globally competitive and prosperous nation with a high quality of life

Sector Medium-Term Goal
Reduce health inequalities and to reverse the downward trend in health-related outcome and impact indicators

Health Sector Policy Objectives

Increase equitable access to health services	*Improve quality and the responsiveness of services in the sector*	Foster partnerships in improving health and delivering services	Improve the efficiency and effectiveness of service delivery	Improve financing of the health sector
Ministry of Medical Services Strategic Thrusts				
	Institute medical services reforms that will ensure high quality services	Institute structures and mechanisms for improved alignment, harmonization and Government ownership of planned interventions	Have reliable access to essential, safe and affordable medicines and medical supplies that are appropriately regulated, managed and utilized	*Establish an equitable financing system that ensures social protection, particularly for the poor and vulnerable*
Strengthen emergency preparedness and disaster management			Improve infrastructure, equipment and ICT investment and preventive maintenance	
	Institute and enforce appropriate regulatory measures for medical services		Develop and manage the health work force	

Note: Italics indicate Vision 2030 flagship programmes.

6.2.1 *Strategic Thrust 1:* Institute Medical Services Reforms That Will Ensure High Quality Services Are Available

The reform agenda aims at ensuring that public hospitals provide appropriate, high quality medical services to meet the 21st century medical care needs of Kenyans. This will be achieved by improving efficiency in the management and delivery of medical services in public hospitals.

The areas of focus for the hospital reform agenda are referral systems (including health informatics), leadership and management skills, governance and accountability systems, hospital autonomy, performance monitoring, decentralization of the human resource, hospital management, and medical tourism.

The key goals of this thrust, with outcomes and deliverables as shown in Table 6.1, are:

- Capacity to offer adequate, quality cost-efficient referral services in all hospitals.
- Adequate capacity for leadership and management to optimize health services delivery in Kenya.
- Functional governance and accountability systems at all levels of the Ministry.
- Application of ICT in the provision and management of information and services in all level 4–6 facilities.
- All level 5 and 6 facilities providing specialized level 6 services.
- Functional Health Service Commission.
- Quality of hospital services improved by at least 50%, as measured technically, and by clients.
- Level 5 hospitals granted autonomy.

Table 6.1: Results framework for Strategic Thrust 1

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators

OUTCOME: Medical services reforms instituted that will ensure equitable high quality services

OUTCOME INDICATORS:
- % of clients satisfied with services
- % facilities with improved performance
- Proportion of facilities that meet the minimum capacity norms

Goals for 2012	Output	Output indicator	Unit	Base-line (07/08)	Yr 1 (08/09)	Yr 2 (09/10)	Yr 3 (10/11)	Yr 4 (11/12)
Capacity to offer adequate, quality cost-efficient referral services in all hospitals in the country	National Referral Strategy (2006) updated	Facilities oriented to National Referral Strategy	%	0	10%	75%	100%	
	Norms and standards for service delivery at level 1 reviewed	GOK and FBO facilities categorized and accredited according to updated norms and standards	%	50%	75%	100%		
		Facilities meeting norms and standards for designated level of service	%	0	7	15	15	20
	Referral guidelines and feedback tools for L 4 and 5 facilities revised and distributed	Facilities with revised referral guidelines and tools in place and used	%	0	10%	75%	100%	
	Zonal health referral district established and operational	Districts with referral and support networks established	%	0	100%			
	Communication systems between facilities in place and functioning	Facilities with 24-hr communications systems in place and operational	%	0	10%	75%	100%	
	Transport systems in place and functioning to facilitate referrals	Hospitals (L4–6) with 24-hr ambulance service in place and used at least once per month	%	0	75	100	100	
		Level 2 and 3 facilities with local emergency transport options in place	%	0	10%	75%	100%	

Continued

Table 6.1, *continued:* Results framework for Strategic Thrust 1

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators								
OUTCOME: Medical services reforms instituted that will ensure equitable high quality services								
OUTCOME INDICATORS: ▪ % of clients satisfied with services ▪ % facilities with improved performance ▪ Proportion of facilities that meet the minimum capacity norms								
Goals for 2012	**Output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Adequate capacity for leadership and man-agement to optimize health services delivery in Kenya	Training policy developed	Policy document in place	No		1			
	Leadership and management modules developed							
	Clarified/mapped reporting relationships for various cadres	Circulars written and cascaded						
	Improved L&M capa-city/competencies in Ministry/facility boards and committees	Leadership and management plan	%		1			
	Succession planning established	Mid level managers (facility heads, upwards) oriented on leadership and management	%	50	100			
		Plans developed and implemented	No		1			
	ICT applied in mgt processes	No of ICT sets procured No of managers trained on ICT use	%		%			
Functional governance and account-ability systems at all levels of the Ministry	Regulations revised and institutionalized	No of regulations reviewed and updated	No		1			
	Reviewed regulations disseminated to boards/committees	% of boards and committees functioning according to regulations	%					
	Institutionalized performance contracting system at all level 4 & 5	% of managers with PC in place and monitored	%		100			
		#/% of PC coordinating units established at provincial level						
	Improved accountability for health care financing	Guidelines developed and disseminated	No		1			
		#/% of acct units set up as planned	%		100			
		% of accounting units performing to standards and guidelines	%		100			
Application of ICT in the provision and man-agement of information and services in all level 4–6 facilities	E-readiness assessed	Assessment report on e-readiness of relevant institutions	No	0	1	-	-	-
	E-health legal framework developed	E-Health Policy	No	0	1			
		Enacted E-health law	No			1		
	Level 5 and 6 hospitals and Medical schools inter-connected	No of hospitals inter-connected	No	0	2	4	4	5
		No of medical schools inter-connected	No		2	3	1	2
	Quality assurance standards developed	QA standards	No		1			

Continued

Table 6.1, *continued:* Results framework for Strategic Thrust 1

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators

OUTCOME: Medical services reforms instituted that will ensure equitable high quality services

OUTCOME INDICATORS:

- % of clients satisfied with services
- % facilities with improved performance
- Proportion of facilities that meet the minimum capacity norms

Goals for 2012	Output	Output indicator	Unit	Base-line (07/08)	Yr 1 (08/09)	Yr 2 (09/10)	Yr 3 (10/11)	Yr 4 (11/12)
All level 5 and 6 facilities upgraded to provide specialized level 6 services	National Medical Tourism Policy developed	Medical Tourism Policy	No.		1			
	Legal framework for medical tourism developed	Act for medical tourism in place	No		1			
	Burns units established	No of level 5 hospitals with burns unit	No	0	1	1	1	1
	Provider hospitals framework for accreditation in place	No of level 5 health facilities with accredited framework	No	0	0	2	2	2
	Trauma centres established	No level 5 hospitals with trauma centres established	No	0	1	1	2	2
	Oncology centres established	No of centres establish-ed and functional	No	0	0	1	1	1
	Communication linkages established between local and international health care institutions	Level 5 and 6 hospitals supported to establish linkages with each other, and international health care institutions	%		100			
	Database for medical tourism developed	Level 5 and 6 hospitals with information in database	%		100			
		Medical tourist numbers as proportion of those targeted	%		50	100	100	100
Functional Health Service Commission	HSC policy developed	HSC policy document	No.	0		1		
	Appropriate legislation for the establishment of HSC formulated	HSC Act	No.	0		1		
	Health Service Commission Act operational	Functions of HSC being carried out by the commission	%	0			20	40
Quality of hospital services improved by at least 50%, as measured technically, and by clients	Hospital standards and norms reviewed	Revised standards and norms	No	1	1			
	Health facilities map-ped against catch-ment population for zoning	Report of mapping of facilities	No	-		1		
		Catchment zones	No[a]				X	X
	Clinical guidelines reviewed and imple-mented for hospital-based conditions including patient safety	No of health facilities utilizing revised guidelines	No	o	8	100	100	100
	Comprehensive clinical support supervision and monitoring tools developed	Tools developed and in use	%		50	50		

Continued

Table 6.1, *continued:* Results framework for Strategic Thrust 1

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators								
OUTCOME: Medical services reforms instituted that will ensure equitable high quality services								
OUTCOME INDICATORS: ▪ % of clients satisfied with services ▪ % facilities with improved performance ▪ Proportion of facilities that meet the minimum capacity norms								
Goals for 2012	**Output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Quality of hospital services improved by at least 50%, as measured technically, and by clients, continued	Quality of hospital processes and outputs improved	Clinical audit reports from facilities	No	-	191[b]	191	191	191
	Emergency care framework developed	*Emergency care framework*	*No*		*1*			
	Hospital governance framework developed	No of hospitals with governance and management structures	No	0	8	50	50	50
	Managers and board members capacity developed	No of facilities with trained managers and board members	%	0	8	50	50	50
	Kenya Quality Model (KQM) implemented	No of facilities implementing KQM	No	0	8	20	30	30
	Hospital accreditation policy developed	Policy document in place	No		1			
	Hospital accreditation commission (HAC) established	Commission in place	%		100			
	Development of updated standards and procedures for hospital quality assurance	No of facilities practising revised Q&A standards and procedures	No	0	8	15	15	20
	Star system policy to stimulate competitive-ness in service delivery developed	No of facilities classified	No		7	15	15	20
Level 5 hospitals autonomy	Hospital autonomy policy developed	Governance framework document	No		1			
	Hospital boards established	No of hospitals with functional boards	No	0	0	2	2	3
	Key managers and board members capacity developed	No of level 5 facilities with programme conducted	No	0	0	2	2	3
	Service agreements for accountability developed	Service agreements in place	%			100		

Notes:
a. The number of catchment zones will be determined by the mapping report expected by December 2009.
b. This number is based on the MOMS *Health and Health-Related Indicators 2008*, which may change with an increase in the number of hospitals.

6.2.2 *Strategic Thrust 2:* Strengthen Emergency Preparedness and Disaster Management

Over the years, emergency response and disaster management have focused primarily on pre-hospital issues such as evacuation and transport of casualties and assumed the role of hospitals. This strategic thrust therefore aims at ensuring that Kenya's hospitals have the capacity to respond to emergencies and manage the medical needs that arise during disasters.

Occurrences of disasters such as the post election violence, fires, bomb blasts and floods witnessed in the recent past have shown that most hospitals could be overwhelmed and would need to refer patients to other facilities. This is because of limited infrastructure, inadequate training on hospital-focused disaster management, inadequate resources, poor

communication and planning, and unprepared management of disasters.

Indeed, during disasters, the coordination and delivery of both routine and emergency medical services are affected as a result of displacement of medical staff, depletion of the stock of essential medicines and supplies, and destruction of health facilities. Disasters also result in psychological trauma related to physical injury and emotional shock, as well as violence that requires counselling services.

As detailed in Table 6.2, the specific goals for this thrust are:

1. Set up functional emergency and disaster preparedness response teams in hospitals, and
2. Ensure adequate support for emergency and disaster response in hospitals.

Table 6.2: Results framework for Strategic Thrust 2

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators								
OUTCOME: Hospitals with functional emergency preparedness and response teams								
OUTCOME INDICATOR: ▪ % of hospitals with functional emergency response and disaster management teams in the country ▪ % of hospitals with emergency and disaster fund kitty ▪ % of hospitals with health workers trained on emergency and disaster response								
Goals for 2012	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Set up functional emergency and disaster prepared-ness response teams in hospitals	Needs assessment on preparedness of hospitals	% of hospitals adequately prepared	%	-	35	50	70	100
	Emergency response team in each hospital	No of hospitals with emergency response teams	No	-	0	15	50	70
	Medical staff trained on emergency response and disaster management	% of trained teams	%	-	0	40	60	100
	Guidelines developed and standard operating procedures in place	No of hospitals using guidelines and standard operating procedures	No	-	0	15	30	60
	Communication system for emergency and disaster response	No of hospitals with functional radio, mobile systems	No	-	0	15	30	60
Ensure adequate support for emergency and disaster response in hospitals	Additional resources provided	No of hospitals with emergency and disaster response kitty	Ksh	-	0	1m	1 m	1m
	Hospital with emergency capability	No of service units with the full range of defined referral services	No	-	0	15	30	60
		No of level 4–5 hospitals with casualty depart-ments and wards to provide emergency response and disaster preparedness services	No	-	0	15	30	60

6.2.3 *Strategic Thrust 3:* Institute and Enforce Appropriate Policy and Regulatory Measures for the Health Sector

Strong regulatory functions of the Ministry of Medical Services are the intended result here. The focus will be on addressing the challenges the sector faces that negatively influence the quality of health care, such as substandard health facilities, professional misconduct, quacks offering bogus medical services and a poorly regulated pharmaceutical sector, amongst others. In addition, the thrust is intended to strengthen the ability of communities and individuals to demand their rights to quality health services. The approach will be to build and enhance coordination amongst professional associations, regulatory (professional) bodies and

the Ministry, while at the same time strengthening the regulatory framework and developing the capacities of the institutions responsible for implementing the regulatory framework.

Key goals of this thrust, as detailed in Table 6.3, are:

- Kenya Quality Assurance Model for Health (KQAMH) implemented.
- Accreditation standards for the health sector developed.
- Public Health Act reviewed, amended and implemented to ensure efficient regulation of health research and professional practice.
- Health professional capacity strengthened through e-learning.
- Regulatory services for quality medical care enhanced.
- Alternative medicine practice regulated.
- Health research well-coordinated and regulated.
- Kenya National Health Policy reviewed and implemented.

Table 6.3: Results framework for Strategic Thrust 3

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Professional standards are continuously being met for quality medical services delivery								
OUTCOME INDICATOR: Proportion of clients satisfied with services								
Goals for 2012	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Implement quality assurance and standards performance measurement framework (KQAM)	KQAM master checklist developed	KQAM tools distributed	No	-	-	20,000	30,000	40,000
	KQAM standards implemented in level 4-6 facilities	Proportion of level 4–6 health facilities implementing the KQAM	%			2,000	3,000	5,000
Develop accreditation standards for the health sector	Accreditation standards for health sector in place	Accreditation standards for health sector developed	No		-	25	35	50
	Health facilities accredited	Proportion of level 4–6 health facilities accredited and meeting the set standards	%	20		60		
Review the Public Health Act to ensure quality medical service delivery	Revised Public Health Act formulated to amend bill	New Public Health Act amendment bill developed	No		-	6	6	6
Strengthen health professional capacity through e-learning	Continuous professional development (CPD) of health care professionals through e-learning	Proportion of health care professionals accessing e-learning services to improve their capacity	%	-	-	5	10	25
Enhance regulatory services for quality medical care	Facilities inspected for compliance with established health standards	Inspection reports compiled	No		2	4	4	4
	Service providers found offering substandard care	Proportion of service providers providing substandard services disciplined	%		100	100	100	100
	Complaints forwarded to boards	Proportion of complaints to boards for which action is taken	%		100	100	100	100

Continued

Table 6.3, *continued*: Results framework for Strategic Thrust 3

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Professional standards are continuously being met for quality medical services delivery								
OUTCOME INDICATOR: Proportion of clients satisfied with services								
2012 goals	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Enhance regulatory services, continued	Establishment of a health professional authority with Integrated professional norms and standards	Proportion of health professional standards and norms integrated into the Kenya Professional Health Authority Act	%		100			
Regulate alternative medicine practice	Current legislation of alternative medicine practice reviewed	Alternative medicine practice legislation in place	No				1	
	Guidelines on alternative medicine practice developed	Guidelines on alternative medicine developed and distributed	No				1	
	Inventory of alternative medicine practitioners developed	Inventory in place	No				1	
Coordinate and regulate health research	National health research policy developed	National health research policy developed	No		Draft -	20,000	30,000	40,000
	Implementation plan for the new health research policy in place	Implementation of health research policy plan adhered to					500	
Revise Kenya National Health Policy 1994 (KNHP), adopt new policy and develop implementation plan	Revised health policy with implementation plan	New health policy developed	No		Draft		500	
	KNHP implementation plan	KNHP implementation plan developed	No.				500	

6.2.4 *Strategic Thrust 4:* Institute Structures and Mechanisms for Improved Alignment, Harmonization and Government Ownership of Planned Interventions

A lot of effort has gone into strengthening partnerships in the sector, such as the development of sector strategic and annual operational plans, signing of the Code of Conduct (COC), and the institutionalization of joint review of health sector performance and partnership structures at the different levels of the health system. There are still challenges that need to be addressed, however, in order to sustain the gains already made and to further strengthen the partnership in line with the current developments of the split of MOH into two ministries. The challenges include lack of a monitoring framework for adherence to the COC, lack of alignment of development partners' support to government priorities and use of common management systems, and the challenge of instituting partnership structures at the different levels of the health system that respond to the shared stewardship of the sector by the two ministries.

