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MINISTRY OF HEALTH

Kenya Health Policy 2014–2030

Towards attaining the highest standard of health

Kenya Health Policy 2014–2030

*Towards attaining the highest standard
of health*

Nairobi, July 2014

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Kenya Health Policy 2014–2030

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FOREWORD

The Kenya Health Policy, 2014–2030 gives directions to ensure significant improvement in overall status of health in Kenya in line with the Constitution of Kenya 2010, the country’s long-term development agenda, Vision 2030 and global commitments. It demonstrates the health sector’s commitment, under the government’s stewardship, to ensuring that the country attains the highest possible standards of health, in a manner responsive to the needs of the population.

This policy is designed to be comprehensive and focuses on the two key obligations of health: realisation of fundamental human rights including the right to health as enshrined in the Constitution of Kenya 2010 and; contribution to economic development as envisioned in Vision 2030; and. It focuses on ensuring equity, people centeredness and a participatory approach, efficiency, a multisectoral approach, and social accountability in the delivery of healthcare services. The policy embraces the principles of protection of the rights and fundamental freedoms of specific groups of persons, including the right to health of children, persons with disabilities, youth, minorities, the marginalised and older members of the society, in accordance with the Constitution.

The policy focuses on six objectives and eight orientations to attain the government’s goals in health. It takes into account the functional responsibilities between the two levels of government (county and national) with their respective accountability, reporting, and management lines. It proposes a comprehensive and innovative approach to harness and synergise health services delivery at all levels and engaging all actors, signalling a radical departure from past approaches in addressing the health agenda. There is therefore, need to raise awareness and ensure that the objectives of this policy are understood and fully owned by the various stakeholders and implementing partners.

The policy was developed through a participatory process involving all stakeholders in health including government ministries, departments and agencies; clients, counties, constitutional bodies, development partners (multilateral and bilateral) and implementing partners (faith-based, private sector, and civil society). The detailed strategies, specific programmes and packages will be elaborated in subsequent five-year strategic and investment plans.

It is my sincere hope that under the devolved system of government, all the actors in health in Kenya will rally around these policy directions to ensure that we all progressively move towards the realisation of the right to health and steer the country towards the desired health goals.

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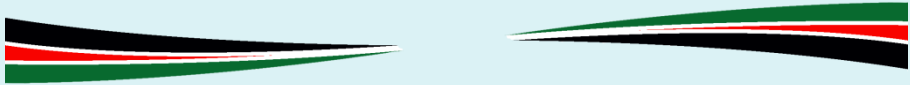
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CSO	Civil Society Organisation
DALY	Disability-adjusted Life Years
FBO	Faith-based Organisation
GDI	Gender Development Index
GDP	Gross Domestic Product
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPT	Health Products and Technologies
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
ICT	Information Communication Technology
IMR	Infant Mortality Rate
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KHPF	Kenya Health Policy Framework
MDA	Ministries, Departments, and Agencies
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NACC	National AIDS Control Council
NCD	Non-communicable Disease
NGO	Nongovernmental Organisation
NMR	Newborn Mortality Rate
NTD	Neglected Tropical Diseases
OOP	Out of Pocket
SACCO	Savings and Credit Co-operative Organisation
SAGA	Semi-autonomous Government Agency
SWAp	Sector-wide Approach
TB	Tuberculosis
U5MR	Under-five Mortality Rate
WHO	World Health Organization

PART 1: BACKGROUND



CHAPTER 1: INTRODUCTION

1.1. Health Policy and the Constitution of Kenya 2010

The Constitution of Kenya 2010 provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery. It provides that every person has a right to the highest attainable standard of health, which includes reproductive health rights. It further states that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants.¹

The Constitution further obligates the State and every State organ to observe, respect, protect, promote, and fulfil the rights in the Constitution and to take “legislative, policy and other measures, including setting of standards to achieve the progressive realisation of the rights guaranteed in Article 43.” State organs and public officers also have a constitutional obligation to address the needs of the vulnerable groups² in society and to domesticate the provisions of any relevant international treaty and convention that Kenya has ratified.³ The State has a further constitutional obligation under Article 46 of the Constitution to protect consumer rights, including the protection of health, safety, and economic interests.

The Constitution outlines the values and principles which all State organs and officers are expected to employ in the delivery of services. The health sector is therefore obligated to implement the principles in Articles 10 and 232, Chapters 6 and 12 of the Constitution, among others, and establish the framework necessary to support their implementation.

Table 1 summarises the main constitutional articles, among others, that have implications for health.

¹ Article 43 of the Constitution of Kenya 2010.

² These include women, older members of society, persons with disabilities, children and youth, members of minority or marginalised communities, and members of particular ethnic and religious or cultural communities.

³ Article 2(6) of the Constitution recognises ratified international treaties as part of the laws of Kenya.

Table 1. Summary of the Main Constitutional Articles that have Implications for Health

ARTICLE	CONTENT
20	20 (5) (a) Responsibility of the State to show resources are not available. 20 (5) (b) In allocating resources, the State will give priority to ensuring widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstance, including the vulnerability of particular groups or individuals
21	Duty of the State and State organs to provide for and take measures for progressive realisation of rights under Article 43, including addressing the needs of vulnerable groups within society and the international obligations regarding those rights.
43	(1) Every person has the right— <ul style="list-style-type: none"> (a) To the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare; (b) To reasonable standards of sanitation; (c) To be free from hunger and have adequate food of acceptable quality; and (d) To clean and safe water in adequate quantities. (2) A person shall not be denied emergency medical treatment.
26	Right to life Life begins at conception; abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.
32	Freedom of conscience, religion, belief, and opinion.
46	Consumers have the right to protection of their health, safety, and economic interests.
53–57	Rights of special groups: <ul style="list-style-type: none"> - Children have right to basic nutrition and healthcare. - People with disabilities have right to reasonable access to health facilities and materials and devices. - Youth have the right to relevant education and protection from harmful cultural practices and exploitation. - Minority and marginalised groups have the right to reasonable health services.
174–175	Objectives and principles of devolved government
189–191	Cooperation between national and county governments, support to county governments, and conflict of laws between different levels of government
Fourth Schedule	<p>National: Health policy; national referral health facilities; capacity building and technical assistance to counties;</p> <p>County health services: County health facilities and pharmacies; ambulance services; promotion of primary healthcare; licensing and control of undertakings that sell food in public places; veterinary services; cemeteries, funeral parlours, and crematoria; refuse removal, refuse dumps, and solid waste; and</p> <p>Staffing of county governments: Within the framework of the norms and standards set by the National government in accordance with the relevant legislation and policies.</p>

1.2. Health under the Devolved System of Government

The most significant feature of the Constitution of Kenya 2010 is the introduction of a devolved system of government, which is unique for Kenya and provides for one (1) national government and forty-seven (47) county governments. The governments at the national and county levels are “distinct and interdependent,” and are expected to undertake their relations through “consultation and cooperation.”⁴ The distinctiveness of the governments under the devolved system is determined by the Fourth Schedule of the Constitution, which has assigned different functions to the two levels of government.

In observance of this provision, the Kenya Health Policy 2014–2030 takes into account the objectives of devolution, which include the following:

- The promotion of democracy and accountability in delivery of healthcare;
- Fostering of seamless service delivery during and after the transition period;
- Facilitating powers of self-governance to the people and enhancing their participation in making decisions on matters of health affecting them;
- Recognising the right of communities to manage their own health affairs and to further their development;
- Protection and promotion of the health interests and rights of minorities and marginalised communities, including informal settlements such as slum dwellers and under-served populations;
- Promotion of social and economic development and the provision of proximate, easily accessible health services throughout Kenya;
- Ensuring equitable sharing of national and local resources targeting health delivery throughout Kenya;
- Enhancing capacities of the two levels of governments to effectively deliver health services in accordance with their respective mandates;
- Facilitating the decentralization of state organs responsible for health, their functions and services from the Capital of Kenya
- Enhancing checks and balances and the separation of powers between the two levels of government in delivery of health care

The policy takes cognisance of the specific functions assigned to the two levels of governments, which are as follows: National government: leadership of health

⁴ Article 6 of the Constitution of Kenya 2010.

policy development; management of national referral health facilities; capacity building and technical assistance to counties; and consumer protection, including the development of norms, standards and guidelines. County governments: responsible for county health services, including county health facilities and pharmacies; ambulance services; promotion of primary healthcare; licensing and control of undertakings that sell food to the public; cemeteries, funeral parlours and crematoria; and refuse removal, refuse dumps, and solid waste disposal.

Details of the activities under the national and county governments' respective functions will be further defined through the unbundling of functions pursuant to the provisions of the Transition to Devolved Government Act and Article 187 of the Constitution, and the sector intergovernmental agreements between the national and county governments. This policy forms the fundamental framework for managing the devolution of the healthcare sector, through and beyond the transition period. The policy provides for the development and strengthening of the necessary national, county, and intergovernmental mechanisms and frameworks within which health will be managed as a devolved function.

1.3. Health Policy and the National Development Agenda

Over the years, Kenya has strived to overcome development obstacles and improve the socioeconomic status of her citizens, including health. Some of the initiatives include the development and implementation of the Kenya Health Policy Framework (KHPF 1994–2010), Vision 2030, the promulgation of the Kenya Constitution 2010, and fast-tracking actions to achieve the Millennium Development Goals (MDGs) by 2015. The Government of Kenya (GOK) also upholds the fundamental right to health access for every Kenyan as envisaged in Vision 2030.

The implementation of KHPF 1994–2010 led to significant investment in public health programmes and minimal investment in medical services, resulting to improvement of health indicators such as infectious diseases and child health. However, the emerging increase of non-communicable diseases is a threat to the gains made so far. This policy aims at consolidating the gains attained so far, while guiding achievement of further gains in an equitable, responsive, and efficient manner. It is envisioned that the

Key objectives of the Kenya Health Policy 2014–2030

- ✓ Eliminate communicable conditions
- ✓ Halt and reverse the rising burden of non-communicable conditions
- ✓ Reduce the burden of violence and injuries
- ✓ Provide essential healthcare
- ✓ Minimize exposure to health risk factors
- ✓ Strengthen collaboration with private and other health-related sectors

ongoing government reforms, together with the anticipated sustained economic growth, will facilitate the achievement of the health goals.

Vision 2030 is the long term development blueprint for the country, aiming to transform Kenya into a “globally competitive and prosperous and newly industrialised middle-income country providing a high quality of life to all its citizens in a clean and secure environment by 2030”. Health is one of the components of delivering the Vision’s Social Pillar, given the key role it plays in maintaining the healthy and skilled workforce necessary to drive the economy. To realise this ambitious goal, the health sector defined priority reforms as well as flagship projects and programmes, including the restructuring of the sector’s leadership and governance mechanisms, and improving the procurement and availability of essential health products and technologies. Other projects include digitization of records and health information system; accelerating the process of equipping of health facilities including infrastructure development; human resources for health development; and initiating mechanisms towards universal health coverage.

The goal of the Kenya Health Policy 2014–2030 is attainment of the highest standard of health in a manner responsive to the needs of the Kenya population. In addition, policy principles and orientations have been formulated to facilitate the development of comprehensive health investments, health plans, and service provision within the devolved healthcare system.

1.4. Principles Guiding the Kenya Health Policy

Articles 10 and 232, together with Chapters 6 and 12 of the Constitution provide guidance on the values and principles that all State organs and officers are expected to uphold in the delivery of services. In the implementation of this policy, the health sector will embrace the following principles: Equity in distribution of health services and interventions;

- i. Public participation, in which a people-centred approach and social accountability in planning and implementation shall be encouraged, in addition to the multisectoral approach in the overall development planning;
- ii. Efficiency in application of health technologies; and
- iii. Mutual consultation and cooperation between the national and county governments and among county governments.

1.5. Organisation of Healthcare Service Delivery System

Kenya’s healthcare system is structured in a hierarchical manner that begins with primary healthcare, with the lowest unit being the community, and then graduates, with complicated cases being referred to higher levels of healthcare.

Primary care units consist of dispensaries and health centres. The current structure consists of the following six levels:

- Level 1: Community
- Level 2: Dispensaries
- Level 3: Health centres
- Level 4: Primary referral facilities
- Level 5: Secondary referral facilities
- Level 6: Tertiary referral facilities

1.6. National, Regional, and Global Health Challenges

Globalisation, political instability, and the emerging regional and national macroeconomic challenges triggered by the global economic downturn, together with climate change, have had an adverse impact on health. In addition, the increased cross-border movements of goods, services, and people, as well as international regulations and institutions, have had a considerable influence on national health risks and priorities. To respond to these challenges, regional and global initiatives focusing on health have been undertaken. This policy was developed at a time when the global development efforts towards the attainment of the MDGs were coming to a close, and other global initiatives, such as those targeting non-communicable diseases (NCDs), social determinants of health, and managing emerging and re-emerging health threats are gaining momentum. Further, there are emerging global efforts and commitments on aid effectiveness, which include Rome 2003, Paris 2005, Accra 2008, and Busan 2011, that focus on aligning donor support to country policies, strategies, and priorities, and using country systems during implementation for purposes of ownership. In line with Article 2 of the Constitution, the policy will conform to these internationally ratified obligations. The country still faces health challenges, especially concerning children, for whom under-nutrition is the single greatest contributor to child mortality. Other factors involved in high mortality include immunisable diseases and high maternal mortality arising from prepartum, childbirth, and postpartum conditions. Many people are also exposed to a heavy and wide-ranging disease burden, partly because of the country's unique geographical and climatic conditions. The difficult, disaster-prone environment in the arid and semi-arid regions of the country, and the lush but malaria-prone regions in other parts of the country, all have unique health risks associated with them. Stunting levels remain unacceptably high, at 35 per cent,⁵ with major national implications for survival, productivity, and economic development.

Kenya also faces problems of emerging and re-emerging diseases. Tuberculosis (TB) has resurfaced as a major cause of ill health. While HIV prevalence has been

⁵ Kenya Demographic and Health Survey (KDHS) 2008/2009.

steadily declining, the number of those infected continues to increase. In addition, the country faces an increasing health burden from injuries and non-communicable diseases, which are exacerbated by the negative underlying social health determinants in the country. Political instability in the Eastern Africa region and the subsequent in-migration of refugees into Kenya has the result of increasing the demand for health services in the country and raising the risk of spreading communicable diseases.

Limitations in the regulatory and resource capacity and utilisation have constrained the health sector's ability to harness fully the existing technology to manage most of the direct causes of ill health and death. The unionisation of health workers and recurrent industrial action also present new demands and challenges to the sector.

This policy provides guidance on how Kenya will address some of the challenges observed and build on the gains made so far.

1.7. The Policy Development Process

The Kenya Health Policy 2014–2030 was developed under the stewardship of the national government over a period of two years through an evidence-based and extensive consultative process with stakeholders. These stakeholders included relevant government ministries, departments, and agencies; county governments; constitutional bodies; multilateral and bilateral development partners; and faith-based, private sector, civil society and implementing partners. The definition and development of the policy objectives and orientations was based on a comprehensive and critical analysis of the status, trends, and achievement of health goals in the country during the implementation period of the previous policy framework of 1994–2010. The outputs from these processes are available as background information for this policy.⁶ The first draft was prepared after initial consultations at the national level and the regions in 2012, and circulated to the county governments and other stakeholders in mid-2013 for their review. The stakeholders' inputs were incorporated in the final policy draft during joint sessions between the national-level and county government representatives that were facilitated by the Commission on the Implementation of the Constitution. The resultant consensus policy document was then presented for consideration by Cabinet and the National Assembly.

⁶ Government of Kenya, 2010. *Health Situation Trends and Distribution, 1994–2010, and Projections to 2030*.

