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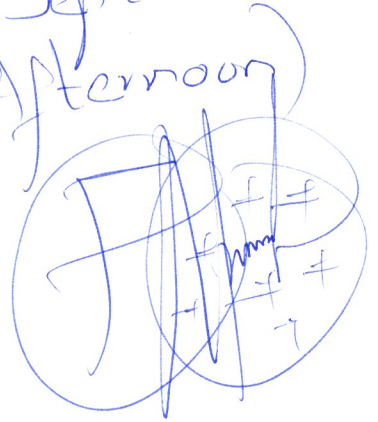
MINISTRY OF HEALTH

**SESSIONAL PAPER
NO. 2 OF 2017 ON
THE KENYA
HEALTH POLICY
2014 - 2030**

Towards attaining the highest standard of health



Paper Laid on the
Table of the
House by the
Leader of the Majority
Party on
Wednesday,
13th September 2017
(Afternoon)



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Nairobi, July 2017

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Sessional Paper No. 2 of 2017, on the Kenya

Health Policy

2014-2030

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Towards attaining the highest standard of health

Sessional Paper No. 2 of 2017, on the Kenya
Health Policy
2014-2030

FOREWORD

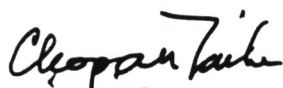
The Sessional Paper No. 2 of 2017 on the Kenya Health Policy 2014-2030, gives direction to ensure significant improvement in the overall status of health in Kenya in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and global commitments. It demonstrates 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 sessional paper is designed to be comprehensive and focuses on the two key obligations of health: the realisation of fundamental human rights including the right to health as enshrined in the Constitution of Kenya 2010 and; the contribution to economic development as envisioned in Vision 2030. It focuses on ensuring equity, people centeredness, participation, efficiency, social accountability and a multisectoral approach, 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 sessional paper 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 by 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 the policy are understood and fully owned by the various stakeholders and implementing partners.

The sessional paper 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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MINISTRY OF HEALTH

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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
KAIS	Kenya Aids Indicator Survey
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
NASCOP	National AIDS and STI Control Programme
NCD	Non-communicable Disease
NGO	Nongovernmental Organisation
NHIF	National Hospital Insurance Fund
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. Sessional Paper No. 2 of 2017 on the Kenya health policy 2014-2030 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 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: 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 take legislative, policy and other 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— (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: -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

ARTICLE	CONTENT
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 to 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 Sessional Paper No. 2 of 2017 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 Sessional Paper No. 2 of 2017 takes cognisance of the specific functions assigned to the two levels of governments, which are as follows: National government: leadership in health 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, 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 have been further defined through the unbundling of functions, and any modifications thereof, 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 Sessional Paper forms the fundamental framework for managing the devolution of the healthcare sector, during and beyond the transition period. The Sessional Paper 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. Sessional Paper No. 2 of 2017 and the National Development Agenda

Over the years, Kenya has strived to overcome development obstacles and improve the socioeconomic

Key objectives of the Sessional Paper No. 2 of 2017

- ✓ 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

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 end of 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 resulting in the improvement of health indicators in infectious diseases and child health. However, the emerging increase of non-communicable diseases is a threat to the gains made so far. This sessional Paper 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 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 a 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 Sessional Paper, the health sector will embrace the following principles:

- i. Equity in distribution of health services and interventions;
- ii. Public participation, in which a people-centered approach and social accountability in planning and implementation shall be encouraged, in addition to the multisectoral approach in the overall development planning;
- iii. Efficiency in application of health technologies; and
- iv. 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 Sessional Paper No. 2 of 2017 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 the declarations in 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 Sessional Paper 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. These challenges will be addressed through the already existing policies and strategies on nutrition such as the National Nutrition Action Plan; the Agriculture and Nutrition Security Policy; Kenya high impact Nutrition interventions; commitment to the Global Scaling up Nutrition (SUN) movement and commitment to the MDGs, specifically goals 1, 4, 5 and 6.

Other factors that contribute to high mortality include immunisable diseases and high maternal deaths 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 26 percent,⁴ with major national implications for survival, productivity, and economic development.

Kenya faces challenges of emerging and re-emerging diseases. Tuberculosis (TB) is a threat and a major cause of ill health. While HIV prevalence has been steadily declining, with a prevalence rate of 5.6% in 2012, the number of those infected continues to increase, with annual new infections standing at 106,000 in 2012(KAIS, 2012). 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.

⁴Kenya Demographic and Health Survey (KDHS) 2014.

This Sessional Paper 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 the policy.⁵The 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.

⁵Government of Kenya, 2010.*Health Situation Trends and Distribution, 1994–2010, and Projections to 2030.*

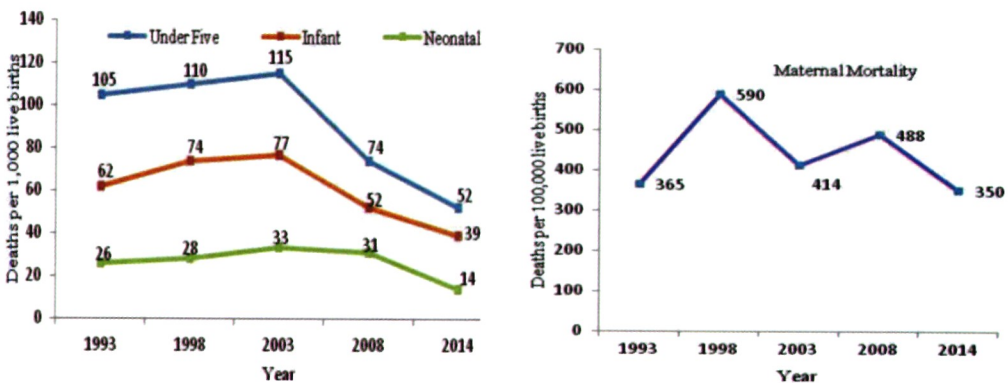
CHAPTER 2: SITUATION ANALYSIS

This section summarises the progress made in Kenya in (1) overall population health status, (2) investment made in health, and (3) outcomes from the implementation of interventions under the previous policy period. The situation analysis was informed by a comprehensive review of the 1994–2010 Kenya Health Policy Framework and periodic health sector and other surveys. More 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, but rose to 59 years by 2009 and is currently estimated to be 61 years⁶. Towards the end of the last policy period, evidence of improvements in indicators for specific age groups emerged, particularly those related to adult, infant, and child health. Based on current impact estimates, improvements in infant and child health indicators have been sustained right up to the beginning of the policy period, while neonatal and maternal health have also started to show improvements (see Figure 1 below).

Figure 1: Recent Trends in Health Impact Indicators in Kenya, 1993–2014



Source: Respective Demographic & Health Surveys

The overall trend in health status is positive, with the sector noting significant improvements in all forms of mortality. There are however significant disparities by county, sex and gender.

⁶Kenya Demographic & Health Surveys, 2014: MMR based on World Health Statistics estimates

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 below.

Table 2: Leading Causes of Death and Disability in Kenya

Causes of Death			Causes of Disability		
Ra nk	Disease or injury	% death total	Ra nk	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 improvement of some indicators, the population growth rate has remained high, at 2.7⁷ per cent per annum, with 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 46⁸ per cent.

Literacy levels reached 78.1 per cent, although inequalities in age and geographical distribution persist⁹. Gender disparities remain significant, with the Gender Inequality Index, the measure of disparity on health, empowerment and labour market standing at

⁷ Economic Survey 2014

⁸ Economic Survey 2014

⁹ Government of Kenya, 2009. National Population and Housing Census

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. In addition, a significant number of people experience domestic violence. According to the 2014 KDHS, 41% of women, and 11% of men have experienced physical or sexual violence from their spouse / partner.

Table 3: Population Distribution by Age and Sex 2013

Age group	Male	Female	Total	%
0-4	3,251,967	3,185,233	6,437,200	15.4
5 - 9	3,067,110	2,993,891	6,061,000	14.5
10 - 14	2,768,681	2,665,318	5,434,000	13.0
15-24	4,202,906	4,407,894	8,610,800	20.6
25-34	3,012,944	3,173,456	6,186,400	14.8
35-49	2,575,517	2,565,883	5,141,400	12.3
50-59	902,721	894,678	1,797,400	4.3
60-64	311,714	315,287	627,000	1.5
65+	661,520	801,479	1,463,000	3.5
Age NS	22,753	19,047	41,800	0.1
TOTAL	20,778,107	21,021,893	41,800,000	100

Source: Computed data from Economic Survey 2014 and 2009 census

¹⁰UNDP, Human Development Report, 2013

¹¹Government of Kenya, 2014, Economic Survey

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 and child health have shown signs of improvement, as shown by trends in the Demographic and Health Surveys between 2008/09 and 2014. Improvements are seen with use of any modern contraceptive method (46% in 2008/09 to 61% in 2014), total fertility rate (4.6 in 2008/09 to 3.9 in 2014), health facility deliveries (44% in 2008/09 to 61.2 % in 2014). There are also improvements in child health; the percentage of children who are stunted reduced from 35% in 2008/09 to 26% in 2014, and those underweight reduced from 16% in 2008/09 to 11% over the same period. However, coverage with childhood vaccinations has stagnated (fully immunized children remaining at 68% in 2008/09 and 2014). Achievement on MDG goals for maternal and child health have remained below the set targets, except for percent of children underweight.