Strengthening the health management information system (HMIS) is a key priority for the health sector. From the many assessments carried out on the HMIS the following strengths can be identified:

- NHSSP II provides policy and strategic directions for the development of national comprehensive HMIS.
- There are 572 health records and information technicians and officers (428 HRITs and 144 HRIOs) with two- (certificate) and three-year (diploma) training, respectively, who are currently serving in the health system. This situation is much better compared with other countries in Africa.
- Review, harmonization and adoption of health sector indicators have been finalized.
- Data requirements, summary tools and data capture tools (registers) have been revised and produced for use. This process involved rationalizing data collection so as to improve quality and timeliness of reporting. Tools are now in line with the data requirements in order to reduce transaction costs of data.
- There is a broad consensus among the stakeholders on what needs to be done in order to strengthen health information systems.

Two key challenges remain. One is insufficient investment to ensure full implementation and sustainability of strategies. The other is that the culture of information use is not fully embraced in the health sector. There are equally many opportunities that can be maximized to improve the HMIS, especially utilization of ICT to improve communication and data transfer in most of the service delivery points. Capitalizing on such opportunities would include rationalizing the different database management software and taking to scale a standard model for information management in the health sector.

Among the ongoing initiatives are:

- HIS policy and strategy development.
- Improved information flow (through electronic data processing, storage, transmission and dissemination.
- File transfer protocol rolled out in 80% of districts.
- Review of all existing software in the health sector so as to inform the development of integrated HMIS software.
- Quality assurance of data management.
- Capacity building for national, provincial and health facility staff.

Against that background, this strategic thrust envisages the following specific goals:

- Planning, monitoring and evaluation tools and mechanisms utilized at all levels of the sector.
- Common arrangements for alignment of planning, budgeting and monitoring systems in use across the whole sector.
- Use of Government procedures and systems by at least 60% of donors.
- Inter-ministerial coordinating process and structures in place and functional by 2008/09
- Framework in place to guide partnership with implementing partners (public private partnership) by 2009/10.
- Availability of quality health information from 90% of the reporting units for evidence-based decision making.

Deliverables and indicators for this strategic thrust are detailed in Table 6.4.

Table 6.4: Results framework for Strategic Thrust 4

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Structures and mechanisms instituted for improved alignment, harmonization and Government ownership of planned interventions								
OUTCOME INDICATOR: Number of development partners subscribing to the Code of Conduct								
Goals for 2012	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Utilize planning, monitoring and evaluation tools and mechanisms at all levels of the sector	Bottom-up joint annual plans developed for all planning units in the sector	Planning units at district, province, HQ and para-statals part of each AOP	%	90	100	100	100	100
		Consolidation of specific plans for all planning units into an annual operation plan	4	1	1	1	1	1

Continued

Table 6.4, *continued:* Results framework for Strategic Thrust 4

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Structures and mechanisms instituted for improved alignment, harmonization and Government ownership of planned interventions								
OUTCOME INDICATOR: Number of development partners subscribing to the Code of Conduct								
Goals for 2012	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Utilize planning, monitoring and evaluation tools, continued	Capacity for reporting on progress strengthened for all planning units	Proportion of planning units reporting in a timely manner	%	56.4%	100%	100%	100%	100%
		Proportion of planning units submitting com-plete data on key indicators	%	68.4%	100%	100%	100%	100%
		Proportion of information assessed and found to be accurate	%			80	80	80
	Performance M&E framework in use	Performance M&E framework developed	No			1		
		Health facilities (level 4–6) with trained personnel on revised M&E framework	No	0	-	300	400-	400-
		Planning units using performance M&E framework	%			30	60	90
		Proportion of districts submitting 4 quarterly reports						
	Regular reviews on progress carried out	Annual review of AOP	No	-	1	1	1	1
		Quarterly report of AOP	No	4	4	4	4	4
		Midterm review report of strategic plan	No	0	-	-	1	-
		End term review report of strategic plan	No	0	-	-	-	1
Use common arrangements for alignment of planning, budgeting and monitoring systems across whole sector	Joint planning and monitoring at all levels of the sector	Joint annual reviews, and summits of AOP	No		2	2	2	2
		Joint planning reviews, and summits of AOP	No		2	2	2	2
		Joint sector MTEF (shadow budget)	No		1	1	1	1
	Improved government ownership of planning and monitoring processes	Review of adherence to Code of Conduct (align-ment, harmonization and simplification of support)	No		1	1	1	1
		Partner support aligned to priorities in AOPs	%		70	100	100	100
		Paris Declaration on Aid Effectiveness applicable to Kenya showing improvement	%			70	80	90
	Participation in planning, monitoring and review by stakeholders enhanced	HSCC meetings held	No	2	4	4	4	4
		No of provinces holding quarterly Provincial Health Stakeholder Forums	No		8	8	8	8
		% of districts holding quarterly District Health Stakeholder Forums	%		60	80	90	100

Continued

Table 6.4, *continued:* **Results framework for Strategic Thrust 4**

GOAL: Reduce health inequalities and to reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Structures and mechanisms instituted for improved alignment, harmonization and Government ownership of planned interventions								
OUTCOME INDICATOR: Number of development partners subscribing to the Code of Conduct								
2012 goals	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Use of Government procedures and systems by at least 60% of donors	Financial management and procurement systems reviewed and implemented	Partner support adhering to govt procedures	%		50	100	100	100
		Financial management and procurement system reviewed as part of AOP reviews	No	1	1	1	1	1
		Proportion of donor agencies using JFA	%			70	80	90
Inter Ministerial coordinating process and structures in place and functional by 08/09	Coordinating structures between the two ministries established and strengthened	Inter-ministerial coordinating committee established No of monthly meetings held	No	-	6	12	12	12
Framework in place to guide partnership with IPs (PPP) by 09/10	PPP policy framework developed	PPP policy document	No	Con-cept paper	Draft 0	Docu-ment		
Availability of quality health information from 90% of the reporting units for evidence-based decision making	Availability of data capture tools and summary tools	Number of data capture tools supplied	No		53.600 Ksh	58,000 Ksh	63,000 Ksh	65,000 Ksh
		No of summary tools supplied	No		90,000 Ksh	100,00 0Ksh	105,00 0Ksh	110,00 0Ksh
	ICT (hardware and software) availed	No of hardware supplied	No		0	50	40	100
		No of soft ware supplied	No		0	1	0	0
	Hospitals health information sys-tem automated	No of hospitals automated	No		0	4	8	100
	Human resources in place	No of HRIOs	No	572				
		No of ICT officers	No	2	10	16	20	30
		No of statisticians	No	0	1	2		
		No of epidemiologists	No	2	1	1		

6.2.5 *Strategic Thrust 5:* Development and Management of the Health Workforce

The health sector is labour-intensive and dependent on its workforce for the precise application of knowledge and technical skills in the provision of health care services. Human resources in the sector constitute both strategic capital and a critical resource for the performance of the health system.

This thrust articulates strategies that provide both for employment of optimal levels of human resources and the development of capacity to meet the health care needs of the population in alignment with KEPH priorities to improve the provision of quality health care services. The strategies address the current human resource for health (HRH) challenges the Ministry is facing, including inadequate and inequitable distribution of health workers, high turnover, and weak HRH development, planning and management systems. In addition, there is a critical need to improve HRH information systems and the performance management framework at all levels.

During the period of this strategic plan, then, the Ministry of Medical Services will address

these challenges through the specific goals listed below and detailed in Table 6.5:

- Institutionalize HRH planning and policy framework.
- Ensure the provision of adequate numbers of equitably distributed health workers.
- Enhance development of HRH capacity to meet the health needs of the population.
- Improve retention of health workers at all levels.
- Institutionalize performance management systems.
- Improve human resource management systems and practices.

Table 6.5: Results framework for Strategic Thrust 5

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Efficient and effective development and management of the health workforce								
OUTCOME INDICATORS: ▪ Number of level 4–5 facilities that achieve the approved staff establishment/staffing norms ▪ Attrition rate by category/cadre per year ▪ Level of achievement of performance targets								
Goals for 2012	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Institution-alize HRH planning and policy framework	HRH strategic plan	HRH strategic plan developed	No		1			
	Recruitment and deployment policy	Policy document	No			1		
		Decentralized recruitment				1	1	1
	A semi-autono-mous institution to manage HRH	Health Service Commission	No				1	
	National HRH training policy	National HRH training policy formulated and disseminated			1			
Ensure ade-quate num-bers of equitably distributed and appro-priately skilled and motivated health workers	Annual recruitment and deployment plan	No of vacant posts filled	No		4,000	10,000	5,000	5,000
	Updated staffing norms	Work load analysis report			1			
		Revised staffing norms	No		1			
	Disaggregated establishments	Revised facility staff establishment	No		1			
		No of facilities meeting the norms	%			25	25	25
Enhance the development of human capacity to meet the health needs of the population	HRH manpower plan	Manpower plan in place	No			1		
	National Health Education Commission	Policy paper and legislative framework in place	No			1		
	National HRH training fund	Policy paper and legis-lative framework in place	No			1		
		Health training levy	No			1		
	Review of institu-tional quality standards of medical training institutions	Revised standards	No			1		
	Human resource development information database	Human resource development information system	No			1		
		No of institutions in HRDIS	%			50	50	

Continued

Table 6.5, *continued:* Results framework for Strategic Thrust 5

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Efficient and effective development and management of the health workforce								
OUTCOME INDICATORS: ▪ Number of level 4–5 facilities that achieve the approved staff establishment/staffing norms ▪ Attrition rate by category/cadre per year ▪ Level of achievement of performance targets								
Goals for 2012	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Enhance the development of human capacity, continued	Ministerial training needs analysis	Ministerial training needs assessment report	No		1			
		Ministerial HRD plan No of staff who attend continuous professional development	No		1			
Improve retention of health workers at all levels	Staff retention strategy	Strategy developed	No		1			
		Revised terms and conditions of service	No		1			
		Revised compulsory retirement age for HW	No		1			
		Revised incentive schemes	%			100		
		Reduced no of health workers exiting the service	%		10	50	50	50
Institution-alize performance appraisal systems	Institutionalized PAS	No of staff on PAS	%		50	50		
		No of regional sensiti-zation workshops	No		8			
		No of PAS champion teams formed	No		8			
		Annual and biannual performance reporting	%		75	100		
		Health facilities with performance contracts	%	50	100	100	100	100
		Mechanism for performance evaluation in place	No		1			
Improve human resource management systems and practices	Improved HRM&D capacity for hos-pital management	Guidelines developed and disseminated on role in the HRM&D	No		1			
		Deployment of HRMOs to facilities	%		50	50		
		No of management and leadership capacity building programmes conducted for hospital managers	%		20	30	30	20
	Succession management	Succession manage-ment plan developed	No.		1			
		No of gaps existing in grading structures	%					
		No of revised schemes of service	No		20	10		

Continued

Table 6.5, *continued:* Results framework for Strategic Thrust 5

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Efficient and effective development and management of the health workforce								
OUTCOME INDICATORS: ▪ Number of level 4–5 facilities that achieve the approved staff establishment/staffing norms ▪ Attrition rate by category/cadre per year ▪ Level of achievement of performance targets								
Goals for 2012	**Outputs**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Improve human resource management, continued	Improved application of ICT in HR management	No of staff undergoing capacity building programmes	%		50	50		
		Computer/accessories needs met	%		35	65		
		Finalized installation and operating HRIS database	%		40	60		
		End user training on HRIS	%			100		
		Linkage of HRIS to existing databases	%			50	50	
		Introduction of employee/customer care ICT applications (SMS)	No		1			
	Improved working environment for health workers	Incentives: housing (No of staff houses constructed), insurance, equipment (No of hospitals with functional equipment), skills development (No of highly integrated IST programmes, motivation factor, etc.)	%		20	30	50	
		Induction programmes for new hospitals put in place						
		Work place safety policy/guidelines in place	No		1			
		Work place HIV/AIDS policy	No		1			
		Facility HIV/AIDS control units established	%		100			
		Evaluation of employee satisfaction survey report	No		1			

6.2.6 *Strategic Thrust 6:* Provide a Network of Functional, Efficient and Sustainable Health Infrastructure for Effective Delivery of Health Care Services

An appropriate and functioning health infrastructure is a prerequisite to the provision of quality health care services. In health, the infrastructure consists of four main components: Buildings – medical and non-medical – including the land on which they stand; equipment; ICT; and general and ambulatory services transport. The approach of this thrust will be to address the key challenges affecting the realization of the required hospital infrastructure. Among these are the following:

- Uneven distribution of the available hospitals, in terms of the numbers available,

level of care and location, thereby reducing accessibility and affordability.

- Lack of defined standard norms for infrastructure, resulting in a variety of different forms of infrastructure available around the country.
- A high proportion of stalled projects, particularly relating to infrastructure improvement. There are different reasons for this, implying that intentions to improve infrastructure have not always led to completion.
- Many hospitals have insufficient land for expansion and most of them lack title deeds.
- Poor maintenance and non repair of hospital infrastructure, owing to poor planning and very low budgetary allocations for maintenance. This has led to a situation where a large proportion of the health infrastructure deteriorated rapidly over a short period.
- Lack of basic equipment to support service delivery, including communication and transport, also stemming from the absence of standard equipment guidelines developed in line with the expected functions and human resources. There is also lack of budgetary provision for procurement of the equipment.

Table 6.6 summarizes the specific goals for this thrust and the deliverables to be achieved by 2012. The goals are to:

- Increase the percentage of level 4–6 facilities that meet the minimum norms and standards on hospital buildings and land from 37% to 70%.
- Increase the percentage of level 4–6 facilities equipped as per norms from 37% to 70%.
- Increase the percentage of level 4–6 hospitals with adequate utility and ambulance services vehicles.
- Provide appropriate ICT in 30% of the hospitals by 2012.

Table 6.6: Results framework for Strategic Thrust 6

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: A network of functional, efficient and sustainable health infrastructure for effective delivery of health care services								
OUTCOME INDICATORS: ▪ Number of hospitals rehabilitated as per approved plans ▪ Number of hospitals equipped as per minimum norms and standards								
Goals for 2012	**Output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Increase the % of level 4–6 facilities that meet the minimum norms on hospital buildings and land from 37% to 70%	Infrastructure policy, norms and standards reviewed and updated	Norms and standards document	No			1		
	Infrastructure development and maintenance plan developed (FBO/GOK facilities)	Comprehensive infrastructure assessment report	No			1		
		No of hospitals with master plans	%	Nil			100	
	Infrastructure development and maintenance plan implemented	No of facilities upgraded to hospitals	No	70	5	18	20	20
		No of facilities rehabilitated	No	TBD				
		Increase in allocation for maintenance of buildings as a % of O&M budget	%	TBD				
	Hospitals with title deeds acquired	No of hospitals with title deeds	%	0	20	50	100	
	Hospital perimeter fences constructed	No of hospitals with perimeter fences constructed	%	10	20	50	80	100
	Two sources of water available in all hospitals	No of hospitals with at least two sources of water	%	15	20	50	80	100

Continued

Table 6.6, *continued:* Results framework for Strategic Thrust 6

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.