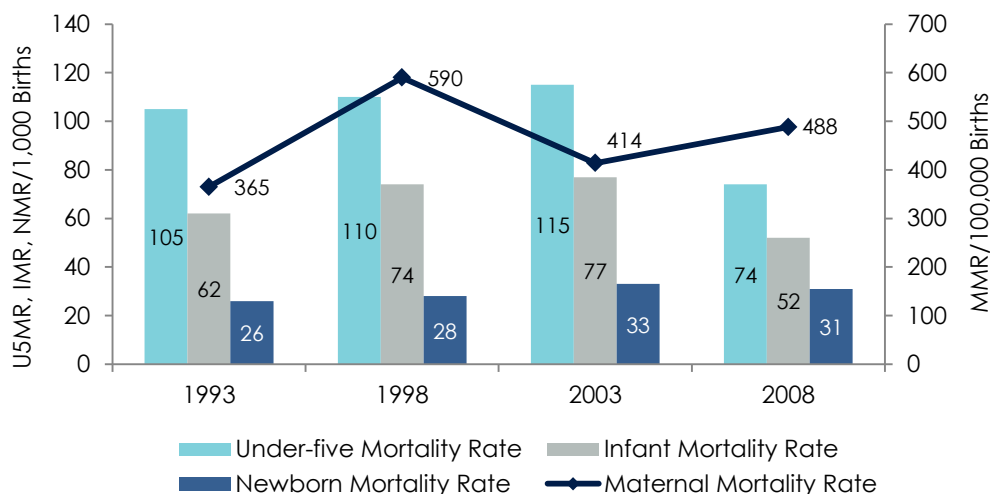
CHAPTER 2: SITUATION ANALYSIS

This section summarises the progress made in Kenya in (1) overall population health status, (2) investment made in health, (3) outcomes from the implementation of interventions under the previous policy period. The situation analysis was informed from a comprehensive review of the 1994–2010 Kenya Health Policy Framework and other surveys, some which provided data only up to 2010. More periodic surveys and reviews will be undertaken during the implementation of the new policy to update this information.

2.1. General Health Profile

Over the past decade, there has been general improvement in the health profile for Kenya. Life expectancy (LE) at birth in Kenya dropped from 58 years in 1993 to a low of 50 years in 2000,⁷ but rose to 60 years by 2009.⁸ Towards the end of the last policy period, some evidence of improvements in indicators for specific age groups emerged, particularly those related to adult, infant, and child health. However, some indicators stagnated, especially those related to neonatal and maternal health, as shown in Figure 1 below.

Figure 1. Recent Trends in Health Impact Indicators in Kenya, 1993–2008



There are geographic and sex/gender-specific differences in health indicators and among different age groups across the country. Disparities between regions persist, with the Gender Development Index (GDI)⁹ ranging from 0.628 (Central Region) to

⁷ Kenya Demographic and Health Survey 2003.

⁸ WHO 2010 World Health Statistics.

⁹ The GDI measures how human development indices for longevity, knowledge, and standards of living are differentiated by gender, ranging from 0.001 for most differentiated to 1.000 for almost equal.

0.401 (Arid/Semi-Arid Lands). Infant and child mortality rates have remained lowest in the Central and Nairobi regions, whereas they persistently are higher than the national average in the Nyanza, Western and Coast regions, as shown in Table 2 below.

Table 2. IMR and U5MR 1998–2008/09, by Region

Region	Infant Mortality Rate			Under-five Mortality Rate		
	1998	2003	2008–09	1998	2003	2008–09
Nairobi	41	67	60	66	95	64
Central	27	44	42	35	54	51
Coast	70	78	71	96	116	87
Eastern	53	56	39	78	84	52
Nyanza	135	133	95	199	206	149
Rift Valley	50	61	48	68	77	59
Western	64	80	65	123	144	121
North Eastern		91	57		163	80
National average	71	77	52	105	115	74

Source: Kenya Demographic and Health Survey 2009.

In addition, the country still faces a significant burden of disease from communicable and non-communicable conditions, and from injuries including those that result from violence. The common leading causes of death and disability are shown in Table 3 below.

Table 3. Leading Causes of Death and Disability in Kenya, 2009

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

Source: GOK 2010. Review of the Kenya Health Policy Framework, 1994–2010.

Note: DALYs = Disability-adjusted Life Years—Time lost due to incapacity arising from ill health.

This trend in the health status is attributed to a number of contextual factors. Specifically, despite noted decreases of some indicators, the population growth rate has remained high, at 2.4 per cent per annum, including a large young and dependent population that is increasingly urbanised. Although there were improvements in Gross Domestic Product (GDP) and a reduction in the percentage of the population living in absolute poverty (especially in urban areas) in the period under review, absolute poverty levels remained high, at 46 per cent. Literacy levels reached 78.1 per cent, although inequalities in age and geographical distribution persist. Gender disparities remain significant, with the Gender Inequality Index, the measure of disparity on health, empowerment and labour market stood at 0.618 and ranking 130 out of 146 countries worldwide in 2012¹⁰. Finally, security concerns persist in some areas of the country, making it difficult for communities to access and use existing services. Gender-based crimes also persisted with reported rape and defilement cases increasing from 3,228 in 2009 to 4,100 in 2012¹¹.

2.2. Progress in Overall Health Status

2.2.1 Status of key health indicators

During the previous policy period, interventions were introduced in the health sector to address key challenges, such as maternal and child health and nutrition, HIV/AIDS and TB, malaria, and the emerging threat of NCDs, with mixed results.

Coverage of critical interventions related to maternal health either stagnated or declined, with improvements seen only in the use of modern contraceptives (33% to 46%). On the other hand, although child health interventions improved in coverage during this period, reports indicate that ill health among children remains high.

HIV/AIDS control and management showed progress, with evidence of declining incidence, prevalence, and mortality. However, differences persist in coverage of interventions with regard to age, sex, geographical location and among high risk groups. Although efforts to control TB were hampered by the HIV epidemic, there were improvements on some key indicators, including case notification, case detection, and treatment successes..... However, the emergence of drug-resistant strains since 2005, particularly in males, is a key challenge. There is also evidence of a reduction in malaria-related mortality, attributed to the scaling up of effective interventions, such as Insecticide Treated Nets (ITNs), Intermittent Prophylaxis Treatment (IPTp), and Inside Residual Spraying (IRS). High coverage has been achieved in interventions addressing Neglected Tropical Diseases (NTDs), although they still exist among different populations in the country.

Non-communicable conditions, which include cardiovascular diseases, cancers, respiratory diseases, digestive diseases, psychiatric conditions, and congenital anomalies, represent an increasingly significant burden of ill health and death in the country. These represented 50–70 per cent of all hospital admissions during the

¹⁰ UNDP, Human Development Report, 2013

¹¹ Economic Survey 2013

previous policy period and up to half of all inpatient mortality. There is no evidence of reductions in these trends. Finally, the incidence of injuries and violence is also high, with mortality levels increasing over the years to account for 3.5% of all deaths in 2009, and mainly affecting the productive and younger population.

2.2.2 Risk factors to health

Risk factors to good health in Kenya include unsafe sex,¹² suboptimal breastfeeding, underweight, alcohol and tobacco use, and obesity and physical inactivity, among others. Table 4 below shows the top 10 risk factors contributing to mortality and morbidity:

Table 4. Leading Risk Factors and Contribution to Mortality and Morbidity, 2009

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

Source: GOK 2010. Review of the Kenya Health Policy Framework, 1994–2010.

DALYs = Disability-adjusted Life Years—Time lost due to incapacity arising from ill health

Available evidence suggests that there has been a reductions in unsafe sexual practices, with people increasingly embracing safer sex; this can be attributed to steady improvements in knowledge and attitudes regarding sexually transmitted infections (STIs) and conditions. Breastfeeding practices have also improved, with exclusive breastfeeding for up to six (6) months showing significant improvement. However, tobacco use remains high, particularly among the productive populations in urban areas and among males. Evidence shows that one in five males between ages 18–29 years and one in two males between 40–49 years use tobacco products. The same pattern is seen in the use of alcohol products, especially the impure products mainly

¹² Unsafe sex leads to many conditions affecting health, such as HIV, reproductive tract cancers/conditions and other sexually transmitted infections, unwanted pregnancies, and psychosocial conditions, among others.

found in the rural areas and urban slums. Cases of alcohol poisoning were reported during the previous policy period, and more than 2 per cent of all deaths in the country were attributed to alcohol use. Other health problems that appear to be gaining ground include obesity. It is estimated that 25 per cent of all persons in Kenya are overweight or obese, with the prevalence being highest among women in their mid- to late 40s and in urban areas.

2.2.3 Social determinants of health

Other health determinants include the literacy levels of women; nutrition; and access to safe water, adequate sanitation, and proper housing, roads and infrastructure among others. The literacy level of women has a strong correlation with a child's health and survival. Although there has been an increase in women's literacy levels in Kenya that peaked to 85.6% in 2013, progress towards improved child nutrition has stagnated. Cases of acute nutrition deficiencies have been recorded, including underweight indicators in children under five (5). However, there has been no change observed in the effects of chronic under-nutrition, such as stunting, wasting and underweight which stood at 37%, 7% and 16% respectively. Additionally, acute and chronically undernourished children are seen more in urban areas than rural areas of the country.

The nutrition status of women has also stagnated. More than 12 per cent of adult women are stunted with an unacceptably low Body Mass Index (BMI). Under-nutrition is higher among women ages 15–19 years and in rural areas of the country, whereas obesity is more prevalent in urban areas.

There are improvements in availability of safe water sources and sanitation facilities. Population with access to safe water increased from 59% in 2008 to 62% in 2013, with rural areas registering 55% access in 2013. However, some regions, such as arid and semi-arid areas, still have poor access to safe water. Housing conditions have also improved, with the number of households using iron sheet roofing or better being 75% and households using earthen floors 47% respectively in 2008.

The proportion of the population in active employment grew marginally from 28.3% in 2009 to 32.4% in 2013; however, there has been an associated increase in the absolute numbers of the inactive population. Migration from rural to urban areas, most noted among people ages 20–34 years, has contributed to an increase in the urban population and their associated health risks mostly affecting the urban informal settlements in the country..

2.3. Review of Health Investments

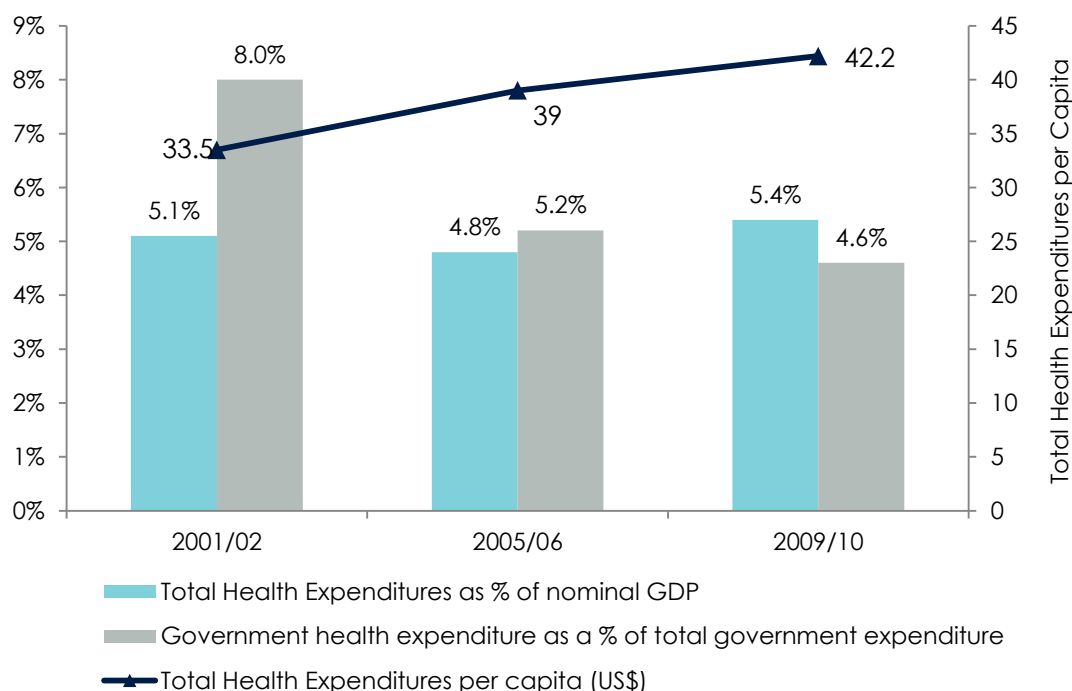
2.3.1 Health sector financial allocations and expenditure

The government expenditure on health as a percentage of total government expenditures has remained fairly constant—between 6 and 8 per cent over the last decade. However, health expenditures as a proportion of GDP increased from 5.1% to 5.4 % while public expenditures as a proportion of general government expenditures have been reduced from 8.0% to 4.6% during the same period. The health sector

continues to be predominantly financed by private sector sources (including by households' out-of-pocket (OOP) spending). The private sector share of total health expenditure (THE) has decreased from a high of 54 per cent in 2001/02 (of which 44.8% constitutes OOP expenditure) to 37 per cent in 2009/10, (of which 24% constitutes OOP expenditure). This decrease in OOP was primarily driven by increases in government and donor resources. Public sector financing has also remained constant over the last decade, at about 29 per cent of THE, whereas donors' contribution has more than doubled, from 16 per cent in 2001/02 to 35 per cent in 2009/10¹³.

Per capita health expenditure also has increased, from \$34 in 2001/02 to \$42 in 2009/10, which is still below the recommended World Health Organization (WHO) target of \$64 to meet a basic package of healthcare. There was evidence of improving fairness in the financing of healthcare, with higher contributions recorded among better-off individuals, and about 17 per cent of the total population had financial risk protection by the end of the policy period.

Figure 2. Overall Public Health Expenditure Trends: 2001–2010



Source: 2001/02, 2005/06, and 2009/10 National Health Accounts.

Evidence from the 2010 National Health Accounts demonstrated improvements in allocative efficiencies, with more services provided using the same amounts of resources in real terms. However, more resources were spent on management

¹³ 2001/02, 2005/06, and 2009/10 National Health Accounts

functions than on service delivery. In actual expenditures, there was limited real improvement in human resources for health and infrastructure during the previous policy period. While the actual numbers of these investments improved, the numbers per person stagnated or reduced, reflecting the stagnation of real resources for health. Improvements in real terms are notable only in the last two (2) years of the policy period (2009 and 2010). Now that health has been included as a basic right in the Constitution, it is expected that the level of investments will increase to meet this obligation.

2.3.2 Human resources

Human resources for health are defined as the stock of all people engaged in actions whose primary intent is to enhance health. An adequate, productive, and equitably distributed pool of health workers who are accessible is necessary for the effective delivery of healthcare.

There has been a general increase in the number of healthcare personnel over the years to peak to an average of 20.7 doctors and 159.3 nurses for every 100,000 persons by 2013 (See Table 5 below). This is below the WHO-recommended average of 21.7 doctors and 228 nurses per 100,000 people, which is the required standard for optimal delivery of services. Further, to deliver on the constitutional right to health, more personnel will be needed. A manpower development programme is therefore essential to ensure a continuous supply of health workers to the sector.

Table 5. Recent Trends in the Number of Registered Selected Healthcare Cadres

Health Personnel	2011	2012	2013	No. per 100,000 pop. (2013)
Doctors	7,549	8,092	8,682	20.7
Dentists	930	985	1,045	2.5
Pharmacists	2,432	2,076	2,202	5.3
Pharmaceutical Technologists	4,436	5,236	6,204	14.8
Nursing Officers	34,071	36,680	39,780	95.1
Enrolled Nurses	24,375	26,621	26,841	64.2
Clinical Officers	9,793	11,185	13,216	31.6

Source: Economic Surveys 2012, 2013, 2014.

