

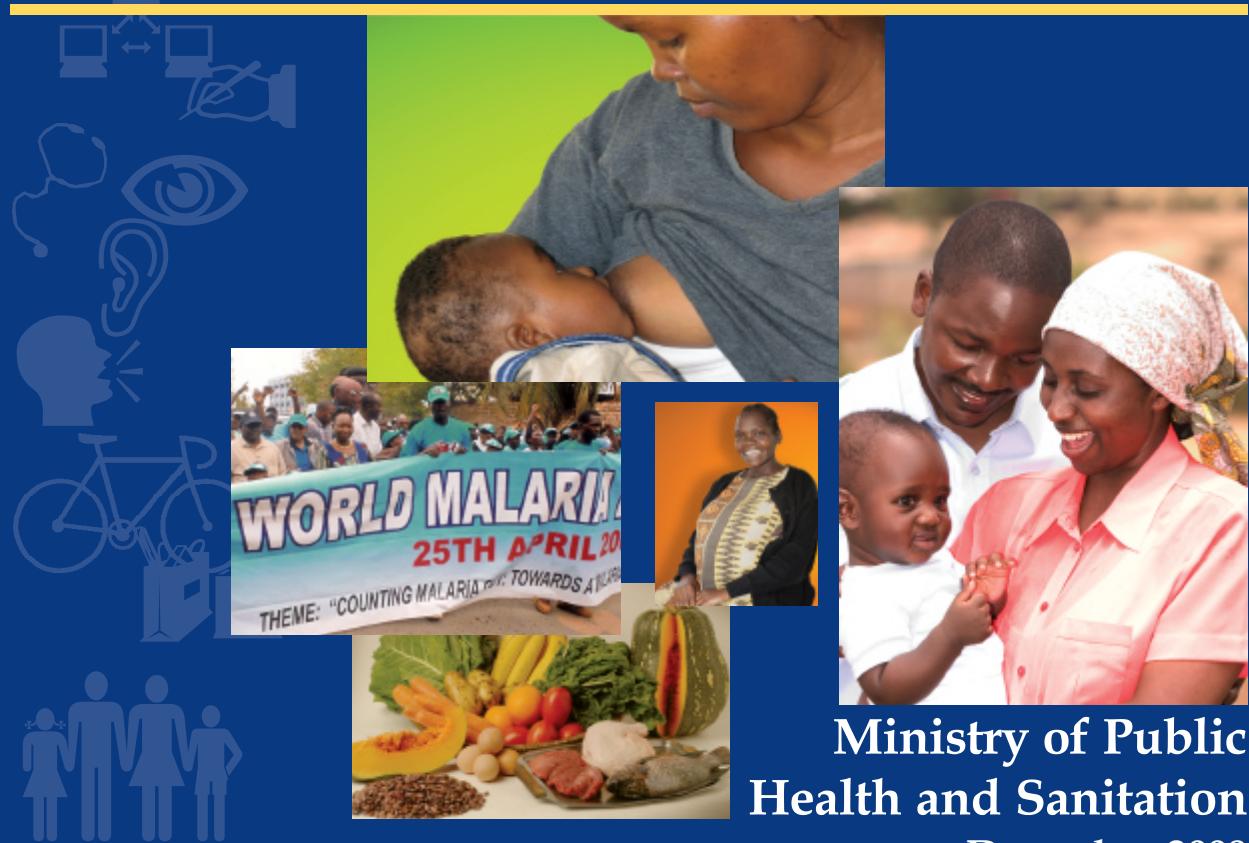


Republic of Kenya

Reversing the trends
The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya



Ministry of Public Health
and Sanitation
STRATEGIC PLAN
2008-2012



Ministry of Public
Health and Sanitation
December 2008





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and Sanitation**

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2008–2012

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December 2008

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Ministry of Public Health and Sanitation Strategic Plan, 2008–2012

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Message from the Minister

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

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

Priority will be given to scaling up the implementation of interventions aimed at enhancing the equitability of access to public health and sanitation services. Such measures will include improving immunization coverage for children, ensuring that most deliveries are conducted under the care of skilled health attendants, and

reducing morbidity and mortality from malaria, HIV/AIDS, tuberculosis and non-communicable diseases.

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

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



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

Acknowledgements

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

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

- *Service Delivery Team:* Dr. John Odondi, Primary Health Services; Dr. Josphine Kibaru, Family Health; Mr. Kepha Ombacho, Sanitation and Environmental Health; and Dr. Salim Ali, Health Promotion.

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

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

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

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

great contributions to the development of this plan.

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



Mark Bor, EBS

Permanent Secretary
Ministry of Public Health and Sanitation
December 2008



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List of Abbreviations

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

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

Executive Summary

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

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

The Process

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

priorities, strategies and implementation matrix of the plan were developed.

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

The Priorities

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

Among the priorities of this Plan are:

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

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

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

Strategic Thrusts

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

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

Specific Goals and Strategies

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

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

- 1.1) Increase the proportion of communities that live within 5 km of a functional health facility from 52% to 62%
- 1.2) Increase the proportion of deliveries conducted by skilled attendants from 42% to 60%

Thrust 2: Improve quality of public health and sanitation services

- 2.1) Reduce the vacancy rate of technical staff by 40%
- 2.2) Increase the health workforce trained to 40,255 staff by 2012, by carrying out a training needs assessment and develop a training programme
- 2.3) Rehabilitate and adequately equip 50% of level 2 and 3 and other public health facilities
- 2.4) Reduce proportion of facilities reporting no stock outs by 100%, by maintaining adequate stock levels of medicines, commodities and supplies through measures such as proper forecasting, timely procurement and efficient distribution.

- 2.5) Increase sanitation coverage from 46% to 66%
- 2.6) Increase the number of households utilizing safe water by 20% by promoting use of treated water at household level
- 2.7) Increase the number of facilities with health care waste management systems from 20% to 100%
- 2.8) Increase client satisfaction by 50% in 2,408 health facilities
- 2.9) Reduce the incidence of food-borne diseases/illnesses by 5%
- 2.10) Reduce mortality rate due to emergency to below 1/10,000 persons at risk per day
- 2.11) Increase the utilization of cost-effective reproductive health services by 50%
- 2.12) Increase the utilization of cost-effective child health care services by 50%
- 2.13) Reduce new HIV infections by 50% by scaling up behaviour change initiatives at community/household level
- 2.14) Increase TB case detection and treatment to 90% by increasing the capacity of level 2 and 3 to diagnose and treat
- 2.15) Reduce malaria incidence to 15% by utilizing cost effective control measures such as long-lasting insecticide treated nets and indoor household spraying
- 2.16) Reduce the incidence of malnutrition of children <5 years by 20% by providing Vitamin A supplements to 100% of all those eligible

Thrust 3: Improve efficiency of public health and sanitation services

- 3.1) Reduce the staff vacancy rate by 60%
- 3.2) Increase the proportion of staff trained as per government policy by 50%
- 3.3) Increase the proportion of employee job satisfaction by 90%
- 3.4) Increase the availability and utilization of information and communication technology (ICT) by 60%
- 3.5) Improve the utilization of transport services by 50%

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

Thrust 4: Fostering partnerships

- 4.1) Strengthen governance structures at 1, 2 and 3 by 2012
- 4.2) Improve stewardship and partnership arrangements at all levels

Thrust 5: Improve financing of public health and sanitation services

- 5.1) Ensure all facilities receive financial resources based on needs
- 5.2) Increase efficiency in utilization of resources
- 5.3) Increase financial resources to MOPHS by 20%

Flagship Projects

The priority projects for this strategic plan are:

- Infrastructure Investment Policy and Strategy
- Opening and operation of 520 non-functioning level 2 and 3 health facilities
- Construction of 260 new level 3 facilities
- Setting up of 40 nomadic clinics
- Creation of 2,550 community units
- Recruitment of 23,645 new technical staff
- Ensuring households are using treated water
- Fumigating 4,000 households to prevent jiggers
- Creating demand for reproductive health services
- Scaling up of behaviour change and communication interventions at community

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

and household level aimed at reducing HIV incidence

- Institutionalization of quality assurance systems, KQM, citizen charters and ISO 22000
- Implementation of the human resources for health (HRH) strategic plan
- Development of key health sector policy documents: revised Kenya Health Policy Framework, the third NHSSP, the Public Health Act and the Public-Private Partnership Policy
- Institutionalization of the Health Services Support Fund

Coordination Framework for the Implementation of the Strategic Plan

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

Capacity to Implement the Strategy

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

Financing the Plan

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

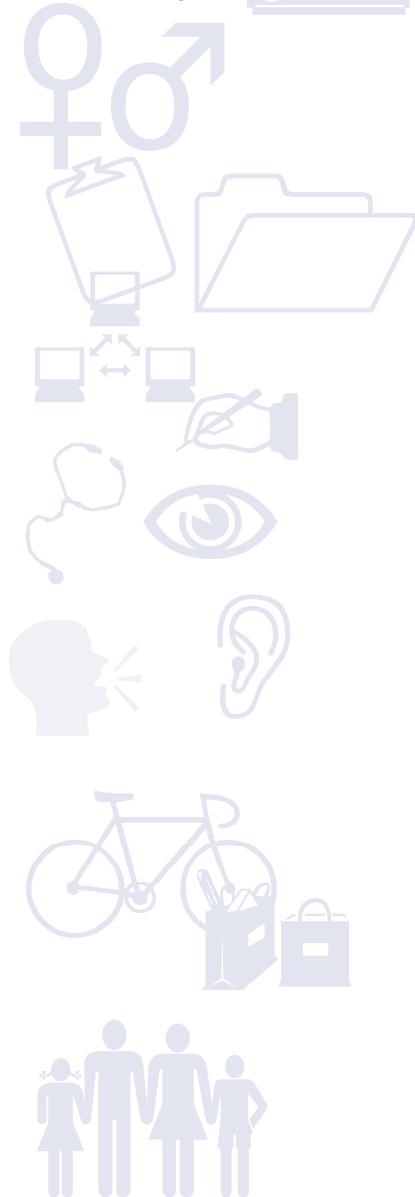
Risks

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

quarterly, and annual monitoring of progress. Impact indicators for evaluating mid and end-term evaluations are also identified. A dashboard approach to measure performance in the delivery of services will be done jointly with the Ministry of Medical Services.