A key policy intervention during implementation of the previous policy was adoption of the multi-sectoral approach in response to HIV and AIDS, following implementation of sessional paper number 4 of 1997 and establishment of NACC in 1999. HIV/AIDS control showed progress, with evidence of declining incidence, prevalence, and mortality with the latest data showing the HIV prevalence at 5.6 in 2012 from a high of 10.5% in 1995-6¹². The 2014 World Health Statistics showing HIV incidence as having reduced from 426, to 226 new cases per 100,000 persons between 1990 and 2012, with the contribution of HIV to under 5 mortality reducing from 13% to 4% in the same period. According to the 2014 KDHS, 83% and 71% of women and men respectively had ever been tested for HIV and received results. 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 detection and treatment success rates that stood at 79% and 87.7% respectively as at 2013. The TB prevalence (all forms), and incidence in 2013 were 299 and 272 per 100,000 persons respectively. However, the emergence of drug-resistant strains since 2005 is a key challenge. There are approximately 250 MDR cases being identified per year, with a treatment success rate at 71%.¹³

There is also evidence of a reduction in vector-borne disease mortality, attributed to the scaling up of effective interventions, such as Insecticide Treated Nets (ITNs),

¹²Kenya AIDS Indicator Survey, 2012

¹³World Health Organization: Tuberculosis Report 2013, Kenya TB annual report 2013

Intermittent Preventive Treatment in pregnancy (IPTp), and Indoor Residual Spraying (IRS). According to the 2014 Demographic and Health Survey, up to 77% of pregnant mothers and under 5s are reported to be using ITNs in households with at least one ITN. 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. In particular, an estimated 39,000 people are diagnosed with cancer and 27,000 die from the disease annually. However, 80% of people with cancer are diagnosed late, when the only treatment option that can be offered is palliative care. The incidence of injuries and violence is also high, with mortality levels increasing over the years to account for 7.9% of all deaths in 2013, and mainly affecting the productive and younger population.

Table 4: Mortality rates, and years of life lost by disease domain, 2013

	Mortality rate, per 100,000 population (% of total)	Years of Life Lost per 100,000 population
Communicable conditions	657 (51.6%)	37,031
Non communicable conditions	515 (40.5%)	9,133
Injuries	101 (7.9%)	5,271

Source: WHO World Health Statistics, 2014

2.2.2 Risk factors to health

Risk factors to good health in Kenya include unsafe sex,¹⁴ suboptimal breastfeeding, under-nutrition, alcohol and tobacco use, obesity and physical inactivity, among others. The table below shows the top 10 risk factors contributing to mortality and morbidity.

¹⁴Unsafe 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.

Table 5: Leading Risk Factors and Contribution to Mortality and Morbidity

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, & hygiene	5.3	2	Childhood underweight	5
3	Suboptimal breast feeding	4.1	3	Household air pollution	4.8
4	Childhood & maternal underweight	3.5	4	Suboptimal breast feeding	3.8
5	Indoor air pollution	3.2	5	Iron deficiency	2.8
6	Alcohol use	2.6	6	Unsafe water and sanitation	2.0
7	Vitamin A deficiency	2.1	7	High Blood Pressure	1.8
8	High blood glucose	1.8	8	Alcohol use	1.7
9	High blood pressure	1.6	9	Smoking	1.3
10	Zinc deficiency	1.6	10	Occupational risks	1.2

Source: GOK 2010. Review of the Kenya Health Policy Framework, 1994–2010; Institute for Health Metrics and Evaluation (IHME) March 2013: The Global Burden of Disease Study (GDB 2010). DALYs = Disability-adjusted Life Years—Time lost due to incapacity arising from ill health

Available evidence suggests that there has been a reduction 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 HIV. The percentage of women of child bearing age who had 2 or more sexual partners in the previous 12 months reduced from 2% to 1% between 2008/09 and 2014. This has however remained the same for men at 13 %.

Breastfeeding practices have also improved, with exclusive breastfeeding for up to six (6) months showing significant improvement. Up to 61% of children less than 6 months are being exclusively breast fed in 2014, up from 32% in 2008/09.

Whereas 5 percent of all deaths from non-communicable conditions and 55 percent of deaths from cancers of the trachea, bronchitis and lungs are attributable to tobacco use, 19.1 percent of males and 4.5 percent of females among adults population 15 years and above or about 2.5 million persons were using tobacco products in 2014¹⁵.

¹⁵Ministry of Health: Global Adult Tobacco Survey 2014

The same pattern is seen in the use of alcohol products among sexes, with the impure and unhealthy alcohol products found more in the rural areas and urban slums¹⁶.

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. Further, 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 determinants of health 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. According to KDHS 2014, 93 % of women had at least primary school education.

Nutrition is a vital building block in the foundation of human health and development. The right nutrition early in life, particularly in the first 1,000 days between a woman's pregnancy and her child's second birthday helps ensure healthy growth and cognitive development, leading to a lifetime of health and economic benefits. Nutrition is not just a social determinant of health, but has a direct relationship with health status. According to the Demographic and Health Surveys, stunting, wasting and underweight have improved from 35%, 7% and 16% in 2008/09, to 26%, 4% and 11% in 2014 respectively. The nutrition status of women has however stagnated. 12.3 per cent of adult women have a low Body Mass Index (BMI – under 18.5), with under-nutrition higher among women ages 15–19 years and in rural areas of the country. On the other hand, 18% of women of reproductive age are overweight, with this higher amongst women residing in urban areas as compared to those in rural areas.

There were 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 2013¹⁷. However, some regions, such as arid and semi-arid areas, still have poor access to safe water.

The proportion of the population in active employment grew marginally from 28.3% in 2009 to 32.4% in 2013¹⁸; however, there has been an associated increase in the absolute numbers of the unemployed 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.

¹⁶ Rapid Assessment of Drug and Substance Abuse in Kenya 2012/13, NACADA

¹⁷ Kenya Household Health Expenditure and Utilization Survey, 2013

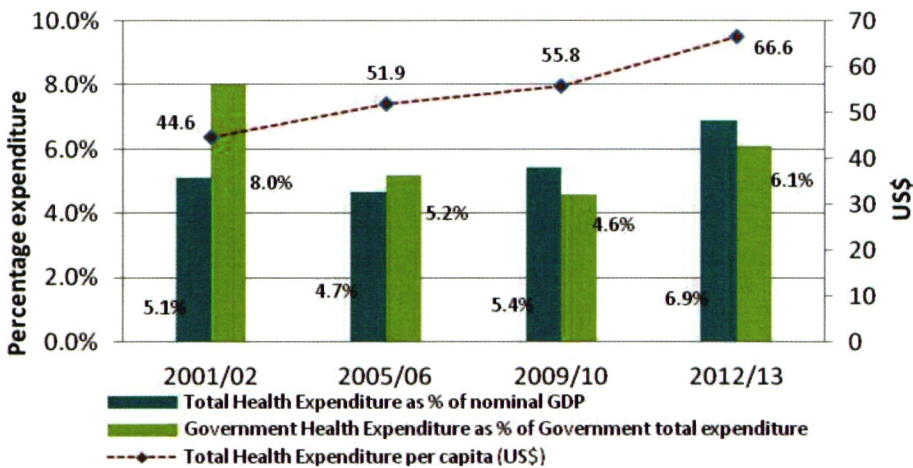
¹⁸ Economic Survey 2014

2.3. Review of Health Investments

2.3.1 Health sector financial allocations and expenditure

As shown in Figure 2, The total health expenditures (THE) have been on an increasing trend, with the latest estimates of 66.6 US\$ spending per person per year.¹⁹ The increases are driven primarily by donor and household spending, though recent initiatives to reduce household expenditures such as the free maternity and primary care services should start to reverse these inequitable trends.

Figure 2: Overall Health Expenditure Trends: 2001–2013



Source: 2001/02, 2005/06, 2009/10, and 2012/13 National Health Accounts

The Government expenditures as percent of total government expenditures are at an estimated 6.1% in 2013, which is still below the commitment of 15% made by the government (Abuja Declaration). This proportion is going to vary in the future, depending on the county level of prioritization.

2.3.2 Human resources

The health workforce constitutes those persons recruited primarily for health and related service provision and management in the state and non-state sectors, who have undergone a defined, formally recognised training programme. An adequate, productive, and equitably distributed pool of trained health workers who are accessible is necessary for the effective delivery of healthcare.