OUTCOME: A network of functional, efficient and sustainable health infrastructure for effective delivery of health care services

OUTCOME INDICATORS:

- Number of hospitals rehabilitated as per approved plans
- Number of hospitals equipped as per minimum norms and standards

Goals for 2012	Output	Output indicator	Unit	Base-line (07/08)	Yr 1 (08/09)	Yr 2 (09/10)	Yr 3 (10/11)	Yr 4 (11/12)
Increase the % of level 4–6 facilities that meet the mini-mum norms, continued	Adequate sanitation available for all hospitals	No of hospitals with adequate sanitation facilities	%	15	20	50	100	
	All hospitals with at least two sources of electricity	No of hospitals with at least two sources of electricity	No	70	Assess-ment	60	61	
	Incinerators construc-ted/ installed in all hospitals	No of hospitals with functional incinerators	No			100	100	
	Equipment policy, norms and standards	Norms and standards document	No	Nil		1		
	Equipment invest-ment and mainte-nance plan (FBO/ GOK facilities) in use	Comprehensive equipment assessment report	No	Nil		1		
		Plan for each hospital	No	Nil			212	
	Guidelines on management of medical equipment and plants in place	No of hospitals using guidelines on man-agement of medical equipment and plants	No	Nil		1		
	Budgetary allocation for maintenance of medical equipment and plants for all hospitals increased	Increase in alloca-tions for maintenance of medical equipment and plants as % of total O&M	%	??		20	30	50
	Annual medical equipment and plants audit in all hospitals	Annual equipment and plants audit report	No	Nil		1	1	1
	Oxygen generating plants installed in targeted hospitals	No of hospitals with oxygen generating plants	No	3l		8	8	9
Provide level 4–6 with adequate transport for utility and ambulance services	New transport policy, norms and standards in place	Norms and standards document	No			1		
	Transport develop-ment and mainte-nance plan (FBO/ GOK facilities) developed	Comprehensive transport assessment report	No			1		
		Complete plan	No	Nil			1	
	Utility vehicles procured	Hospitals with func-tional utility vehicle	No	70	30	30	30	31
	Staff vans vehicles procured	Zones with staff van	No	Nil		20	20	30
	Supervision vehicles for zonal medical services	Zones with supervision vehicles	No	Nil	70	70		
	At least one ambulance procured per facility	Hospitals with functional ambulances	No	115		40	36	
	16 vehicles for the 8 provinces procured	Provinces with at least 2 supervision vehicles	No	Nil	8	8		

Continued

Table 6.6, *continued:* Results framework for Strategic Thrust 6

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: A network of functional, efficient and sustainable health infrastructure for effective delivery of health care services								
OUTCOME INDICATORS: ▪ Number of hospitals rehabilitated as per approved plans ▪ Number of hospitals equipped as per minimum norms and standards								
Goals for 2012	**Output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Provide appropriate ICT in 30% of the hospitals by 2012	Ministerial ICT strategy for health services developed	ICT strategic plan in place	No	0		1		
	E-health policy developed	Policy document	No	0		1		
	ICT infrastructure in hospitals scaled up	Hospitals with ICT infrastructure in place	No		8	10	15	20
	E-health package defined	E-health package		0	1			
	E-health package implemented in hospitals	Hospitals implementing e-health	No	0	-	8	10	15
	Health personnel trained on ICT	Personnel trained	No		50	100	200	300
	Linkage of districts with the central level	Hospitals linked with the central level	No					

6.2.7 *Strategic Thrust 7:* Ensure Reliable Access to Quality, Safe and Affordable Essential Medicines and Medical Supplies That Are Appropriately Regulated, Managed and Utilized

Sustainable and equitable access to needed medicines and medical supplies is the aim here, as stipulated by the Kenya National Drug Policy (KNDP). The approach will be to revise the KNDP, which was adopted in July 1994 and is therefore outdated, so as to remove the bottlenecks that exist at the different stages of the process of ensuring the availability of quality and adequate drugs at the point of service delivery at all times. The major constraints include: An ineffective medium-term procurement plan that is not linked to available resources and timelines; duplication of procurement roles among parent ministries, KEMSA and parallel programmes; inadequate and dilapidated storage infrastructure; ineffective distribution systems as a result of inadequate transport and budget; and inappropriate use of essential medicines by health workers and consumers.

As detailed in Table 6.7, this strategic thrust will aim to achieve the following objectives by 2012:

- Revise/adopt KNDP and develop an implementation plan for its use.
- Provide KEMSA with the autonomy to perform its legal mandate as the agency to procure, warehouse and distribute medical commodities to the entire health sector in accordance with good distribution practices, including:
  - Evidence-based selection of essential medicines and medical supplies (EMMS) in the health sector.
  - Quantification of EMMS institutionalized at all KEPH levels.
  - Transparent, accountable and timely procurement of EMMS at institutional level (only for bridging gaps).
- Ensure secure institutional EMMS storage infrastructure with product quality assurance.
- Achieve optimal therapy through good prescribing and dispensing practices.
- Ensure the safe and environmentally-friendly disposal of EMMS waste.
- Educate the public to ensure that EMMS are appropriately utilized by clients.

- Mobilize adequate financial resources for procurement and distribution of EMMS.
- Ensure EMMS provided for the public sector are of quality, safe, efficacious, and in accordance with legal requirements and professional standards.
- Support operational research on EMMS and their use to address related health issues.
- Rationalize EMMS donations.

Table 6.7: Results framework for Strategic Thrust 7

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Reliable access to quality, safe and affordable essential medicines and medical supplies that are appropriately regulated, managed and utilized								
OUTCOME INDICATORS: ▪ Annual KNDP status implementation reports ▪ % of public health facilities reporting no stock outs of tracer commodities all year round (Target 100%) ▪ % of health facilities with functional medicine and therapeutic committees (Target 60%)								
Goals for 2012	**Expected output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Revise/adopt KNDP and develop an implementation plan for its use	Revised KNDP with an implementation plan	Approved revised KNDP document	Document	Draft KNPP	KNPP adopted			
		Revised KNDP Implementation plan	Document			1		
Provide KEMSA with the autonomy to perform its legal mandate as the agency to procure warehouse and distribute medical commodities primarily to public health sector in accordance with good distribution practices	Revised legal framework and new legislation on KEMSA	KEMSA Policy Paper (Sessional Paper)	No		1			
		Amended Legal Notice No 17 of 2000 - KEMSA Act	No		1		Draft	Final
	New KEMSA leadership and governance, and Institutional structures de-linked from the parent ministries	New KEMSA board and management	No		1			
		New organizational structure of KEMSA	No			1		
		All procurements for medical commodities transferred to KEMSA	No			1		
	Transparent, accountable and timely procurement	KEMSA procurement compliant with Public Procurement and Disposal Act 2005 and the regulations of 2006	%			100		
		Integrated and comprehensive MTPP for medical commodities	No			1		
		Guidelines for EMMS procurement for emergencies and disasters						
	International standards for warehousing	Compliance with international warehousing standard operating procedures	%			100		
	Good distribution practices	Compliance with good distribution procedures	%			100		
	Non-profit financial self-sustainability at KEMSA	Capitalization of KEMSA	%					100
	Use of ICT in all business processes	ICT policy	No		1			
		Functional enterprise resource platform	%				100	
	Adequate number and capacity of HR at KEMSA	KEMSA performance reports	No		1			

Continued

Table 6.7, *continued:* Results framework for Strategic Thrust 7

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Reliable access to quality, safe and affordable essential medicines and medical supplies that are appropriately regulated, managed and utilized								
OUTCOME INDICATORS: ▪ Annual KNDP status implementation reports ▪ % of public health facilities reporting none-stock outs of tracer commodities all year round (Target 100%) ▪ % of health facilities with functional medicine and therapeutic committees (Target 60%)								
Goals for 2012	**Expected output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Evidence-based selection of essential medicines and medical supplies in the health sector	Functional National Medicines and Therapeutic Committee	NMTC established	No.	-	1			
	Functional institutional Medicines and Therapeutic Committees	MTCs established in all level 4–6 hospitals	No	10	10	70	60	60
	Kenya Essential Drugs List (KEDL) revised and updated	Revised and update KEDL document	No	-	1			
	Essential Medical Supplies List developed	New EMSL document	No	-		1		
	EMMS incorporated into pre- and in-service training curricula for core health workers	Pre- and in-service EMMS curricula	Document			Draft	final	
Quantification of EMMS institutionalized at all KEPH levels	Logistics management and information system at all health facilities (electronic for levels 4 & 5 and manual for levels 2 & 3)	Functional LMIS at all health facilities (electronic and manual tools)	Electronic	-	50	50	50	50
			Manual			1600	1600	
Transparent, accountable and timely procurement of EMMS at institutional level (only for bridging gaps)	Institutional procurement compliant with the Public Procurement and Disposal Act 2005 and the regulations of 2006	Compliance with procurement procedure	%			100		
						1		
	Institutional EMMS procurement plan	Compliance with EMMS procurement plan	%				100	100
	Guidelines for EMMS procurement for emergencies and disasters	Compliance with guidelines for EMMS procurement for emergency and disaster response at institutional level	%					100

Continued

Table 6.7, *continued:* Results framework for Strategic Thrust 7

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.

OUTCOME: Reliable access to quality, safe and affordable essential medicines and medical supplies that are appropriately regulated, managed and utilized

OUTCOME INDICATORS:

- Annual KNDP status implementation reports
- % of public health facilities reporting none-stock outs of tracer commodities all year round (Target 100%)
- % of health facilities with functional medicine and therapeutic committees (Target 60%)

Goals for 2012	Expected output	Output indicator	Unit	Base-line (07/08)	Yr 1 (08/09)	Yr 2 (09/10)	Yr 3 (10/11)	Yr 4 (11/12)
Ensure secure institutional EMMS storage infrastructure with product quality assurance	Institutional storage infrastructure rehabilitation, upgrading and maintenance plan	Report on assessment of status of storage infrastructure in health facilities	No			1		
		Approved plan on rehabilitation upgrading and maintenance	No				1	
	Commodity management guidelines including storage & inventory management operational	Implementation of assessment reports on storage SOPs from health facilities	%			100	100	100
	Annual commodity & equipment audits	Annual EMMS and equipment audit reports	%	Nil		50%	50%	50%
Achieve optimal therapy through good prescribing and dispensing practices	Review and update of standard treatment guidelines	Reports of prescribing and dispensing audits	%			10	20	35
	Review and update of KEDL		Doc			1		
	EMSL & formularies developed		Doc			1		
	MTCs institutionalized in all hospitals							
	Guidelines for good prescribing practice (GPP) including prescribing by International non-proprietary name (INN) developed		Doc			1		
	Guidelines developed for good dispensing practice (GDP) (including generic substitution)							

Continued

Table 6.7, *continued:* Results framework for Strategic Thrust 7

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Reliable access to quality, safe and affordable essential medicines and medical supplies that are appropriately regulated, managed and utilized								
OUTCOME INDICATORS: ▪ Annual KNDP status implementation reports ▪ % of public health facilities reporting none-stock outs of tracer commodities all year round (Target 100%) ▪ % of health facilities with functional medicine and therapeutic committees (Target 60%)								
Goals for 2012	**Expected output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Ensure safe and environ-mentally-friendly disposal of EMMS waste	Guidelines for disposal of medical supplies developed	Standard operating procedures developed from guidelines for disposal of medical supplies	No				1	
	Guidelines on safe disposal of pharmaceutical waste reviewed and updated	Standard operating procedures developed from guidelines for safe disposal of pharmaceutical waste	No			1		
Educate the public to ensure that EMMS are appropriately utilized by clients	IEC strategy developed for the promotion of appropriate EMMS use	IEC strategy	Docu-ment				Draft	Final
		IEC guidelines for promotion of appropriate EMMS use by clients	No			1		
	Enforcement of regulation and control of medi-cines and med-ical supplies advertising and promotion	Annual operational licences/permits for EMMS promotion and advertisement	Docu-ments			Final		
	Development of effective mechanism for client feedback on EMMS	Reports for feedback from health facilities on EMMS	No					1
Mobilize adequate financial resources for procurement and distribution of EMMS	Strategy devel-oped for pooled financing of EMMS pro-curement and distribution	Signed financial agreement on pooled EMMS procurement and distribution	Docu-ment			1		
	Annual inte-grated EMMS procurement and distribution budget developed	Annual procurement and distribution plan linked to available budget	Docu-ment			1		
	Recurrent EMMS budget increased to 9% of total MOH budget	Annual printed estimates reflecting the 9% allocation for EMMS in MOH total budget	Docu-ment				1	

Continued

Table 6.7, *continued:* Results framework for Strategic Thrust 7

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Reliable access to quality, safe and affordable essential medicines and medical supplies that are appropriately regulated, managed and utilized								
OUTCOME INDICATORS: ▪ Annual KNDP status implementation reports ▪ % of public health facilities reporting none-stock outs of tracer commodities all year round (Target 100%) ▪ % of health facilities with functional medicine and therapeutic committees (Target 60%)								
Goals for 2012	**Expected output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Ensure EMMS provided for public sector are high quality, safe, efficacious and in accordance to legal requirements and professional standards	Guidelines developed for pre- and post-quality testing of EMMS designated for a public sector	Pre- and post-quality assurance testing reports	Document				1	
	Pharmaco-vigilance guidelines enforced	Pharmaco-vigilance reports	Document				1	
Support operational research on EMMS and their use to address related health issues	Priority EMMS for operational research selected	Selected EMMS items for operational research	No				1	
	Utilization of research findings	Plans for utilization of findings	Document				1	
	Database on operational research	Updated database	No				1	
Rationalize EMMS donations	Medicine donation guidelines (to include medical supplies) reviewed and updated	Reviewed and updated guidelines for medicine donations to include medical supplies	Document			1		

*NB: Targets based on 210 hospitals, the current number of hospitals drawing supplies from KEMSA.

6.2.8 *Strategic Thrust 8:* Establish an Equitable Health Care Financing Mechanism That Ensures Social Protection, Particularly for the Poor and Vulnerable

According to the 2003 Household Health Expenditure Report, 44% of Kenyans who fall sick do not seek health care services because they lack the financial wherewithal. The study on *Well Being in Kenya* also indicates that over 40% of the poor undertake self-diagnosis when sick.

Despite a notable increase in government allocations to the health sector, from Ksh15.3 billion in 2003/04 to Ksh33.5 billion in 2007/08, financing health care services for the poor remains a challenge. The share of government expenditure on the sector decreased from 7.66% in 2004/05 to 7.3% in 2007/08. This is well below the ERS target of 12% of total government spending on health and the 15% commitment in the Abuja Declaration. Out-of-pocket expenditure (cost-sharing), although it has exceptions built in, seems to deter poor people from accessing care. The available Social Health Insurance Fund (NHIF) covers close to 25% of the population, but only partially and does not cater for the poor and the unemployed. There is lack of a financing strategy to ensure that the poor have access to the essential health services they require as a human right. Activities proposed under this strategic thrust intend to bridge the financial gap.

The specific 2012 goals for this thrust are:

- Develop a financing strategy to ensure access to health and provide social health protection.
- Ensure evidence-based decision making on health financing.