Due to the lack of the application of appropriate health personnel deployment norms and standards, the distribution of workforce has tended to favour regions perceived to have high socioeconomic development, leaving marginalised and hard-to-reach areas at a disadvantage. Poor areas have fewer health facilities and are not preferred by health workers, while other regions report surpluses in staff. There is also a skewed urban-rural distribution of staff, with the urban areas having the highest proportions of staff at the expense of rural and remote areas where 70% of the population lives.

Advanced medical care is also mostly available in urban areas. Lack of essential tools and medical and non-medical supplies in health facilities, and a poor and unsafe working environment contribute to low morale and productivity of staff. Other challenges that affect performance and motivation include uneven remuneration and disparities in terms of reference among the same cadres, poor working conditions, unequal distribution of staff, and diminishing productivity among the health workforce.

2.3.3 Infrastructure

The distribution of facilities across the 47 counties is illustrated in the table below (Table 6). The data demonstrates that there are significant regional disparities. However, the number of facilities does not imply that basic equipment and supplies are available. It is envisaged that the regional disparities will be addressed by equalisation and affirmative efforts as enshrined by the Constitution of Kenya 2010.

Table 6. Distribution of Health Facilities 2012

County	Population 2013	No. of hospitals level 4-6	Hospitals per 100,000 population	No. of health centres and dispensaries (Levels 2-3)	Health centres and dispensaries per 100,000 population
Kenya	40,700,000	512	1.3	8,104	19.9
Baringo	593,840	6	1.0	182	30.6
Bomet	782,105	5	0.6	113	14.4
Bungoma	1,473,458	12	0.8	134	9.1
Busia	796,646	7	0.9	74	9.3
Elgeyo - Marakwet	396,663	8	2.0	113	28.5
Embu	550,438	8	1.5	131	23.8
Garissa	457,068	14	3.1	105	23.0
Homa Bay	1,033,941	14	1.4	201	19.4
Isiolo	206,306	5	2.4	42	20.4
Kajiado	732,356	14	1.9	224	30.6
Kakamega	1,781,528	17	1.0	232	13.0
Kericho	799,515	14	1.8	162	20.3
Kiambu	1,734,694	27	1.6	391	22.5
Kilifi	1,179,956	10	0.8	227	19.2
Kirinyaga	564,022	5	0.9	239	42.4
Kisii	1,234,634	20	1.6	137	11.1
Kisumu	1,030,986	21	2.0	145	14.1
Kitui	1,061,296	15	1.4	290	27.3
Kwale	694,612	3	0.4	96	13.8
Laikipia	417,538	7	1.7	96	23.0
Lamu	106,877	3	2.8	41	38.4
Machakos	1,174,587	8	0.7	293	24.9
Makueni	946,292	13	1.4	175	18.5
Mandera	1,005,003	6	0.6	73	7.3
Marsabit	312,325	4	1.3	83	26.6
Meru	1,448,606	24	1.7	369	25.5

Migori	981,319	15	1.5	170	17.3
Mombasa	995,334	15	1.5	275	27.6
Murang'a	1,013,325	8	0.8	299	29.5
Nairobi	3,324,894	54	1.6	599	18.0
Nakuru	1,693,008	21	1.2	318	18.8
Nandi	802,347	6	0.7	169	21.1
Narok	908,597	6	0.7	147	16.2
Nyamira	640,844	7	1.1	126	19.7
Nyandarua	631,034	3	0.5	119	18.9
Nyeri	832,877	10	1.2	401	48.1
Samburu	239,416	3	1.3	70	29.2
Siaya	902,753	11	1.2	154	17.1
Taita Taveta	297,579	7	2.4	72	24.2
Tana River	258,261	2	0.8	62	24.0
Tharaka - Nithi	389,731	8	2.1	96	24.6
Trans Nzoia	875,697	7	0.8	91	10.4
Turkana	868,209	6	0.7	139	16.0
Uasin Gishu	940,112	12	1.3	165	17.6
Vihiga	594,457	6	1.0	75	12.6
Wajir	566,454	10	1.8	102	18.0
West Pokot	525,970	5	1.0	87	16.5

Source: Economic Survey 2013, 2014 and Ministry of Health, Master Facility List 2012

2.4. Review of the Outcomes of the Implementation of the Previous Policy

The previous policy framework (KHPF 1994-2010) included interventions listed under seven policy imperatives and a comprehensive reform agenda. Overall, the outcomes from the implementation of those interventions are mixed, as detailed in the following sections.

2.4.1 Policy imperative: *Ensure equitable allocation of government resources to reduce disparities in health status*

A comprehensive bottom-up planning process was instituted in the second half of the policy period. However, other systemic issues, such as actual capacity to implement priorities, affected the prioritisation process. As a result, the interventions chosen did not necessarily lead to equitable access to essential curative and preventive services. Additionally, inadequate information on resources available made it difficult to link the microeconomic framework with the epidemiological information for a rational planning framework. A criterion was not established for geographic allocation of resources. Nevertheless, a standard resource allocation criterion for district hospitals and rural health facilities (health centres and dispensaries) was in use, but only for operations and maintenance. The norms and standards for health service delivery, which include human resources, equipment, and infrastructure, were developed in June 2006 but not operationalised. Allocation for essential medicines and supplies, based on facility type for lower-level facilities, was in place for most of the policy period. Some

regions of the country had negative experiences with the pull system, which was based on special drawing rights for pharmaceuticals and medical supplies from the Kenya Medical Supplies Agency (KEMSA).

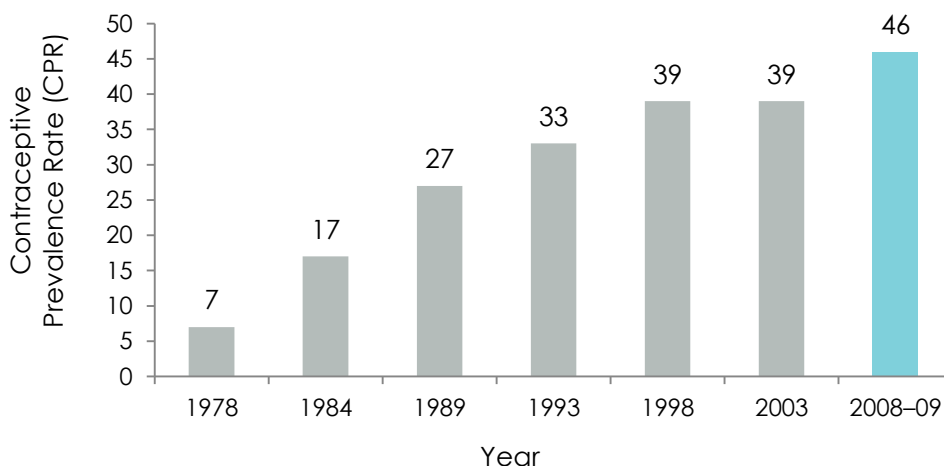
2.4.2 Policy imperative: Increase the cost-effectiveness and cost efficiency of resource allocation and use

The burden of disease and cost-effectiveness analyses were not completely applied to determine priority interventions, but the process took into account the feasibility of implementation, the system’s capacity for implementation, and availability of resources to facilitate implementation. Data from the health management information system (HMIS) was used to determine the disease burden during the policy period, and this was also partially taken into consideration in setting priorities. While norms and standards defining the appropriate mix of personnel, operations, and maintenance inputs at all levels were in place, these were not utilised to ensure cost efficiency. Additionally, the health sector was not able to define and use unit costs for service delivery in its priority setting.

2.4.3 Policy imperative: Continue to manage population growth

Reproductive health services were strengthened across the country, and improvements were achieved in the availability and range of modern contraceptives for users, resulting in a gradual increase in contraceptive prevalence rates, as shown in Figure 3 below.

Figure 3. Trends in Contraceptive Use Rate among Married Women



*Data from the first five sources omit several northern districts, while the 2003 and 2008-09 KDHS surveys represent the whole country.

Information, education, and communication (IEC) materials and strategies were developed throughout the policy period, facilitating dissemination of family planning messages. There was also community involvement in the advocacy and dissemination of information, leading to increased access, availability, and uptake of services. This

contributed to a drop in the fertility rates from 5.4 in 1993 to 4.6 in 2003, a trend observed in most regions of the country. Efforts were made to raise awareness of sexual and reproductive health among youth and a strategy put in place to roll out youth-friendly services in health facilities aimed at reducing unwanted teenage pregnancies.

2.4.4 Policy imperative: Enhance the regulatory role of government in all aspects of healthcare provision

Measures were put in place to decentralise governance and management decision-making to provinces and districts and leave the central level to focus on policy functions. However, their impact was limited due to the lack of a legal framework and weak management capacity in the decentralised units. The promulgation of the new Constitution in 2010 provided the necessary framework for entrenching devolution, although the Public Health Act has not been amended to reflect the stewardship role of the government in the current health delivery environment. The national-level and subnational-level regulatory boards were strengthened to improve their capacity to deliver. Gradual decentralisation of the management and control of resources to lower-level institutions was initiated through the Hospital Management Services Fund (HMSF) and the Health Sector Services Fund (HSSF).

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

A framework for sector coordination and partnership was established in 2006 with the formalisation of the Kenya Health Sector-wide Approach (SWAp) process. Necessary instruments were defined, based on memoranda of understanding and a code of conduct to guide this dialogue and collaboration. In addition, the government supported health service delivery by non-state actors by providing access to public health commodities and medical supplies, and giving tax exemptions for donations in some of the facilities. The government also seconded critical public health staff to non-state facilities in specific cases, especially in under-served areas. However, the major beneficiaries of these initiatives have been faith-based service providers and not the private for-profit sector, which accounts for a 17.9% of all hospital admissions in 2007¹⁴. Collaboration with private for-profit actors and alternative medicine practitioners is still weak. The government has also begun providing health promotion and targeted disease prevention and curative services through community-based initiatives as defined in the 2007 Comprehensive Community Health Strategy (MOH 2006).

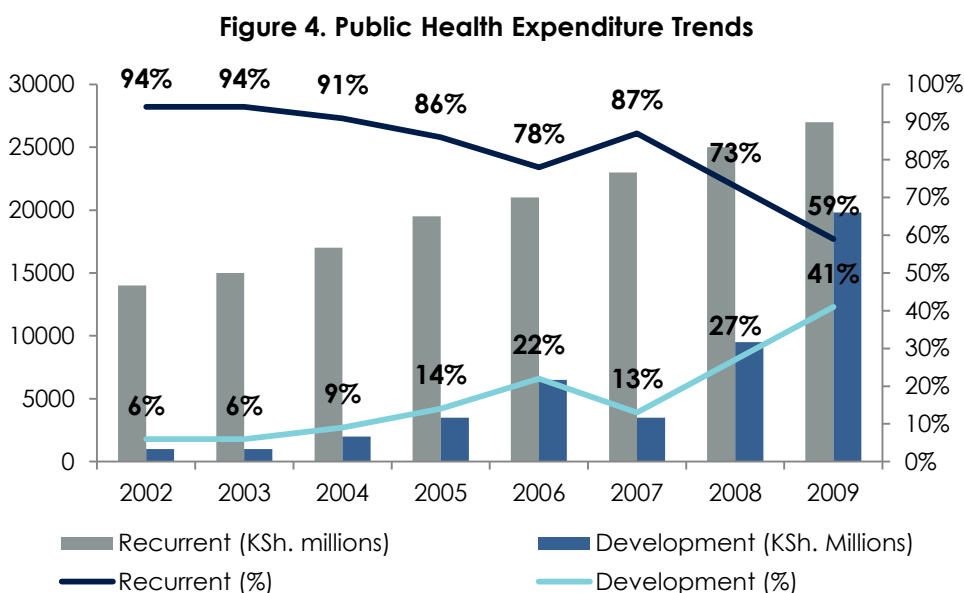
2.4.6 Policy imperative: Increase and diversify per capita financial flows to the health sector

The health sector was not able to expand the budgetary allocations, in real terms, to healthcare. However, strategies were put in place to influence resource allocation,

¹⁴ Kenya Household Expenditure and Utilisation Survey Report 2009

which included the development and costing of sector plans and active participation in resource allocation discussions. Nominal increases in allocations were achieved, especially in the period after 2006, and accelerated with the Economic Stimulus Program (ESP) in 2009. These increases are nominal, not real, and represent a shift in total sector financing away from government and households and towards donors.

There was also a relative increase in financing for preventive and promotive healthcare as a proportion of recurrent versus development expenditures, implying less investment in real terms for medical care (see Figure 4). The result of this weak financing was that the opportunity cost of new programmes was high—with common programmes having less financing. Nevertheless, the financing of health services has increasingly become progressive. The National Hospital Insurance Fund has been transformed into a state corporation to improve effectiveness and efficiency. It has expanded its benefits package to include more clinical services and preventive and promotive services.



Provision of insurance services has also expanded, with increases in the numbers of firms and the people covered. However, insurance coverage has remained limited to urban areas and to formal sector employees. The 10/20 policy on cost sharing introduced in 2004 reduced the contributions of users of facilities to a token amount in dispensaries and health centres. Further, exemptions for user fees were introduced for some specific health services, including treatment of children under five years old, inmates (prisoners) maternity services in dispensaries and health centres, TB and HIV/AIDS treatment in public health facilities, and immunisation services. Although this has significantly improved financial access to services, it has greatly reduced the

amounts of resources mobilised through user fees. Community-based health financing initiatives have not been applied effectively in the country, despite the existence of a relatively strong community-based Savings and Credit Cooperative Organisation (SACCO) system that could have acted as a backbone for community-based insurance initiatives.

2.4.7 Policy imperative: Implementation of the reform agenda

A number of reform initiatives were undertaken in the policy period, with mixed results:

- i. Strengthening the capacity of the Ministry of Health (MOH) in planning and monitoring was achieved, although capacity limitations persist in other areas, such as leadership and management;
- ii. An essential package of health has been defined with each strategic plan, though its application to guide service delivery priorities has been limited;
- iii. Innovative service delivery strategies have been applied, such as mobile clinics, outreach programmes or community-based services, although their application has been limited to some areas and programmes;
- iv. Subnational management functions have been strengthened to allow them to better facilitate and supervise service delivery, though this mandate has been exercised differently in the various provinces/regions and districts;
- v. New statutes, laws, and policies guiding different aspects of the health sector have been introduced, though in an uncoordinated manner, and no update of existing laws has been undertaken;
- vi. The sector has made some efforts to develop a health financing strategy to guide its resource rationalisation and mobilisation approaches;
- vii. The human resource component has been strengthened through staff redistribution, an increase in numbers and a review of management structures of application of norms and standards, as well as motivation of existing staff. The sector also does not have an investment plan to guide the distribution and improvement of health infrastructure, leading to low investments for both new and existing infrastructure.
- viii. Control of HIV/AIDS and other STIs is now coordinated through a semi-autonomous institution—the National AIDS Control Council (NACC)—which, prior to 2013 was managed through a different line ministry from the MOH. However, this administrative arrangement brought about challenges in coordinating financing and integrating the HIV response into the overall health agenda. However, the new political dispensation has placed the NACC under the MOH.
- ix. While an explicit National Drug Policy existed, its implementation during the policy period was slow; only a fraction of the steps set out were realised. Some of the notable achievements include improvement in commodity management, and harmonisation of procurement, warehousing, and distribution mechanisms through KEMSA. An Essential Medicines List has been made available, although adherence to its use has been poor. Attempts to introduce a demand-driven procurement system were instituted, and there is evidence that it led to better availability of the required commodities in public health facilities.