The World Health Organisation recommends 21.7 doctors per 100,000 population and 228 nurses per 100,000 population. However, due to sub-optimal working conditions, brain drain is a common feature in the Kenyan health labour market.

¹⁹2014 National Health Accounts

Kenya had 21 doctors per 100,000 population and only 159 nurses per 100,000 respectively in 2013 as shown in Table 6.

Table 6: Breakdown of Selected Registered Health Personnel

Health Personnel	2010	2011	2012	2013	No. per 100,000 pop. (2013)
Doctors	7,129	7,549	8,092	8,682	21
Dentists	898	930	985	1,045	3
Pharmacists	3,097	3,205	2,076	2,202	5
Pharmaceutical Technologist	2,233	2,409	5,236	6,204	15
Nursing officers	29,678	34,071	36,680	39,780	95
Enrolled Nurses	34,282	34,576	26,621	26,841	64
Clinical Officers	8,598	9,793	11,185	13,216	32

Source: Economic Surveys (Various)

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, despite the contribution of FBO sector health workers in hard-to-reach areas. There is a skewed urban-rural distribution of health workers, with the urban areas having the highest proportions at the expense of rural and remote areas where 70% of the population lives²⁰. Moreover, specialized medical care is 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 health workers. Other challenges that affect performance and motivation include uneven remuneration and disparities in the terms of service among the same cadres of staff in the public sector.

²⁰2013 Economic Survey

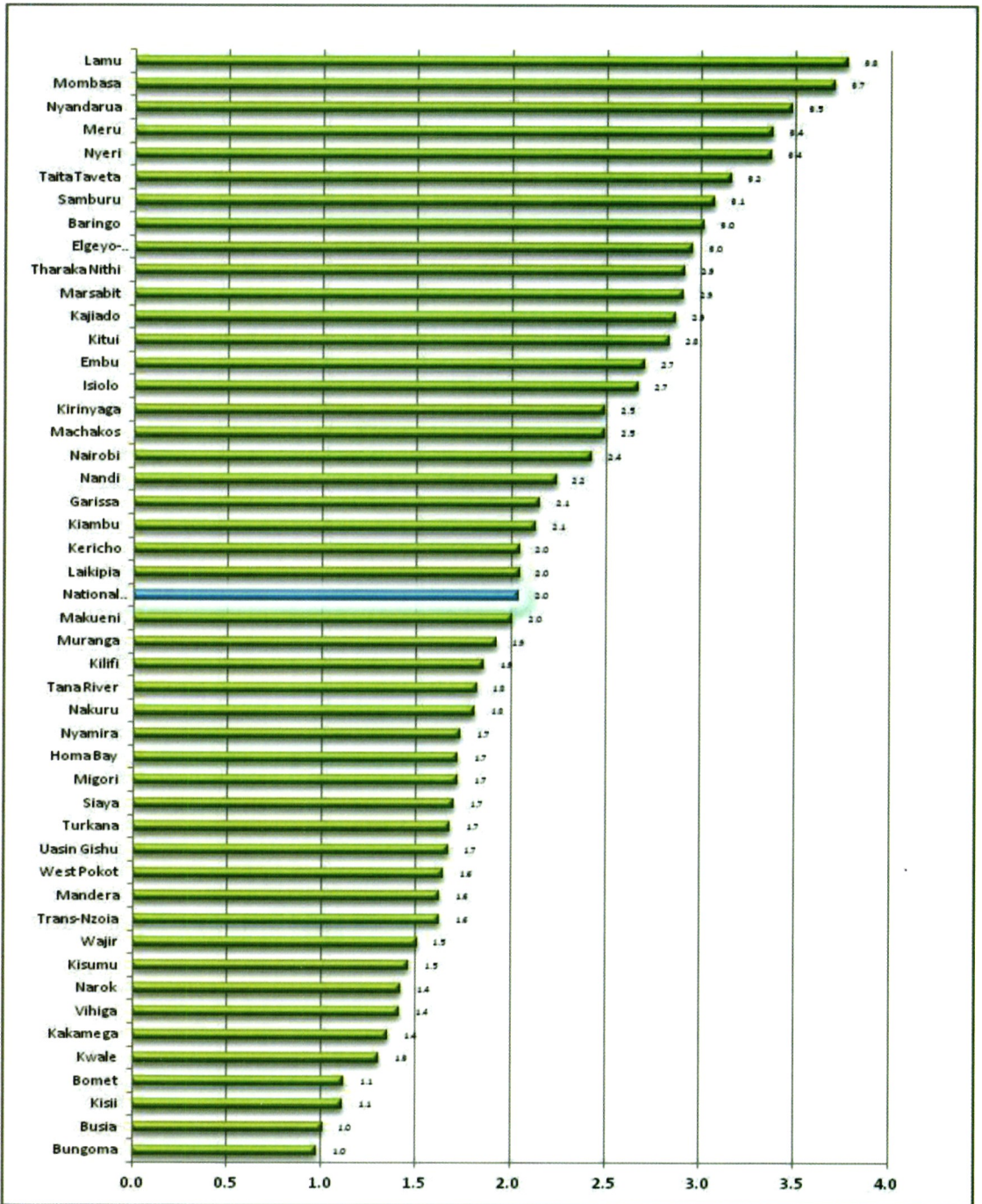
2.3.3 Infrastructure

At the beginning of the policy period, the country had 8,401 registered health facilities²¹, with Nairobi County having the highest number of facilities (10.4%) while Isiolo County had the least number of health facilities (0.5%). 49% of all the health facilities in the Country are public, 16% are private not-for-profit and 33% are private for-profit. Of the total health facilities, 66% are in rural areas and 34% in urban areas. Hospitals constituted 7%, Health Centres 13%, dispensaries 46% private clinics 30% and Maternity and nursing homes 4%.

Bungoma County has the lowest facility density of less than 1 facility per 10,000 persons, while Mombasa had the highest health facility density of over 3.5 per 10,000 population. The national average facility density was 2.04 facilities per 10,000 persons. The facility density by type was dispensaries with 0.93, private clinics 0.62, hospitals 0.15 and health centres 0.26 in that order per 10,000 populations. Public health facilities had the highest density of 0.99 or 1, Private not-for profit 0.33 and private for-profit 0.67 per 10,000 persons.

²¹Ministry of Health: Kenya Service Availability and Readiness Assessment Mapping, 2013.

Figure 3: Facility density by County 2013



Source: Ministry of Health: Kenya Service Availability and Readiness Assessment Mapping, 2013.

Table 7: Facility numbers and type by level of care and county, 2013

County	Population 2012	Total number of facilities	Numbers of facilities by type		Density of facilities by type (per 10,000 persons)	
			Hospitals	Primary care facilities	Hospitals	Primary care facilities
Baringo	593,840	169	7	162	1.18	27.28
Bomet	782,105	111	5	106	0.64	13.55
Bungoma	1,473,458	141	11	130	0.75	8.82
Busia	796,646	80	7	73	0.88	9.16
Elgeyo-Marakwet	396,663	116	9	107	2.27	26.98
Embu	550,438	149	8	141	1.45	25.62
Garissa	457,068	129	9	120	1.97	26.25
Homa Bay	1,033,941	180	13	167	1.26	16.15
Isiolo	206,306	41	3	38	1.45	18.42
Kajiado	732,356	224	30	194	4.10	26.49
Kakamega	1,781,528	229	16	213	0.90	11.96
Kericho	799,515	174	11	163	1.38	20.39
Kiambu	1,734,694	346	52	294	3.00	16.95
Kilifi	1,179,956	199	11	188	0.93	15.93
Kirinyaga	564,022	142	22	120	3.90	21.28
Kisii	1,234,634	140	18	122	1.46	9.88
Kisumu	1,030,986	154	17	137	1.65	13.29
Kitui	1,061,296	313	13	300	1.22	28.27
Kwale	694,612	95	4	91	0.58	13.10
Laikipia	417,538	86	4	82	0.96	19.64
Lamu	106,877	42	3	39	2.81	36.49
Machakos	1,174,587	255	8	247	0.68	21.03
Makueni	947,376	184	12	172	1.27	18.16
Mandera	1,005,003	64	5	59	0.50	5.87
Marsabit	312,325	89	4	85	1.28	27.22
Meru	1,448,606	361	25	336	1.73	23.19
Migori	981,319	169	13	156	1.32	15.90

County	Population 2012	Total number of facilities	Numbers of facilities by type		Density of facilities by type (per 10,000 persons)	
			Hospitals	Primary care facilities	Hospitals	Primary care facilities
Mombasa	995,334	293	15	278	1.51	27.93
Muranga	1,013,325	184	10	174	0.99	17.17
Nairobi	3,324,894	868	78	790	2.35	23.76
Nakuru	1,693,008	317	17	300	1.00	17.72
Nandi	802,358	175	5	170	0.62	21.19
Narok	908,597	129	7	122	0.77	13.43
Nyamira	640,844	114	8	106	1.25	16.54
Nyandarua	631,034	116	13	103	2.06	16.32
Nyeri	735,368	245	40	205	5.44	27.88
Samburu	239,416	71	4	67	1.67	27.98
Siaya	902,753	155	8	147	0.89	16.28
Taita Taveta	297,579	81	3	78	1.01	26.21
Tana River	258,261	49	3	46	1.16	17.81
Tharaka Nithi	389,731	116	7	109	1.80	27.97
Trans-Nzoia	875,697	137	6	131	0.69	14.96
Turkana	868,209	136	7	129	0.81	14.86
Uasin Gishu	940,112	146	12	134	1.28	14.25
Vihiga	594,457	87	8	79	1.35	13.29
Wajir	566,454	110	11	99	1.94	17.48
West Pokot	525,970	84	5	79	0.95	15.02

Source:

2013 and 2014 Economic Surveys

Ministry of Health: Kenya Service Availability and Readiness Assessment Mapping, 2013.