- Expand contributors to NHIF from 2.2 million to 9.6 million persons.
- Protect all households facing catastrophic health expenditures.
- Improve the efficiency and effectiveness of revenue collection and utilization.
- Increase the amount of resources reaching the point of use/health facilities.
- Ensure equitable resource allocation and utilization.

Results and output indicators for this strategic thrust are elaborated in Table 6.8.

Table 6.8: Results framework for Strategic Thrust 8

GOAL: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators.								
OUTCOME: Equitable health care financing mechanism that ensures social protection, particularly for the poor and vulnerable								
OUTCOME INDICATORS: ▪ % population covered by public health insurance ▪ Government health expenditure as % of total government expenditure ▪ % of public finances utilized at the facility level								
Goal for 2012	**Output**	**Output indicator**	**Unit**	**Base-line (07/08)**	**Yr 1 (08/09)**	**Yr 2 (09/10)**	**Yr 3 (10/11)**	**Yr 4 (11/12)**
Increase access to health and social health protection	Financing strategy developed	Health financing policy/legislation	No.		1	1		
	Tool for identifying the poor in place	Actuarial study report		1		1		
	Revised NHIF	Amendments to NHIF Act				1		
	Regulation mechanism on health insurance	Health Insurance Regulatory Board					1	
Evidence-based financial decision making	Funding mechanisms for the ministry developed	National Health Accounts report	No.	1	1		1	
	Financing scenarios developed	Costing model for services			1			
Expand contributors to NHIF from 2.2 million to 9.6 million persons	Increased membership	No of contributors	2.2 M	2.467M	3.45 M	4.31M	6.27 M	9.63M
	Increased revenue collection	Revenue (Ksh)	4.5 B	5 B	15.09B	16.6B	36.6B	41.6B
	Legislation under the Finance Bill	Gazette notice			1			
	Administrative efficiency	Benefit payout ratio	55 %	71%	76%	78%	81%	84%
Reduce number of households facing catastrophic health expenditures	Tax rebate policy on HCF	Tax rebate policy on HCF	-		1			
	Reimbursement scheme reviewed	Reimbursement scheme reviewed	-		1			
	NHIF Act amended	NHIF Act amendment	-		1			
Increase the amount of resources reaching point of use from 40% to 70%	Efficient financial management system	Public expenditure tracking survey		1		1		1
		No of budget management centres			12[a]	79[b]	102[c]	
	Revenue collection and accountability by public hospitals	Public facilities receiving direct financing	-	-	100%			
Ensure equitable resource allocation and utilization	Resource allocation criteria and mapping for underserved areas	Improved service delivery indicators of under-served areas	-	Base-line survey		1		
	OBA implemented in selected facilities	Utilization of critical services [d]				1		
	A well informed and costed resource envelope	Shadow budgets developed	-	1	1	1	1	1

Notes: a.) The seven provincial hospitals and five high volume district hospitals. b.) No. of district hospitals according to the MOMS *Facts & Figures 2008* on health and health related indicators. c.) No. of subdistricts according to the MOMS *Facts & Figures 2008* on health and health related indicators. d.) The critical services will be determined on the basis of a survey.

Chapter Seven

Coordination Framework

Better coordination of service delivery is an intrinsic element of the Ministry's strategy for maximizing outputs and improving service delivery to the people of Kenya. Guidance on coordination is provided through three oversight structures:

- ***The management structure:*** This frames internal Ministry coordination to guide implementation of defined interventions and activities at the different levels. It is described in Chapter 8 on capacity.

- ***The governance structure:*** This looks at defining and guiding the strategic direction, and following up on the operation of interventions. It is largely established by formal legislation, with members and functions formally gazetted by the Government.

- ***The partnership structure:*** This guides external coordination of service delivery by all stakeholders at the respective levels of care. All partners providing services at a given level of care engage with each other through this structure.

The governance and partnership framework described in this chapter intends to set up a substantive sector-wide governance mechanism, to foster agreement on other common procedures for consultation and decision making. Among the measures are annual planning, procurement and disbursement mechanisms, monitoring and reporting, and review and evaluation. Others are audits, financial management and the exchange of information in this collaboration.

The Partnership Code of Conduct will serve as the formal instrument to guide the functioning

The Joint Interagency Coordinating Committee (JICC) is charged with the governance and partnership oversight necessary for achieving the goals set out in this plan. The committee's key role is political and policy coordination, ensuring the sector is working towards its policy objectives as set out in the policy framework and Vision 2030.

of the partnership in health. It is grounded in the principles of the 2005 Paris Declaration on Aid Effectiveness.

7.1 National Level Governance and Partnership

Governance and partnership are both managed through the same structures at the national and provincial levels. These structures have overall responsibility for achievement of health objectives. As such, they are jointly formed by the Ministry of Medical Services and the Ministry of Public Health and Sanitation. They remain similar to structures defined in the health sector's *Joint Programme of Work and Funding* (JPWF), adjusted to take into consideration the situation with the dual management centres (MOMS and MPHS).

Overall governance and partnership oversight is to be provided through the Joint Interagency Coordinating Committee (JICC). Its key role is political and policy coordination, ensuring the sector is working towards its policy objectives as set out in the policy framework and Vision 2030. The JICC is therefore responsible for development and monitoring of the overall policy direction for the sector. This function includes:

- Articulating a health policy framework that takes broader Government objectives into consideration.
- Endorsing the health sector strategic approach.
- Monitoring adherence to the policy direction of the sector.
- Mobilizing resources for achievement of the sector policy direction.

The committee will meet under the leadership of the Minister for Medical Services and the Minister for Public Health and Sanitation as co-conveners. The offices of the Permanent Secretaries in the two ministries will serve as its secretariat. Overall strategic coordination will be through the Health Sector Coordinating Committee (HSCC), which will undertake managerial coordination and serve as the key governance organ. HSCC functions will be:

- Formulating strategic approaches for the sector, either jointly or individually in consultation with both ministries.
- Approving annual planning processes and operational plans guiding each ministry, either jointly or individually as will be agreed.
- Monitoring implementation of operational and strategic plans on a regular basis (annual reviews), either jointly or individually as will be agreed.

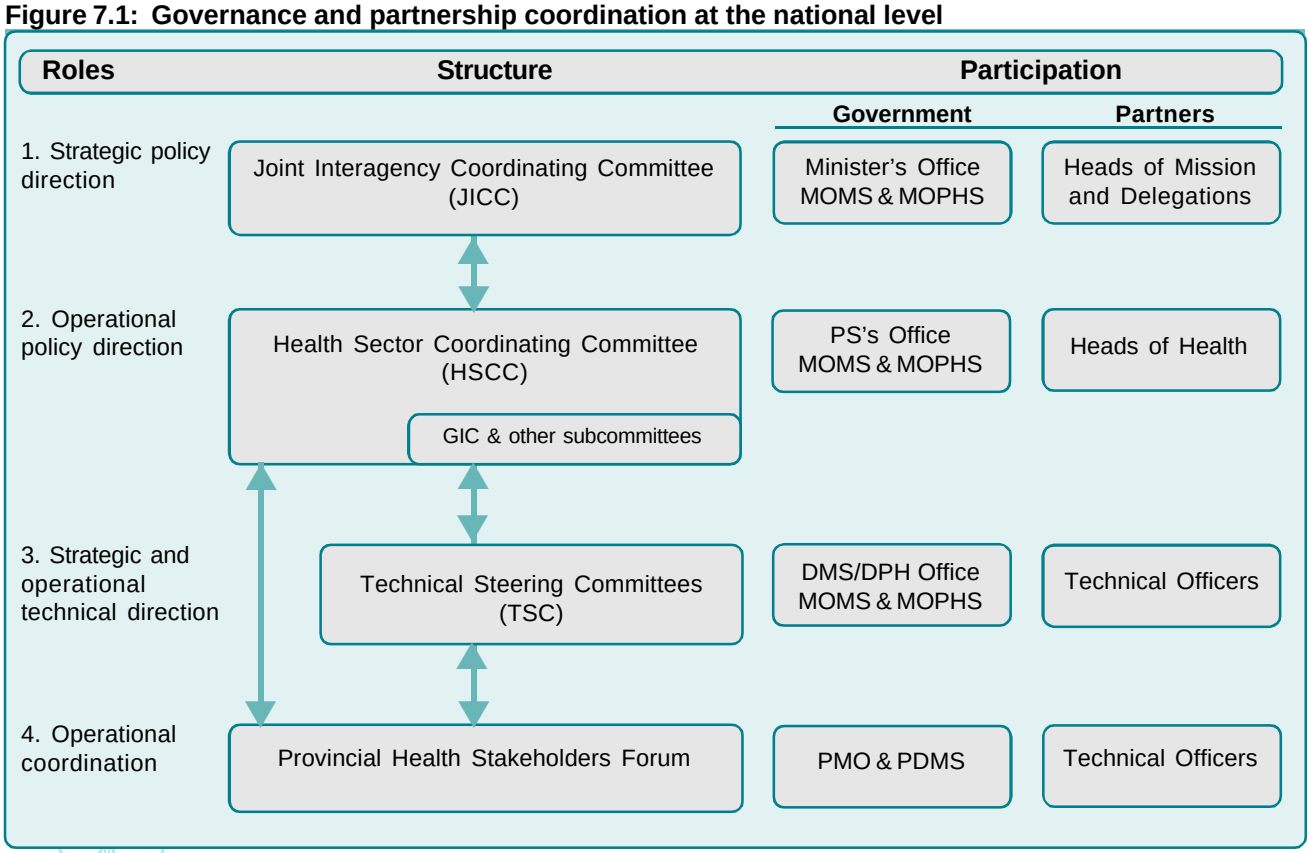
HSCC will be co-chaired by the Permanent Secretaries of the Ministry of Medical Services and the Ministry of Public Health and Sanitation. Each ministry is to appoint members to the secretariat. Actual technical coordination will be through respective technical steering committees (the present ICCs) focused on a specific technical area. These committees will be the forum through which technical issues are debated and agreed and specific recommendations and actions from the HSCC are implemented. All the technical committees will be managed through the HSCC and will be formed on an ad hoc basis.

Two or more technical stakeholder committee can cooperate to address particular issues that cut across them. In such instances, they will define the modalities of cooperation. One functioning example is the Global Fund Country Coordinating Mechanism (CCM), which brings together Global Fund related issues from the malaria, TB and HIV technical stakeholders committees.

Sector partners, both development and implementing, will participate at all these levels. They will participate at JICC through their political representatives (heads of agencies). Technical representation will be at respective technical stakeholders committees and at the HSCC.

The national level governance is illustrated in Figure 7.1.

Figure 7.1: Governance and partnership coordination at the national level



7.2 Governance and Partnership at the Subnational Level

Structures to facilitate governance and partnership will be separate at the provincial, district and facility levels. At the provincial level, governance and partnership will be through the Provincial Health Stakeholders Forum. It will be co-chaired by the PDMS and PMO with the following as members:

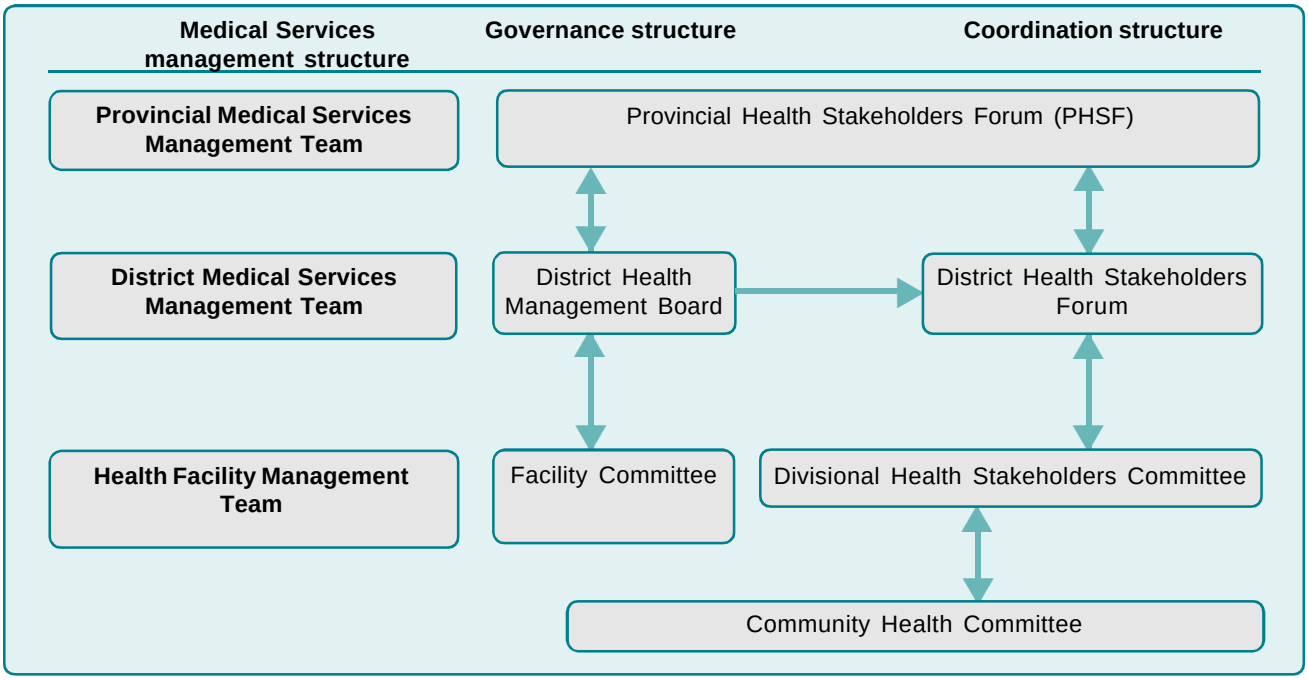
1. Medical Superintendents of all hospitals (public and non public) in the province
2. Zonal specialists for Medical Services
3. CEOs of FBOs
4. CEOs of NGOs
5. Representative of private health service providers
6. Provincial Commissioner
7. Representatives from other social sectors in the district
8. All other actors in health in the district

District level governance will be through the District Health Management Board (DHMB); the partnership will be coordinated through the District Health Stakeholders Forum (DHSF). The mandate and functions of the DHMB will be as defined in the gazette notice establishing them. On the other hand, the DHSF will be responsible for coordination of all health service actors at the district level. It will be co-chaired by the District Medical Services Officer and the District Medical Officer, with the following members:

1. Medical Superintendents of all hospitals (public and non public) in the district
2. Zonal specialists for Medical Services
3. CEOs of FBOs
4. CEOs of NGOs
5. Representative of private health service providers
6. CEO of Local Authority
7. District Commissioner
8. Representatives from other social sectors in the district
9. Members of Parliament from the district
10. Councillors on the social services committee
11. All other actors in health in the district

Subnational governance and coordination is depicted in Figure 7.2. Facility governance will be coordinated by the respective boards and/or committees under the supervision of the DHMB.

Figure 7.2: Governance and partnership coordination at the subnational level



Chapter Eight

Implementation Capacity

Following the split of MOH into two separate ministries on the basis of function, the Ministry of Medical Services was organized to encompass the following:

- Clinical services.
- Surgical and rehabilitative services.
- Pharmaceutical services.
- Nursing services.
- Diagnostic and forensic services.
- Standards and regulatory services.
- Planning and technical administrative services.

All this is backed by supportive services in line with the Ministry's mandate spelt out in Presidential Circular No. 1 of 2008. The circular can be summarized into the following key areas:

- Development of policy and guidelines.
- Clinical services, i.e., curative, diagnostic, HIV/AIDS/STD treatment and management.
- Registration and regulation of health workers and medical services.
- Hospitals, clinics, rural health services and medical supplies.
- Training of health workers.
- Health insurance.