Monitoring, Evaluation and Reporting

A framework for monitoring and evaluating progress on the implementation of the strategic plan has been developed. Specific indicators for service delivery, support systems, partnerships and financing have been identified for monthly,



1 Introduction

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

1.1 The Rationale for Ministerial Strategic Planning

For the Ministry of Public Health and Sanitation (MOPHS), this strategic plan, like others within the public sector, is expected to support the implementation of Vision 2030 and MTP 2008–2012, along with the broad

goals of the second National Health Sector Strategic Plan (NHSSP II) 2005–2010.¹ The MOPHS strategic plan will also form the basis for identifying deliverables under the performance contracting mechanism and for individual annual performance appraisal.

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

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

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

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

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

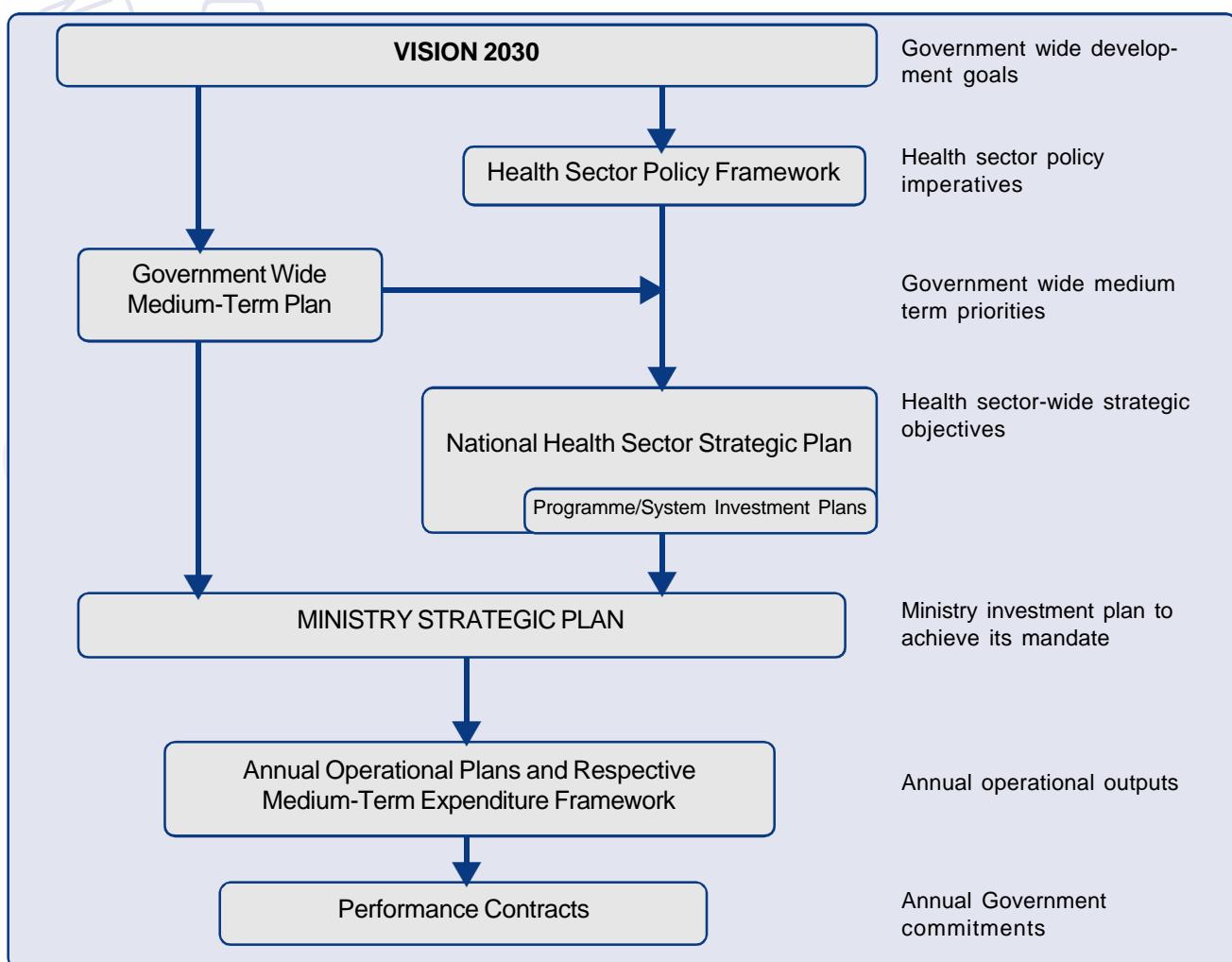
Both the current Health Sector Policy Framework (HSPF) 1994–2010 and NHSSP II, therefore, informed this strategic plan. Together with the medium-term plan of our sister health ministry, the Ministry of Medical Services (MOMS), and the input of our development partners and implementing partners, this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

performance contract of the Ministry. These linkages and processes are schematically presented in Figure 1.1.

1.2 Methodology for Developing the Strategic Plan

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

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



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

Representatives from all departments and divisions conducted a desk situation assessment, which was followed by a five-day workshop to develop the priorities, strategies, outputs and implementation matrix of the plan. The basic structure of the plan follows guidelines provided to all the ministries by the Ministry of Planning, National Development and Vision 2030. The

draft plan was circulated internally and to health sector stakeholders for comments; these were incorporated into the final plan.

Chapter Notes

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

² Ministry of Health, 2006, *Joint Programme of Work and Funding for the Kenya Health Sector 2006/07–2009/10*, Nairobi, Kenya.

³ Ministry of Health, 2006, *Norms and Standards for Health Service Delivery*, Nairobi, Kenya.

Kenya's Development Agenda and Challenges

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

2.1 The National Development Agenda – Kenya Vision 2030

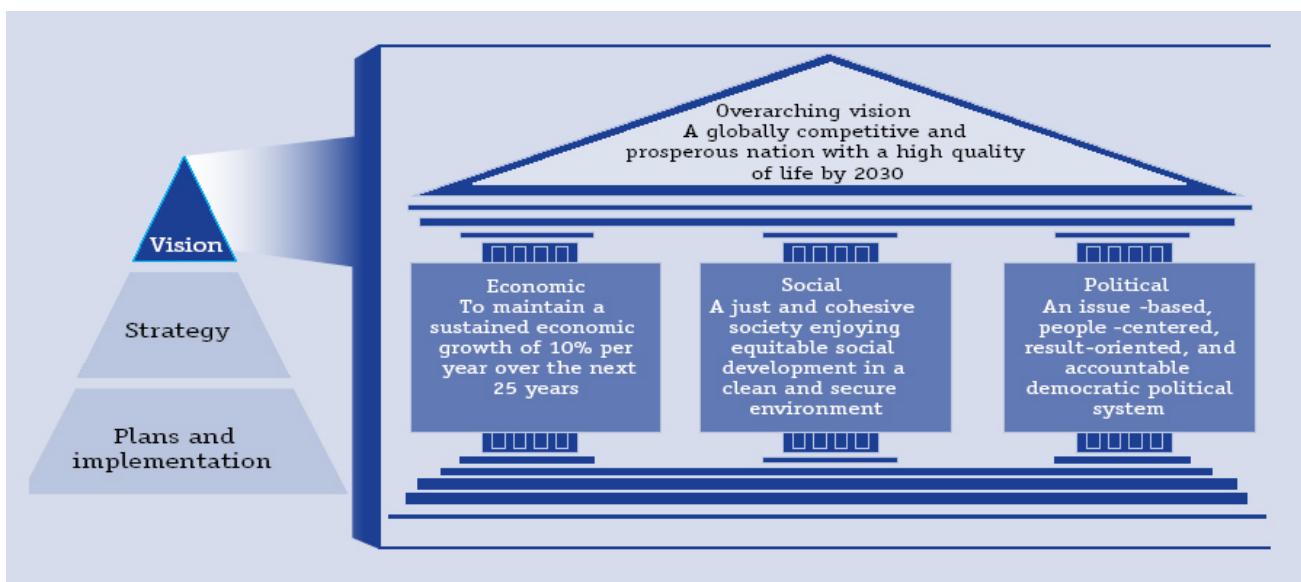
Vision 2030 details the Government of Kenya's long-term development aspirations for the country. The aim of Vision 2030 is to create "a globally competitive and prosperous country with a high quality of life by 2030" by transforming Kenya from a third world country into an industrialized, middle

income country. The First Medium-Term Plan (MTP) for realizing the ambitions of the Vision outlines the key policy actions, reforms, programmes and projects that the Grand Coalition Government intends to implement between 2008 and 2012, the first stage in the push towards accomplishing the Vision.