- x. HMIS architecture has improved information completeness. However, the information collected is still limited to a few conditions, and there are weaknesses in its completeness and quality. Additionally, information analysis, dissemination, and use is not well entrenched in the sector. The use of information sources beyond routine health management information remains weak.
- xi. Cost containment and control strategies have not been wholly applied in the sector. Cost information is missing, and expenditure review data and recommendations have not been applied. Strategies to contract health services from providers were not employed as a means of cost control.
- xii. There has been an increase in the amount and scope of systems; clinical and biomedical research and a number of operational decisions have been affected as a result of some of these studies. However, there is little collaboration among different research institutions, and poor linkage between research and policy.
- xiii. The decentralisation of functions of the MOH to the provinces/regions and districts did not take place as anticipated. The central level has instead expanded as more vertical programmes were established, necessitating more programme management units. However, this is expected to change with the implementation of the new Constitution.

2.5. Overall Performance in Country Commitments

From the situation analysis, it is evident that progress towards attaining the stated health goals achieved mixed results. Notably, there has been slow progress towards attaining its commitments to MDG¹⁵ 1 (eradicate extreme poverty and hunger), 4 (reduce child mortality rates), and 6 (combat HIV, malaria, and other diseases). There has been no progress towards MDG 5 (improve maternal health), and limited progress towards meeting the obligations in the African Union Maputo Plan of Action,¹⁶ which aimed to reduce poverty levels.

Regarding investments in health, there has been a limited increase in financing. Although the Paris Declaration on Aid Effectiveness¹⁷ was prioritised, implementation of the principles has remained poor. In addition, limited progress has been made towards achieving the commitments of the Abuja Declaration, in which countries committed to spend at least 15 per cent of their public expenditures on health.

This policy provides a framework to address some of these pending issues and build on successes to enable Kenyans to attain the right to the highest standard of healthcare, including reproductive health and the right to emergency treatment within Kenya's system of devolved government.

¹⁵ United Nations Millennium Summit, 2000.

¹⁶ African Union Commission. 2006. *Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action)*.

¹⁷ OECD. 2005. *Paris Declaration on Aid Effectiveness*.

PART 2:
POLICY
DIRECTIONS

CHAPTER 3: POLICY PROJECTIONS AND FRAMEWORK

The health sector, in its endeavour to provide the desired highest standards of health as enshrined in the Constitution, has projected the achievable decline in mortality based on the situation analysis and assuming an appropriate policy framework. This section provides the policy projections, the components of the policy framework, and the underlying principles that will guide the health sector towards the realisation of the better health desired by all in Kenya

3.1. Policy Projections

The emerging trends point to the fact that non-communicable diseases, injuries, and violence-related conditions will increasingly, in the foreseeable future, be the leading contributors to the high burden of disease in the country, even though communicable diseases will remain significant. This implies that future policy frameworks will address the high disease burden arising from all three of these conditions.

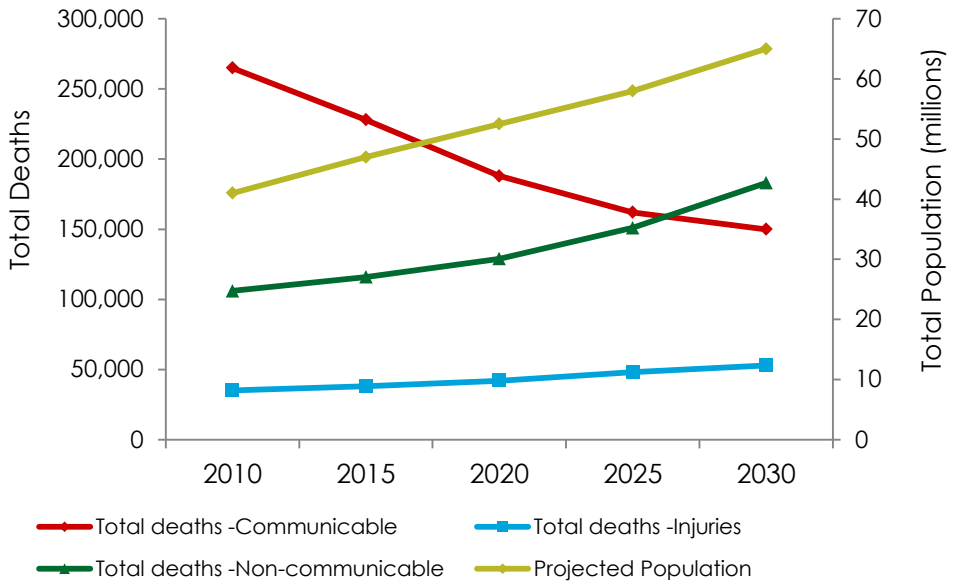
The current total annual mortality is estimated at approximately 420,000 persons, out of which 64 per cent, 26 per cent, and 10 per cent are due to communicable, non-communicable, and injury conditions, respectively. As interventions to address communicable conditions reach maturity and attain sustained universal coverage, projections show that there will be reductions in this category of disease burden, although these reductions will be slow due to the large populations facilitating communicable disease transmission.

Future projections indicate that, if the current policy directions and interventions¹⁸ are effectively implemented, the overall annual mortality will decline by 14 per cent by 2030. The contribution to the annual mortality by disease domain would be different: communicable diseases would decline to 39 per cent and non-communicable and injuries conditions will increase to 47 per cent, and 14 per cent respectively. This represents a 48 per cent reduction in absolute deaths due to communicable conditions, but a 55 per cent increase in deaths due to non-communicable conditions and a 25 per cent increase in deaths due to injuries and violence, as shown in Figure 5.

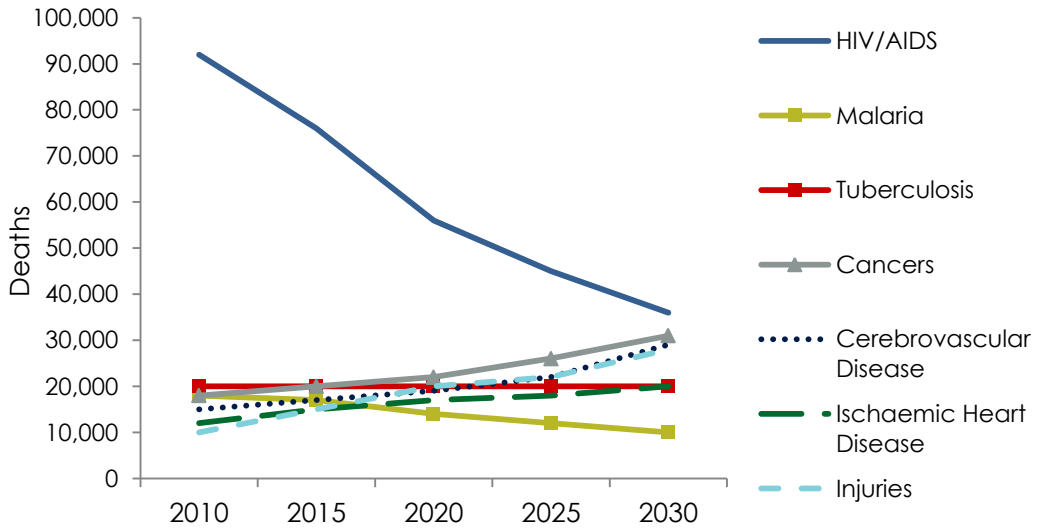
¹⁸ That is, the existing policy directions and interventions that the Kenya Policy 2014–2030 aims to change.

Figure 5. Health Projections: 2011–2030

a) By disease domain



b) By disease condition



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

Current efforts to tackle malaria, TB, and HIV are expected to bear fruit in the short and medium term. Their contributions to the overall disease burden will be reduced significantly. However, other dormant or emerging conditions, such as dietary-related diseases, will continue to contribute immensely to the overall disease burden, and thus erode out any gains made through existing interventions on communicable diseases. To ensure significant reductions in the overall ill health and mortality in Kenya, continuous availability of resources and minimum population growth should be guaranteed.

The Kenya Health Policy 2014–2030 therefore seeks to ensure a significant reduction in the general ill health in the Kenyan population by achieving reductions in deaths due to communicable diseases by at least 48 per cent and reducing deaths due to non-communicable conditions and injuries to below levels of public health importance without losing focus on emerging conditions. This would translate to a 31 per cent reduction in the absolute numbers of deaths in the country, as opposed to only a 14 per cent reduction. This target corresponds well with current mortality trends in middle-income countries. WHO’s 2008 Global Burden of Disease estimates suggest a 0.68 per cent mortality rate in a representative group of middle-income countries (Argentina, Brazil, Indonesia, and Egypt) as compared to the 0.94 per cent mortality rate for Kenya (a 27% difference).

This level of mortality in 2030 represents a 50 per cent reduction in overall deaths per 1,000 persons when the population estimates are taken into consideration, translating to a reduction of 62 per cent for communicable conditions, 27 per cent for non-communicable conditions, and 27 per cent for violence/injuries (see Table 7).

Table 7. Absolute and Relative Mortality Targets for Kenya, 2010–2030

	2010		2030 Targets	
	Absolute Numbers of Deaths	Deaths per 1,000 Persons	Absolute Numbers of Deaths	Deaths per 1,000 Persons
Total	420,000	10.6	290,000	5.4
Communicable conditions	270,000	6.8	140,000	2.6
Non-communicable conditions	110,000	2.8	110,000	2.0
Violence/injuries	40,000	1.0	40,000	0.7
Population estimates	38,500,000		54,150,000	

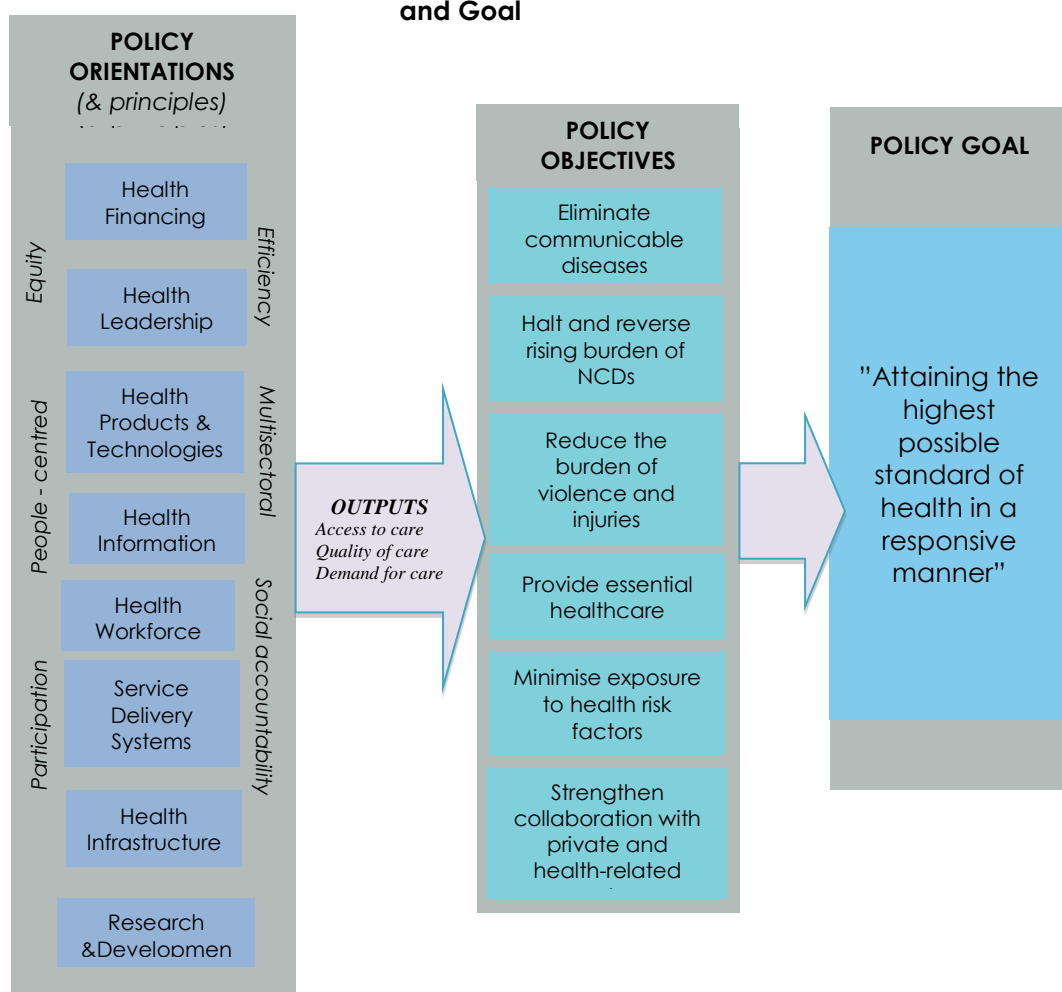
Source: Projections by Ministry of Health.

The scenarios and outcomes anticipated in Table 7 are achievable over the policy implementation period. However, an ingenious and logical arrangement of the applicable and interlinked policy elements into a comprehensive and coherent framework is important, as described in the next section.

3.2. Components of the Policy Framework

The health sector will adopt the policy framework presented in the following sections to address the prevailing and emerging health challenges that the country is facing. Figure 6 shows how high-priority policy investment areas (policy orientations) will operate to influence outcomes (policy objectives). It also delineates linkages among relevant contextual (environmental) factors that play a role in reaching specific policy goals.

Figure 6. Policy Framework for Health: Orientations, Principles, Objectives, and Goal



The components and elements of the framework are as follows:

The **policy goal** defines the overarching intent and impact that the policy is designed to accomplish regarding the health of all people in Kenya. This is elaborated qualitatively (aim of policy), and quantitatively (target of policy). The goal of “attaining the highest possible standard of health in a responsive manner” will be achieved progressively.

The **policy objectives** define the sector’s intent relating to the desired health outcomes needed to facilitate attainment of the overall goal, and are based on ill health and disease burden.

The **policy outputs** are key areas of intervention that will be the focus so as to attain the policy objectives. These relate to improving access, demand, and quality of care.

The **policy principles** will guide sector investments as provided for in the Constitution (Article 10).

The **policy orientations** define the sector’s intent relating to investments to be made, which will facilitate attainment of the policy objectives. They relate to leadership/governance, the health workforce, health products, health infrastructure, health financing, and service delivery systems. Their effectiveness is measured in terms of improvements in *health outputs*, relating to better access to care, improved quality of care, and demand for care. Prioritisation of investments in each policy orientation will be informed by the set of policy principles.

Each of the policy objectives and orientations is not mutually exclusive and must be addressed from a synergistic viewpoint—investments in each are dependent on investments in others to support attainment of the policy goal.

To achieve its goal, this policy is designed to be comprehensive, balanced, and coherent. “Comprehensive” means the policy will provide guidance across the health spectrum for actions required to attain the country’s overall health goals. “Balanced” means it shall cover all aspects of interventions in health that are needed to achieve the health goals, giving appropriate weight to their importance. “Coherent” means it shall ensure that different policy directions are mutually exclusive, but all contribute to a common overarching agenda. Based on this three-pronged framework, policy directions are defined as focusing on the overall policy goal, objectives, principles, and orientations.

3.3. Policy Principles

The principles aim to guide investments, interpretation of targets, and performance of the sector towards attaining its overall aspirations. These principles are based on an interpretation of primary healthcare principles. They include:

3.3.1 Equity in the distribution of health services and interventions

There will be no exclusion or social disparities in the provision of healthcare services. Services shall be provided equitably to all individuals in a community, irrespective of their gender, age, caste, colour, geographical location, tribe/ethnicity, and socioeconomic status. The focus shall be on inclusiveness, non-discrimination, social accountability, and gender equality.

3.3.2 People-centred approach to health and health interventions

Healthcare services and health interventions will be based on people's legitimate needs and expectations. This necessitates community involvement and participation in deciding, implementing, and monitoring interventions.

3.3.3 Participatory approach to delivery of interventions

The different actors in health will be involved in the design and delivery of interventions in order to attain the best possible outcomes. A participatory approach should be applied when potential for improved outcomes exists. The private sector shall be seen as a complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided.