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.

Policy imperative 1: 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 operationalized. 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 Authority (KEMSA).

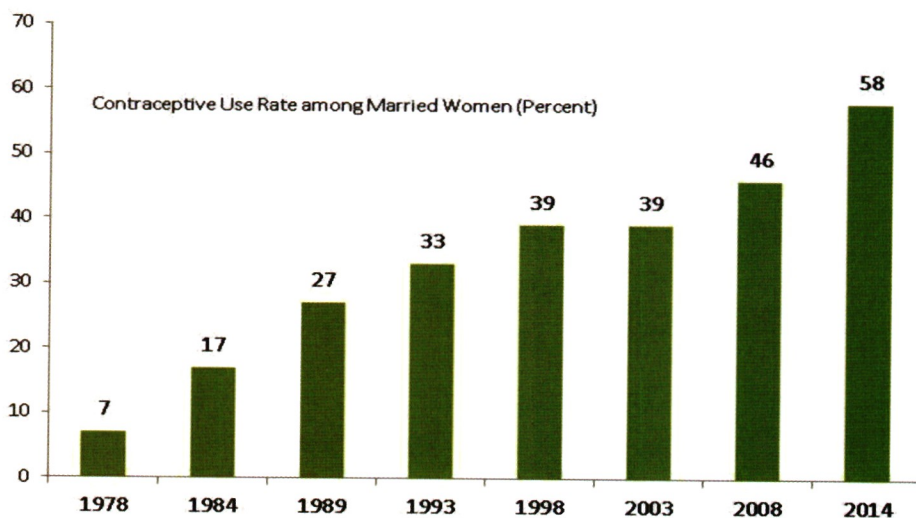
Policy imperative 2: Increase the cost-effectiveness and efficiency of resource allocation and use

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 partially considered 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 efficiency. Additionally, the health sector was not able to define and use unit costs for service delivery in its priority setting.

Policy imperative 3: 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 below.

Figure 4 Trends in Contraceptive Use Rate among Married Women



Source: Kenya Demographic and Health Surveys

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 3.9 in 2014, 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.

Policy imperative 4: 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. 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).

Policy imperative 5: Create an enabling environment for increased private sector and community involvement in health services provision and finance

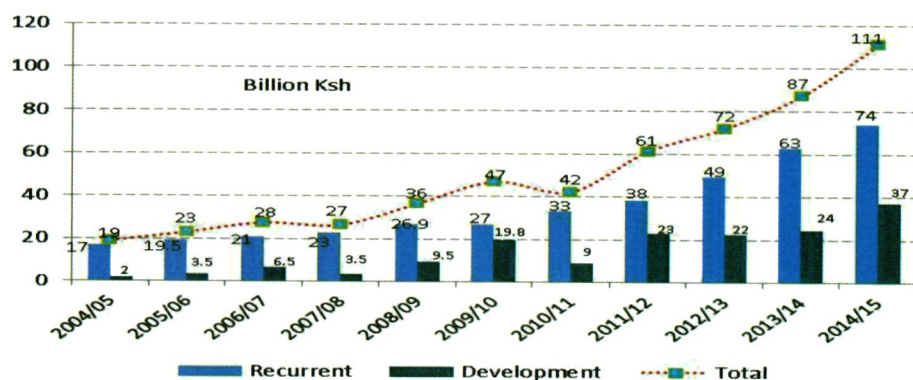
A framework for sector coordination and partnership was established in 2006 with the formalisation of the Kenya Health Sector-wide Approach (SWAp) process. Necessary instruments were defined, based on memoranda of understanding and a code of conduct to guide this dialogue and collaboration. In addition, 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 accounted for 17.9% of all hospital admissions in 2013²². Collaboration with private for-profit actors and alternative medicine practitioners is not well structured. The government began 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).

Policy imperative 6: Increase and diversify per capita financial flows to the health sector

The health sector was not able to expand the budgetary allocations to health care in real terms. However, strategies were put in place to influence resource allocation, 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 were nominal, not real, and represented a shift in total sector financing away from government and households towards donors. The trends in government health expenditure are sensitive to events in government, as seen by the real reductions in 2009.

²²Kenya Household Expenditure and Utilization Survey Report 2013

Figure 5: Trends in recurrent and development expenditure, 2002 – 2014



Source: Respective Sector Report, Controller of Budget office (*2014/15 are budget allocations as obtained from Controller of Budget)

There was a relative increase in allocations to development, up to 33% of government health expenditures in 2014/15²³ and mainly focused on expansion of preventive and promotive healthcare infrastructure. Overall, the financing of health services has become increasingly progressive.

Access to health insurance has also expanded, with an increase in the number of insurance providers and the population covered. The contributions and the benefit package for the NHIF members have been enhanced through revised policy and legislation while the civil servants, teachers and the disciplined forces have been receiving comprehensive medical cover since 2012. However, insurance coverage has remained mostly limited to urban areas and formal sector employees.

Table 8: Trends in NHIF resources and membership, 2008/09 to 2013/14

		2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
NHIF resources	Receipts	5,079.0	6,025.7	6,765.8	9,595.6	12,054.9	13,630
	Benefits	2,813.0	3,110.0	3,677.4	5,999.8	8,236.2	9,080
	Contributions net of benefits	2,266.0	2,915.7	3,088.4	3,595.8	3,818.7	4,550
Members	Formal	1,800,000	2,286,205	2,197,940	2,441,795	2,679,370	2,770,711
	Informal	376,470	555,730	688,746	898,364	1,115,424	1,486,840
	Total	2,176,470	2,841,935	2,886,686	3,340,159	3,794,794	4,257,551

Source: National Hospital Insurance Fund; Informal membership includes those enrolled through micro-insurance entities

²³Various Health Sector Reports

The 10/20 policy on cost sharing introduced in 2004 reduced the direct payment for services to a token amount in public dispensaries and health centres. Further, exemptions for user fees were introduced for some specific health services, including treatment of children under five years old, prisoners, maternity services, TB and HIV/AIDS treatment, and immunisation services. In 2013, the Government further abolished the 10/20 policy in public health centres and dispensaries and provided a budgetary allocation to compensate health facilities for lost revenue. This has significantly improved financial access to services.

Community-based health financing initiatives have not been prominent in the country, despite the existence of a relatively strong community-based Savings and Credit Cooperative Organisations (SACCO) system that could have acted as a backbone for community-based insurance initiatives.

Policy imperative 7: 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. Sub-national management functions have been strengthened to allow them to better facilitate and supervise service delivery, though this mandate has been exercised differently in the various provinces/regions and districts;
- v. New statutes, laws, and policies guiding different aspects of the health sector have been introduced, though 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 rationalization and mobilization approaches;
- vii. The human resource component has been strengthened through motivation of existing staff, redistribution, increase in numbers and review of management structures in accordance with the norms and standards. . However, the sector lacks 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 under 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, hence the need to continue coordinating the multi-sectoral response to HIV and AIDS through NACC.

- 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 realized. Some of the notable achievements include improvement in commodity management, and harmonization of procurement, warehousing, and distribution mechanisms through KEMSA. An Essential Medicines List has been made available, the first one in 1981, 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. Information on costing of services is inadequate, 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 scope of clinical and biomedical research and a number of operational decisions have been influenced 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 decentralization of functions of the MOH to the provinces and districts did not take place as anticipated. The central level 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 the country's commitment to MDGs²⁴ 1 (eradicate extreme poverty and hunger), 4 (reduce child mortality rates), and 6 (combat HIV, malaria, and other diseases). There has been slow progress towards MDG 5 (improve maternal health), and limited progress towards meeting the obligations in the African Union Maputo Plan of Action,²⁵ which aimed to reduce poverty levels.

²⁴United Nations Millennium Summit, 2000.

²⁵African Union Commission. 2006. *Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action)*.

Although the Paris Declaration on Aid Effectiveness²⁶ was prioritised, adherence to the principles has been a challenge especially on alignment to country systems. 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.

