MINISTRY OF HEALTH

Kenya
Health Policy
2012 – 2030
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>DALY</td>
<td>Disability Adjusted Life Years</td>
</tr>
<tr>
<td>ESP</td>
<td>Economic Stimulus Program</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organization</td>
</tr>
<tr>
<td>GDI</td>
<td>Gender Development Index</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GOK</td>
<td>Government of Kenya</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>ICT</td>
<td>Information Communication Technology</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education Communication</td>
</tr>
<tr>
<td>KEMSA</td>
<td>Kenya Medical Supplies Authority</td>
</tr>
<tr>
<td>KEPH</td>
<td>Kenya Essential Package for Health</td>
</tr>
<tr>
<td>KHPF</td>
<td>Kenya Health Policy Framework</td>
</tr>
<tr>
<td>MDA</td>
<td>Ministries, Departments and Agencies</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOMS</td>
<td>Ministry of Medical Services</td>
</tr>
<tr>
<td>MOPHS</td>
<td>Ministry of Public Health and Sanitation</td>
</tr>
<tr>
<td>NACC</td>
<td>National AIDS Control Council</td>
</tr>
<tr>
<td>NCD</td>
<td>Non Communicable Disease</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>SACCO</td>
<td>Savings and Credit Co-operative Organization</td>
</tr>
<tr>
<td>SAGA</td>
<td>Semi-Autonomous Government Agencies</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>SWAp</td>
<td>Sector-Wide Approach</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Foreword

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

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

The policy embraces the principles of protection of rights and fundamental freedoms to specific groups of persons, including the right to health of children, persons with disabilities, youth, minorities, the marginalized and the older members of the society, in accordance with the Constitution.

The policy focuses on six objectives, and seven 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 respective accountability, reporting and management lines. It proposes a comprehensive and innovative approach to harness and synergize health services delivery at all levels by engaging all actors, signaling a radical departure from past approaches in addressing the health agenda. There is therefore a need to raise awareness and ensure that the objectives of this policy are understood and fully owned by the various stakeholders and implementing partners.

The policy was developed through a participatory process involving all stakeholders in health including government ministries, departments, and agencies, clients, counties, constitutional bodies, development partners (multisectoral 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 realization of the rights to health and steer the country towards the desired health goals.

JAMES W. MACHARIA
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MINISTRY OF HEALTH
PART 1: BACKGROUND
Chapter 1: Introduction

1.1 Health policy and the national development agenda
Over the years, Kenya has taken important steps to lay a firm foundation in a bid to overcome development obstacles and improve the socio-economic status of her citizens, including health. The development of the Kenya Health Policy Framework (KHPF 1994-2010), the launch of Vision 2030, the enactment of the Constitution 2010, and fast tracking of actions to achieve the Millennium Development Goals (MDGs) by 2015 are some of these steps.

Implementation of KHPF 1994-2010 led to significant improvement in key health indicators such as infectious diseases and child health. However, the emerging trend of non-communicable diseases poses a threat to the gains made so far. This new health policy aims at consolidating the gains attained so far, while guiding achievement of further health gains in an equitable, responsive and efficient manner. It is anticipated that the ongoing government reforms, together with the expected sustained economic growth, will facilitate the achievement of these health goals.

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

1.2 Health policy and the Constitution of Kenya 2010
The Constitution of Kenya 2010 provides an overarching legal framework to ensure a comprehensive rights-based and people-driven approach to health services delivery. The Constitution provides that every person has a right to the highest attainable standard of health. 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. The Constitution introduces a devolved system of government to enhance access to services by all Kenyans, including those in rural and hard to reach areas. The Constitution also singles out health care for specific groups such as children and persons living with disabilities. The underlying determinants of the right to health, such as adequate housing, food, clean safe water, social security and education, are also guaranteed in the Constitution. This policy therefore seeks to make the realization of the right to health by all Kenyans a reality.

1.3 Health under devolved system of government
This policy further provides mechanisms and frameworks within which health systems strengthening and development will be defined and considered, to ensure the progressive realization of the right to health for every person across the country under the devolved system.