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

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

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



Source: Kenya National Economic and Social Council.

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

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

The health sector objectives stipulated in the MTP are to:

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

6. Reduce the proportion of in-patient malaria fatality to 3%.
7. Reduce the national adult HIV prevalence to less than 2%.

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

2.2 National, Regional and Global Public Health Challenges

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

2.2.1 National Public Health Challenges

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

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

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

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

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

2.2.2 Regional Public Health Challenges

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

2.2.3 Global Public Health Challenges

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

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

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

Chapter Notes

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

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

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

3 Role of the Ministry of Public Health and Sanitation

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

3.1 MOPHS Core Functions

Defined roles and functions for MOPHS are stipulated in Presidential Circular No. 1/2008. The Ministry is central in providing a leadership role in ensuring that public health policy objectives are implemented to facilitate the attainment of the health sector

objectives and targets set in the Strategy for National Transformation (SNT) 2008–2012 and the MDGs.

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

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

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

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

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

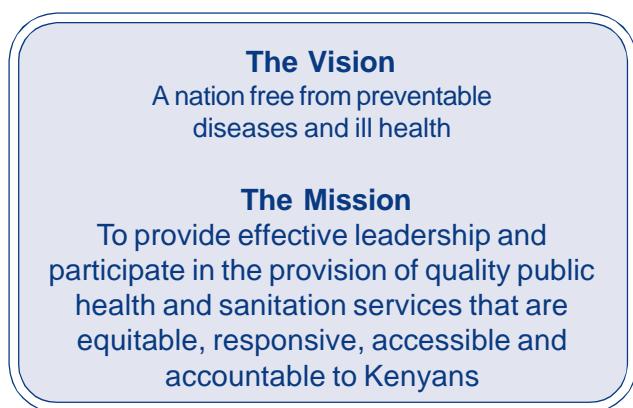
3.2 Vision and Mission

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

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

| Level 1 | Levels 2 and 3 |
|--|---|
| <ul style="list-style-type: none"> • Reproductive health <ul style="list-style-type: none"> – Community midwifery – Family planning • Child health <ul style="list-style-type: none"> – Community nutrition • Basic health care <ul style="list-style-type: none"> – Treatment of common ailments – Referral – Home based care • TB/HIV/malaria <ul style="list-style-type: none"> – Follow-up/defaulters – Case management • School health programme • Behaviour change communication • Environmental health <ul style="list-style-type: none"> – Water – Sanitation and hygiene – Food safety • Community surveillance | <ul style="list-style-type: none"> • Maternal health care <ul style="list-style-type: none"> – Antenatal care – Delivery – Postnatal care – Family planning • Child health care <ul style="list-style-type: none"> – Immunization – Growth monitoring • Basic health care/Treatment of minor ailments • HIV/AIDS/TB • Voluntary counselling and testing • Anti-retroviral therapy/Prevention of mother to child transmission • Malaria • Environmental health <ul style="list-style-type: none"> – Waste management • Health promotion (behaviour change communication/Health education) • Outreach • Surveillance |

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



3.3 Core Values Guiding Public Health and Sanitation Services

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

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

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

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

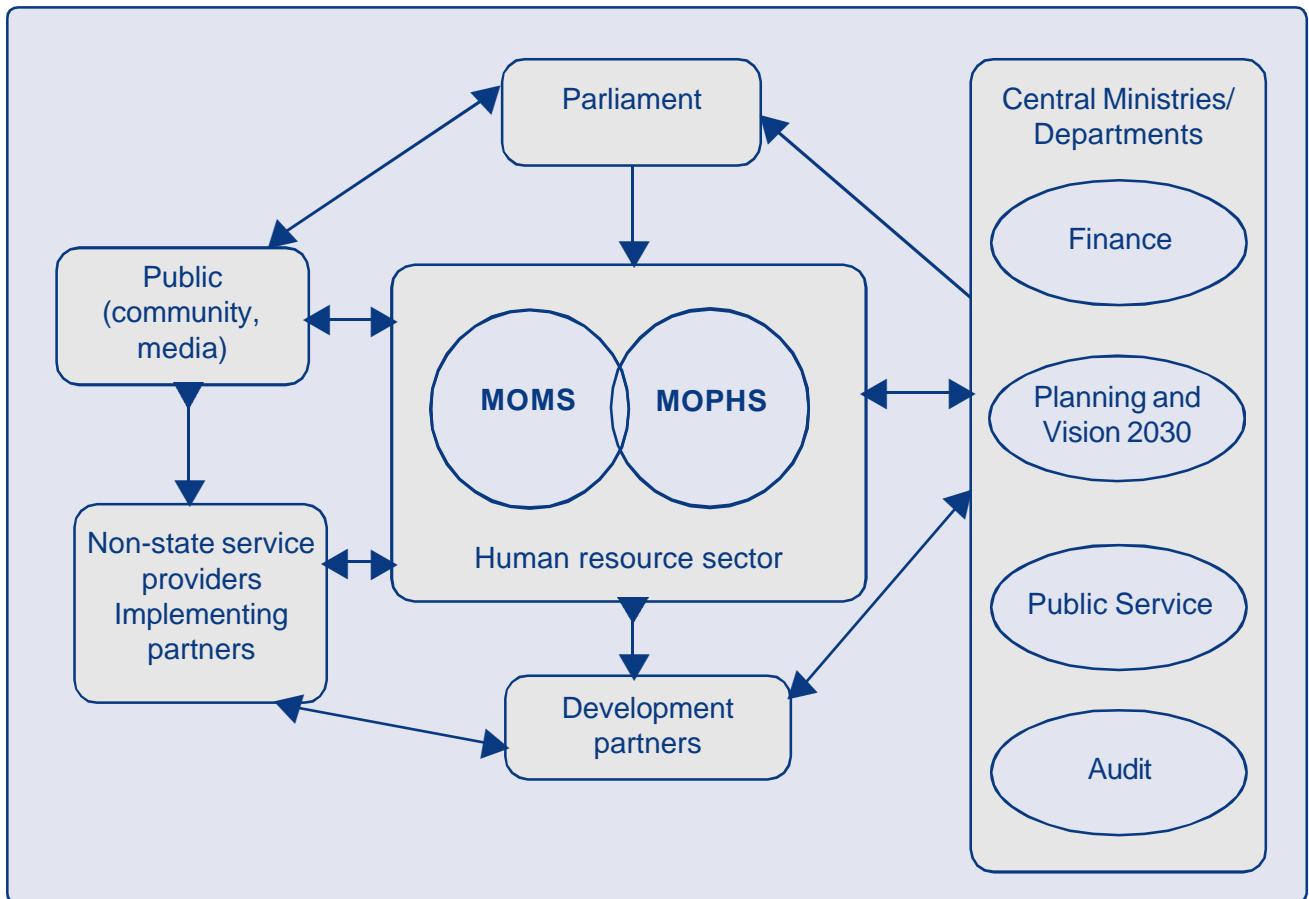
3.2 Linkages with Government and Health Sector

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

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

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

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



The nature of the interactions can be summarized as follows:

- Policy development, strategic planning, resource management, monitoring and evaluation
 - The Ministry of Medical Services
 - Development partners
 - Non-state health service providers (non-government organizations, private not-for-profit and private for-profit health care providers)
 - Quasi-formal working arrangements that guide the linkages defined in the Code of Conduct
- Implementation of programmes and interventions
 - Not-for-profit health care service providers (faith-based organizations – FBOs)
 - Community organizations

- Management of public health service delivery
 - MOMP at provincial and district levels in the coordination of health interventions
 - The Office of the President in financial management through the district treasury
 - The community in the management of health facilities and community programmes (the Health Sector Services Fund [HSSF] and the Community Strategy initiative)



Review of Health Sector Progress and Challenges

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

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

4.1 Service Delivery Output Indicators

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

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



The NHSSP II/KEPH Life-Cycle Cohorts

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

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

For cohort 1, performance has been poor and it is likely that the targets for this cohort will not be achieved by the end of the NHSSP II implementation period. Tables 4.1–4.3 summarize the annual achievements against the NHSSP II baseline and targets for the KEPH indicators for the different cohorts. Refer to Annex A, as well,

for a summary of the priority health sector interventions recommended by the Midterm Review¹ of NHSSP II for acceleration in the medium term.

4.2 Service Delivery Impact Indicators

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

Table 4.1: KEPH indicator targets for cohort 1

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

Source: AOP 1, 2 and 3 reports.