The 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 the Kenya's system of devolved government.

²⁶OECD. 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 highest standards of health as enshrined in the Constitution, has projected an 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 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 be significant contributors to the high burden of disease in the country, even though communicable diseases will remain dominant. This implies that future policy frameworks will address the high disease burden arising from all of these conditions.

The total annual mortality is estimated at 426,000 persons, out of which 64 per cent, 26 per cent, and 10 per cent are due to communicable, non-communicable, and injury conditions, respectively²⁷. 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 that facilitate transmission of communicable diseases.

Future projections indicate that, if the current policy directions and interventions²⁸ 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 the Figure 6.

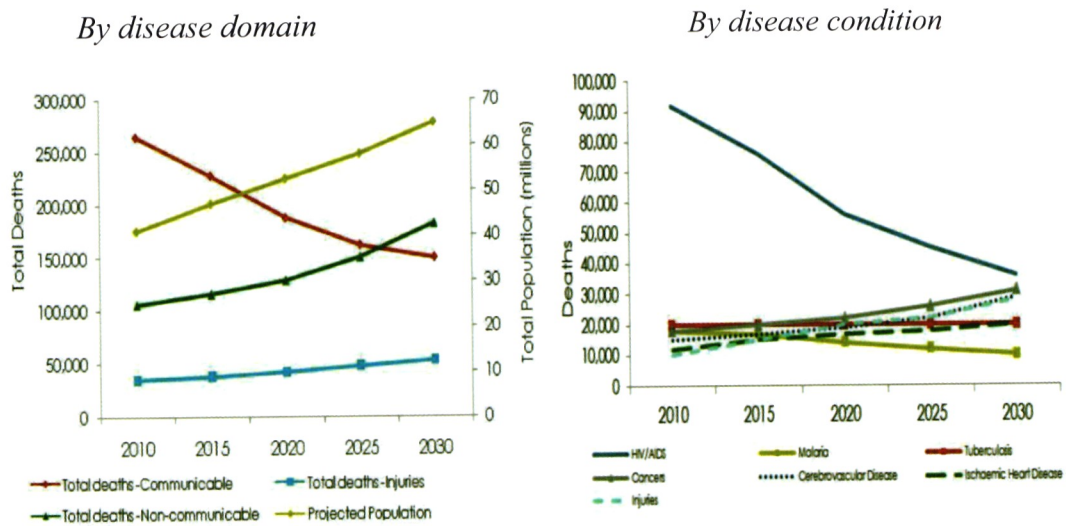
Current efforts to tackle malaria, TB, and HIV are expected to bear fruit in the short and medium term. Their contributions to the overall disease burden will be reduced significantly. However, non communicable conditions will continue to contribute immensely to the overall disease burden, and thus erode out any gains made through existing interventions on communicable diseases. To ensure significant reductions in

²⁷ MOH, Synthesis Report 2010 and MOH Annual Status Report, 2013

²⁸ That is, the existing policy directions and interventions that the Kenya Policy 2014–2030 aims to change.

the overall ill health and mortality in Kenya, efforts should be put in place to ensure increased investments for health interventions to address communicable and non-communicable conditions including social determinants of health.

Figure 6: Projections for mortality, by disease domain area, 2010 – 2030



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

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). It is evident that reducing deaths due to HIV and AIDS will make the biggest contribution in reducing overall mortality caused by communicable diseases. 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.

Table 9: 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	426,000	10.6	291,000	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	

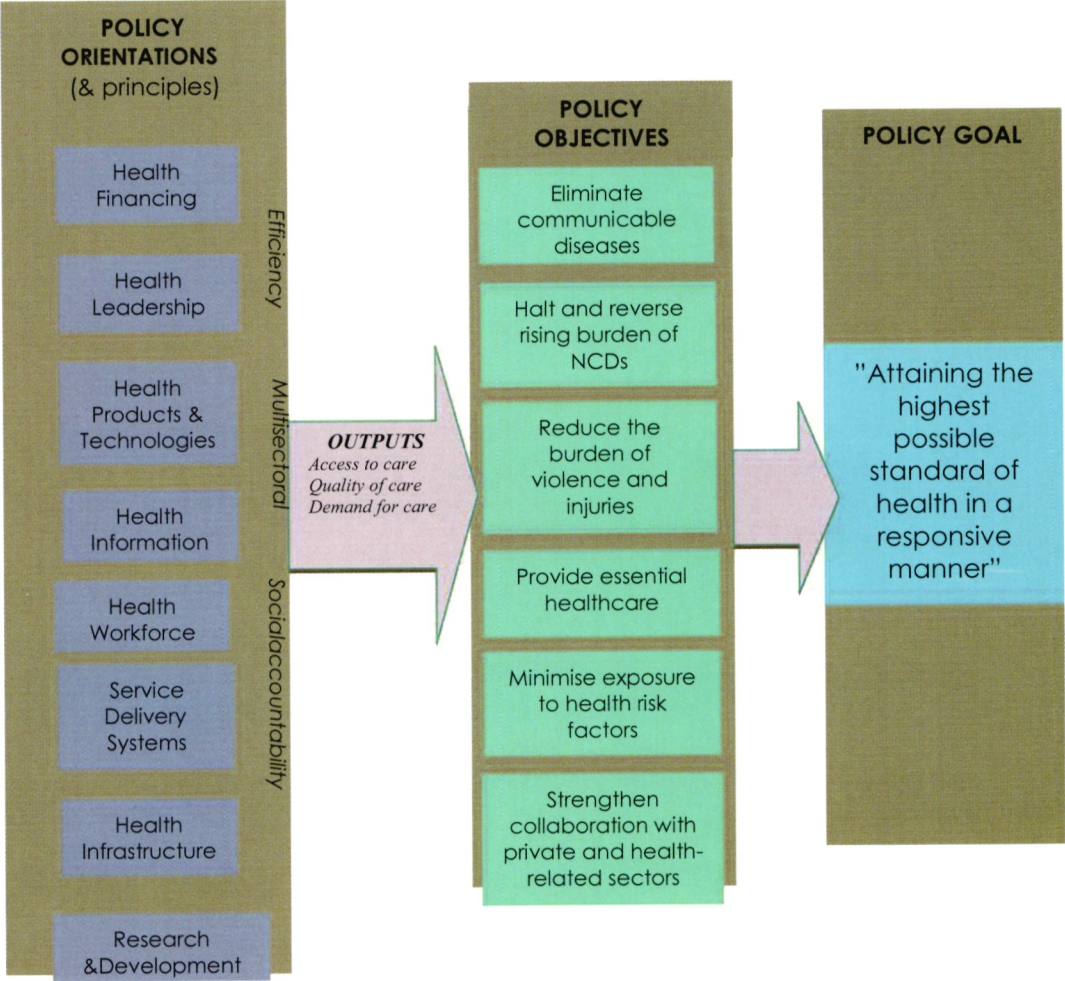
Source: Projections by Ministry of Health

The scenarios and outcomes anticipated 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. The figure below 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 7: 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 creating demand and improving access 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 and technologies, health infrastructure, health financing, service delivery systems, and research and development. 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, all resulting in better health service utilisation. 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 point of view to support attainment of the policy goal.

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-centered 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 regarded as being complementary to the public sector in terms of increasing access to health services, including 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 to attain the objectives of the 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 consider 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 the 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 and targets

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,²⁹ which remains the most efficient and cost-effective way to organise a health system.³⁰ 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*.³¹ This calls for attainment of targets presented in Table 10.

Table 10: Kenya Health Policy Targets

Indicator	Current status	Policy target (2030)	% Change
Life Expectancy at Birth (years)	61	72	18% improvement
Annual Deaths (per 1,000 persons)	10.6	5.4	50% reduction
Years Lived with Disability	12	8	33% improvement

In the policy period, the sector will 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 realize the right to health as outlined in Article 21 of the Constitution. The sector will employ a

²⁹ 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.

³⁰ World Health Organization. 2008. *Primary Health Care: Now, More than Ever*. World Health Report.

³¹ 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.

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 marginalized 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 the 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 resources available for 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:** The 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.

4.2. Policy Objectives

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

Policy objective 1: Eliminate communicable conditions

The 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 realization 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 the elderly and the vulnerable, marginalized, 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, combating existing public health concerns;
- iv. Control vaccine-preventable diseases;
- v. Put in place mechanisms for elimination of HIV and AIDS;
- vi. Promote good hygiene and sanitation to control food and water -borne diseases;
- vii. Improve nutrition and food safety throughout the life-course;
- viii. Eradicate vector- and insect-borne diseases and other NTDs;
- ix. Promote rational use of antimicrobials and other drugs, in order to minimize drug resistance to pathogens;
- x. Promote disease surveillance, epidemic preparedness and response;
- xi. Control entry of infectious conditions at national borders;
- xii. Strengthen health information systems for complete and timely reporting of communicable disease incidences;
- xiii. Increase access to improved water safety and sanitation;
- xiv. Scale up implementation of high-impact health interventions and integrate them with the community health strategy; and
- xv. Adherence to international health regulations and health related issues.