The Ministry functions at both national and subnational levels. The concern at the national level is the coordination of overall guidance for the sector in Medical Services, while the sub-national level focuses on provision of defined medical services. In drawing up the organization structure the emphasis was on its responsiveness to the requirements of the health sector policy and the strategic plan. The structure has clearly defined levels of operation and management and offers the best prospect for a lean, effective system.

The organization is such that there are clear communication linkages among the national, provincial and district levels for ease of planning, operations, monitoring and evaluation. At the

> The entire structure of MOMS, from the national to the district level, is targeted at perfecting curative services across the board, as per the Ministry mandate, and at instilling efficiency and effectiveness in its systems.

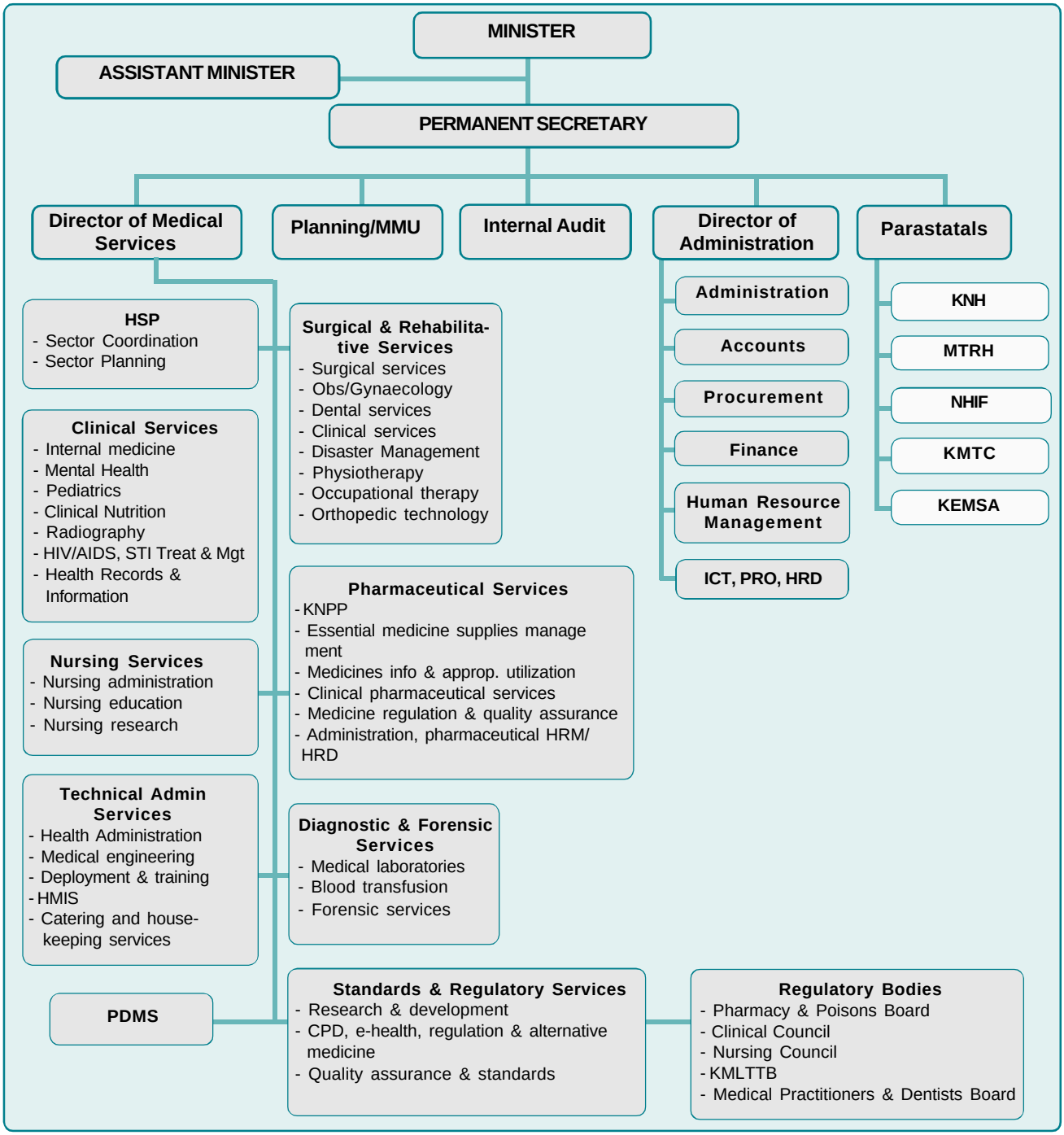
district level, the district medical service officers and their teams will be in charge of health services at their level, addressing both the management and governance issues in the district. At the provincial level, the PDMS and team coordinate, supervise and monitor on behalf of the DMS. The entire structure is targeted at perfecting curative services at all levels as per the Ministry mandate and at instilling efficiency and effectiveness in its systems. Figure 8.1 illustrates the structure of the Ministry.

8.1 Management Structure and Functions at the National Level

The national level is made up of the MOMS headquarters, with the provincial level serving as a de-concentrated unit of the national level. The functions of the national level will not change, and will be:

1. Strategic planning and policy formulation,

Figure 8.1: Ministry of Medical Services organogram



2. Ensuring commodity security,
3. Performance monitoring,
4. Capacity strengthening,
5. Resource mobilization, and
6. Operational and other research.

The province will serve as the unit to coordinate the operation of these functions by the districts.

As highlighted in the organogram in Figure 8.1, the oversight functions will be managed through the Minister and an Assistant Minister. The Permanent Secretary will be the link between the technical and administrative functions and the oversight function. The Director of Medical Services will be the main coordinator of technical functions of the Ministry. Duties of these have been defined by Government.

8.1.1Office of the Permanent Secretary

The work of the Permanent Secretary will be supported by:

- Coordinating units
  - Director of Medical Services
  - Support services
  - Parastatals
- Supportive units
  - Ministerial Monitoring Unit
  - Internal Audit

8.1.2 Office of the Director of Medical Services

On the other hand, the Director of Medical Services will execute the functions of the office through eight departments. These are:

- Department of Medicine
- Department of Surgery
- Department of Nursing
- Department of Pharmacy
- Technical Administration Department
- Department of Diagnostics and Forensic Services
- Department of Standards and Regulatory Services
- Department of Technical Planning and Coordination

The mandate, functions and composition of the departments are outlined in Table 8.1.

8.1.3 Support Services

Support services are the range of functions that complement the health technical activities of the Ministry. They are meant to ensure that MOMS is planning and implementing its interventions and activities in line with the overall Government orientation. These services are in the areas of:

- Administration
- Accounts
- Procurement
- Finance
- Human resource deployment and management
- Policy and planning
- Information communication technology and public relations office

8.1.4 Parastatals

Several semi-autonomous government agencies complement the work of the Ministry in discharging its core functions through service delivery, research and training, and procurement and distribution of drugs. Of these, there are six parastatals and six statutory institutions responsible for quality control. These are:

- The six parastatals:
  - Kenyatta National Hospital (KNH) – Curative services and teaching
  - Moi Teaching and Referral Hospital (MTRH) – Curative services and teaching
  - Kenya Medical Supply Agency (KEMSA) – Procurement and distribution of commodities
  - Kenya Medical Research Institute (KEMRI) – Research
  - National Health Insurance Fund (NHIF) – Finance
  - Kenya Medical Training College (KMTC) – Training
- The six statutory institutions:
  - Medical Practitioners and Dentists Board
  - Pharmacy and Poisons Board
  - Clinical Officers Council
  - Nursing Council of Kenya
  - Radiation Protection Board
  - Kenya Medical Laboratory Technicians and Technology Board

Table 8.1: Description and functions of departments and divisions at the national level

Department	Divisions/units	Core functions
Clinical Services Department	Internal Medicine (adult health)	▪ Coordinate medical services at the district/provincial hospitals and link them with national referral hospitals
	Paediatrics (child health)	▪ Formulate policy on child health ▪ Improve the management of child care through inpatient management of common childhood illnesses (IMCI) ▪ Improve the management of newborns
	Clinical Nutrition and Dietetics	▪ Conduct planning and coordination, policy formulation, provision of therapeutic and supplementary feeds ▪ Supervise inpatient feeding, nutrition and dietetic services
	Radiography	▪ Ensure availability of quality and adequate radiography services in hospitals
	HIV/AIDS, STI treatment and management	▪ Formulate policy and articulate planning for HIV/AIDS ▪ Ensure security of HIV/AIDS commodities ▪ Monitor performance of implementation of HIV/AIDS activities ▪ Build institutional and human resource capacity to deal with HIV/AIDS ▪ Mobilize resources for HIV/AIDS interventions ▪ Carry out operational and other research on HIV/AIDS
	Medical Social Workers	▪ Coordinate, monitor and evaluate the medical social services provided in the country
	Internal Medicine	▪ Address social factors that affect health
	Mental Health	▪ Provide and coordinate quality mental health services
Surgical and Rehabilitative Services	Surgical (orthopaedic/ ENT/ophthalmology)	▪ Develop, disseminate and oversee the implementation of national standards and norms on best practices in surgery and rehabilitation services
	Obs/Gynaecology	▪ Monitor and evaluate the provision of quality surgical and rehabilitation services in all hospitals
	Dental Services	▪ Undertake capacity strengthening and retooling of management, support and service delivery staff
	Clinical Services	▪ Ensure security for the relevant medical commodities and supplies
	Orthopaedics Technology Services	▪ Ensure availability of appropriate and functional infrastructure and skills to deliver quality surgical and rehabilitative services
	Physiotherapy Services	▪ Ensure implementation of the National Referral Strategy, particularly establishing effective linkage within the various levels of care (district to regional to referral hospitals)
	Occupational Therapy Services	▪ Ensure implementation of regular medical audits of all surgical and rehabilitative services in the hospitals
	Disaster Management	▪ Set up training of hospital emergency and disaster preparedness response teams ▪ Coordinate and monitor ministerial and interministerial disaster activities ▪ Mobilize resources to support emergency response activities
	Eye and ENT	▪ Coordinate the provision of ophthalmic and ENT services in the country
Pharmaceu-tical Services	Administration/Pharmaceutical HR management and development	▪ Pharmaceutical HR Management and Development
	KNPP development and coordination	▪ Coordinate, monitor, evaluate and report on KNPP implementation
	Essential medicines supplies management	▪ Coordinate, develop, monitor and evaluate selection, quantification, technical and commercial evaluation, procurement, storage, inventory control, distribution, disposal, tracking and audit of essential medicines
	Medicines regulation and quality assurance	▪ Oversee national agencies involved in medicines quality assurance
	Medicines information and appropriate utilization	▪ Identify, plan and coordinate initiatives to support appropriate medicines utilization by health professionals, patients and the general public
	Clinical Pharmaceutical Services	▪ Coordinate development, monitoring and evaluation of the

Continued

Table 8.1, *continued:* Description and functions of departments and divisions at the national level

Department	Divisions/units	Core functions
Technical Administration Services	Health Administration	▪ Coordinate implementation of projects in infrastructure development and maintenance
	Medical Engineering	▪ Coordinate and support management of medical equipment and plants
	Health Management Information System	▪ Coordinate provision of health information for use in planning and management
	Health Administration	▪ Oversee development and dissemination of policy guidelines on equipping health facilities, provision of technical support services and improvements in management of health information
		▪ Coordinate departmental staff training
Standards, Research and Regulatory Services	Inspectorate	▪ Strengthen quality management in health care, set standards and norms
	Research and Development	▪ Enhance the regulatory role of the Ministry of Medical Services
	Health and CPD	▪ Enhance contribution of health research in informing policy and in development agendas
	Regulation and alternative medicine	▪ Provide scientific, diagnostic, analytical and forensic services
	Quality Assurance and Standards, Gender, Youth Governance	▪ Coordinate e-health, continuing professional development and alternative medicine activities/programmes within the health sector
	Medical Legal	▪ Coordinate medical legal services in the Ministry of Medical Services
		▪ Audit public, private, FBO, NGO drug stores and pharmacies
Technical Planning and Coordination Services	Planning	▪ Conduct annual operational planning and strategic planning technical policy development
	Health records and information	▪ Plan and coordinate and deploy professional advancement aimed at quality health records and information services for evidence based decision making
	Monitoring and evaluation	▪ Monitor and evaluate performance
	Sector coordination	▪ Coordinate various health sector partners, JFA, SWAp
Diagnostic and Forensic Services	Medical Laboratories	▪ Analyse specimens
	Blood Transfusion	▪ Advise the government on issues related to medical laboratory services
	Forensic Services	▪ Deploy medical laboratory technologists and technicians throughout the country
		▪ Purchase and distribute laboratory chemicals/reagents throughout the country
		▪ Provide reference services in the country
		▪ Manage and coordinate laboratory services countrywide
		▪ Develop and review national laboratory services
		▪ Manage hospital blood transfusion services
		▪ Plan and budget for laboratory service
Support services departments	Administration	▪ Carry out general administration, including
		▪ Transport services
		▪ Asset management
		▪ Corruption prevention
		▪ Safety and security
		▪ State functions/events
		▪ AIDS Coordinating Unit (ACU)
		▪ ICT
		▪ Public relations

Continued

Table 8.1, *continued:* Description and functions of departments and divisions at the national level

Department	Divisions/units	Core functions
Support services, continued	Finance	▪ Prepare budgets, including
		▪ Analysis of financial and management reports for planning and budgeting purposes
		▪ Implementation of Treasury guidelines
		▪ Compilation of requirements from departments
		▪ Submission of Ministry requirements to Treasury
		▪ Prioritization of Ministry requirements
		▪ Implement and control budget, including:
		▪ Preparation of Ministry's cash requirement projections
		▪ Preparation of disaggregated budget
		▪ Issuance of AIEs
		▪ Preparation of AIE financing schedules
		▪ Compilation and review of pending bills
		▪ Vetting of commitments (LPOs, LSOs and imprests)
		▪ Preparing responses to audit issues
	HRM	▪ Interpret and implement human resources policies
		▪ Promote officers in Job Group "L" and below under delegated authority
		▪ Process of retirement documents
		▪ Manage employee satisfaction
		▪ Manage performance appraisal system
		▪ Manage staff welfare
		▪ Conduct disciplinary control and management
		▪ Plan succession management
		▪ Administer payroll
		▪ Prepare annual personnel emolument budget
	Procurement	▪ Procure goods and services on time
		▪ Manage contracts
		▪ Maintain register of suppliers and procuring agents
		▪ Prepare, publish and distribute procurement opportunities through invitation to tender and expression of interest
		▪ Coordinate the receiving and opening of tender documents
		▪ Maintain and safeguard procurement and disposal documents and records
		▪ Coordinate the evaluation of tenders, quotations and proposals
		▪ Prepare and publish notices of tender awards and the ensuing contracts to the PPOA
		▪ Prepare and issue rejection and debriefing letters
		▪ Provide information as required for any petition or investigation under procurement review
		▪ Implement the decisions of the procurement, tender and disposal committee
		▪ Act as secretariat to the tender, procurement and disposal committees
		▪ Monitor contract management to ensure successful implementation
		▪ Report any significant departures from the terms and conditions of contract to the Accounting Officer
		▪ Prepare consolidated procurement and disposal plans
		▪ Advise the Ministry on aggregation of procurement to promote economies of scale

Continued

Table 8.1, *continued:* **Description and functions of departments and divisions at the national level**