Table 4.2: KEPH indicator targets for cohorts 2 and 3

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

Source: AOP 1, 2 and 3 reports.

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

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

Source: AOP 1, 2 and 3 reports.

Table 4.4: Progress towards achievement of MDG targets

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

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

4.3 Equitable Access to Quality Public Health Services

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

4.3.1 Geographical Access

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

The Millennium Development Goals

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

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

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

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

4.3.2 Economic Access

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

4.3.3 Socio-Cultural Access

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

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

Targeted measures include ensuring privacy in the course of service delivery, especially for women. The human rights approach will be promoted in clinical settings, as well as estab-

lishing youth-friendly clinics and prioritizing gender issues.

4.4 Quality of Public Health Services

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

4.4.1 Human Resources

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

The *Norms and Standards for Health Service Delivery* estimated that to deliver KEPH services, 321,253

Human resource constraints:

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

community health workers (CHWs) and 12,500 community health extension workers (CHEWs) were required at level 1.

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

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

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

4.4.2 Health Facilities

The quality of service delivery is influenced by the quality of the service delivery environment –

Facility constraints:

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

specifically, the availability of adequate and serviceable facilities such as surgical theatres, examination rooms, offices and staff houses. Inadequate facilities affect staff motivation and ser-

vice quality. Poor preventive maintenance of existing facilities is a major obstacle to service quality.

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

4.4.3 Equipment

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

Equipment constraints:

- Lack of basic equipment
- Lack of standard equipment guidelines
- Poor maintenance

4.4.4 Drugs and Supplies

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

4.4.5 Insufficient Evidence for Decision Making

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

4.4.6 Quality Standards and Guidelines

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

4.4.7 Public Health Legislation

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

4.5 Human Resources Management System

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

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

4.5.1 HR Information Systems

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

4.5.2 Recruitment and Deployment

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

The current authorized establishment for the health ministry has not been reviewed for over ten years and preceded the scale up of HIV services and the renewed commitment to achieving the MDGs. Thus it should be informed by the recommendations of the 2008 joint task force review, which looked at the current establishment and current needs. Moreover, the

current establishment is an aggregate, hence does not give a regional breakdown of different cadres nor does it take into account the level of education attained by the staff. One result is that regional distribution depends on administrative decisions, thus the mal-distribution. There is need for MOPHS to develop its recruitment and deployment policy, quantify the norms and standards, and revise the staff establishment. Of note is that an HRH strategic plan is currently under development as a joint effort of the two health ministries. (Refer to Annex C for a breakdown of the staff requirements and establishment.)

4.5.3 Staff Development

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

4.5.4 HR Planning and Management

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

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

4.5.5 Staff Performance Systems

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

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

4.5.6 Salaries, Attrition and Staff Distribution

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

4.6 The Health Infrastructure

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

4.6.1 Buildings and Equipment

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

- Lack of a defined standards for infrastructure and equipment in the Ministry, resulting in different forms of buildings and equipment, some of which are substandard.
- Poor maintenance of buildings and equipment, leading to malfunctioning of a large proportion of them.
- Poor maintenance of infrastructure as a result of lack of a comprehensive maintenance plan, absence of written guidelines or manuals on infrastructure maintenance, inadequate budget allocation for maintenance of infrastructure or security of equipment items, and inefficient disposal of non functioning equipment.

- Absence of a master plan on health facility construction and rehabilitation, which results in unequal distribution of health facilities and haphazard construction of new health facilities, especially through the CDF.

4.6.2 Transport System

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

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

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

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

4.6.3 Information and Communication Technology (ICT)

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

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

4.7 Public Finance Management System (PFMS)

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

4.7.1 Budget

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

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

Moreover, budget release to districts is not efficient. Dispersal of funds to district health offices is done by the central Ministry office through the Treasury in the form of an authority to incur expenditure (AIE). The districts are usually not informed about the final approved budgets and have to operate on the basis of their quarterly AIEs. The AIEs are approved late and sometimes are not followed by availability of funds in the district accounts. The provincial and

district health offices are not allocated funding in the current budget. Primary health facilities have been allocated financial resources for operation and maintenance, as is the case with levels 4 and 5. The facilities rely on handouts of supplies from the district level. It is important therefore to ensure that the new initiative to release funding from headquarters directly to provincial, district and primary health facilities is implemented.

4.7.2 Financial Information System

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

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

4.8 Health Management Information System (HMIS)

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

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

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

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

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

4.9 Procurement and Commodity Logistics Management Systems (General)

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

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

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

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

4.10 Policy Planning

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

4.11 Partnership

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

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

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

The main outputs that have been achieved since 2005 are:

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

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

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

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

in place a mechanism for assessing compliance with the COC by all the signatories.

4.12 Financing Public Health Services

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

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

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

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

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

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

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

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

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

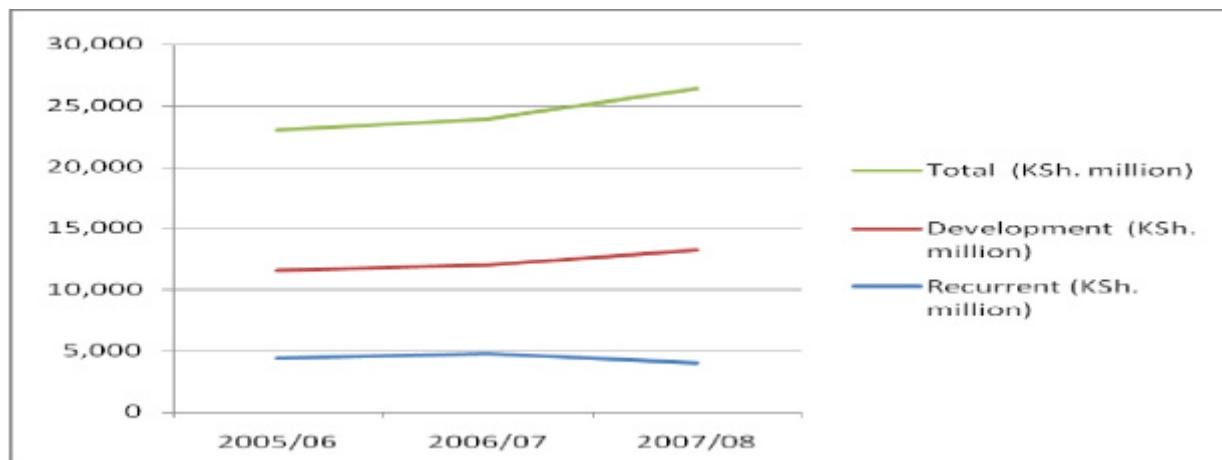


Table 4.6: Analysis of total recurrent MOPHS expenditures by category (Ksh million)

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

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

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

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

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

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

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

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

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

Chapter Notes

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



5 Strategic Model

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

5.1 Strategic Thrusts for Public Health and Sanitation

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

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

5. *Strategic thrust 5:* Improving financing of public health and sanitation services

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

5.2 Implementation Framework for Achieving the Strategic Priorities

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

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

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

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



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

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

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

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

- 1.1.1) Carrying out GIS mapping for development of a policy and strategy (norms and standards) for investing in health infrastructure,
- 1.1.2) Increasing the number of functional public health facilities by 480 for level 3 and 300 for level 2:
- Rehabilitation of 100 non-functional GOK and 100 CDF level 2 facilities.

- Construction of 100 new level 2 facilities.

- Rehabilitation of 160 non-functional GOK and 160 CDF level 3 health facilities.

- Construction of 160 additional new level 3 health facilities.

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

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

- 1.1.5) Implementing a comprehensive school health programme.

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

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

- 1.2.2) Strengthening the referral system,

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

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

demand for RH services at level 1, identifying and providing orientation for community midwives to create awareness and offer skilled attendance at delivery at level 1).

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

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

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

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

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

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

- 2.1.1) Recruiting 23,645 new health workers: 7,385 to fill existing vacancies and another 16,260 to fill vacancies arising from the rehabilitation of GOK and CDF facilities, and the addition of new facilities, and
- 2.1.2) Identifying 321,426 CHWs to provide services at the community units.

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

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

- 2.3.1) Renovating 2,262 health facilities (1,788 level 2 and 474 level 3) and procuring equipment, and
- 2.3.2) Conducting annual preventive maintenance in all level 2 and 3 health facilities.

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

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

- 2.5.1) Implementing the environmental and hygiene policy and strategy,
- 2.5.2) Constructing 32,000 demonstration pit latrines in public institutions annually, with an equal

number of rural waste disposal methods (compost pits) for replication, and

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

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

- 2.6.1) Working with other sector partners to promote use of treated water by 1,700,000 households at the end of five years, and
- 2.6.2) Working with communities to identify and protect/treat communal water supply sources, e.g., springs, wells, catchment surfaces (roofs, rocks, dams, pans) and water treatment at household level using approved chlorine-based compounds.

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

- 2.7.1) Identifying a central regional facility and providing an incinerator, as well as providing appropriate transport to collect waste from the satellite facilities, and
- 2.7.2) Implementing health care waste guidelines and training staff on same.