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 maximize utilization 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 the elderly, marginalized 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;
- ix. Support optimal health and survival of children by improving technical guidance, regulation, and protection of children's rights; and
- x. Adopt and implement the Kenya High Impact Nutrition Interventions, integrating it in the community health strategy

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, persons living with disability and geographical distribution. The priority policy strategies include the following:

- i. Promote corrective and intersectoral preventive interventions to address causes of injuries and violence;

- ii. Facilitate universal access to timely and high-quality emergency care services that mitigate the effects of injuries and violence;
- iii. Put in place interventions directly addressing marginalized and indigent populations affected by injuries and violence;
- iv. Scale up physical and psychosocial rehabilitation services to address long-term effects of violence and injuries;
- v. Address the health effects of emergencies, disasters, crises, and conflicts, and minimize 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.

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 vulnerable and marginalized population groups;
- ii. Ensure access to emergency care;
- iii. Ensure Disaster Risk Management with emphasis on Emergency Preparedness and Response (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 access to curative and rehabilitative services
- xi. Ensure provision of safe and adequate blood and blood components in the country through supporting nationally coordinated blood transfusion services;
- xii. Promote establishment of institutes and centres of excellence as a means to ensure availability of highly specialized quality care in the country and in addition promote health tourism;
- xiii. Ensure that complete, reliable, timely, efficient and effective health management information for healthcare is provided and shared among all stakeholders in the sector;
- xiv. Plan, design and install Information, Communication and Technology (ICT) infrastructure and software for the management and delivery of care;
- xv. Make hospitals semi- autonomous and strengthen management capacity at all levels within hospitals including community health departments;
- xvi. Strengthen a National referral system for primary, secondary and tertiary care; and
- xvii. 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.

Policy objective 5: Minimize 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 diets and lifestyles across all lifecycles;
- ii. Promote breastfeeding and complementary feeding practices;
- iii. Reduce anaemia among women and children to levels below it being a public health problem(less than 20%);
- iv. Reduce Vitamin A deficiency to levels below it being a public health problem(less than 10%)

- v. Promote a healthier environment and intensify primary prevention of environmental threats to health, including protection from bio-hazardous materials;
- vi. Ensure that Health Impact Assessment(HIA) is conducted for any major infrastructural development;
- vii. Reduce unsafe sexual practices, particularly among key populations;
- viii. Mitigate the negative health, social, and economic impacts resulting from the excessive consumption and adulteration of alcoholic products;
- ix. Reduce the prevalence of tobacco use and exposure to tobacco smoke and other harmful addictive substances;
- x. Institute population-based, multisectoral, multidisciplinary, and culturally relevant approaches to promoting health, diet, and physical activity;
- xi. Strengthen mechanisms for the screening and management of conditions arising from health-risk factors at all levels;
- xii. Strengthen intersectoral collaboration mechanisms for regulation of the food industry to promote healthy products and responsible marketing;
- xiii. Promote control of micronutrient deficiency diseases and disorders through intersectoral collaboration;

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, 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, 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 other sector’s impact on health.

The private health sector includes Private-Not-For-Profit (PNFP), Private For Profit Health Providers (PFP), Faith Based Organizations (FBOs) 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.

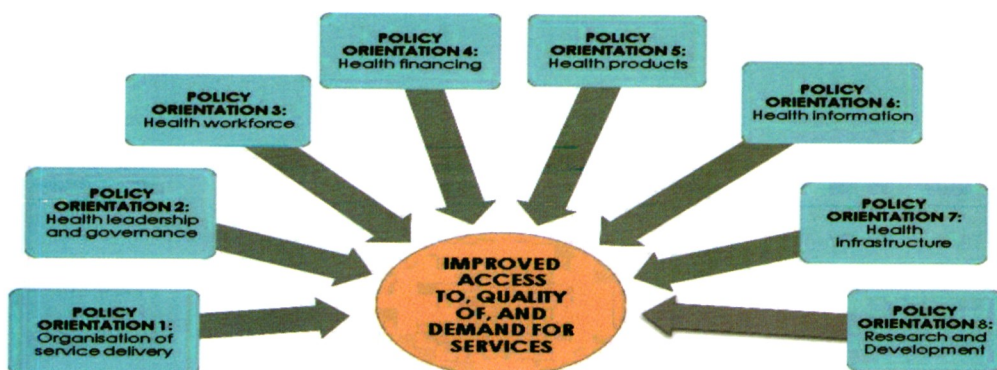
4.3. Policy Orientations

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 be made to facilitate the attainment of the policy objectives as follows:

- i. **Organization of Service Delivery:** Organizational 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 utilization 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 8, 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 8: Policy orientations and desired outputs



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 minimized or removed for all persons requiring health and related services; guided by the concepts of Universal Health Coverage and Social Health Protection; and
- c) Socio-cultural 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 and patients shall have positive experiences during utilization of health and related services;
- b) The available health and related services shall be provided in a manner that ensures patient, client and health worker safety—potential harm as a result of using services should be anticipated and mitigated against;
- c) The health and related services provided shall be 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 recognized 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 and patients shall have adequate awareness of the health actions needed to maximize their health;
- b) Clients and patients shall practice appropriate health-seeking behaviours when they are made aware of an existing potential threat to their health;
- c) Clients and patients shall practice healthy lifestyles;
- d) Clients shall be well-informed of available services at the various health service providers and facilities; and
- e) Clients shall be encouraged to enrol in schemes that enhance social health protection.

4.3.1 Policy orientation 1: Organization 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 the policy, the sector will focus on and invest in the eight areas shown below;

Table 11. 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
iii. 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 behaviours
		Programme-targeted community services to improve supply of services by taking services to the community
iv. Organisation of facility services	How the facility organises itself internally, to provide and manage delivery of care	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 levels of facilities	Physical client movement (physical referral)
		Patient parameters movement (e-health)
		Specimen movement (reverse cold chain and reference laboratory system)
	The focus is on ensuring holistic delivery of services	Expertise movement (reverse referral)
		Formulation of National referral strategy and guidelines

Service Area	Description	Scope and Focus
		Formulation of an Emergency Medical Services (EMS) policy
vi. 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 risk management policy and legislation; management of cross-border outbreaks will also be carried out through intergovernmental mechanisms
vii. 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
iii. Organisation of supervision and mentorship services	How health workers are mentored and supported to continually improve their competences, skills and expertise in providing high-quality services	Integrated facilitative supervision
		Emergency supervision
		Technical supervision and coaching

i. Organization 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 will be provided:
 - 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 prioritized 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. *Organization 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 period 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. The table below illustrates the current situation at the beginning of the policy and desired levels of care at the end of the policy.

Table 12. 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 organized around a comprehensive community strategy defined for the health sector;
- b) The *primary care services* will comprise all dispensaries, health centres, and maternity and nursing 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, both public and private. 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;