Department	Divisions/units	Core functions
Support services, continued	Planning	▪ Guide investment in the health sector
		▪ Formulate and analyse policies for the sector
		▪ Assist in budget preparation
		▪ Conduct operation research and surveys
	Accounts	▪ Direct, control and coordinate accounting matters
		▪ Liase with Treasury/CBK on accounting matters relating to Ministry operations
		▪ Manage and control Government financial reporting system to ensure delivery of timely management decisions
		▪ Coordinate Accounting Unit operations; requisition exchequer funding and grants
		▪ Disburse funds to authorized beneficiaries
		▪ Prepare ministries/departments accounts
		▪ Prepare annual accounts, follow-up audit reports and Public Accounts Committee submissions
		▪ Administer, deploy, train and develop accounts staff in Ministry
	Internal Audit	▪ Review the existing procedures in the Ministry
		▪ Evaluate the effectiveness of internal control systems and ascertain whether they are functioning properly
		▪ Carry out spot checks on areas such as revenue and appropriation in aid
		▪ Review and evaluate the reliability and integrity of record keeping
		▪ Review budgetary reallocation process to ensure legislative and administrative compliance
		▪ Ensure that revenue, AIA and other receipts due to the government are collected and banked promptly
		▪ Carry out a pre-audit of all documents used in initiating commitment and expenditure and in effecting payments such as AIEs, LPOs and contract agreements
		▪ Review and pre-audit annual appropriation accounts, fund accounts and annual audited statements
		▪ Carry out investigations of irregularities identified or reported on any wastage of public funds
		▪ Determine whether the risk management, control and governance processes are adequate and functioning effectively
		▪ Follow up on outstanding issues to ensure that prompt appropriate action is taken on reported audit findings
		▪ Ensure that the government's physical assets, plant and equipment, supplies, stores, etc, are appropriately recorded in the relevant registers and are kept under safe custody
		▪ Report on the results of audit work and recommendations to the Permanent Secretary

8.2 Management Structure and Functions at the Subnational Level

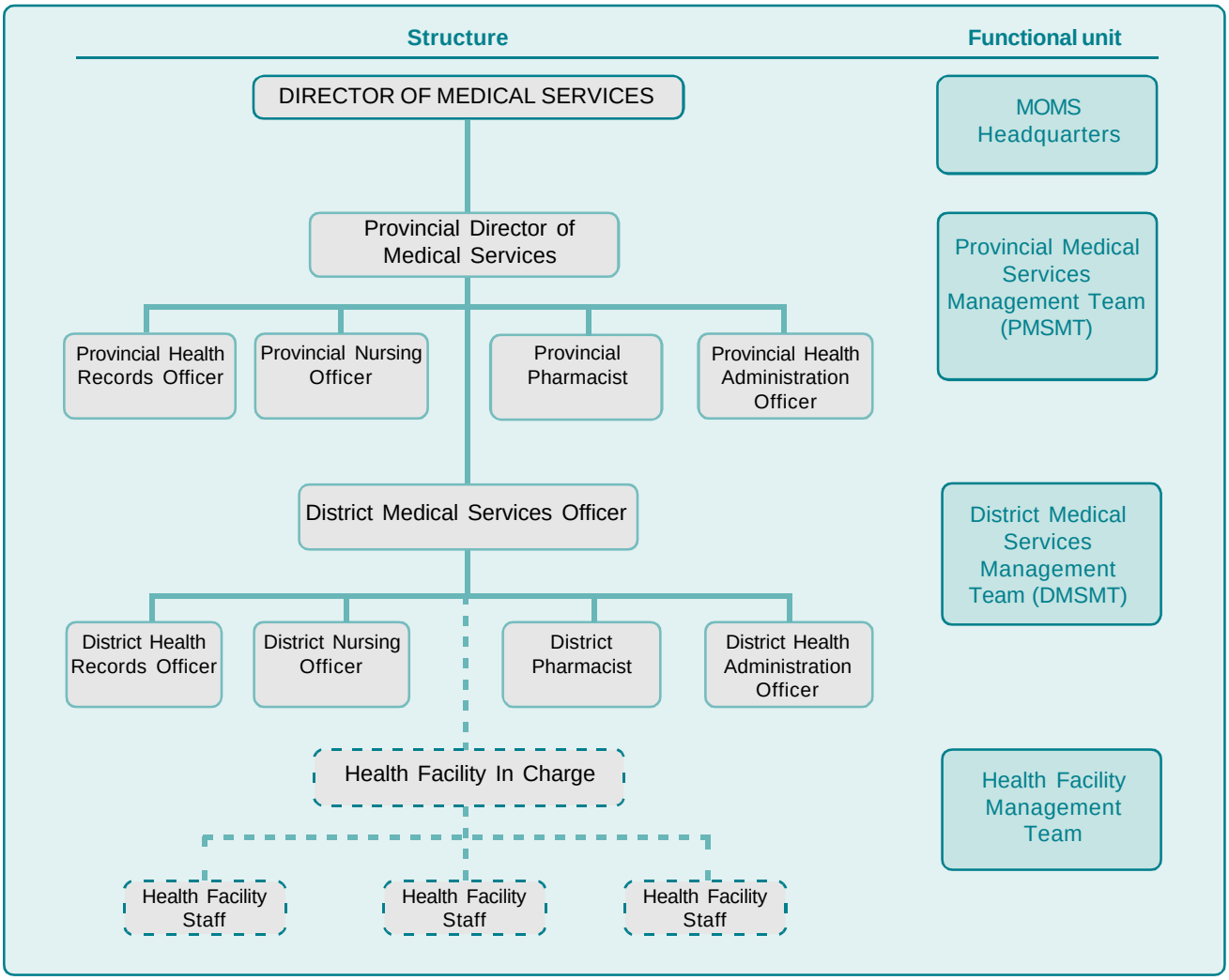
The DMS secretariat coordinates management functions at the national level with those at the subnational level. These management structures are in place at the provincial and district levels (see Figure 8.2).

8.2.1 Management at the Provincial Level

There will be a Provincial Medical Services Management Team (PMSMT), headed by the Provincial Director of Medical Services (PDMS) and housed at the Provincial General Hospital. The team's core membership will be:

- Provincial Director of Medical Services
- Provincial Nursing Officer

Figure 8.2: Organizational structure for Medical Services at the subnational level



- Provincial Health Administrative Officer
- Provincial Medical Services Records Officer
- Provincial Pharmacist

Additional members can be co-opted, depending on the particular tasks being addressed. Specific Medical Services will be provided through the respective hospitals. Zonal specialists, for example, will be responsible for technical coordination of the provision of a defined service across a defined set of districts. They will be drawn from the hospitals amongst the cluster of districts chosen.

The PMSMT, headed by the PDMS, will have the overall objective of coordinating the provision of Medical Services in the province, by ensuring the following functions:

- Liaison between the national level and the province on Medical Services issues
- Planning for delivery of Medical Services in the province through development of annual operational plans for the province
- Monitoring and review of delivery of Medical Services in the province by compiling and analysing quarterly and annual reports
- Coordination of integrated supportive supervision for Medical Services in the province
- Coordination of provision of technical services by zonal specialists
- Equitable distribution of human resources within the province

The PMSMT, headed by the PDMS, will be responsible for coordinating the provision of Medical Services in the province, while the DMSMT, headed by the DMSO, will coordinate the provision of Medical Services in the districts.

- Liaison for Medical Services in the Provincial Health Stakeholders Forum
- Monitoring and following up on ethical practices and discipline amongst medical staff
- Ensuring regular medical audits are done and standards maintained in facilities as per norms, e.g., mortality audits should be held monthly

8.2.2 Management at the District Level

District Medical Services Management Teams (DMSMTs) will be headed by the District Medical Services Officer (DMSO) and housed at the District Hospital. The team will consist of:

- District Medical Services Officer
- District Nursing Officer
- District Health Administrative Officer
- District Medical Services Records Officer
- District Pharmacist

The DMSMT, headed by the DMSO, will have the overall objective of coordinating the provision of Medical Services in the districts under their responsibility, by ensuring the following functions:

- Liaison between provincial level and the hospitals on Medical Services issues
- Planning for delivery of Medical Services in the district through development of annual operational plans for hospitals, clinics and the DMSMT
- Monitoring and review of delivery of Medical Services in the district by compiling and analysing quarterly and annual reports
- Coordination of integrated supportive supervision for Medical Services in the district
- Equitable distribution of human resources within the districts
- Liaison for Medical Services in the District Health Stakeholders Forum
- Monitoring and following up on ethical practices and discipline amongst medical staff
- Ensuring regular medical audits are done and standards maintained in facilities as per norms, e.g., monthly mortality audits

The facility management teams complete the subnational management structure for Medical Services.

Chapter Nine

Resource Flows

Guiding principles for the sector budgeting process and resource allocation at all levels of service delivery are contained in the annual health sector reports. These reports take into account the Kenya Health Policy Framework, the National Health Sector Strategic Plan and the annual sector priorities as agreed by the stakeholders at the National Health Summit. The budget for the sector is aligned to the Government of Kenya's medium-term expenditure framework (MTEF), which is the overall mechanism by which resources expected from government, including donor budget support, is allocated to and within sectors. The MTEF sets sector and local government spending ceilings within a three-year rolling framework.

9.1 Budget Process and Resource Allocation

Allocation of resources in the health sector will be guided by the principles of efficiency and equity. In improving allocative efficiency, it is clear that the sector needs to increase consumption of services (to reach more people) and concentrate resources on cost-effective activities that tackle the greatest burden of disease. A needs-based approach to resource allocation will be developed that takes into account the size of the population, poverty levels, health status of the district, special health needs and access to other funding sources.

9.1.1 Health Sector Working Groups

The health sector working groups (HSWG) – to be constituted by the two Ministries responsible for health – oversee the management of the annual health sector budget process and maintain internal mechanisms to determine and ensure operation of the budget. They should also

> MOMS will use a needs-based approach to resource allocation that takes into account the size of the population, poverty levels, health status of the district, special health needs and access to other funding sources.

ensure a timely consolidation of sector priorities and their cost. The HSWG framework offers the opportunity to key stakeholders to review new health sector projects to ensure that all new investments in the sector are within the framework of NHSSP II and that those new projects represent good value for money.

9.1.2 Health Sector Service Fund

The purpose of the HSSF is to decentralize decision making in respect to budget allocation. The health ministries will prepare work plans that will be financed centrally, the funds channelled into their respective bank accounts. The facility committees (Boards) will provide the oversight role. Partners will be expected to pool resources into a common fund, which will then be disbursed according to agreed criteria. The funds will support provision of medical supplies, rehabilitation and equipment of health facilities, capacity building in management of facilities, empowerment of rural communities to take charge of their health issues, and other identified and agreed services.

9.2 Costing of the Ministry of Medical Services Strategic Plan

The costing of the strategic plan for the next five years involves an aggregate estimate of the entire sector spending requirements for the period. It entails costing the interventions and inputs intended to yield reasonable progress towards the achievement of the strategic plan and MDG targets.

9.2.1 Costing Methodology

The logic of the model rests in two main data sets – actual facility costs and normative resource inputs. These two data flows produce unit costs of services and then projections of total costs of providing services. The estimates are based first on current utilization (current number of inpatients, outpatients, community outreach services, etc.). Targets or projections for future utilization of services (scenario utilization) are then drawn.

Final unit and total costs are based on a series of core assumptions, including numbers of facilities (by level); proportion of patients/population served by public, FBO, NGO and private providers; services included in the KEPH; normative assumptions about the way KEPH services are provided; core inflation rates including wage increases; and target occupancy of services.

Total cost of services amounts to around Ksh61.4 billion; of this 54% is for public sector facilities, 17% for FBO/NGO facilities, 22% for private for profit; and 6% for overall administration provided directly by the Ministry, province and district. Around 38% of this cost is absorbed by salaries (53% of recurrent funding) and 21% by drugs and medical supplies.

The recurrent cost for the public sector (Ksh27 billion) is comparable to the Ksh21 billion reported by the Ministry of Health for budget year 2006/07. The remainder of the cost is financed through formal facility user charges, user demand-side costs (transport, prescriptions purchased outside facilities) and contributions from other sources including direct donor funding.

The cost of implementation was calculated by building on the cost estimates compiled in the costing model under the auspices of the Health Financing Strategy and adjusting for new initiatives and scaling up of key interventions,. Costing was done by level, considering the cost of delivering a package of services to a given population in an integrated manner, as opposed to costing out individual programmes.

9.2.2 Annual Costs of Financing Health Care

As shown in Table 9.1, the costs are classified as recurrent and non-recurrent and cover all GOK hospital and profit/non-profit services.

9.3 General Assumptions

Calculation of the growth in cost requirements assumed an annual inflation rate of 20% and an exchange rate of Ksh75 to US$1.00. Personnel costs include salaries and all consolidated allowances to the sector staff. To cost the total annual earnings, the following were taken into consideration:

Table 9.1: Total costs for financing health care (by economic classification)

Category	Drugs and other supplies	Staffing	Fixed recurrent (O&M, etc.)	Recurrent	Annualized capital	Total
Community (public)	57,280,000			57,280,000	8,340,000	65,620,000
Dispensary (public)	1,273,315,841	2,241,855,401	164,389,281	3,679,560,522	1,208,367,670	4,887,928,192
Health centre (public)	559,423,997	1,833,782,252	155,150,122	2,548,356,370	869,208,606	3,417,564,976
District hospital (public)	3,897,234,115	6,952,332,632	1,224,195,724	12,073,762,471	5,633,333,168	17,707,095,639
Provincial hospital (public)	492,937,012	1,501,691,183	214,070,239	2,208,698,435	371,581,873	2,580,280,308
Tertiary hospital (public)	864,564,638	2,565,353,328	478,825,975	3,908,743,941	385,456,530	4,294,200,472
Nursing home/Enhanced Health centre (public)	11,194,155	41,345,779	4,302,559	56,842,493	12,941,071	69,783,564
2/3 Health centre/Dispensary (FBO/NGO)	945,086,374	991,019,590	405,621,921	2,341,727,884	1,255,283,892	3,597,011,777
District hospital (FBO/NGO)	1,715,037,667	1,770,434,407	811,814,765	4,297,286,838	2,273,099,348	6,570,386,187
Nursing home/Enhanced Health centre (FBO/NGO)	3,584,664	21,559,166	4,150,211	29,294,041	12,508,573	41,802,615
2/3 Health centre/Dispensary (Private)	1,364,857,076	2,964,743,438	697,008,234	5,026,608,748	3,138,209,731	8,164,818,479
District hospital (private)	616,558,450	791,394,619	344,253,941	1,752,207,010	1,729,532,113	3,481,739,123
Tertiary hospital (private)	675,808,000	290,410,416	321,241,000	1,287,461,416	385,456,530	1,672,917,947
Nursing home/Enhanced Health centre (private)	110,843,406	132,407,042	84,295,557	327,546,004	70,881,916	398,427,920
District administration	9,032,904	782,370,676	635,237,840	1,426,641,421	-	1,426,641,421
Provincial administration	0	89,063,229	55,303,606	144,366,834	-	144,366,834
Ministry of Health	0	556,553,659	2,312,992,099	2,869,545,758	-	2,869,545,758
Total	12,596,758,299	23,526,316,816	7,912,855,074	44,035,930,188	17,354,201,022	61,390,131,210
	21.0%	38.0%	13.0%	72.0%	28.0%	100.0%

Operations and maintenance costs include equipment maintenance, travel expenses, utilities, office supplies, food and linen for inpatients, and other recurrent expenditures.