3.3.4 Multisectoral approach to realising health goals

A multisectoral approach is based on the recognition of the importance of the social determinants of health in attaining the overall health goals. A 'Health in all Policies' approach will be applied in attaining the objectives of this policy. The relevant sectors include, among others, agriculture—including food security; education—secondary-level female education; roads—focusing on improving access among hard-to-reach populations; housing—decent housing conditions, especially in high-density urban areas; and environmental factors—focusing on a clean, healthy, unpolluted and safe environment.

3.3.5 Efficiency in the application of health technologies

This aims to maximise the use of existing resources. The health sector will choose and apply technologies that are appropriate (accessible, affordable, feasible, and culturally acceptable to the community) in addressing health challenges.

3.3.6 Social accountability

Healthcare service delivery systems will be reoriented towards the application of principles and practices of social accountability, including reporting on performance, creation of public awareness, fostering transparency, and public participation in decision making on health-related matters.

CHAPTER 4: POLICY GOAL, OBJECTIVES, AND ORIENTATIONS

This section defines the goal of this policy, describes the six key policy objectives that must be met to achieve that goal, and outlines the various orientations that will lead towards realisation of those objectives.

4.1. Policy Goal

The goal of the Policy is “**to attain the highest possible standard of health in a responsive manner.**”

The health sector aims to achieve this goal by supporting *equitable, affordable, and high-quality health and related services at the highest attainable standards for all Kenyans*. The sector will be guided by the primary healthcare approach,¹⁹ which remains the most efficient and cost-effective way to organise a health system.²⁰ This will be realised progressively during the policy period (2014–2030).

The **target** of the health sector is to attain a level of health that is commensurate with that of a middle-income country.²¹ This calls for attainment of the targets presented in Table 8 below.

Table 8. Kenya Health Policy Targets

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

¹⁹ The primary healthcare approach aims to provide essential healthcare based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

²⁰ World Health Organization. 2008. *Primary Health Care: Now, More than Ever*. World Health Report.

²¹ Average values for Argentina, Brazil, Egypt, and Indonesia are taken as representative of middle-income countries to provide the target Kenya will aim to achieve.

In the policy period, the sector will also seek to deliver on two obligations on health:

- i. **Progressive realisation of the right to health:** The national and county governments will put in place measures to progressively realise the right to health as outlined in Article 21 of the Constitution. The sector will employ a human rights-based approach in healthcare delivery and will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programmes. This includes human dignity; attention to the needs and rights of all, with special emphasis on children, persons with disabilities, youth, minorities and marginalised groups, and older members of the society (Constitution of Kenya 2010 Article 53–57); and ensuring that health services are made accessible to all.

During this policy period, a basic and expandable package—the Kenya Essential Package for Health (KEPH), will be defined and shall consist of the most cost-effective priority healthcare interventions and services, addressing the high disease burden, that are acceptable and affordable within the total resource envelop of the sector. The package shall consist of the following clusters:

- (a) Health promotion, environmental health, disease prevention and community health initiatives , including epidemic and disaster preparedness and response
- (b) Maternal and Child health
- (c) Prevention, management and control of communicable diseases
- (d) Prevention, management and control of non-communicable diseases

The composition of the package shall be re-visited periodically depending on changes in disease burden, availability of new interventions based on evidence and changes in the cost-effectiveness of the interventions.

- ii. **Contribution to development:** This policy will contribute to the attainment of the country’s long-term development agenda outlined in Kenya’s Vision 2030 through the provision of high-quality health services to maintain a healthy and productive population able to deliver the agenda.

4.2. Policy Objectives

The main objective of this policy is to **attain universal coverage of critical services that positively contribute to the realisation of the policy goal**. Six policy objectives are defined.

4.2.1 Policy objective 1: *Eliminate communicable conditions*

This policy aims to reduce the burden of communicable diseases to a level that is not of major public health concern. The priority policy strategies include the following:

- i. Promote provision and progressive realisation of universal access to the preventive and promotive services addressing major causes of the disease burden due to communicable conditions;
- ii. Put in place interventions directly addressing marginalised elderly persons and vulnerable, marginalised, and indigent populations affected by communicable conditions;
- iii. Enhance comprehensive control of communicable conditions by designing and applying integrated health service provision tools, mechanisms, and processes such as, but not limited to, combatting existing public health concerns;
- iv. Control vaccine-preventable diseases;
- v. Promote good hygiene and sanitation to control food and water- and food-borne diseases;
- vi. Improve nutrition and food safety throughout the life-course;
- vii. Eradicate vector- and insect-borne diseases and other NTDs;
- viii. Promote rational use of antimicrobials and other drugs, and the control of drug resistance to pathogens;
- ix. Promote disease surveillance, epidemic preparedness and response;
- x. Control entry of infectious conditions at national borders;
- xi. Strengthen health information systems for complete and timely reporting of communicable disease incidences;
- xii. Increase access to improved water safety and sanitation;
- xiii. Scale up implementation of high-impact health interventions and integrate them with the community health strategy; and
- xiv. Adherence to international health regulations and health related issues.

4.2.2 Policy objective 2: Halt and reverse the rising burden of non-communicable conditions and mental disorders

This will be achieved through implementing strategies to address all of the identified non-communicable conditions and mental disorders in the country. The priority policy strategies include the following:

- i. Promote universal access to interventions addressing priority non-communicable conditions and mental disorders in the country;
- ii. Ensure that services relating to non-communicable conditions meet set standards, with a view to maximise utilisation of the services the population has access to;
- iii. Strengthen advocacy for health-promoting activities aimed at preventing increased burden of non-communicable conditions;
- iv. Put in place intersectoral programmes for non-communicable disease prevention and control;
- v. Put in place interventions directly addressing marginalised and indigent populations affected by non-communicable conditions;
- vi. Design and implement integrated health service provision tools, mechanisms, and processes, with a view to enhancing comprehensive control of non-communicable diseases;
- vii. Decentralise screening for non-communicable diseases to lower levels to increase access and early detection;
- viii. Strengthen the integrated surveillance system to monitor trends in non-communicable diseases and mental disorders, including risk factors, to inform policy and planning; and
- ix. Support optimal health and survival of children by improving technical guidance, regulation, and protection of children's rights.

4.2.3 Policy objective 3: Reduce the burden of violence and injuries

This will be achieved by putting in place strategies to address the causes of injuries and violence, with special consideration for gender, age, geographical distribution, and other factors. The priority policy strategies include the following:

- i. Promote corrective and intersectoral preventive interventions to address causes of injuries and violence;
- ii. Facilitate greater universal access to timely and high-quality emergency care (curative and rehabilitative) that mitigates the effects of injuries and violence;

- iii. Put in place interventions directly addressing marginalised and indigent populations affected by injuries and violence;
- iv. Scale up physical and psychosocial rehabilitation services to address long-term effects of violence and injuries;
- v. Address the health effects of emergencies, disasters, crises, and conflicts, and minimise their social and economic impacts;
- vi. Promote public health aspects of road safety;
- vii. Enhance disaster risk management through disaster forecasting and emergency response; and
- viii. Mainstreaming gender in planning and implementation of all health programmes.

4.2.4 Policy objective 4: Provide essential healthcare

The provision of essential health services will be geared towards providing affordable, equitable, accessible and quality healthcare that is responsive to clients' needs. This will be achieved by strengthening the county and national planning and monitoring processes relating to healthcare provision to ensure that demand-driven priorities are efficiently and effectively implemented. The health sector shall also continue to delegate relevant functions to autonomous national institutions. The priority policy strategies to achieve this are as follows:

- i. Design, pilot and implement appropriate service delivery models for hard to reach areas and disadvantaged population groups;
- ii. Ensure access to emergency care;
- iii. Ensure Disaster Risk Management with emphasis on Emergency Preparedness (EPR)
- iv. Ensure access to comprehensive maternal, neonatal, and reproductive health services;
- v. Provide a quality KEPH as per the set norms, standards and guidelines in accordance with the defined levels of care;
- vi. Ensure quality of care in provision of preventive and promotive services addressing major causes of the burden of disease due to communicable conditions;
- vii. Integrate NCD prevention and control in the established communicable diseases infrastructure to leverage the existing infectious diseases programmatic capacity;
- viii. Integrate nutritional interventions in all disease management;
- ix. Ensure access to quality diagnostic services;

- x. Ensure provision of safe and adequate blood and blood components in the country through supporting nationally coordinated blood transfusion services;
- xi. Promote establishment of institutes and centres of excellence as a means to ensure availability of highly specialised quality care in the country and in addition promote health tourism;
- xii. Ensure that complete, reliable, timely, efficient and effective health management information for healthcare is provided and shared among all stakeholders in the sector;
- xiii. Plan, design and install Information, Communication and Technology (ICT) infrastructure and software for the management and delivery of care;
- xiv. Make hospitals semi- autonomous and strengthen management capacity at all levels within hospitals including community health departments;
- xv. Strengthen a National referral system for primary, secondary and tertiary care; and
- xvi. Provide services in an integrated manner in order to harness efficiency and only maintain vertical programmes where they remain the most efficient and effective way of achieving specific objectives.

4.2.5 Policy objective 5: Minimise exposure to health risk factors

To minimise health risks, the sector will strengthen health promotion interventions and facilitate the use of products and services that lead to healthy lifestyles in the population. During the policy period, the key policy strategies that will be employed to achieve this objective include the following:

- i. Promote healthy lifestyles across all lifecycles;
- ii. Promote a healthier environment and intensify primary prevention of environmental threats to health;
- iii. Ensure that Health Impact Assessment(HIA) is conducted for any major infrastructural development;
- iv. Reduce unsafe sexual practices, particularly among key populations;
- v. Mitigate the negative health, social, and economic impacts resulting from the excessive consumption and adulteration of alcoholic products;
- vi. Reduce the prevalence of tobacco use and exposure to tobacco smoke and other harmful addictive substances;
- vii. Institute population-based, multisectoral, multidisciplinary, and culturally relevant approaches to promoting health, diet, and physical activity;

- viii. Strengthen mechanisms for the screening and management of conditions arising from health-risk factors at all levels;
- ix. Strengthen intersectoral collaboration mechanisms for regulation of the food industry to promote healthy products and responsible marketing;
- x. Develop and facilitate the implementation of a prioritised national health research agenda in collaboration with research-based organisations and institutions; and
- xi. Promote control of micronutrient deficiency diseases and disorders through intersectoral collaboration;

4.2.6 Policy objective 6: Strengthen collaboration with private and other sectors that have an impact on health

There are many sectors that have an impact on health and should include health in their programmes. These include **economic growth and employment, security and justice, education and early life, agriculture and food, nutrition, infrastructure, planning and transport, environments and sustainability, housing, land and culture, and population growth**. This will be achieved by adopting a ‘**Health in all Policies**’ approach, which ensures that the health sector interacts with and influences the design, implementation, and monitoring of interventions in all of these sectors.

Consequently, the policy will also seek to influence the following social determinants of health: women’s literacy, access to safe water and adequate sanitation, nutrition, safe housing, occupational hazards, road safety, security, income, and community participation, among others. The level of involvement of the health sector shall depend on the anticipated level of the sector’s impact on health. A **nutrition policy** will be developed and implemented to reduce the burden of malnutrition, control nutrition-related diseases in the population, and promote the growth and survival of children.

The private health sector includes Private-Not-For-Profit (PNFP), Private Health Providers (PHP), Faith Based Organizations (FBO) and Traditional and Complementary Medicine Providers (TCMP), and collaboration will be strengthened through;

- i. Development of a Public Private Partnership in Health (PPPH) policy framework;
- ii. Establishment of appropriate legislative frameworks and guidelines to facilitate and regulate the private sector in line with existing laws and regulations; and
- iii. Work with the private sector to reform incentive mechanisms (e.g. fiscal) that would attract registered private health practitioners to the under-served and difficult to reach areas.

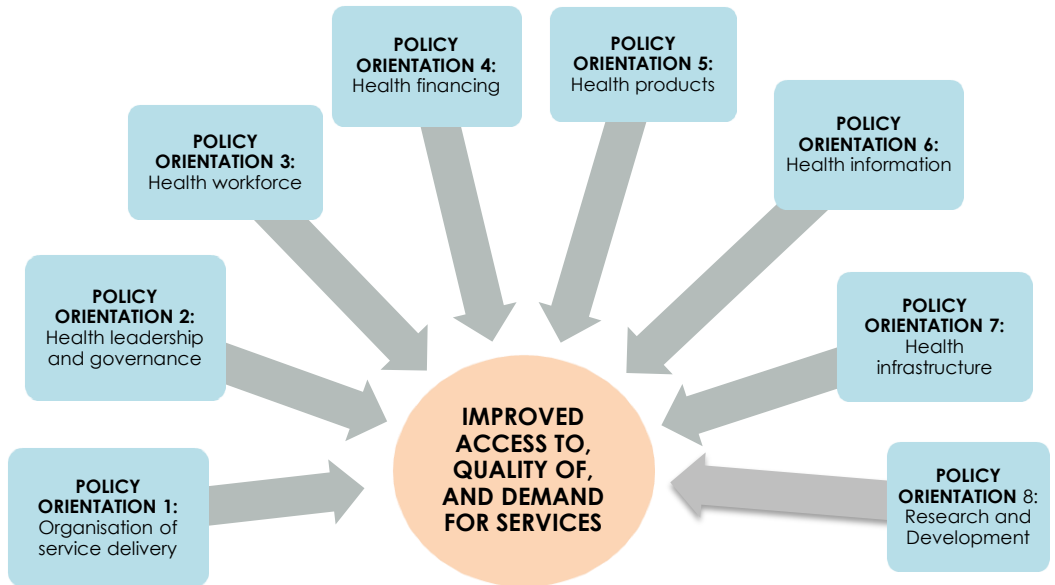
4.3. Policy Orientations

These define how the health sector will be structured to facilitate the attainment of the six objectives. There are eight orientations, or key action areas, where investments will need to be made to facilitate the attainment of the policy objectives as follows:

- i. **Organisation of Service Delivery:** Organisational arrangements required for delivery of services;
- ii. **Health Leadership and Governance:** Oversight required for delivery of services;
- iii. **Health Workforce:** Human resources required for provision of services;
- iv. **Health Financing:** Financial arrangements required for provision of services;
- v. **Health Products and Technologies:** Essential medicines, medical supplies, vaccines, health technologies, and public health commodities required for provision of services;
- vi. **Health Information:** Systems for generation, collation, analysis, dissemination, and utilisation of health-related information required for provision of services;
- vii. **Health Infrastructure:** Physical infrastructure, equipment, transport, and information communication technology (ICT) needed for provision of services; and
- viii. **Research and Development:** Creation of a culture in which research plays a significant role in guiding policy formulation and action to improve the health and development of the people of Kenya,

As illustrated in Figure 7, the effects of investments in these eight orientations will be measured through attainment of desired health outputs; these are improved access, quality of care, and demand for services.

Figure 7. Effects of Investments on Policy Orientations



The specific commitments related to each of the three outputs (improved access, quality of care, and demand for services) are as follows:

Policy commitments in relation to improving access to services:

- a) All persons shall have adequate physical access to health and related services, defined as “living at least 5km from a health service provider where feasible, and having the ability to access the health service”;
- b) Financial barriers hindering access to services will be minimised or removed for all persons requiring health and related services; guided by the concepts of Universal Health Coverage and Social Health Protection; and
- c) Sociocultural barriers hindering access to services shall be identified and directly addressed to ensure all persons requiring health and related services are able to access them.