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

- 2.8.1) Reviewing, developing and implementing standards and guidelines,
- 2.8.2) Implementing KQM model,
- 2.8.3) Implementing ISO 9001, and
- 2.8.4) Scaling up implementation of the Citizens' Charter in those facilities.

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

- 2.9.1) Finalizing, disseminating and implementing food safety policy and strategy, and
- 2.9.2) Ensuring compliance with Cap 254 and 242.

- 2.10) Reduce mortality rate due to emergency to below 1/10,000 persons at risk per day.**
- 2.11) Increase the utilization of cost-effective reproductive health services by 50%.**
- 2.12) Increase the utilization of cost-effective child health care services by 50%, by:**
- 2.12.1) Increasing the capacity of level 2 and 3 facilities to provide integrated management of childhood illness (IMCI) services, and
 - 2.12.2) Increasing the proportion of children receiving immunization services.
- 2.13) Reduce new HIV infections by 50% by scaling up behaviour change initiatives at community/household level.**
- 2.14) Increase TB case detection and treatment to 90% by increasing the capacity of level 2 and 3 to diagnose and treat.**
- 2.15) Reduce malaria incidence to 15% by utilizing cost effective control measures such as LLITNs and indoor household spraying.**
- 2.16) Reduce the incidence of malnutrition of children <5 years by 20% by providing Vitamin A supplements to 100% of all those eligible.**

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

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

Continued

Table 5.2, continued: Results framework for Strategic Thrust 2

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

Continued

Table 5.2, continued: Results framework for Strategic Thrust 2

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

Continued

Table 5.2, continued: Results framework for Strategic Thrust 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 3.8.1) Providing data capture and summary tools at all health facilities,

3.8.2) Utilizing ICT in health information to strengthen data management capacity (collection, analysis, computerization and use) at all levels,

- 3.8.3) Scaling up establishment of integrated surveillance and response systems,
- 3.8.4) Establishing a community-based health management information system (CBHMIS),
- 3.8.5) Strengthening operational research, and
- 3.8.6) Coordinating PM&E, HMIS and IDSR information sources.

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

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

3.10) Strengthen the financial management systems, by:

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

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

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

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

Continued

Table 5.3, continued: Results framework for Strategic Thrust 3

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

Continued

Table 5.3, continued: Results framework for Strategic Thrust 3

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

5.2.4 Strategic Thrust 4: Fostering Partnerships

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

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

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

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

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

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

Continued

Table 5.4, continued: Results framework for Strategic Thrust 4

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

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

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

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

- 5.1.1) Allocating financial resources based on needs, and

- 5.1.1) Fostering pro-poor financing mechanisms.

5.2) Increase efficiency in utilization of resources, by:

- 5.2.1) Improving budget management and efficient and equitable resource allocation and distribution,
- 5.2.2) Rolling out the operation of HSSF,
- 5.2.3) Institutionalizing OBA, and
- 5.2.4) Developing cost containment measures.

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

- 5.3.1) Tapping into NHIF benefit package,

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

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

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

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

Coordination Framework

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

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

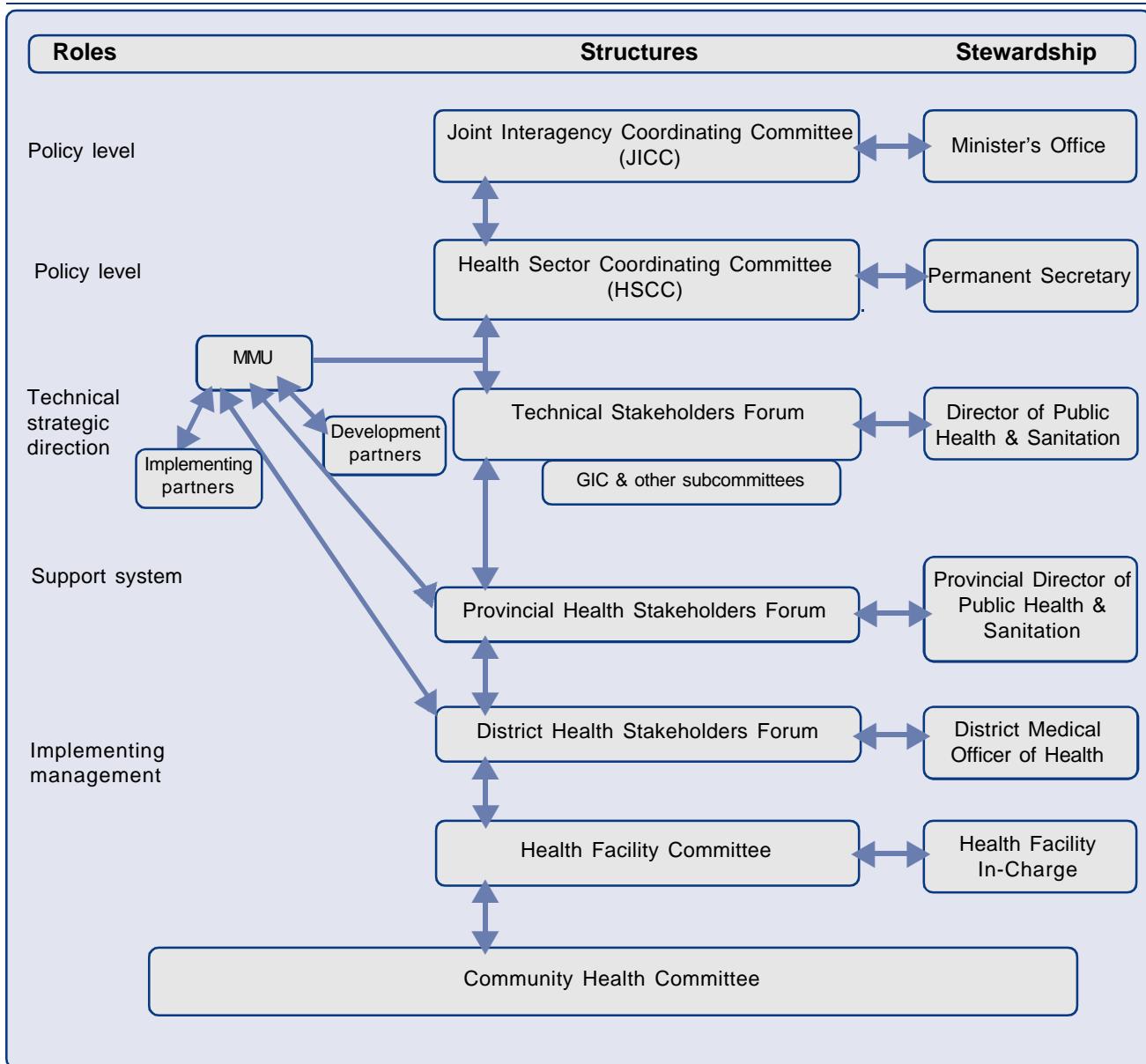
- Ensuring that the partnership structures are functioning adequately at all the levels of care: national Health Sector Coordinating Committee (HSCC), Provincial Health Stakeholders Forum (PHSF), District Health Stakeholders Forum (DHSF), Divisional Health Stakeholders Forum (DIVHSF) and the community health committee (CHC).
- Defining the framework to guide pooled funding arrangements (Joint Financing

Agreements) and commence implementation.

- Completing the framework for aligning funding from all partners (shadow budget).
- Strengthening the process of monitoring adherence to the Code of Conduct.
- Accelerating the articulation of public-private partnership policy.
- Undertaking comprehensive leadership and management training for all managers especially at subnational levels.
- Scaling up measures of social accountability towards clients of health services.

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

Figure 6.1: Ministry of Public Health and Sanitation coordination structure



6.1 Coordination Structures at the National Level

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

6.1.1 Joint Inter Agency Coordinating Committee (JICC)

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

6.1.2 Health Sector Coordinating Committee (HSCC)

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

6.1.3 Technical Stakeholders Committee (TSC)

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

6.1.4 Ministerial Management Unit (MMU)

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

6.2 Coordination Structures at the Subnational Level

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

6.2.1 Provincial Health Stakeholder Forum (PHSF)

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

6.2.2 District Health Stakeholder Forum (DHSF)

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

6.2.3 Health Facility Committee (HFC)

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

6.2.4 Community Health Committee (CHC)

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

7 Capacity

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

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

1. Identifying competent persons to *fill all the posts* within the management structure in order to have the required management capacity needed to carry out the respective mandates of the different units in the structure.
2. Articulating *performance targets* for each unit in the management structure, in line with the Government's results-based