- Salary scale by all cadres
- Staff in post per the revised staff norms

Four categories of recurrent costs are considered:

- Human resources
- Drugs, vaccines and medical supplies – EMMS, anti-retroviral drugs (ARVs), artemisinin combination treatment (ACT) for malaria
- PHC services like supplemental immunization activities, IEC, blood transfusion, reproductive health
- Operations and maintenance

In terms of human resources for health, the proportion of approved (authorized) posts filled with qualified health workers was found to be 45%. By applying sector minimum norms, guided by expert knowledge of the sector and taking into consideration the output of training schools, the capacity of recruitment agencies and the availability of funds, the targets for the proportion of authorized posts filled with qualified health workers were estimated at 55% in year 1 rising to 75% in year 4. The personnel cost was calculated by using the estimated salary levels at different levels of health care and the 10% salary increments recommended by the Ministry of State for Public Service and applying an inflation rate of 10%.

Operations and maintenance costs are the recurrent costs of running all levels of health facilities and systems. They include equipment maintenance, travel expenses, utilities, office supplies, food and linen for inpatients, etc. Estimates are based on unit costs per level, as shown in Table 9.2.

9.4 Costs for Medical Services Goals

Table 9.3 summarizes expenditure requirements by the objectives of NHSSP II and the strategic thrusts of this strategic plan. The table shows the goals for 2012 and the annual cost estimates.

Table 9.2: Unit costs per facility

Unit costs (Ksh)	Outpatient visit	Admission	Bed-days	Adjusted bed-days	CI (% average)
Dispensary (public)	153	-	-	763	44%
Health centre (public)	219	3,500	3,500	1,187	34%
District hospital (public)	514	12,970	2,186	2,316	84%
Provincial hospital (public)	407	13,195	1,381	1,485	38%
Tertiary hospital (public)	1,206	49,744	3,255	3,468	0%
Nursing home/Enhanced health centre (Public)	174	1,713	1,375	947	86%
2/3 Health centre/Dispensary (FBO/NGO)	435	1,995	3,732	2,245	38%
District hospital (FBO/NGO)	1,087	14,862	3,685	4,067	56%
Nursing home /Enhanced health centre (FBO/NGO)	18,965	13,807	8,787	12,154	196%
2/3 Health centre/Dispensary (private)	769	3,504	7,409	4,002	61%
District hospital (private)	1,631	44,659	10,552	9,651	86%
Tertiary hospital (private)	2,197	96,857	18,704	16,107	0%
Nursing home /Enhanced health centre (private)	1,355	14,142	3,943	4,756	44%

Table 9.3: Resource requirements for implementation of different goals

NHSSP II objective	Strategic thrust	Goal for 2012	Resource requirements (Ksh million)				
			2008/09	2009/10	2010/11	2011/12	Total
Improve the quality and responsive-ness of services in the sector	Institute medical services reforms that will ensure high quality services	Capacity to offer quality cost efficient referral services is adequate in all hospitals in the country	40	44	48	53	185
		Adequate capacity for leadership and management to optimize health services delivery in Kenya	30	70	100	120	320
		Functional governance and accountability systems at all levels of the Ministry	20	40	60	90	210
		Application of ICT in the provision and management of information and services at a distance practised in all level 4–6 facilities	10	12	15	18	55
		All level 5 and 6 facilities providing services for medical tourists to Kenya	300	254	250	250	1,054
		Functional Health Service Commission	60	100	150	250	560
		Quality of hospital services improved by at least 50%, as measured technically and by clients	65	35	40	50	190
		Level 4–6 hospitals having operational autonomy	65	35	30	35	165
	Strengthen emergency prepared-ness and disaster manage-ment	Delivery of routine services restored 100% in affected areas	400	600	200	50	1,250
		Increase health services to displaced persons to 100%	20	40	0	0	60
		Reforms to the waiver systems to address bureaucratic bottlenecks	60	58	20	10	148
		Provision of both medical and psychosocial services to affected populations including GBV services	155	120	280	200	755
		Staff increased by 1,000 in the affected regions	200	70	50	10	330
		Buffer stocks replenished in the affected hospitals to full capacity	300	300	100	50	750

Continued

Table 9.3, *continued*: Resource requirements for implementation of different goals

NHSSP II objective	Strategic thrust	Goal for 2012	Resource requirements (Ksh million)				
			2008/09	2009/10	2010/11	2011/12	Total
	Emergency preparedness, cont.	Maintenance and repair of equipment and buildings in affected hospitals	18	15	9	8	50
	Institute and enforce appropriate regulatory measures for medical services	Updated roles and responsibilities of boards and councils in line with current expectations	5	7	10	12	34
		Updated Public Health act	25	27	10	5	67
		Professional bodies strengthened and able to contribute to professionalism and ethics, as well as the enforcement of standards and regulations	10	10	10	10	40
Subtotal			*1,783*	*1,837*	*1,382*	*1,221*	*6,223*
Foster partnerships in improving health and delivering services	Institute structures and mechanisms for improved alignment, harmonization and Government ownership of planned interventions	Monitoring and evaluation tools and mechanisms utilized at all levels of the sector	25	30	40	55	150
		Common arrangements for alignment of planning, budgeting and monitoring systems in use across whole sector	80	100	80	70	330
		Use of Government procedures and systems by at least 60% of donors	5	5	5	5	20
		Inter-ministerial coordinating process and structures in place and functional by 08/09	20	20	25	35	100
		Framework in place to guide partnership with IPs (PPP) by 09/10	60	120	70	40	290
Subtotal			*190*	*275*	*220*	*205*	*890*
Improve the efficiency and effectiveness of service delivery	Have reliable access to essential, safe and affordable medicines and medical supplies that are appropriately regulated, managed and utilized	KEMSA strengthened to be a strategic procurement and distribution agency for the entire health sector and able to supply medical goods and supplies at all levels with improved efficiency, in accordance with Good Distribution Practices 9 (includes seed capital)	600	800	1,000	600	3,000
		Selection of Essential Medicines and Medical Supplies is evidence-based in the whole country	8,400	9,240	10,164	11,180	38,984
		EMMS procurement based on needs quantification at all levels					0
		EMMS procured in a timely, transparent and accountable manner	100	80	70	60	310
		Quality and secure stocks of EMMS maintained at all levels	8	8	8	8	32
		EMMS are distributed in accordance to Good Distribution Practice (GDP) at all levels	15	20	10	12	57
		Optimal therapy through good prescribing and dispensing practices	11	10	12	15	48
		Safe and environmentally-friendly disposal of EMMS waste	10	15	20	18	63

Continued

Table 9.3, *continued*: Resource requirements for implementation of different goals

NHSSP II objective	Strategic thrust	Goal for 2012	Resource requirements (Ksh million)				
			2008/09	2009/10	2010/11	2011/12	Total
	Improve infrastructure, equipment and ICT investment and preventive maintenance	Percentage of level 4–6 facilities that meet minimum norms on infrastructure increased from 37% to 70%.	525	2,570	2,675	2,100	7,870
		Percentage of level 4–6 facilities equipped as per norms increased from 37% to 70%	1,238	2,330	2,325	2,500	8,393
		Level 4–6 facilities have the necessary communication and ICT infrastructure to support business processes	70	85	100	50	305
		100% of level 4–6 with adequate transport for utility and ambulance services	250	180	200	100	730
		Health service provision improved through appropriate technology in 45 hospitals by 2012	100	80	60	100	340
	Develop and manage the health workforce	Improved development of human resource capacity to meet the health needs of the population	300	400	550	800	2,050
		Adequate numbers of equitably distributed and appropriately skilled and motivated health workers	25,000	28,750	33,062	38,021	124,834
Subtotal			*36,631*	*44,578*	*50,270*	*55,584*	*187,063*
Improve financing of the health sector	Establish an equitable financing system that ensures social protection, particularly for the poor and vulnerable	Financing strategy that ensures social protection	100	65	20	120	305
		Contributors to NHIF expanded from 2.2 million to 9.6 million persons	700	400	350	250	1,700
		Number of households facing catastrophic health expenditures reduced	200	200	200	200	800
		Amount of resources reaching point of use increased from 40% to 70%	60	50	40	30	180
		Resources are allocated and utilized in an equitable manner	40	40	40	40	160
		Increase in predictable resources during the MTEF period by 50%	10	30	15	25	80
Subtotal			*1,110*	*785*	*665*	*665*	*3,225*
Overall total			39,714	47,475	52,537	57,675	191,178

9.5 Available Financing for Medical Services Goals

Provisional GOK funding allocations are summarized in Table 9.4 by MTEF category. The table presents known financing available to support programme goals, by source of financing and by year of implementation.

Table 9.4: Allocations in Ksh millions

	2008/09	2009/10	2010/11	2011/12
AIA	62.0	64.3	67.1	69.5
Equipment	599.2	621.5	648.3	671.7
Infrastructure	444.2	460.7	480.6	497.9
Grants	7,772.7	8,062.1	8,409.4	8,713.3
HR	12,564.7	13,032.5	13,593.9	14,085.1
O&M	1,294.5	1,342.7	1,400.5	1,451.1
Specialized materials	4,121.4	4,274.8	4,459.0	4,620.1
Total	**26,858.7**	**27,858.7**	**29,058.7**	**30,108.7**

9.6 Financing Gaps for the Medical Services Goals

Estimated financing gaps are summarized in Table 9.5. They are based on provisional GOK funding allocations. The estimated funding gap for MTEF categories of equipment, human resources, infrastructure and specialized materials is Ksh90.6 million over three years. Estimated gaps for AIA, grants and O&M cannot yet be allocated against the requirements.

Table 9.5: Estimated funding gap (Ksh millions)

Category	2008/09	2009/10	2010/11	2011/12	Total
Equipment	-	2,053	2,037	2,078	7,826
Human resources (PME)	-	15,717	19,470	23,937	59,124
Infrastructure	-	2,109	2,194	1,602	6,430
Specialized materials	-	4,966	5,706	6,560	17,231
Grand total	-	24,845	29,407	34,177	90,611

Chapter Ten

Accountability and Risk

A formal risk assessment was carried out in the course of the development of this strategic plan, along with the identification of the parties responsible for the various phases of the proposed activities. The section presents, first, the responsible units for accountability purposes and then an itemized tracking of the identified risks.

10.1 Responsible Units

Responsible units for the different goals are highlighted in Table 10.1 by the objectives of NHSSP II, the strategic thrusts of this strategic plan and the goals to be achieved over the period of the plan.

10.2 Risk Assessment

The strategic direction outlined in this document is considered "medium to high risk", and potentially of high impact judged against the purpose of achieving the targets of NHSSP II. Some key risks that may hinder the ability of the Ministry to implement the planned strategies are discussed in the following sections. A risk–impact matrix is presented in Table 10.2.

Table 10.2: Summary risk–impact matrix

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

Note: Letter designations refer to risks itemized below.

The plan takes the following risks into account:

- GOK does not adequately increase its allocation to medical services
- Funding partner support is not forthcoming
- Inadequate progress in improving credibility of common management arrangements
- Viability of the health sector as an integral entity
- Inability to adhere to the ministry's defined principles
- Political changes in the country leading to shifting priorities
- Inadequate accountability mechanisms
- Funding partners do not adhere to good partnership principles
- Emerging priorities beyond those planned

Table 10.1: Accountability for accomplishing this strategic plan

NHSSP II objective	Strategic thrust	Goal for 2012	Responsible unit
Improve the quality and respon-siveness of services in the sector	Institute medical services reforms that will ensure high quality services	Capacity to offer quality cost efficient referral services is adequate in all hospitals in the country	DMS
		Adequate capacity for leadership and management to optimize health services delivery in Kenya	Technical planning and coordination department
		Functional governance and accountability systems at all levels of the Ministry	PS
		Application of ICT in the provision and management of information and services at a distance practised in all level 4–6 facilities	ICT department
		All level 5 and 6 facilities providing services for medical tourists to Kenya	DMS
		Functional Health Service Commission	Standards and regulations
		Quality of hospital services improved by at least 50%, as measured technically and by clients	M/E
		Level 4–6 hospitals having operational autonomy	PS
	Strengthen emergency preparedness and disaster management	Disaster response team in each hospital	Surgery
		Trained medical personnel on disaster response and management	Surgery
		Guidelines developed for standard operating procedures	Surgery
		Increased infrastructure for disaster and emergency response	Technical administration
	Institute and enforce appropriate regulatory measures for medical services	Implement quality assurance and standard performance measurement framework	Standards and regulation
		Accreditation standards for the health sector developed	"
		Strengthened health professional capacity through e-learning	"
		Enhanced regulatory services for quality medical care	"
		Kenya National Health Policy 1994 (KNHP) revised, new policy adopted and implementation plan developed	"
		Regulations in place for alternative medicine practice	"
		Health research coordinated and regulated	"
		Public Health Act reviewed to ensure quality medical services delivery	"
Foster partner-ships in improving health and delivering services	Institute structures and mechanisms for improved alignment, harmonization and Government ownership of	Planning, monitoring and evaluation tools and mechanisms utilized at all levels of the sector	
		Common arrangements for alignment of planning, budgeting and monitoring systems in use across whole sector	Technical planning and coordination
		Use of Government procedures and systems by at least 60% of donors	"
		Inter-ministerial coordinating process and structures in place and functional by 08/09	"

Continued

Table 10.1, *continued:* Accountability for accomplishing this strategic plan

NHSSP II objective	Strategic thrust	Goal for 2012	Responsible unit
Partner-ships, continued		Availability of quality health information from 90% of the reporting units for evidence-based decision making.	HMIS
Improve the efficiency and effective-ness of service delivery	Ensure reliable access to quality, safe and affordable essential medicines and medical supplies that are appropriately regulated, managed and utilized	KEMSA strengthened to be a strategic procurement and distribution agency for the entire health sector and able to supply medical goods and supplies at all levels with improved efficiency, in accordance with Good Distribution Practices	
		Revise, adopt and develop an implementation plan for the KNDP	Pharmacy
		KEMSA is provided with autonomy to perform its legal mandate as the agency to procure , warehouse and distribute medical commodities primarily to public sector in accordance with Good Distribution Practices	"
		Evidence-based selection of Essential Medicines and Medical Supplies in the health sector	"
		Quantification of EMMS institutionalized at all KEPH levels	"
		Transparent, accountable and timely procurement of EMMS at institutional level (only for bridging gaps)	"
		Secured institutional EMMS storage infrastructure with product quality assurance	"
		EMMS are distributed in accordance to Good Distribution Practice (GDP) at all levels	"
		Optimal therapy through good prescribing and dispensing practices	"
		Safe and environmentally-friendly disposal of EMMS waste	"
		EMMS appropriately utilized by clients	Pharmacy
		Adequate financial resources mobilized for procurement and distribution of EMMS	Pharmacy
		EMMS provided for public sector are high quality, safe, efficacious and in accordance with legal requirements and professional standards	Pharmacy
		Operational research on EMMS and their use supported to address related health issues	"
		EMMS donations rationalized	Pharmacy
	Provide a network of functional, efficient and sustainable health infra-structure for effective delivery of health care services	Percentage of level 4–6 facilities that meet the minimum norms on hospital buildings and land increased from 37% to 70%.	Technical administration/bio-medical engineering
		Percentage of level 4–6 facilities equipped as per norms increased from 37% to 70%	"
		Levels 4–6 equipped with adequate transport for utility and ambulance services	"
		Appropriate ICT in 30% of the hospitals by 2012	ICT

Continued

Table 10.1, *continued:* Accountability for accomplishing this strategic plan

NHSSP II objective	Strategic thrust	Goal for 2012	Responsible unit
Improve the efficiency and effective-ness of service delivery, continued	Develop and manage the health workforce	Adequate numbers of equitably distributed and appropriately skilled and motivated health workers	Human resource for health dept
		Improved development of human capacity to meet the health needs of the population	"
		Improved retention of health workers at all levels	"
		Institutionalized performance management systems	"
		Improved human resource management systems and practices	"
Improve financing of the health sector	Establish an equitable financing system that ensures social protection, particularly for the poor and vulnerable	Financing strategy that ensures social protection	Policy planning
		Regular review and evidence-based financial decision making	Policy planning
		Contributors to NHIF expanded from 2.2 million to 9.6 million persons	NHIF
		No. of households facing catastrophic health expenditures reduced	
		Amount of resources reaching point of use increased from 40% to 70%	
		Resources are allocated and utilized in an equitable manner	
		Predictable resources during the MTEF period increased by 50%	

10.2.1 *Risk A:* GOK Does Not Adequately Increase Its Allocation to Medical Services

GOK continues to prioritize allocation of funding to health and MOH has been the third largest recipient of public expenditure, but at a level far below GOK's own target. As a result of a large amount of off-budget fungible funding going to programme areas and other public health initiatives, GOK may not increase its allocation to Medical Services. Fundamental to the success of this plan is that the GOK will continue to prioritize funding to Medical Services as the Ministry's primary source for financing investments. Current levels of funding fall short of the minimum requirement to provide for the planned investments.