Policy commitments in relation to improving quality of care:

- a) Clients/patients shall have positive experiences during utilisation of health and related services;

- b) The available health and related services shall be provided in a manner that ensures patient/client safety—potential harm as a result of using services should be anticipated and mitigated against;
- c) The health and related services provided shall be of the most effective as is feasibly possible;
- d) The sector shall have a quality management policy that will act as a guide for quality management implementation and coordination;
- e) Establish a national accreditation framework for the sector through a recognised legal body to accredit health provider institutions to comply with standards; and
- f) Establish mechanisms for a regular review of standards of care.

Policy commitments in relation to improving demand for health and related services:

- a) Clients/patients shall have adequate awareness of the health actions needed to maximise their health;
- b) Clients/patients shall practice appropriate health-seeking behaviours when threats exist to their health;
- c) Clients/patients shall practice healthy lifestyles; and
- d) Clients shall be well-informed of available services at the health provider.

4.3.1 Policy orientation 1: Organisation of service delivery

This relates to how the delivery of health and related services are organised to create an efficient service delivery system that maximises health outcomes. Under this policy, the sector will focus on and invest in the eight areas shown in Table 9 below, as follows:

Table 9. Areas of Intervention in Organisation of Service Delivery

Service Area	Description	Scope and Focus
i. Organisation of the health service package	What the services that will be provided are, and their linkages	Identification and monitoring of the health interventions to be provided
		Organisation of interventions by life cohorts and service areas
ii. Organisation of the health system	How the health system is to be structured to deliver desired services	Levels of care for provision of services
ii. Organisation of community services	How communities are able to engage in improving their health	Comprehensive community strategy to build demand for services through improving community awareness and health-seeking behaviors
		Programme-targeted community services to improve supply of services by taking services to the community
v. Organisation of facility services	How the facility organises itself internally, to provide and manage care delivery	Micro-planning for service delivery to reach under-served communities
		Epidemic preparedness and planning
		Therapeutics management and monitoring
		Patient safety initiatives
		Developing long-term facility master plans for long-term development
v. Organisation of emergency and referral services	How services are planned and delivered across different types of facilities	Physical client movement (physical referral)
		Patient parameters movement (e-health)
	The focus is on ensuring holistic delivery of services	Specimen movement (reverse cold chain and reference laboratory system)
		Expertise movement (reverse referral)
ri. Coordination of national disasters, emergencies, and disease outbreaks	How services will be organised to respond to national disasters, emergencies, and disease outbreaks	Coordinated by the national government in line with the disaster management policy and legislation; management of cross-border outbreaks will also be carried out through intergovernmental mechanisms
ii. Organisation of outreach services	How services (preventive and curative) are supplied to communities, as per their needs	Outreaches by facilities to under-served communities
		Mobile clinics in hard-to-reach areas
ii. Organisation of supervision and mentorship services	How health workers are mentored and supported to continually improve their skills and expertise in providing high-quality services	Integrated facilitative supervision
		Emergency supervision
		Technical supervision and coaching

i. Organisation of the health service package

This relates to the services and interventions that will be provided over each five-year period—in line with the requirements of the Bill of Rights in the Constitution. The national government, in consultation with stakeholders, will define a service package and delivery system that will constitute the following elements:

- a) The six lifecycle cohorts for which services are to be provided, as follows;
 - i. Pregnancy and the newborn child (up to 28 days of age)
 - ii. Early childhood (28 days to 5 years)
 - iii. Late childhood (6 to 12 years)
 - iv. Adolescence and youth (13 to 24 years)
 - v. Adulthood (25 to 59 years)
 - vi. Elderly (60 years and over)
- b) The programme areas that will be prioritised every five years. These will be informed by the burden of disease and risk factors at the time;
- c) The service areas around which integration of care will be effected;
- d) The interventions that will be provided during the given five years for each service area: interventions will be comprehensive, reflecting the broad scope required for addressing health needs; and
- e) The coverage targets that need to be attained for each intervention area.

ii. Organisation of the health system

The health delivery system will progressively transform from the current six tiers to a four-tier system by the end of the policy through periodic reviews every five years in accordance with norms and standards: community, primary care, secondary referral, and tertiary referral. Community services will focus on creating appropriate demand for services, while primary care and referral services will focus on responding to this demand. Table 10 illustrates the current situation at the beginning of this policy and desired levels of care at the end of this policy.

Table 10. Tiers and Levels of Care

Policy tiers of care	Corresponding levels of care at beginning of policy	Desired levels of care by end of policy
Tier 1: Community	Level 1: Community	Level 1: Community
Tier 2: Primary care	Level 2: Dispensaries and clinics Level 3: Health centres	Level 2: Primary care facilities
Tier 3: Secondary referral	Level 4: Primary care hospitals Level 5: Secondary care hospitals	Level 3: County hospitals
Tier 4: Tertiary referral	Level 6: Tertiary care hospitals	Level 4: National referral hospitals

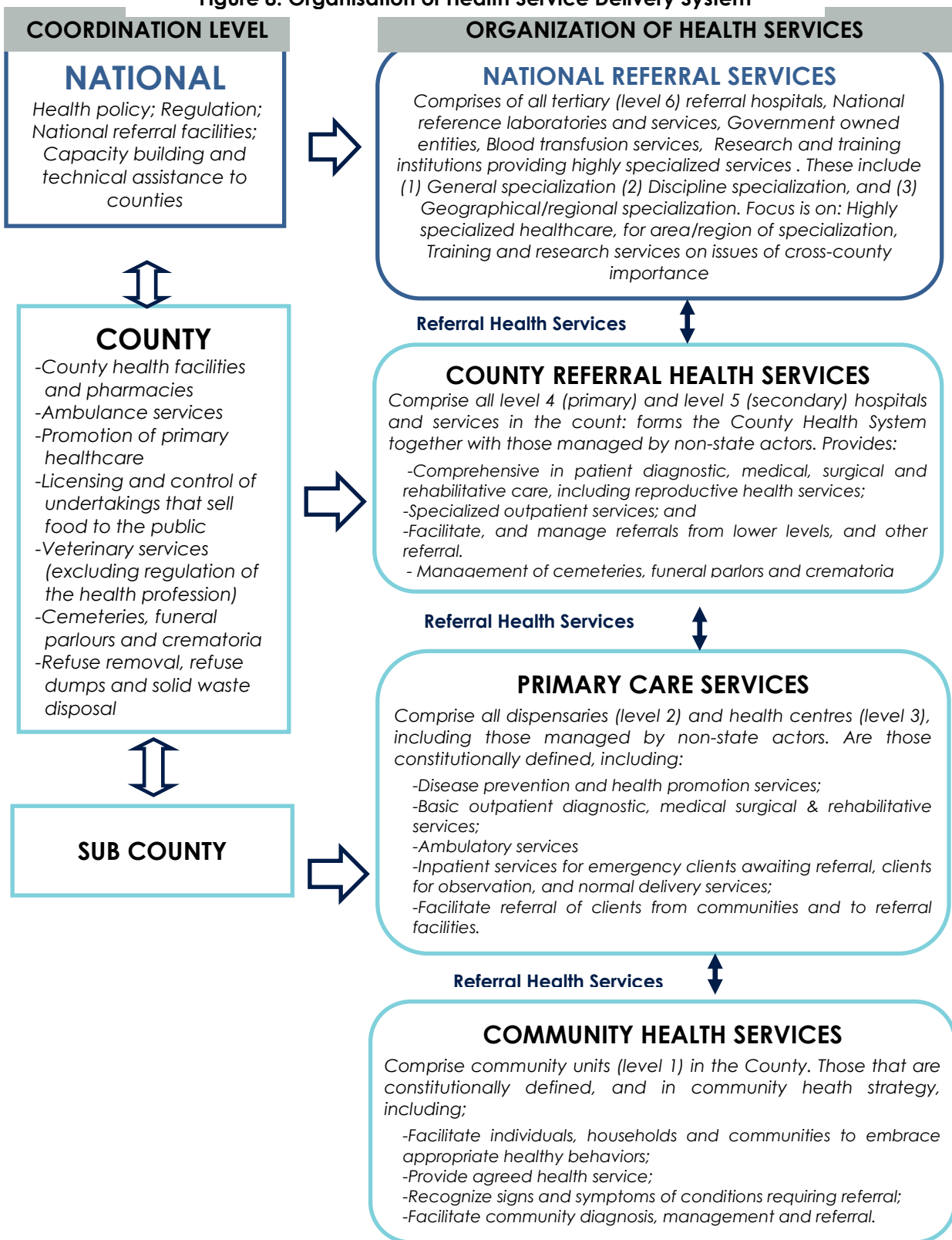
- a) The *community services* will focus on creating appropriate demand for services., The community services will comprise all community-based demand creation activities and health services organised around a comprehensive community strategy defined for the health sector;
- b) The *primary care services* will comprise all dispensaries, health centres, and maternity homes in both public and private sectors. Their capacity will be upgraded to ensure that all of them can provide appropriate services. It is envisaged that by the end of the policy period, the health centre will be the lowest level of a health facility;
- c) The *county referral services* will include hospitals operating in and managed by a given county. These will consist of all the former level 4 and level 5 hospitals in the county—government and private. Together, all these hospitals in a given county form the county referral system, with specific services shared among the existing county referral facilities to form a virtual network of comprehensive services;
- d) The *national referral services* will include the service units providing tertiary/highly specialised services, including high-level specialist medical care, reference laboratory support, blood transfusion services, and research. The units include national-level semi-autonomous agencies and shall operate under a defined level of self-autonomy from the national health ministry, allowing for self-governance.

A National Referral Health Facility is the highest level of health care which provides highly specialized health care services. It links up with other national and international health care providers. Its functions include:

- a) Provision of highly specialized services
- b) In consultation with other levels of health and social care, setting national norms and standards for quality patient care
- c) Provides specialist outreach and reference support services to lower level health facilities.
- d) Provides clinical and practical training for attached students
- e) Conducts scientific and operational research.
- f) Monitors and evaluates and reviews the functioning of the referral system; and
- g) Conducts consultative meetings with private health care providers and establish referral procedures including air transportation of clients

The corresponding intergovernmental coordination and cross-tier linkages including the levels of care to be provided at each tier are illustrated in Figure 8.

Figure 8. Organisation of Health Service Delivery System



The National government, in consultation with the county governments, will develop legislative and administrative frameworks that will guide the classification and operations of each level of the health service delivery system.

iii. Organisation of community services

A comprehensive approach shall be defined, which outlines how health and related services are organised and managed at the community level. The community services shall consist of the following:

- a) Promotion of healthy lifestyles;
- b) Personal and domestic hygiene;
- c) Treatment of minor ailments; and
- d) Interventions focusing on building demand for existing health and related services, by improving community awareness and health-seeking behaviours and taking defined interventions and services closer to the clients/households.

iv. Organisation of the health facility services

Each health facility will organise and manage the delivery of expected services based on its level. Each facility will be managed by a health management team with an approved organisational structure and oversight governance team. The services will include, but not be limited to:

- a) Provision of essential medical services;
- b) Provision of preventive and promotive health services to the communities within facility catchment areas;
- c) Disease surveillance and epidemic response;
- d) Emergency preparedness including disaster management;
- e) Promotion of rational use of drugs as per national essential drug policies;
- f) Health promotion and education;
- g) Continuous professional development (CPD) of technical staff;
- h) Infrastructural development;
- i) Provision of outreach services;
- j) Responding to national public health commitments, such as mass campaigns;
- k) Implementation of quality improvement standards, including infection prevention and patient safety; and
- l) Implementation of national standards and regulations.

v. Organisation of emergency and referral services

This is to ensure that clients receive the benefits of care available in the health system, irrespective of the point of service, to ensure continuity of care. Emergency health services shall be a part of the referral services and shall be provided by the nearest

health facility, regardless of ownership (both public and private). An emergency policy will be developed with strategies for establishing an emergency response mechanism. Emergency services will comprise of:

- a) Pre-hospital emergency care
- b) Protection of vulnerable groups against the impacts of a disaster or emergency
- c) Hospital emergency care and psychosocial support for victims
- d) Ambulance services for referral services

A referral policy will be developed with strategies that will lead to effective referral services. Referral services shall cover four elements or movements:

1. Physical client movement (physical referrals);
2. Patient parameters movement, using e-health initiatives;
3. Specimen movement, through ensuring a reverse cold chain and a reference laboratory system; and
4. Expertise movement, through reverse referrals and outreach services.

vi. *Coordination of national disasters, emergencies, and disease outbreaks*

The health response to national disasters, emergencies, and disease outbreaks will be coordinated by the national government in conjunction with county governments and in line with its disaster management policy and legislation. Management of cross-border outbreaks will also be carried out through intergovernmental mechanisms. The office of Director of Medical Services or its successor will be responsible for declaring any epidemics and disease outbreaks of public health concerns, and the appropriate emergency response.

vii. *Organisation of outreach services*

The aim of outreach services is to bring services closer to where they are needed. Outreach services could be in the form of preventive, curative, or rehabilitative health services. The national referral health services, the county health services, and community health services will coordinate outreach services. Outreach services will include the following:

- a) Community health outreach services
- b) Mobile health services for under-served areas and populations
- c) Specialist services to lower levels
- d) Disease outbreak control

viii. *Organisation of supervision and mentorship services*

Supervision is essential for continuous quality improvement and maintenance of the highest standards of healthcare. Mentorship is key in skills and competence development for all health workers. Supervision will be done at different levels and cover all facilities (GOK, faith-based, and private for-profit), comprising the following:

- a) National-level supervision—which can be programmatic, cadre-based, or specialisation-based—of national referral services and counties to maintain standards and the highest quality of healthcare delivery;
- b) County supervision will be done by the county health management teams for the county as a whole to ensure that health policies are implemented and regulations and standards are adhered to in the delivery of healthcare;
- c) Sub-county level supervision will be carried out by the sub-county health management teams within their areas of jurisdiction to ensure continued delivery of high-quality healthcare; and
- d) Supervision within the health facility and community will ensure that there is continuous delivery of all required health services in a responsive manner.

Mentorship will be done at all the above levels for healthcare workers to improve their knowledge, skills, and competencies to accomplish various tasks for high-quality health service delivery. Mentorship will take the form of the following:

- a) Technical assistance, from the national level to the county, in the form of expertise and service delivery tools;
- b) Technical assistance from county to county;
- c) On-the-job skills development; and
- d) Training courses, workshops, seminars, and attachments or internships.

The MOH will, from time to time, in conjunction with county governments, professional regulatory bodies, FBOs, and private sector and facility managers, develop a comprehensive, harmonised, effective, and efficient supervision and mentorship strategy and guidelines.

4.3.2 Policy orientation 2: Health leadership and governance

This relates to how the oversight of the delivery of health and related services shall be provided. The policy aspiration is for **a comprehensive leadership that delivers on the health agenda**. The sector shall focus on six areas in which it will make its investments, as follows.

1. Management systems and functions
2. Partnership and coordination of healthcare delivery
3. Governance systems and functions
4. Engaging of public and private services providers
5. Planning and monitoring systems and services
6. Health regulatory framework and services

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

- i. *Operationalisation of a two-level management system corresponding with the national and county governments.*

The national government functions shall be as defined in the Constitution of Kenya 2010. It shall operate through the national ministry responsible for health. The delivery of these functions will employ management structures that will be defined in each strategic plan and government directive. These functions will include specialised clinical services offered by national referral facilities, policy development, setting standards, quality assurance and regulations for clinical services, preventive and promotive health services, planning, and healthcare financing and administrative services. The functions of autonomous or semi-autonomous agencies shall be defined in the instruments establishing these agencies.

The county government health functions shall be as defined in the Constitution of Kenya 2010. These functions will be performed through the County Departments of Health and their semi-autonomous agencies, which will be established as per their need. The County Departments of Health will establish management and governance to deliver services in accordance with the set policies, legislation, norms and standards, and, with the values and principles of the Constitution.

The national and county governments shall mutually consult and determine the services that require intergovernmental relations to deliver. County governments may consult with respect to any services that require inter-county relations to deliver.