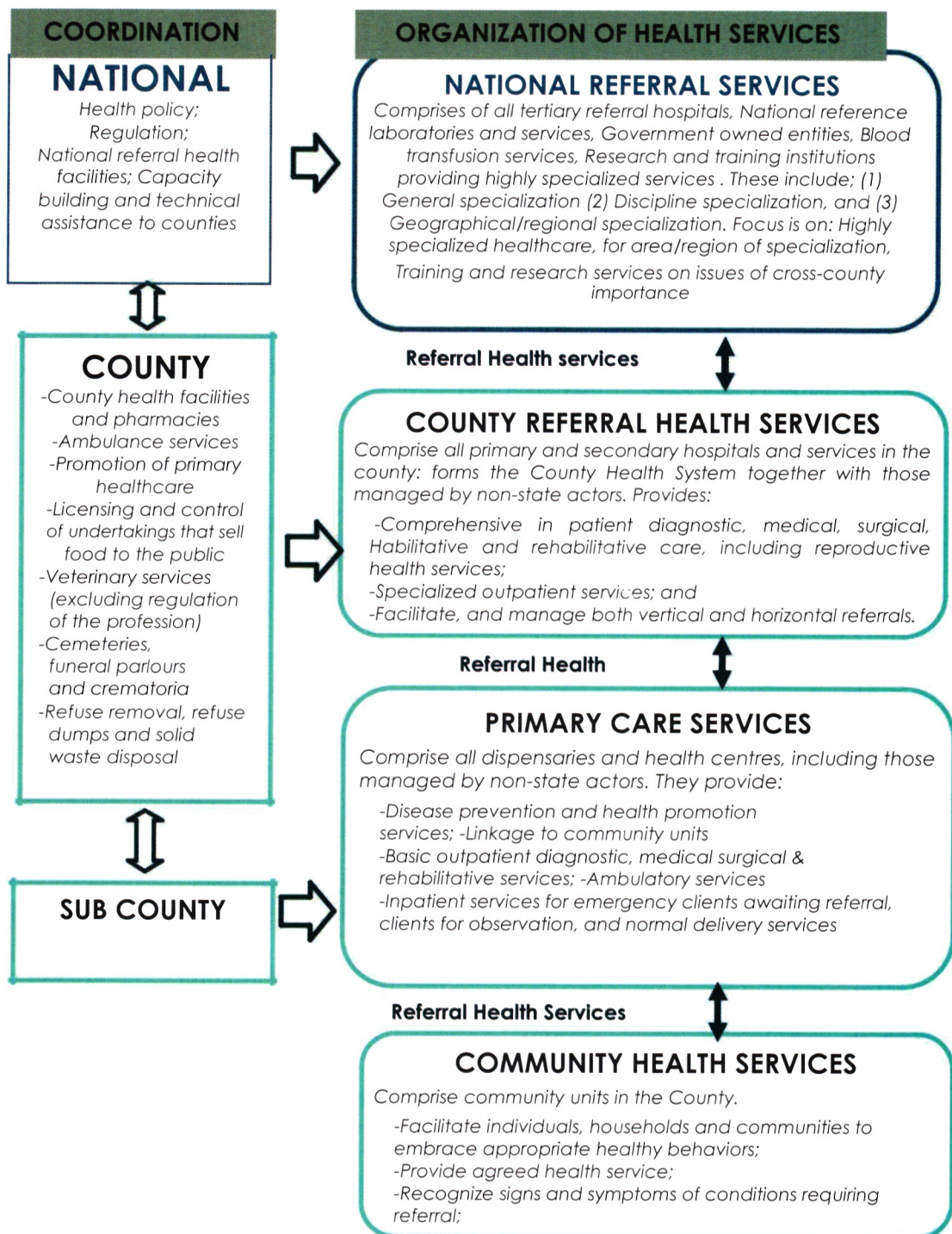
d) The *national referral services* will include the service units providing tertiary and highly specialized services, including high-level specialist medical care, reference laboratory support, blood transfusion services, and research. The units include national-level semi-autonomous agencies and such public hospitals shall operate with a defined level of self-autonomy from the Ministry of Health, 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 9.

Figure 9: Organization of the 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. Organization 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. Organization 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, including rehabilitative 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 and response, including disaster management;
- e) Promotion of rational use of drugs as per national pharmaceutical 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, guidelines and regulations.

v. *Organization 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 medical services (EMS) 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

The envisaged referral system will be actualized through medium term referral strategies and guidelines that will ensure delivery of effective referral services, which will comprise of:-

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 the disaster management policy and legislation. Management of cross-border outbreaks will also be carried out through intergovernmental mechanisms. *The office of the 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. *Organization of outreach services*

The aim of outreach services is to bring services closer to the people. Outreach services will 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. Organization 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 specialization-based—of national referral services to maintain standards and the highest quality of healthcare delivery;
- b) County supervision will be done by the county health management teams to ensure that health policies are implemented and regulations and standards, adhered to in the delivery of healthcare;

Mentorship will be done at both National and county 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:-

- 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, attachment, apprenticeship and internship.

The MOH will, from time to time, in conjunction with county governments, professional bodies, FBOs, the private sector and facility managers, develop comprehensive continuous professional development (CPD) guidelines and a monitoring and evaluation framework.

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 the following six areas in which it will make its investments:-

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, monitoring and evaluation framework.

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

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.

Intergovernmental structures formed in accordance with the Intergovernmental Relations Act will be charged with the responsibility of 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 by 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.

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

4.3.3 Policy orientation 3: The health workforce

The health workforce constitutes those persons recruited primarily for health and related service provision and management in the state and non-state sectors 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 that is fit for purpose and fit for practice in support of Universal Health Coverage through the implementation of the Kenya Essential Package of Health.**

The policy aspiration will be attained through systemic implementation of medium and long term human resources for health policies, strategies and plans based on comprehensive health labour market analyses developed by national and county governments in consultation with the Ministry responsible for devolution and planning, Public Service Commission and County Public Service Boards, among others; focussing on the following:

i) Availability of health workforce

a) Ensuring an adequate supply on the health labour market of all health workers required for the implementation of the current and future KEPH as defined in the 2014 HRH norms and standards, and to progressively expand the effective coverage of the KEPH. Supply refers to the number of health workers produced annually from relevant state and non-state training institutions, and their competencies upon graduation.

On production of health workforce, the development, implementation, monitoring and regular review of the strategies will specify the relationship of outputs from training institutions with labour market objectives such as the number of available positions, national staffing needs and international career opportunities; as well as guide programmes for professional development and progression of staff.

Further, the strategies and plans will provide for adequate investments in relevant pre-service training programmes, including direct investment by national government, creating an attractive investment climate for private investments, and advocacy among external actors for investments in pre-service training of health workers.

b) On the demand side, the national and county governments shall endeavour to progressively adhere to the required set norms and standards; maintain databases for all health worker positions and vacancies; and strengthen the capacity of health service providers in the public and private sectors to incentivise young

people to enter health labour market, and to retain them. The latter will be achieved by systematic identification, monitoring and action on the main factors that contribute to failure to attract and retain workers in the health sector, such as unfair remuneration, inadequate social protection, poor career prospects, lack of training opportunities, poor and unsafe working environments, and poor access to dispute settlement mechanisms, among others.

ii) Equitable distribution of health workers

To ensure equity in the availability of health workers, specific attention will be given to the hard to reach and marginalized parts of the country, including development and implementation of innovative health financing mechanisms that incentivise health workers in such areas, innovations in intergovernmental collaborations such as sharing of services from specialists; as well as encouraging investments from both private-for-profit and private-not-for profit health subsectors including public-private partnerships.

iii) Health workforce performance

In order to improve the performance of the health workforce in terms of quality ('fit for purpose and practice') and productivity, the sector will focus on:

a) general and subsector-specific policy, legislative and regulatory frameworks, including ensuring the development, enforcement and sanctioning of appropriate regulations on licensing of practitioners and professional misconducts; setting standards of quality and productivity (professional categories and tasks) to be achieved through establishment of a national appraisal mechanism for clinical practices and interventional procedures for some categories of health workers; and developing, as appropriate, and implementing schemes of service for all health workers.

b) health workforce management improvements, including establishment of functional structure and innovations to support performance at workplace and elsewhere, where necessary; strengthening performance appraisal in the public sector; strengthening supportive supervision and providing opportunities for in-service training and continuing professional development.

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 increased budget allocations to health 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 mobilization 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. Establishing a mechanism for sustainable financing for HIV and AIDS, TB, and other strategic commodities including for immunization and non-communicable diseases such as cancer and diabetes;
- vi. Developing and strengthening innovative healthcare financing for communities by periodically reviewing the criteria for resource allocation and purchasing mechanisms to improve efficiency and utilization of resources;
- vii. Progressively working towards the elimination of payment at the point of use for health services, especially by the marginalized and indigent populations, through social health insurance and government subsidies;
- viii. Putting in place comprehensive mechanisms for financing of emergency health services;

- ix. Promoting private sector participation in financing of healthcare through public-private partnerships and other mechanisms;
- x. Pooling of resources to increase efficiency in utilization of health resources by undertaking comprehensive health care financing reforms in the health sector;
- xi. Supporting financing innovations that ensure availability of modern medical equipment, infrastructure and other capital investments for provision of quality health care services; and
- xii. Developing and implementing a healthcare financing strategy.

4.3.5 Policy orientation 5: Health information

The ministry of health will put in place mechanisms to ensure generation, and management of information to guide evidence-based decision making in the provision of health and related services at the national and county levels. 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. The target consumers of information 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. Ensure digitalization of all health records and systems on an architectural platform with emphasis on interoperability
- ii. Collaborating, harmonizing, 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 and service delivery;
- iii. Continued strengthening of accuracy, timeliness, and completeness of health information from the population and health facilities;
- iv. Strengthening mechanisms for health information dissemination to ensure information is available where and when needed;
- v. Putting in place health surveillance and response mechanisms;
- vi. Ensure all counties carry out nutrition surveillance monitoring and incorporate the data in the health information system
- vii. The National government, in consultation with county governments, will develop reporting guidelines;
- viii. Developing and implementing a health information systems (HIS) policy;
- ix. 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 geared 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 on the following strategies:

- x. 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 standardized equipment.

The commodities will be categorized as

Strategic commodities that include vaccines and drugs for TB, HIV/AIDS, epidemics and FP commodities

Special and expensive commodities that include cancer drugs, immunosuppressive agents among others

Basic essential products

- xi. 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.
- xii. Putting in place a harmonized 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; management of bio-hazardous products; and emerging health technologies.
- xiii. 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.
- xiv. 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 ensure value for money across the system.