MITIGATION: Strengthened advocacy for increased GOK resources by the sector, guided by evidence, particularly on impact of additional investments on overall morbidity and mortality.

10.2.2 *Risk B:* Funding Partner Support Is Not Forthcoming for Planned Strategies

In line with the partial interpretation of the PHC approach, Kenya's funding partners have not focused investments in Medical Services. Some new partners are now coming on board, particularly for investments in commodities and infrastructure. As yet, however, these are at too low a level to achieve the necessary impact. The available support is not well harmonized, leading to high transaction costs in managing the support, some duplication in financing and difficulty in ensuring that the funds are aligned to the priorities.

MITIGATION: The Ministry will have to engage with more funding partners to raise the additional resources needed to implement the planned strategies. Strengthened implementation of strategies for guiding and monitoring harmonization and for aligning partner funds is needed.

10.2.3 *Risk C:* Inadequate Progress in Improving Credibility of Common Management Arrangements

Many of the funding sources that would potentially support Medical Services would like to utilize common arrangements, particularly for procurement and financial management. Presently, however, there are varying levels of confidence amongst these partners in the existing Government management arrangements. This is related to different perceptions of trust, confidence and transparency in these processes.

MITIGATION: Addressing these concerns has the potential of making available a significant amount of additional resources to Medical Services. Implementation of the interventions to improve procurement and financial management systems will therefore not only improve the efficiency of use of available resources, but also improve potential for mobilizing more resources and reducing transaction costs as more funding sources use the common systems.

10.2.4 *Risk D:* Viability of the Health Sector as an Integral Entity

Medical Services represents just one part of the overall health sector. Success or failure of the other parts of the sector will directly affect our ability to carry out our planned strategies. For example, if Public Health interventions are not adequately provided, there will be a significant increase in the population seeking medical care, placing and unplanned strain on resources for Medical Services. Mechanisms to coordinate the sector have been maintained in this plan, with NHSSP II providing overall sector guidance and inter-ministerial coordination of the proposed interventions.

MITIGATION: It is necessary to ensure that effective systems be put in place for inter-ministerial coordination, particularly with the MOPHS. In addition, mechanisms for strengthening sector-wide partnership should be actively implemented at both national and subnational levels.

10.2.5 *Risk E:* Inability to Adhere to the Ministry's Defined Principles of Efficiency, Equity, Quality, Effectiveness and Partnership

Implementation of all the planned interventions is to be guided by these principles to ensure the best possible outcomes. Yet even though they form the basic principles for the provision of Medical Services, the sector has not traditionally monitored itself against them. For example, new facilities constructed has been an output measure, which was not related to how efficiently the facilities were constructed, whether they were constructed in the area of greatest need, whether the new investments represented the most effective use of the invested resources, and so on. Adherence to principles gives the Ministry its best possible outcomes with available resources and improves the potential for mobilizing additional resources.

MITIGATION: The Ministry will have to review its monitoring and review mechanisms to ensure it is able to monitor how well the implemented strategies adhere to the principles of the Ministry.

10.2.6 *Risk F:* Political Changes in the Country Leading to Shifting Priorities

The Ministry of Medical Services was set up as a result of the political settlement of the post-election events of December 2007. While the establishment of the Ministry provides the opportunity to focus on improving the provision of Medical Services, its viability is intricately linked to the survival of the Grand Coalition Government. The political landscape, and

therefore the health ministries and their priorities, cannot be predicted in the absence of this coalition arrangement.

MITIGATION: The Ministry will have to accelerate implementation of its priority interventions, to ensure they are institutionalized into the priorities of the health sector. It will need to clearly illustrate the overall health benefits of the investments and focus on Medical Services. This should enable dissociation of the survival of the Medical Services priorities from the political arena.

10.2.7 *Risk G:* Inadequate Mechanisms for Follow Up of Accountability

Many levels of the Ministry are not used to a culture of accountability for planned activities and resources. This is a function of the partial implementation and follow up of the results-based management approach in Government.

MITIGATION: This risk can be mitigated by scaling up the use of performance contracts in the Ministry and instituting a mechanism to reward/punish the different levels of the system depending on outputs as this process is put in place. Capacity for appropriate results-based planning and monitoring will continue to be strengthened.

10.2.8 *Risk H:* Funding Partners Will Not Adhere to Good Partnership Principles of Harmonization, Alignment, Predictability of Funding and Respect for Government Ownership

The Paris Declaration outlined the principles of aid effectiveness. These are built on the premise of government ownership of country strategies and call for improvements in the harmonization of partner support, which should be aligned to support the defined government priorities to improve government ownership. Additionally, support should be more predictable to allow for better planning. The current support from funding partners adheres to these principles in varying degrees.

MITIGATION: Stronger mechanisms to monitor adherence to the Paris principles through the Code of Conduct are needed to ensure adherence by all partners (including Government), along with home grown mechanisms for reward/punishment. Instruments to guide partnership should be strengthened.

10.2.9 *Risk I:* Emerging Priorities beyond What Has Been Planned, Such as Emergencies or Disasters

This strategic plan is a reform-based plan that is attempting to revamp and take forward the provision of quality medical services in the country. Strategies are based on the current situation. In the event that interventions arise that lead to a shift in the present situation, there is a risk that the planned priorities may not get implemented.

MITIGATION: There is some urgency to the need to fortify emergency and disaster preparedness and response.

Chapter Eleven

Monitoring, Evaluation and Reporting

Our ability to plan, monitor and evaluate the functioning of this plan is essential if we are to correctly target interventions and assess whether they are having the desired impact. The Ministry will use a key set of indicators to monitor progress. The selection of indicators was guided by the need to be able to detect change and progress in the key outcomes that are targeted. The indicators relate to both the level and the distribution of inputs and outputs.

11.1 Framework for Monitoring and Reporting

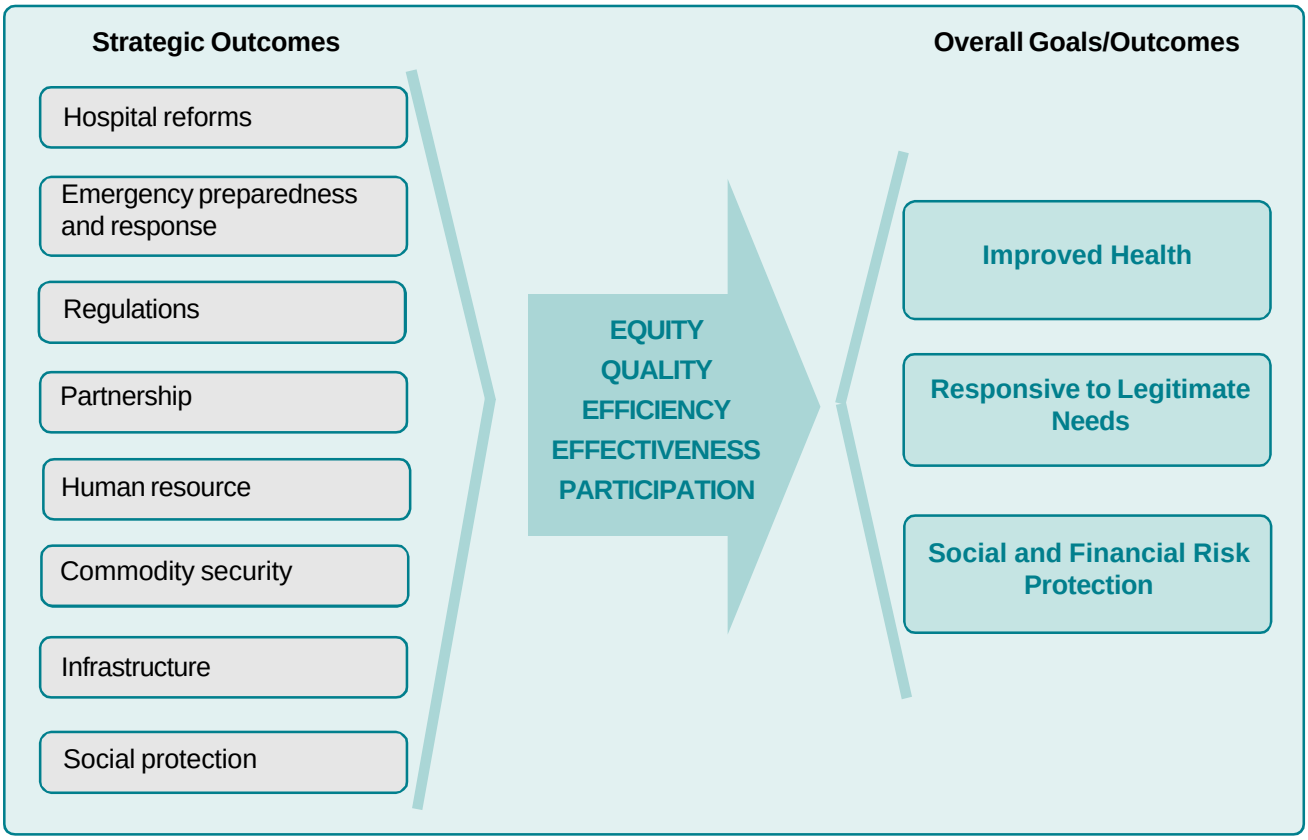
The monitoring framework for tracking progress is informed by the WHO Health Systems Assessment Framework, relying on the definition of information on the core outcomes and principles and their relation to overall sector goals. These are inter-related as shown in Figure 11.1.

Core indicators are structured to inform on and compare trends across the different outcomes, using a "dashboard" approach. This is a planning and monitoring concept that takes into consideration the inter-linkages of the respective indicators. That is, the indicators are not viewed in isolation, but rather are intricately linked to provide information on overall progress. Progress is not just in client health, but also in terms of the responsiveness of the system to the legitimate needs of the clients and the ability to provide social and financial risk protection. Progress will be seen in the context of our impact according to our defined principles, and therefore on reaching the MDGs.

Subanalyses of the selected indicators by sex, age, geographical distribution and contribution by different partners will also be monitored to ensure that the principles of equity, effectiveness partnership and efficiency are followed up.

> The monitoring and review process will be interlinked across the different planning units, with service delivery information to feed the monitoring and review process derived from the bottom up.

Figure 11.1: Framework linking the outcomes of the health system with its goals and desirable attributes



11.2 Indicators for Monitoring Progress

Selected indicators for monitoring the outcomes for each strategic thrust of this plan are specified in Table 11.1, with the Ministry's specific national level indicators highlighted.

The Ministry has in the past not been able to adequately use monitoring information to inform its overall direction. Progress has been interpreted according to individual indicators, without taking into consideration the progress (or lack of it) among other related indicators. In this strategic plan, however, the additional value of the dashboard is to ensure that our progress is measured not by individual indicators, but by

Table 11.1: Indicators of achievement of the strategic thrusts

No	Outcome area	No	Indicator	Value				Indicator description	Frequency of collection
				08/09	09/10	10/11	11/12		
1	Hospital reforms	1a	% of clients satisfied with services	65	70	75	80	***Numerator:*** Number of sampled clients expressing satisfaction with services ***Denominator:*** Total number of sampled clients	Annually, through client satisfaction exit surveys
		1b	% of facilities with improved performance	--	30	60	100	***Numerator:*** Number of facilities for which performance is measured as improving ***Denominator:*** Total number of facilities	Annually, from districts and provinces during AOP monitoring

Shaded cells: Ministerial national indicators

Continued

Table 11.1, *continued:* Indicators of achievement of the strategic thrusts

No	Outcome area	No	Indicator	Value				Indicator description	Frequency of collection
				08/09	09/10	10/11	11/12		
2	Disaster preparedness and management	2a	% of hospitals with functional emergency response and disaster management teams in the country	0	7	31	64	***Numerator:*** Number of hospitals with functional emergency response and disaster management teams ***Denominator:*** Total number of hospitals assessed	
		2b	% of hospitals with health workers trained on emergency and disaster response	0	40	60	100	***Numerator:*** Number of hospitals with health workers trained on emergency and disaster response. ***Denominator:*** Total number of hospitals assessed	
3	Regulation	3	% of health facilities meeting accreditation standards	20	40	60	60	***Numerator:*** Number of facilities meeting accreditation standards ***Denominator:*** Total number of facilities visited	Annually, from districts and provinces during AOP monitoring
4	Partnership and governance	4a	Number of partners subscribing to COC	14	17	20	20	Number	Annually
5	Human resource for health	5a	% of level 4–6 facilities that achieve at least 80% of the approved staff establishment					Number	Annually, from districts and provinces during AOP monitoring
		5b	% of facilities that meet minimum staffing norms	TBD		80	100		
6	Infrastructure	6a	% of hospitals rehabilitated as per approved plans	37	45	56	70	Number	Annually, from districts and provinces during AOP monitoring
		6b	Number of hospitals equipped as per minimum norms and standards	37	45	56	70	Number	Annually, from districts and provinces during AOP monitoring
7	Commodity security	7a	% of public health facilities reporting no stock outs of tracer commodities all year round			100	100	***Numerator:*** Number of assessed facilities having all defined tracer medicines and commodities in stock all year round ***Denominator:*** Total number of assessed facilities	Annually, from districts and provinces during AOP monitoring
		7b	% of health facilities with functional medicine and therapeutic committees	10	30	50	60	***Numerator:*** Health facilities with functional medicine and therapeutic committees ***Denominator:*** Total number of assessed facilities	
8	Social protection	8a	% population covered by public health insurance	25	30	35	40	***Numerator:*** Total number of persons covered under any form of public health insurance ***Denominator:*** The total population	Annually, from NHIF data

TBD: To be determined
Shaded cells: Ministerial national indicators

how they are all progressing. Interpretation of progress will therefore be based on the structure summarized in Table 11.2.

The AOPs represent the framework for guiding information on the annual, quarterly and monthly reviews. All planning units will prepare specific AOPs, which will be consolidated into one Ministry-wide AOP.

11.2.1 Linkage of Different Levels

The monitoring and review process will be interlinked across the different planning units. Service delivery information to feed the monitoring and review process will be derived from the bottom up. This implies that information at each level will be provided from the planning units below it. Management support, on the other hand, as well as governance/ partnership information will be analysed at the same level it is to be provided.

11.2.2 Role of Governance, Partnership and Stewardship

Respective reviews will be guided by information developed by the Government management structures at each level. These will compile the review information with inputs from the other implementing partners.

With the exception of the monthly reviews, all other reviews will be presented and endorsed at the respective partnership structures for the level. These are the stakeholder forums for districts and provinces, and the Health Sector Coordinating Committee at the national level.

Table 11.2: Monitoring and review process

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

References

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ministry of Medical Services
Afya House
Cathedral Road
PO Box 30016 GPO
Nairobi 00100, Kenya
www.health.go.ke