The national MOH and the county governments will form an Intergovernmental Health Forum in accordance with Intergovernmental Relations Act. This forum will be charged with responsibility of discussing and resolving any cross-cutting issues of the two tiers of government. The forum will be chaired by the cabinet secretary responsible for health, who will be deputised an executive committee member for health from one of the counties. The national government and the county governments will establish intersectoral collaboration and partnership frameworks.

- ii. *Ensuring functional strategic partnership and coordination mechanisms: This will be premised on the five principles of aid effectiveness: Ownership, Alignment, Harmonisation, Mutual Accountability, and Managing for Results. This shall bring together all stakeholders in the health sector at their respective levels, representing the recognised constituencies of:*
 - a) The government, including the ministry responsible for health and the other health-related ministries, functioning at their respective tiers of service delivery; and
 - b) Development partners supporting health and health-related interventions, and other non-state implementing partners providing health services.
- iii. *Providing collaborative oversight for implementation of a functionally integrated, pluralistic health system will enable optimisation of the equitable*

use of available resources, accountability, and investing in the comparative advantages of the implementing partners in delivering this policy's objectives.

- iv. *Ensuring functional health governance, management and coordination mechanisms.* The structure and functioning of the healthcare system shall be guided by a defined policy and legal framework. For the country to continue providing standardized health services across all counties, the national government will provide policy guidelines for standard governance and management structures at all tiers of healthcare.

The health governance and management structures will ensure that the following are provided:

- a) Oversight for implementation of a functionally integrated, pluralistic health system
 - b) Putting in place mechanisms for engaging with health-related actors
 - c) Jointly developing operational and strategic plans and undertaking review processes
 - d) Oversight to regulate and assess standards and quality of services
 - e) A comprehensive legal and regulatory framework that guides sector actions
- v. *Putting in place means for engaging with health-related actors.* This aims to ensure that the health-related sectors are prioritizing investments in outcomes that have an impact on health.
 - vi. *Synchronising development of operational and strategic plans and undertaking review processes.* These will be linked to the overall planning and review framework of the health sector and shall apply to all entities in the health sector.
 - vii. *Providing oversight to regulate and assess standards and quality of services.* The national government will define and ensure, through the county governments, that a defined level of quality of care is provided to the population.
 - viii. *Legal and regulatory framework in the health sector.* The national government shall ensure the review of the health sector legal and regulatory frameworks and align them to this policy and the Constitution. The county governments shall, where necessary, develop the county policies, laws to implement their functions in line with the Constitution and this policy. The ministry responsible for health will also put in place measures to regulate traditional and complementary medicines.

4.3.3 Policy orientation 3: Adequate and equitable distribution of the health workforce

The health workforce constitutes those persons recruited primarily for health and related service provision and management who have undergone a defined, formally recognised training programme. The policy's aspiration is for an **adequate and equitable distribution of a productive health workforce.**

The national government will provide, in conjunction with Public Service Commission, and review from time to time, the norms and standards as far as human resources for health are concerned. The national and county governments shall endeavour to progressively adhere to the required set norms and standards for human resources at all times in all health facilities.

The norms and standards for the health workforce required to deliver on the health goals shall include adequate numbers, skills mix, competence, and attitudes of the health workforce required to deliver on the health goals. The national government shall provide the necessary capacity building and provide technical assistance to the counties.

The national and county governments with the Public Service Commission and county public service boards shall put in place the necessary policies to guide the training programmes for professional development and progression of staff. The training of health workers will be guided by the National Training Policy. Both national and county health services will facilitate the training of health workers through the following:

- a) Identify training needs and provide opportunities for training;
- b) Provide scholarships for health workers as needed;
- c) Ensure that the salaries and remunerations of officers on training continue to be paid by their stations during the training period;
- d) Ensure appropriate redeployment of health workers on completion of their training;
- e) Ensure appropriate human resource training and continuous professional development and career progression;
- f) Ensure placement on attachment or internship; and
- g) Increase and equitably distribute health worker specialists through an intergovernmental relations mechanism with the goal of ensuring equitable access to health specialist services.

Training of health workers will be guided by a national health workforce training policy. Health workers seeking further training must fulfil the requirements of the public service policy and regulations. Professional bodies responsible for various cadres will continuously ensure that all health workers undertake continuous professional development and provide the required accreditation.

Post-graduate training and internship programmes are part of capacity building and will remain national functions. The placement of interns and their bonding after training will be guided by the health workforce policy.

To improve retention of health workers in hard-to-reach areas, affirmative action shall be applied in the following areas:

- a) Promoting multiskilling and multitasking of the health workforce;

- b) Ensuring that health personnel interact in a professional, accountable, and culturally sensitive way with clients; and
- c) Improving management of the existing health workforce by putting in place attraction, retention, and motivational mechanisms for the workforce.

The national and county governments will maintain a database for all registered health workers providing services in the entire country and in every county. The national government, in consultation with the county governments, will develop a comprehensive training policy for all health workers. The national government, in consultation with county governments, will implement schemes of service for all health workers. Health workers providing services in corrective facilities and other institutions will be managed by the county governments where such institutions are located.

Faith-based health facilities may enter into agreements with county governments for support in human resources deployment. The national and county governments will put in place systems to measure the performance and competencies of health workers, which would also be informed by the clients/consumers of the services.

The sector shall focus on four areas in which it will make its investments:

1. Reviewing and applying evidence-based health workforce norms and standards for the different tiers of services delivery;
2. Facilitating rational capacity development of the health workforce through alignment of curricula and training to needs, based on the above-mentioned policy objectives. This will ensure that health personnel interact in a professional, accountable, and culturally sensitive way with clients. Promotion of multiskilling and competencies of the health workforce will also be enhanced;
3. Improving management of the existing health workforce by putting in place attraction, retention, and motivational mechanisms, especially in marginalised areas; and
4. Putting in place systems to measure the performance and competencies of the health workforce, informed by clients/consumers of the services.

4.3.4 Policy orientation 4: Health financing

This relates to the process of mobilising and managing required finances to ensure provision of health and related services. The policy's commitment is to progressively facilitate access to services by all by ensuring social and financial risk protection through adequate mobilisation, allocation, and efficient utilisation of financial resources for health service delivery. The primary responsibility of providing the financing required to meet the right to health lies with the national and county governments.

This will be attained through ensuring equity, efficiency, transparency, and accountability in resource mobilisation, allocation, and use. Efforts will be made to progressively build a sustainable political, national, and community commitment with a

view towards achieving and maintaining universal health coverage through increased and diversified domestic financing options. This will be achieved through the following:

- i. Advocacy for greater allocations by both national and county governments to attain universal health coverage;
- ii. Advocating for increased financing for health and related sectors to meet agreed national and international benchmarks and to ensure that required interventions are implemented;
- iii. Establishing a social health protection mechanism to progressively facilitate attainment of universal coverage;
- iv. National and county governments shall put in place resource mobilisation strategies targeting all sources of funds, including specific levies and taxes, domestic and international, to progressively move towards increasing per capita expenditures in health;
- v. Developing and strengthening innovative healthcare financing for communities' by periodically reviewing the criteria for resource allocation and purchasing mechanisms to improve efficiency and utilisation of resources;
- vi. Progressively working towards the elimination of payment at the point of use for health services, especially by the marginalised and indigent populations, through social health insurance and government subsidies;
- vii. Putting in place comprehensive mechanisms for financing of emergency health services;
- viii. Promoting private sector participation in financing of healthcare through public-private partnerships and other mechanisms;
- ix. Pooling of resources to increase efficiency in utilisation of health resources; and
- x. Developing and implementing a healthcare financing policy.

4.3.5 Policy orientation 5: Health information

This relates to the process of generating and managing information to guide evidence-based decision making in the provision of health and related services at the national and county levels. The policy's aspiration is for adequate health information for evidence-based decision making. All healthcare providers shall therefore be obligated to report on information emanating from their activities through established channels in a manner that meets safety and confidentiality requirements, and according to the health research and information policies, regulations, and standards that will be developed in consultation between the national government and stakeholders.

The target consumers include health managers, policymakers, clients and all other actors in the health sector, with a view to guiding their decision-making processes. This will be attained through focusing on implementation of the following strategies:

- i. Collaborating, harmonising, and integrating data collection, analysis, storage, and dissemination mechanisms of state and non-state actors to ensure availability of adequate and complete information for decision making;
- ii. Continued strengthening of accuracy, timeliness, and completeness of health information from the population and health facilities;
- iii. Strengthening mechanisms for health information dissemination to ensure information is available where and when needed;
- iv. Establishing mechanisms to promote, coordinate, regulate, and ensure sustainability of health research and development;
- v. Putting in place health surveillance and response mechanisms;
- vi. National government, in consultation with county governments, will develop reporting guidelines;
- vii. Progressive utilization of information and communication technologies to aid service delivery;
- viii. Developing and implementing a health information systems (HIS) policy;
- ix. Developing and implementing a health research and development policy; and
- x. Facilitating access to information to the public while protecting privacy and confidentiality.

4.3.6 Policy orientation 6: Health products and technologies

Investments under this orientation will be aimed towards ensuring that effective, safe, and affordable health products and technologies are available and rationally used at all times, while moving towards maintaining a strategic national health products and technologies (HPT) reserve. This will be attained through the development and implementation of a national HPT policy and relevant regulatory frameworks that will further elaborate the following strategies:

- i. **Defining and applying an evidence-based essential package of health products and technologies.** This shall be judiciously applied in acquisition, financing, and other access-enhancing interventions. It will incorporate national lists of essential medicines, health products and diagnostics, treatment protocols, and standardised equipment.
- ii. **Establishing a national appraisal mechanism for health products and technologies.** This will provide guidance on the clinical and cost-effectiveness of new health products, technologies, clinical practices, and interventional procedures.
- iii. **Putting in place a harmonised national regulatory framework for health products and technologies.** This shall advance quality, safety, and efficacy/effectiveness based on sound science and evidence. The regulatory framework shall be autonomous in its operations and shall encompass human drugs; vaccines, blood and its products; diagnostics, medical devices, and

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

- iv. **Rational investment in and efficient management of health products and technologies.** This aims to ensure the most effective management of patients in line with established standards. This will incorporate cost-effective prescribing and other interventions to improve the rational use of drugs and other health products.
- v. **Have in place effective and reliable procurement and supply systems.** These shall leverage public and private investments to advance patient access to essential health products and technologies and deliver value for money across the system.
- vi. **Promoting local production, research, and innovations of essential health products and technologies.** This shall be done in a manner that advances universal access and promotes national competitiveness.
- vii. **Ensuring availability of affordable, good quality health products and technologies.** This shall be done through full application of all options (e.g., promoting use of generics and exploiting all provisions in the trade-related aspects of intellectual property rights) and public health safeguards relating to health products and technologies, through multisectoral interventions on trade, agriculture, food, and related sectors.
- viii. **The national government to ensure strategic reserves** for public health commodities (Tuberculosis, Vaccines, Anti-retrovirals, Family Planning) and any other commodities for emerging global conditions of public health concerns.

The health products and technologies will be categorized as;

- Strategic –vaccines and drugs for TB, HIV/AIDS, epidemics
- Special and expensive –Cancer drugs, immunosuppressive agents
- Essential/Basic products

The National government will acquire and maintain adequate stocks of the Strategic and Special/Expensive categories of products whereas county governments will focus on ensuring the availability of Essential/Basic products at county health facilities and in line with Kenya Essential Medicines List (KEML).

4.3.7 Policy orientation 7: Health infrastructure

Health infrastructure relates to all the physical infrastructure, non-medical equipment, transport, and technology infrastructure (including ICT) required for effective delivery of services **by the national and county governments and other health service providers.** The goal of this policy is to have **adequate and appropriate health infrastructure.** There shall be a network of functional, efficient, safe, and sustainable health infrastructure based on the needs of the clients. This will be attained through focusing on the following strategies:

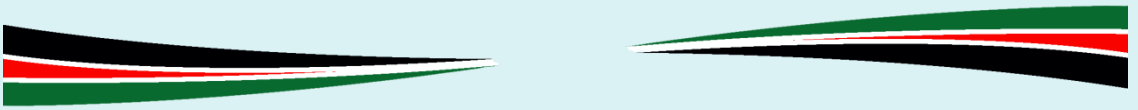
- i. Adopting evidence-based health infrastructure investments, maintenance, and replacement through utilisation of norms and standards in line with national policies;
- ii. Facilitating development of infrastructure that progressively moves towards the prevailing norms and standards;
- iii. Developing norms and standards to guide the planning, development, and maintenance of health infrastructure;
- iv. Both national and county governments shall invest in health infrastructure to ensure a progressive increase in access to health services;
- v. Providing the necessary logistical support for an efficiently functioning referral system;
- vi. Promoting and increasing private sector investments in the provision of health services through infrastructure development;
- vii. Developing guidelines for donations and purchases of vehicles, medical equipment, and the disposal of the same;
- viii. Strengthening the regulatory framework to enforce health infrastructure standards; and
- ix. Developing and implementing health infrastructure policy.

4.3.8 Policy orientation 8: Research and Development

The Ministry of health prioritises research in order to support evidence based policy and intervention formulation, identifying gaps and critical factors for special needs for vulnerable groups especially the women, children and the elderly. Particular attention will be given to how research can be used to guide the development and implementation of health systems, health promotion, environmental health, disease prevention and early diagnosis and treatment. The health sector shall take lead in formulation of the agenda for operations research while other institutions such as the universities shall be more involved in the execution of research. This will be achieved through the following:

- i. Development of a prioritized national health research agenda;
- ii. Effective dissemination of research findings;
- iii. Harnessing development partners' and government funds to implement the national health research agenda
- iv. Promotion of research to policy dialogue in order to ensure that research is relevant to the needs of the people;
- v. Strengthening of health research capacity in institutions at all levels and develop quality human resource and infrastructure
- vi. Ensuring an ethical code of conduct for health research in Kenya in accordance with the Science, technology and Innovation Act of 2013

PART 3:
POLICY
IMPLEMENTATION



CHAPTER 5: IMPLEMENTATION FRAMEWORK

5.1. Institutional Framework

This policy recognises that coordination of service delivery in the health sector has, in the previous policy period, been done through a sector-wide approach, the Kenya Health SWAp (KHSWAp),²² which brought together all health stakeholders and was managed through a partnership instrument, the Code of Conduct.²³ Governance structures and systems have also existed through boards and committees at the respective service delivery levels (hospitals and county), including a common framework for planning and implementation.

The successful implementation of this policy will be dependent upon the collaborative efforts and synergies of all the stakeholders and actors through establishment of an effective partnership framework via new institutional and management arrangements. This policy is also alive to the functional assignments between the two levels of government with respective accountability, reporting, and management responsibilities. The policy therefore provides a structure that harnesses and synergises health service delivery at all levels of this devolved system and seeks to meet the following objectives:

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

²² Government of Kenya, 2005. Kenya Health SWAp concept paper. October 2005. Ministry of Health.

²³ Government of Kenya, 2007. Health Sector Code of Conduct. August 2007. Ministry of Health.

Under the existing legal and other government policy frameworks, this policy will be implemented through five-year National Strategic Plans, Multi-year County Sectoral Plans, and Annual Plans.