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

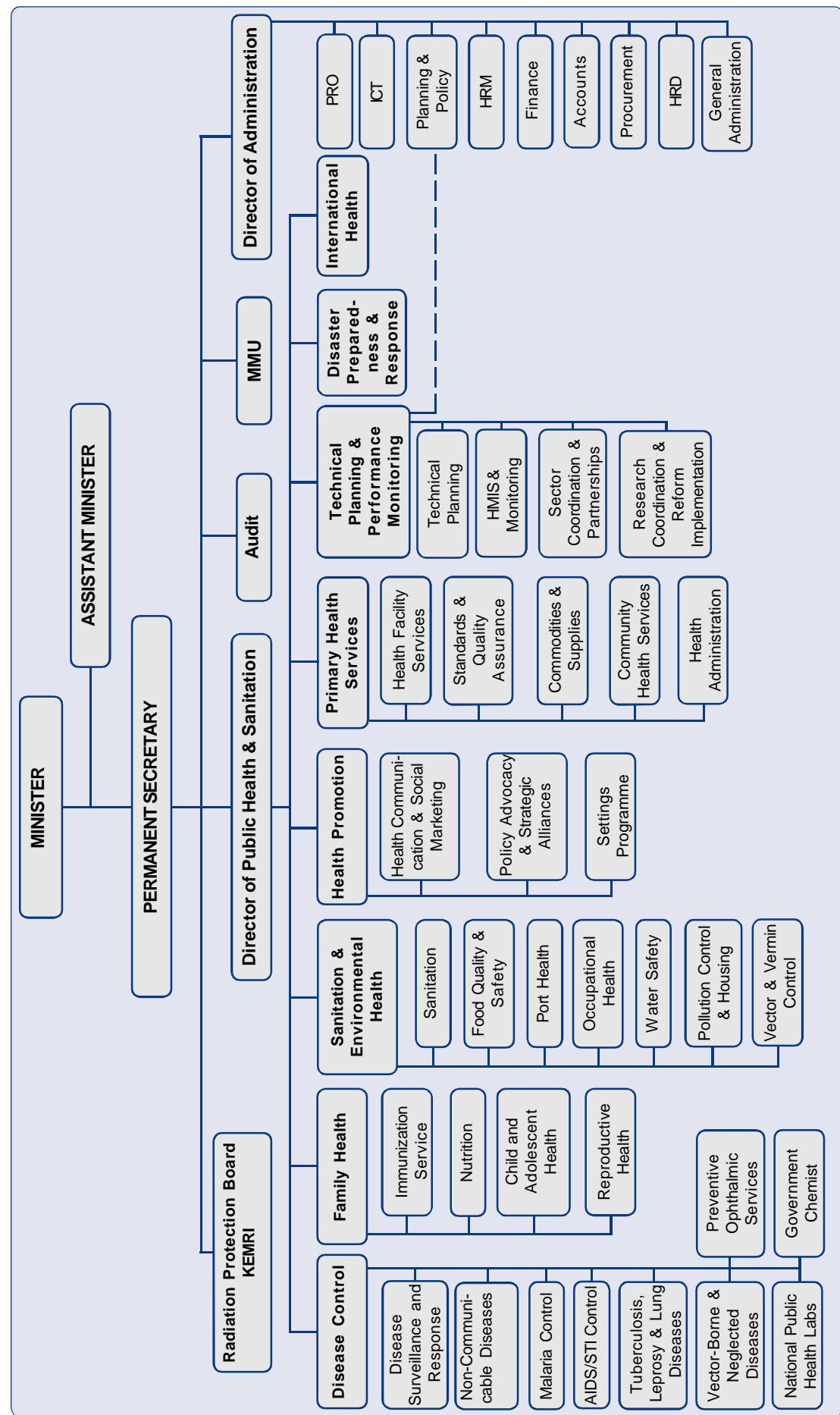
management framework, to ensure that the units are clear about the performance expected of them in terms of their mandates.

7.1 Management Structure and Functions at the National Level

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

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

Figure 7.1: Ministerial structure at national level



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

7.1.1 Office of the Permanent Secretary

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

Permanent Secretary through their respective mandates.

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

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

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

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

Continued

Table 7.1, continued

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

7.1.3 Parastatals and Statutory Boards

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

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

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

7.1.4 Support Services

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

7.1.5 Ministerial Support Units

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

Table 7.4: Core functions of ministerial support units

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

7.2 Management Structures and Functions at the Subnational Levels

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

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

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

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

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

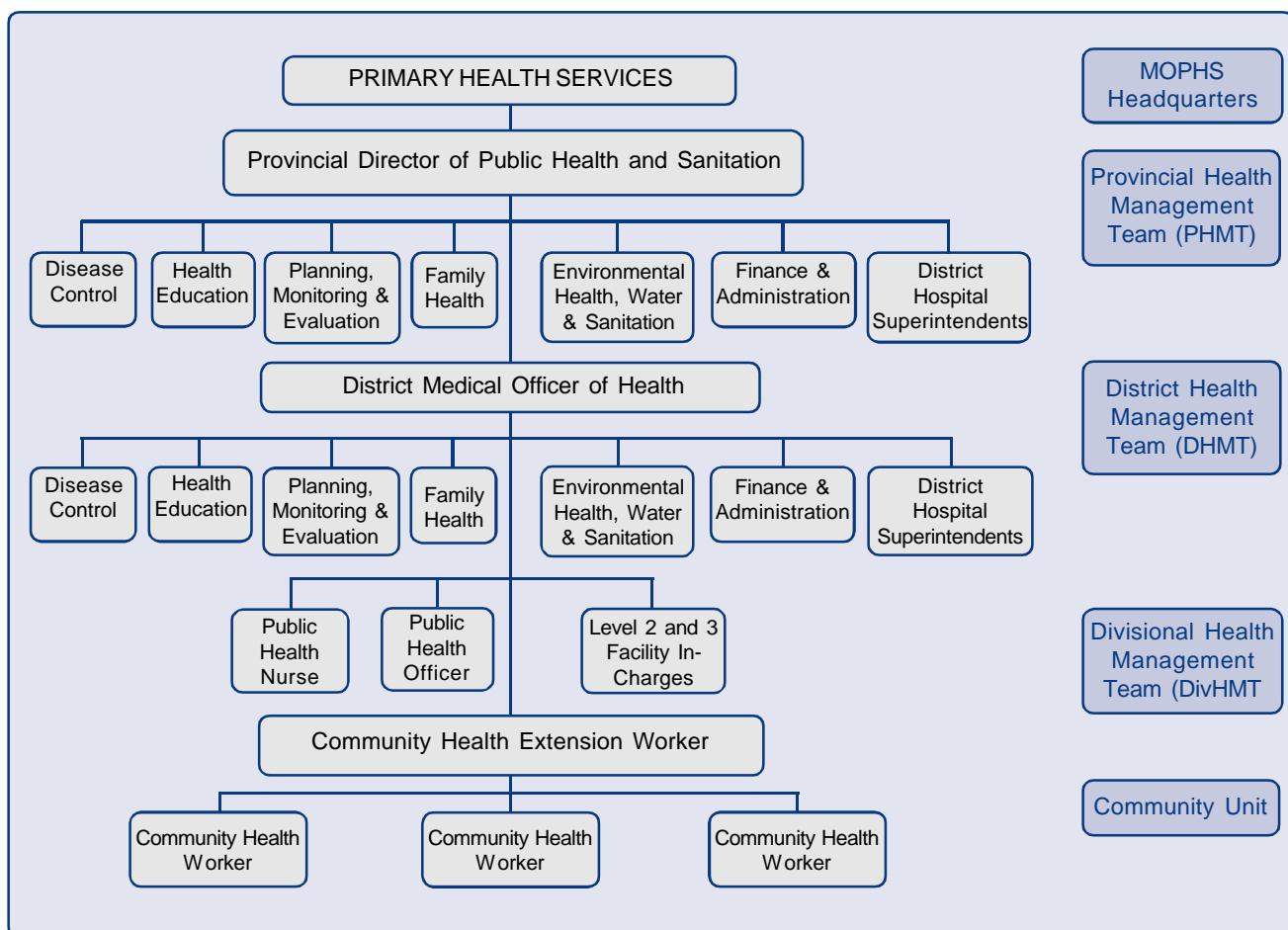


Table 7.5: Core functions of subnational management structures

| Level | Core functions/Mandate |
|--------------|---|
| Province | <ul style="list-style-type: none"> • Overall coordination and management of health services in the province • Strategic, and operational planning for public health services in the province • Performance monitoring, evaluation and supervision • Capacity building and support to districts and local authorities • Quality assurance • Disease surveillance and control • Emergency response • Governance and linkages with other sectors • Infrastructure development • Logistics support and commodity security • Resource mobilization • Environmental protection and sanitation |
| District | <ul style="list-style-type: none"> • Overall coordination and management of health services in the district • Strategic and operational planning for public health services in the district • Performance monitoring, evaluation and supervision • Capacity building and support to divisions, community and local authorities • Quality assurance • Disease surveillance and control • Emergency response • Governance and linkages with other sectors • Infrastructure development • Logistics support and commodity security • Resource mobilization • Environmental protection and sanitation |
| Division | <ul style="list-style-type: none"> • Planning for health services in the division • Coordination of monitoring and reporting (for public health services) in division • Provision of preventive services • Logistics management • Resource mobilization • Supervision of community health care services |
| Community | <ul style="list-style-type: none"> • Coordination of implementation of the comprehensive community health services • Participatory planning and action • Targeted health promotion • Water and sanitation activities • Vector control • Home-based care • Delivery of defined health programme interventions • Monitoring and reporting on community actions |

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

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

8 Resource Flows

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

8.1 Costing of Public Health Interventions

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

8.1.1 Overall Cost of the Plan

Table 8.1 presents the cost estimates for the five strategic thrusts. The annual cost of the plan

increases from Ksh33.7 billion in 2008/09 to Ksh64.6 billion in 2011/12, bringing the total cost of the plan to Ksh195.2 billion over the four years. (See Figure 8.1.)