- xv. 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.
- xvi. Ensuring availability of affordable, quality health products and technologies. This shall be done through full application of all options (such as 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.
- xvii. The national government will to ensure strategic reserves for public health commodities (Tuberculosis, Vaccines, Anti-retrovirals, Family Planning), special and expensive categories of products and any other commodities for emerging global conditions of public health concern; which the county governments will focus on the availability of basic essential products at county health facilities in accordance with the 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 the 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 utilization 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.
- x. Digitalize the inventory of all infrastructure and any other asset.

4.3.8 Policy orientation 8: Research and Development

The Ministry of health will prioritise 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 Sessional Paper 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),³² which brought together all health stakeholders and was managed through a partnership instrument, the Code of Conduct.³³ 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 Sessional paper will be dependent upon the collaborative efforts and synergies of all the stakeholders and actors through establishment of an effective partnership framework through new institutional and management arrangements. This Sessional Paper is also alive to the functional assignments between the two levels of government with respective accountability, reporting, and management responsibilities. The Sessional Paper 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. Complementarity of efforts and interventions.

³²Government of Kenya, 2005. Kenya Health SWAp concept paper. October 2005. Ministry of Health.

³³Government of Kenya, 2007. Health Sector Code of Conduct. August 2007. Ministry of Health.

Under the existing legal and other government policy frameworks, this Sessional Paper will be implemented through five-year Strategic and Investment Plans, Medium Term Plans (MTPs) 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 the policy:

5.2.1 The Ministry of Health and health-related semi-autonomous government agencies (SAGAs)

The Ministry for health 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 the policy. The MOH and related SAGAs shall be responsible for the following functions:

- i. Developing national policy and legislation, setting of standards, national reporting, sector coordination, and resource mobilization;
- 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 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 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: The 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: The 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. They include the private sector, NGOs, FBOs, and CSOs. The 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 the policy. In addition, the 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. Development Partners 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 the 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 Kenya²⁰¹⁰ 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 be responsible for 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 recommend 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.

CHAPTER 6: MONITORING AND EVALUATION

The implementation of the 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 workplans and medium-term plans. The policy will undergo a mid-term review. The targets will be benchmarked against best practices from across the globe.

6.1. Monitoring and Evaluation Framework

The Sessional Paper No: 2 of 2017 on Kenya Health Policy 2014-2030 is the primary policy document providing long-term direction for health in Kenya for the period 2014–2030. The 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.

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

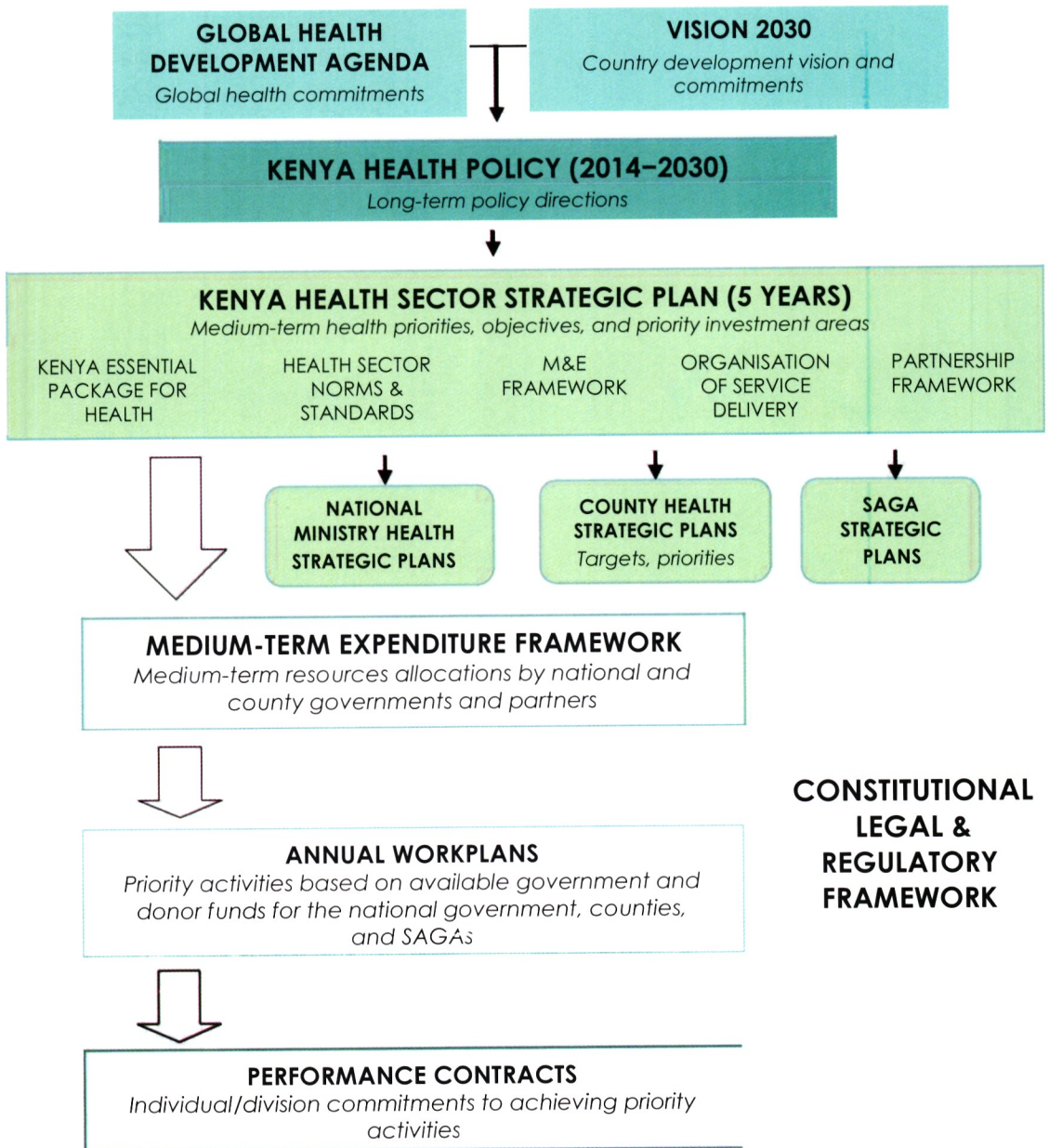
Health Sector Investment Plans shall be used to identify key investment areas in HSSPs. These plans shall be developed for specific decision-making units, including the following:

- i. Counties: as autonomous, decentralized management units that are able to plan and raise resources for defined services;
- ii. Referral facilities: as critical service delivery units in counties and the national level (national referral facilities); 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 eight 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 and the priority activities for implementation in the short term, based on the resources available.

Figure 10: Overarching health planning and review framework



6.2. Progress Indicators

These are based on the respective domain areas. Indicators that will be used are shown 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 13: Indicators for Measuring Kenya Health Policy 2014–2030 Performance

Policy Area	Domain	Impact-level Indicators	2014 Estimates	2030 Target	% Change
Policy Goal	Level and distribution of health	Life expectancy at birth (years)	61	72	18% increase
		Annual deaths (per 1,000 persons)	10.6	5.4	50% reduction
		Years lived with disability	12	8	33% reduction
	Responsiveness of services	Client satisfaction	84.87	95	12% increase
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	29% reduction
	Violence and injuries	Annual deaths due to violence/injuries (per 1,000 persons)	1.0	0.7	30% reduction
	Essential healthcare	Neonatal mortality rate (per 1,000 births)	14	7	50% reduction
		Infant mortality rate (per 1,000 births)	39	18	54% reduction
		Under-5 mortality rate (per 1,000 births)	52	24	54% reduction

Policy Area	Domain	Impact-level Indicators	2014 Estimates	2030 Target	% Change
		Maternal mortality rate (per 100,000 births)	350	113	68% reduction
		Adult mortality rate (per 100,000 births)	23	20	13% reduction
	Risk factors and healthy behaviours	Deaths due to top 10 risk factors	56%	37%	34% reduction
		Disabilities due to top 10 risk factors	47%	31%	34% reduction
		Stunting	26%	10%	62% reduction
		Underweight	11 %	4%	64% reduction
	Health-related sector services	Coverage of health-related sector outcome index ³⁴	63%	85%	35% improvement

³⁴ Index is the average % value of a group of health related indicators with the highest effects on health. These are (with baseline values): Population above the Poverty Line (54%); Literate population (87.4%); Population with access to toilet facilities (31%); Population with adequate food security (77%); Population with access to safe water (59%); and Road network classified as good / fair (69%). Achievement will be derived from surveys by the respective sectors

CONCLUSION

The 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.

The 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 the 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 the 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. Mentorship is part and parcel of supportive supervision.

Non-state Actors (NSA): Individuals or institutions whose primary purpose are 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.³⁵

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.³⁶

³⁵World Health Organization. 2004. *Unsafe Abortion: Global and Regional Estimates of Unsafe Abortion and Associated Mortality in 2000*.

³⁶World Health Organization. 2010. *The World Health Report – Health Systems Financing: The Path to Universal Coverage*.

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