5.2. Stakeholders in Health Service Delivery

The policy implementation process will adopt a multisectoral approach involving different stakeholders—state actors (government ministries and agencies) at the national and county levels; clients/consumers (individuals, households, communities); regulatory bodies; professional associations; health workers unions; non-state actors (civil society organisations [CSOs], FBOs/nongovernmental organisations [NGOs], the private sector); and development partners. The following are the key health sector actors and their respective roles in implementing this policy:

5.2.1 National government ministry and semi-autonomous government agencies (SAGAs) responsible for health

The national ministry shall establish and facilitate an institutional and management structure to coordinate and manage delivery of the constitutionally defined health mandates and services at the national level while championing the implementation of this policy. The MOH and related SAGAs shall be responsible for the following functions:

- i. Developing national policy and legislation, standards setting, national reporting, sector coordination, and resource mobilisation;
- ii. Offering technical support, with emphasis on planning, development, and monitoring of health service delivery quality and standards throughout the country;
- iii. Providing guidelines on tariffs chargeable for the provisions of health services;
- iv. Promoting mechanisms for improving administrative and management systems, including conducting appropriate studies; and
- v. Capacity building of county governments to effectively deliver high-quality and culturally responsive health services.

5.2.2 County government departments and entities responsible for health

The Constitution of Kenya 2010 has assigned delivery of health services to the counties, with the exception of national referral services. Counties shall establish structures that harness competencies at the county level and synergise health service delivery across counties and between the two levels of government. Counties shall put in place departments and entities to coordinate and manage

delivery of the constitutionally defined health mandates and services at the county level. The roles and responsibilities of the departments and entities shall be aligned to the following functions, as defined in the Fourth Schedule of the Constitution:

- i. County health facilities and pharmacies
- ii. Ambulance services
- iii. Promotion of primary healthcare
- iv. Licensing and control of undertakings that sell food to the public
- v. Veterinary services (excluding regulation of the health profession)
- vi. Cemeteries, funeral parlours, and crematoria
- vii. Refuse removal, refuse dumps, and solid waste disposal

In addition to the above functions, county governments may be assigned other functions agreed upon during the intergovernmental consultative forums and shall take a lead role in advising, mobilising, and collaborating with other government ministries, departments, and agencies.

5.2.3 Clients/consumers

- **Individual:** This policy recognises the role an individual plays through adoption of appropriate health practices and healthcare-seeking behaviours as key in the realisation of the country's health goals. The policy shall therefore seek to enhance the capacity of the individual to effectively play this role.
- **Household:** The sector shall ensure that households are empowered to take responsibility for their own health and well-being, and are facilitated and capacitated to participate actively in the management of their local healthcare systems.
- **Communities:** This policy recognises the significant role that communities have traditionally played in contributing to the achievement of national, community, and family health goals through various innovative interventions. These have ranged from informal community programmes to home-based interventions. These will continue to be encouraged.

5.2.4 Non-state actors

These are implementing partners that play a role in health service delivery to communities. They include the private sector, NGOs, FBOs, and CSOs. This policy recognises the strengths of these actors in mobilising resources for health service delivery, designing and implementing development programmes, and organising and interacting with community groups. The implementing partners have also been a critical source of human and monetary resources that would be critical in the implementation of this policy. In addition, this policy

acknowledges the range of interventions implemented by these partners in addressing risk factors to health in the areas of education, health, food security, and water sectors, among others.

Other non-state actors include firms involved in the manufacturing, importation, and distribution of HPT and health infrastructure, as well as health insurance companies.

5.2.5 Development partners

Health services require significant financial and technical investment in a context of limited domestic resources. Donors and international nongovernmental organisations have traditionally played a key role in providing resources for the health sector. This role has been structured around principles of aid effectiveness, which place emphasis on government ownership, alignment, harmonisation, mutual accountability, and managing for results of programmes in the health sector. The implementation of this policy will require the continued support of development partners in health, including support to the devolved system of government.

5.3. Mechanisms for Intergovernmental Relations in Health

The Constitution of Kenya 2010 requires that the national and county governments, though distinct, shall conduct their mutual relations on the basis of consultation and cooperation. This requirement formed the basis for the establishment of the Health Sector Intergovernmental Consultative Forum (HSICF) established in August 2013.

This consultative forum will provide a platform for dialogue on health system issues of mutual interest to the national and county governments. Overall, the forum will seek to ensure that health services remain uninterrupted during the transition period and beyond, while maintaining the focus on delivering the constitutional guarantee to the highest attainable standard of health for all Kenyans. More specifically, the forum will do the following:

- Identify issues for discussion during the intergovernmental consultative mechanisms and establish systems to address these issues;
- Facilitate and coordinate the transfer of functions, power, or competencies from and to either level of government;
- Coordinate and harmonise development of health policies and laws;
- Evaluate the performance of the national or county governments in realising health goals and recommending appropriate action;

- Monitor the implementation of national and counties' sectoral plans for health;
- Produce annual reports on national health statistics pertaining to the health status of the nation, health services coverage, and utilisation;
- Promote good governance and partnership principles across the health system;
- Implement and follow up on actions and recommendations from the National and County Government Coordinating Summit; and
- Consider issues on health that may be referred to the forum by members of the public and other stakeholders, and recommend measures to be undertaken.

The consultation process between the national and county governments at both levels will also observe the principles of intergovernmental relations in line with Article 189 of the Constitution and Article 4 of the Intergovernmental Relations Act 2012. These include recognition of the sovereignty of the people as provided for under Article 1 of the Constitution—inclusive and participatory, and respect for the function and constitutional integrity of the two levels of the government.

CHAPTER 6: MONITORING AND EVALUATION

The implementation of this policy will be tracked using a set of financial and non-financial targets and indicators. These targets will reflect the constitutional requirements, national goals and targets, and health sector priorities elaborated in Vision 2030, and county-specific targets and goals that will be elaborated in the National and County Multi-year Sectoral Plans. These plans will be implemented and monitored through annual work plans and medium-term plans. This policy will also be reviewed through a mid-term review. The targets will be benchmarked against best practices from across the globe.

6.1. Monitoring and Evaluation Framework

The Kenya Health Policy is the primary policy document providing long-term direction for health in Kenya for the period 2014–2030. This policy will be implemented through medium-term strategic plans that will elaborate on the comprehensive medium-term strategic and investment approaches through two key elements:

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

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

This policy will be implemented through five-year Health Sector Strategic Plans (HSSPs). These plans will be supported by programme business plans with sector-wide objectives around specific services (e.g., HIV or malaria) or systems (e.g., human resources for health (HRH) or health financing strategy).

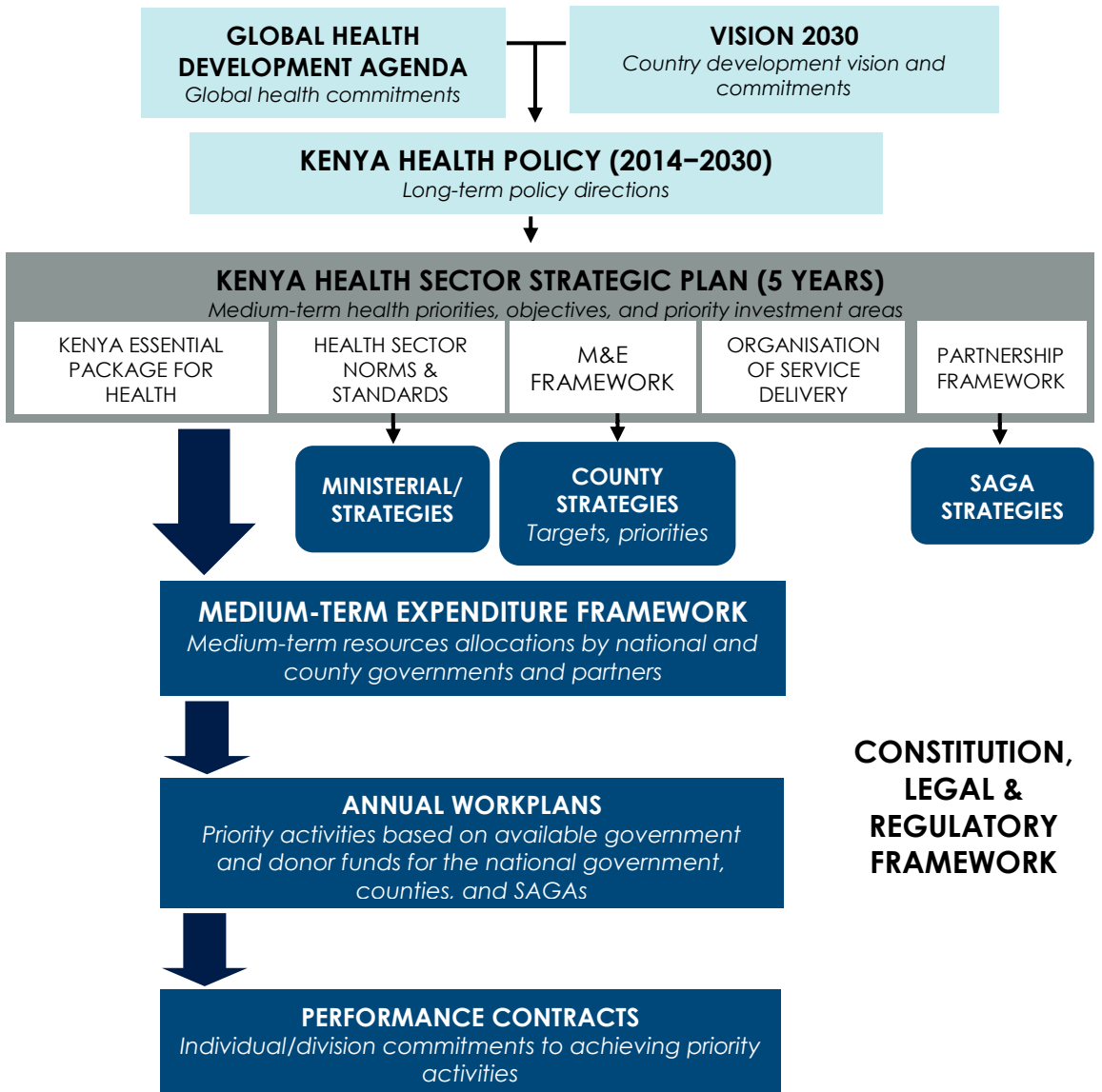
Health Sector Investment Plans shall be used to identify key investment areas in HSSPs. These plans shall be developed for specific decision-making units, including the following:

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

Investment plans provide information and guidance on the annual targets and budgeting processes. The budgeting process and framework therefore will be based on agreed-upon priority investments in the respective investment plans. During the budgeting process, the priorities for investment should be directly derived from the building block investments. The seven policy orientations form the sector programmes in the budget, around which priorities and budgets are defined.

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

Figure 9. Overarching Planning and Review Framework for Kenya's Health Policy



6.2. Progress Indicators

These are based on the respective domain areas. Indicators that will be used are shown in Table 11 below. Targets are based on the WHO statistics of the average value of four middle-income countries—Argentina, Brazil, Egypt, and Indonesia. These targets shall be measured in absolute achievement and variation in achievement across counties in the country.

Table 11. Indicators for Measuring Kenya Health Policy 2014–2030 Performance

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

CONCLUSION

This policy represents a commitment towards improving the health of the people of Kenya by significantly reducing ill health to levels similar to those of middle-income countries, such as Argentina, Brazil, Egypt, and Indonesia. The policy proposes a comprehensive and innovative approach to addressing the health agenda, which represents a radical departure from past approaches to addressing the health challenges in the country. It is based on the Constitution of Kenya 2010, Vision 2030, and Kenya's global health commitments.

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

The policy defines the health goal, objectives, principles, orientations, and strategies aimed at achieving the highest standard of healthcare in Kenya. It also outlines a comprehensive implementation framework to achieve the stated goal and objectives. It delineates the roles of the different stakeholders in the sector in delivering the health agenda and details the institutional management arrangements under the devolved system of government, taking into account the specific roles of the national and county levels of government. It therefore provides a structure that harnesses and gives synergy to health service delivery at all levels of government.

Finally, the policy defines the monitoring and evaluation framework to enable tracking of the progress made in achieving its objectives. The monitoring of progress will be based on the level of distribution of health services; responsiveness of health services to the needs of the people; progress in respective disease domain areas, including communicable, non-communicable, and injury/violence conditions; risk factors; and the interventions of health-related sectors.

GLOSSARY OF TERMS

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

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

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

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

Emergency: Health threats that are of sudden onset in nature, are beyond the capacity of the individual/community to manage, and are life threatening or will lead to irreversible damage to the health of the individual/community if not addressed.

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

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

Habilitative Services: 'are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition....' The services include but are not limited to physical therapy, occupational therapy and speech therapy for the treatment of a child with a congenital or genetic birth defect

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

Healthcare services: The prevention and management of disease, illness, injury, and other physical and mental impairments in individuals delivered by healthcare professionals through the healthcare system; they can either be routine health services or emergency health services.

Healthcare workforce: The workforce that delivers the defined healthcare services. The workforce includes all those whose prime responsibility is the provision of healthcare services, irrespective of their organisational base (public or non-public).

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

Health system: The mechanism to deliver high-quality healthcare services to all people when and where they need them.

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

Human Resources for Health (HRH): The stock of all individuals engaged primarily in the improvement of the health of populations. The public health workforce includes those primarily involved in protecting and promoting the health of whole or specific populations, as distinct from activities directed to the care of individuals.

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

Injury: Physical damage to a person.

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

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

Mentoring: A bilateral process through which mentors, because of their seniority, commitment, and willingness to listen, build the critical level of confidence necessary

to help their mentees understand more fully and learn comprehensively from their day-to-day experience. Mentorship is key in skills and competence development for all health workers. Supervision of health services will be done at different levels. Mentorship is part and parcel of supportive supervision.

Non-state Actors (NSA): Individuals or institutions whose primary purpose is provision of health services but are not part of the state. They include service providers (for profit and not for profit), health CSOs, NGOs, and their related management systems.

Post-delivery period: This represents the six weeks following delivery. It corresponds with the postpartum period.

Public health services: The healthcare services concerned with the science and art of preventing disease, prolonging life, and promoting health through organised efforts and informed choices of society, organisations (public and private), communities, and individuals, and are concerned with threats to the overall health of a community.

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

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

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

Routine health services: Healthcare services necessary to prevent and manage damaging health effects from non-emergency situations. It involves services across ALL aspects of healthcare services.

Supervision: A process of guiding, helping, building capacities, and learning from staff at their places of work to ensure that services are managed and provided according to established leadership and service provision standards and shared objectives, while fostering an enabling working environment. It is therefore part of

monitoring and called ‘supportive supervision.’ Supportive supervision is essential for continuous quality improvement and maintenance of highest standards of healthcare.

Trained health professional: In relation to Article 26 of the Constitution, a trained health professional is a member of a health profession who is licensed and regulated to provide technical expertise in the specific field.

Trained health professional (in the context of provision of legal termination of pregnancy): A health professional, with formal medical training at the proficiency level of a Medical Officer (doctor), nurse midwife, or clinical officer, who has been educated and trained to proficiency in the skills needed to manage uncomplicated abortion and post-abortion care and the identification, management, and referral of abortion-related complications in women and families. Such a health professional should have a valid license from the Medical Practitioners and Dentists Board to practice, and provide the service from a legally recognised health facility with an enabling environment consisting of the minimum human resources, infrastructure, commodities, and supplies for the facility as defined in the health sector norms and standards.

Transitional period: The period between commencement of the Transition Act (2012) and three years after the first elections under the Constitution 2010. The transition period has two phases:

Phase One: The period between commencement of the Act and the date of the first elections under the Constitution; and

Phase Two: The period between the date of the first elections and three years after the elections.

Unsafe abortion: A procedure carried out by persons lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both.²⁴

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

Universal healthcare: A term referring to organised healthcare systems built around the principle of universal coverage for all members of society, combining mechanisms for health financing and service provision.

Universal Health Coverage (UHC): Ensuring that everyone who needs health services is able to get them without undue financial hardship.²⁵

²⁴ World Health Organisation. 2004. *Unsafe Abortion: Global and Regional Estimates of Unsafe Abortion and Associated Mortality in 2000*.

²⁵ World Health Organisation. 2010. *The World Health Report – Health Systems Financing: The Path to Universal Coverage*.

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