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

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

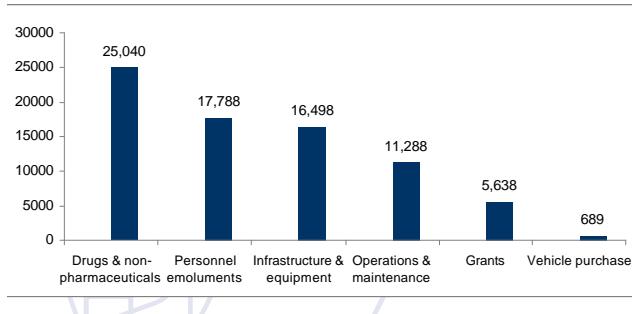
Financial projections made for allocating resources are aligned to the five strategic thrusts of this strategic plan:

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

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

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

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



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

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

8.1.2 Distribution of Costs by Input Categories

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

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

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

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

8.2 Available Financing

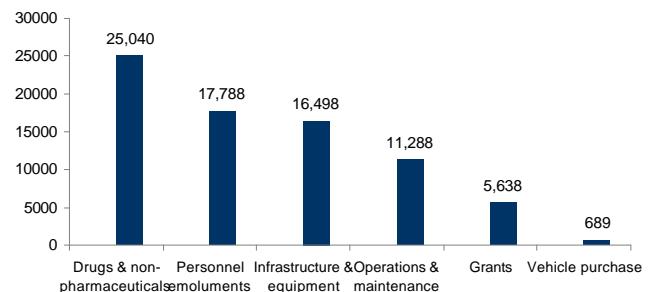
Budgetary allocations complemented with cost sharing revenues collected and retained by health facilities are expected to form the main sources of finance for MOPHS over the current MTEF period. The level of cost sharing revenues has been kept constant over the period at the amount reported in 2007/08.

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

8.3 Resource Gap

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

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



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

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

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

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

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

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

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

Source: MTEF estimates.

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

| | MTP cost estimates | | | | | | MTEF budget (Ksh 000) | | | | | | Funding gap | | | |
|--|--------------------|-------------------|-------------------|-------------------|------------------|-------------------|-----------------------|-------------------|--------------------|--------------------|--------------------|--------------------|---------------------|--|--|--|
| | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Total | | | |
| Strategic thrust 1: Increase equitable access to public health | | | | | | | | | | | | | | | | |
| Infrastructure development | 2,615,856 | 2,625,856 | 2,635,856 | 2,645,856 | 98,147 | 1,517,663 | 1,584,394 | 1,343,066 | -2,517,709 | -1,108,193 | -1,051,462 | -1,302,790 | -5,980,153 | | | |
| Community health services (O&M) | 2,018,256 | 3,612,557 | 3,627,557 | 3,642,557 | 628,274 | 996,280 | 1,026,134 | 1,054,433 | -1,389,982 | -2,616,277 | -2,601,423 | -2,588,124 | -9,195,805 | | | |
| Subtotal/ | 4,634,112 | 6,238,413 | 6,263,413 | 6,288,413 | 726,421 | 2,513,944 | 2,610,529 | 2,397,499 | -3,907,691 | -3,724,469 | -3,652,884 | -3,890,914 | -15,175,958 | | | |
| Strategic thrust 2: Improve quality and responsiveness of public health and sanitation services | | | | | | | | | | | | | | | | |
| O&M for L2 &3 facilities | 3,380,000 | 3,380,000 | 3,380,000 | 3,380,000 | 1,052,179 | 932,145 | 956,107 | 978,429 | -2,327,821 | -2,447,855 | -2,423,893 | -2,401,571 | -9,601,139 | | | |
| PE (technical) | 2,428,715 | 5,600,256 | 9,443,550 | 13,992,462 | 2,875,983 | 4,991,002 | 4,999,132 | 4,923,894 | -447,268 | -609,254 | -4,444,418 | -9,068,568 | -13,674,972 | | | |
| Medicines and public health commodities | 15,025,721 | 18,628,680 | 23,187,092 | 28,817,751 | 2,370,719 | 6,403,510 | 7,431,722 | 8,836,322 | -12,655,002 | -12,225,170 | -15,755,370 | -19,981,429 | -60,616,971 | | | |
| O&M for central programmes | 1,776,240 | 1,931,678 | 2,305,325 | 2,233,911 | 552,936 | 532,723 | 652,112 | 646,664 | -1,223,304 | -1,398,955 | -1,653,213 | -1,587,247 | -5,862,719 | | | |
| Infrastructure/Equip. | 5,608,806 | 6,386,145 | 7,441,031 | 8,294,000 | 210,442 | 3,690,994 | 3,999,132 | 4,210,128 | -5,398,364 | -2,695,151 | -3,441,899 | -4,083,872 | -15,619,286 | | | |
| Subtotal/ | 28,219,482 | 35,926,759 | 45,756,998 | 56,718,124 | 7,062,259 | 16,550,374 | 18,038,206 | 19,595,437 | -21,157,223 | -19,376,385 | -27,718,792 | -37,122,687 | -105,375,087 | | | |
| Strategic thrust 3: Improve efficiency | | | | | | | | | | | | | | | | |
| O&M for administration/management/province and district | 482,457 | 682,749 | 980,487 | 1,291,435 | 150,187 | 188,290 | 277,352 | 373,839 | -332,270 | -494,459 | -703,135 | -917,556 | -2,447,459 | | | |
| Infrastructure | 20,000 | 5,000 | 8,000 | 10,000 | 750 | 2,890 | 4,300 | 5,076 | -19,250 | -2,110 | -3,700 | -4,924 | -29,984 | | | |
| Vehicles/Motorboats, etc. | 138,050 | 138,050 | 138,050 | 130,000 | 100,450 | 194,342 | 196,450 | 199,550 | -37,600 | 56,292 | 58,400 | 69,550 | 146,642 | | | |
| Subtotal/ | 640,507 | 825,799 | 1,126,537 | 1,431,435 | 251,387 | 385,522 | 478,102 | 578,466 | -389,120 | -440,277 | -648,435 | -852,969 | -2,330,801 | | | |
| Strategic thrust 4: Foster partnerships | | | | | | | | | | | | | | | | |
| O&M | 188,751 | 223,805 | 139,906 | 170,351 | 58,757 | 61,722 | 39,575 | 49,313 | -129,994 | -162,083 | -100,331 | -121,038 | -513,446 | | | |
| Subtotal/ | 188,751 | 223,805 | 139,906 | 170,351 | 58,757 | 61,722 | 39,575 | 49,313 | -129,994 | -162,083 | -100,331 | -121,038 | -513,446 | | | |
| Strategic Thrust 5: Improve financing | | | | | | | | | | | | | | | | |
| O&M | 19,600 | 179,200 | 44,400 | 51,000 | 6,101 | 49,420 | 12,560 | 14,763 | -13,499 | -129,780 | -31,840 | -36,237 | -211,356 | | | |
| Subtotal/ | 19,600 | 179,200 | 44,400 | 51,000 | 6,101 | 49,420 | 12,560 | 14,763 | -13,499 | -129,780 | -31,840 | -36,237 | -211,356 | | | |
| Grand total | 33,702,452 | 43,393,976 | 53,331,254 | 64,659,323 | 8,104,926 | 19,560,982 | 21,178,971 | 22,635,478 | -25,597,526 | -23,832,994 | -32,152,283 | -42,023,845 | -123,606,648 | | | |

9 Accountability and Risk

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

Table 9.1: Summary risk-impact matrix

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

9.1 Goals and Responsibilities

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

9.2 Risk Assessment

The plan will be implemented during a period of unprecedented global recession.

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

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

Table 9.2: Objectives, goals and responsible parties

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

planned strategies are discussed in the following sections.

9.2.1 Risk A: Government Funding Does Not Increase

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

Mitigation: MOPHS engaged in the MTEF process for the first time, and

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

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

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

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

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

9.2.3 Risk C: Corruption in the Country Remains Unchanged

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

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

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

9.2.4 Risk D: Further Increase in Poverty Levels

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

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

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

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

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

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

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

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

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

The Ministry of Finance has for the first time added two big ministries to the traditional health

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

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

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

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

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

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

9.2.9 Risk I: The Insecurity in Commodity Management Will Persist

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

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

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

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

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

Monitoring, Evaluation and Reporting

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

10.1 Framework for Monitoring and Reporting

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

Strategic monitoring will be done at the midterm and end term of this plan period. The

midterm review will coincide with the formal articulation of a new policy direction for the health sector. As such, it will focus on:

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

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

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

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

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

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

progress will be the responsibility of the respective programme area.

10.2 Indicators for Monitoring Progress

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

Table 10.1: Core indicators for monitoring outcomes

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

Continued

Table 10.1, continued

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

Table 10.2: End of term and midterm measure indicators

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

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

10.3 Interpretation of Performance

We will use what is known as a “dashboard” approach to measure our progress towards the goals of this strategic plan. This means that rather than

assessing each target individually, we will be looking at our achievements in the aggregate – forward (ideally) movement on all or most of the indicators together. (See Table 10.3 for the mechanism.) This is really the only way to make substantive progress in public health and sanitation services.

Table 10.3: Interpretation of indicators against dashboard

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

10.4 Monitoring and Reporting Process

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

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

Table 10.4: Monitoring and review framework

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

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Annex A

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

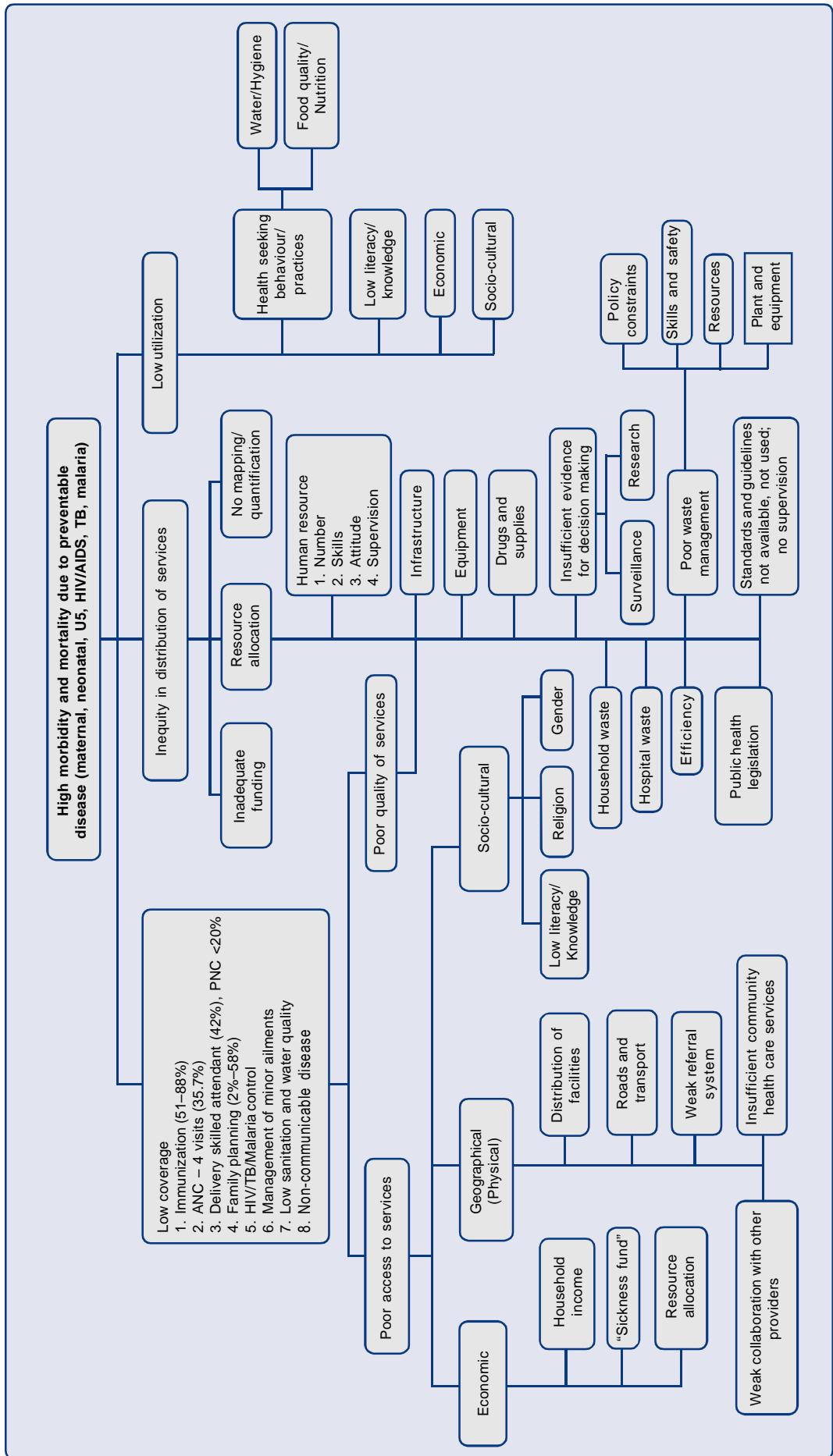
| NHSSP II objective | Priority interventions |
|--|---|
| Objective 1: Increase equitable access to health services | <ul style="list-style-type: none"> ▪ Provide support to ensure universal access to maternal and neonatal health services for cohort 1, involving demand creation and supply-side interventions such as free delivery, skilled attendants, effective referral and other emergency obstetric care components. ▪ Comprehensively implement guides and frameworks for cohorts 4 and 6. ▪ Develop a policy, strategic approach and implementation framework for NCDs to address healthy lifestyles and provision of direct medical care for individuals in a clinical setting (all cohorts). ▪ Reduce morbidity and mortality from malaria by accelerating implementation of the national malaria strategy, which has been revised in line with NHSSP II, particularly targeting cohorts 2, 3 and 5. ▪ Strengthen implementation of existing service delivery efforts for child health for cohorts 2 and 3, with a particular focus on coordination. ▪ Accelerate implementation of TB control initiatives (cohort 5). ▪ Accelerate Community Strategy implementation (level 1), by rolling out the community health worker structure, providing behaviour change communication, scaling up outreach services, etc. ▪ Accelerate dissemination of the Kenya Essential Package for Health (KEPH) throughout the sector. ▪ Develop a strategy to influence the implementation of KEPH outside the health sector. ▪ Strengthen public-private partnerships in delivery of services, particularly in under-served areas, by improving formal frameworks and facilitating access to the HSSF. |
| Objective 2: Improve the quality and responsiveness of services | <ul style="list-style-type: none"> ▪ Roll out service charter – to be displayed publicly – containing information on services, standards, complaints and the mechanisms to redress. ▪ Develop and implement country-specific hospital reforms to support and complement services at the primary care level. ▪ Re-categorize and accredit health facilities in line with KEPH to guide the identification of inputs required within the context of existing KEPH Norms and Standards. ▪ Update and implement clinical and management guidelines for service delivery. ▪ Creating facility-based incentives to improve quality of services, such as institutionalizing processes for recognition and reward. ▪ Put in place national strategy for integrated supportive supervision, involving clear definitions and implementation arrangements and linkages to annual plans and performance appraisal, as well as incorporating new service delivery guidelines. ▪ Fast track leadership and management capacity strengthening initiatives in accordance with the decentralization of management in the sector, including in-service training and patient centred accountability. |
| Objective 3: Foster partnerships in improving health and delivery services | <ul style="list-style-type: none"> ▪ Strengthen sector coordination and participation structures at all levels. ▪ Monitor adherence to COC principles and obligations, including the development of aid effectiveness indicators and targets, and integrate their measurement in sector annual reviews. ▪ Provide joint support and responsibility to strengthen common management arrangements, so as to ensure use of country systems for support. ▪ Ensure partners are providing coordinated and demand driven technical assistance and cooperation. ▪ Support implementation of common monitoring tools and systems including utilization of the Joint Review Missions for review and planning of sector interventions. ▪ Develop mechanisms for generating, sharing and using information with implementing partners. ▪ Build the capacity of coordinating secretariats for partnership (HENNET and private sector). ▪ Encourage development partners to increasingly channel funds through joint financing arrangements and use in-country systems ▪ Establish and implement coordination mechanism for partner missions to the country. ▪ Coordinate and pool capacity development support, particularly for systems strengthening. |

Continued

| NHSSP II objective | Priority interventions |
|---|--|
| Objective 4: Improve efficiency and effectiveness | <ul style="list-style-type: none"> ▪ Fast track implementation of HRH initiatives. ▪ Strengthen the management and availability of commodities and supplies. ▪ Align infrastructure, communication & ICT strategies to ensure they support service delivery effectively. ▪ Strengthen the public financial management systems. ▪ Strengthen use of strategies for bottom up planning and budgeting. ▪ Scale up use of performance monitoring mechanism (including HMIS). |
| Objective 5: Improve financing of the health sector | <ul style="list-style-type: none"> ▪ Establish mechanisms to increase availability of resources. ▪ Improve budget management and the efficiency and equitability of resource allocation and utilization, particularly by developing costing frameworks, improving pro-poor resource allocation formulas, instituting cost-effectiveness analysis to aid prioritization, availing finance/cost information to the public, and incorporating all income sources for expenditure tracking. ▪ Complete and implement health care financing strategy. ▪ Implement HSSF, through more comprehensive district budgeting, finalization of guidelines, training, and ensuring that fiduciary risk is low. ▪ Implement the shadow budget as a means to link planning and budgeting processes for the entire sector. ▪ Improve predictability of resources by holding partners accountable to provide information on their frameworks and budgets, and quarterly disbursement data. |



Causes of Prevailing Health Problems and Challenges



MOPHS Staff Requirements, Establishment and Gaps

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

Continued

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

Continued

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

Continued

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

Continued

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



Annex D

Transport Requirements

Table C1: Vehicles per level and units

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

Table C2: Transport requirements by province, district and location

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

Notes:

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

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