The policy takes cognisance of the specific functions assigned to the two levels of governments as elaborated in the Fourth Schedule of the Constitution, where the National Government will provide leadership in policy development, management of national referral facilities and capacity development while the County Governments will be responsible for service delivery. This policy
therefore forms the fundamental framework for managing the health care from a centralized to a
devolved system of government, through and beyond the transition period, in order to mitigate the risk
of service disruption.
Under this arrangement, this policy aims to:

a) To promote democracy and accountability in delivery of health care;
b) Foster seamless service delivery during and post transition period;
c) Give powers of self-governance to the people and enhance their participation in making
decisions on matters of health affecting them;
d) Recognize the right of communities to manage their own health affairs and to further their
development;
e) Protect and promote the health interests and rights of minorities and marginalized
communities;
f) Promote social and economic development and the provision of proximate, easily accessible
health services throughout Kenya;
g) Ensure equitable sharing of national and local resources targeting health delivery throughout
Kenya;
h) Enhance capacities of the two levels of governments to effectively deliver health service in
accordance with their respective mandates.

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

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

1.5 The Policy development process
The Kenya Health Policy, 2012 – 2030 was developed through an evidence-based and consultative
process under the stewardship of the national government, over a period of two years. Various
stakeholders in healthcare in Kenya contributed to the process, who included relevant government
ministries, departments and agencies, county governments, as well as constitutional bodies. Other
stakeholders who participated in the process included multilateral and bilateral development partners
and implementing partners from faith-based organizations, the private sector, and the civil society.
The definition and development of the policy objectives and policy orientations was based on a
comprehensive analysis of the status, trends and achievement of health goals in the country during the
implementation of the previous policy framework of 1994-2010. The outputs from these processes are
available as background information to this policy.1,2

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Chapter 2: Situation Analysis

A comprehensive review of the 1994 – 2010 Kenya Health Policy Framework was undertaken to obtain a deeper understanding of the challenges affecting the health sector, the existing opportunities and to define the interventions needed to improve health status in Kenya. Using the results of this review, this chapter highlights the progress made in the overall health of the country. To help in understanding the health patterns, it summarizes the situation regarding progress in (a) overall health status; (b) investment made in health and (c) implementation of planned interventions. Based on these, the chapter outlines future trends in disease burden in the country up to 2030.

2.1 Overall Health Profile

Life expectancy (LE) at birth in Kenya dropped to a low of 45.2 years during the earlier years of the 1994–2010 policy period, but was estimated to have risen to 60 years by 2009.3. Towards the end of the last policy period, some evidence of improvements in indicators for specific age cohorts emerged, particularly in adult, infant, and child health. However, there was observed stagnation and even worsening of some of the health indicators especially in neonatal and maternal health (see Figure 1).

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

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

3 WHO 2010 World Health Statistics.
Table 1. Leading Causes of Death and Disability in Kenya, 2009

<table>
<thead>
<tr>
<th>Causes of death</th>
<th>% total deaths</th>
<th>Causes of disability</th>
<th>% total DALYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ran k</td>
<td>Disease or injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>HIV/AIDS</td>
<td>29.3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Conditions arising during perinatal period</td>
<td>9.0</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Lower respiratory infections</td>
<td>8.1</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Tuberculosis</td>
<td>6.3</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Diarrhoeal diseases</td>
<td>6.0</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>Malaria</td>
<td>5.8</td>
<td>7</td>
</tr>
<tr>
<td>7</td>
<td>Cerebrovascular disease</td>
<td>3.3</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>Ischemic heart disease</td>
<td>2.8</td>
<td>9</td>
</tr>
<tr>
<td>9</td>
<td>Road traffic accidents</td>
<td>1.9</td>
<td>10</td>
</tr>
</tbody>
</table>

DALY’s = Disability Adjusted Life Years – Time lost due to incapacity arising from ill health

This trend in health status has been because of a number of contextual factors. The population growth rate has remained high (2.4% annual growth rate), with a high young and dependent population that is increasingly urbanized. Although the period under review showed improvements in GDP and reduction in population living in absolute poverty, especially in urban areas, absolute poverty levels still remained very high (46%). Literacy levels remained good at 78.1%, though inequities in age and geographical distribution persist. Gender disparities too were significant, although there were improvements particularly after 2003, a reflection of better opportunities for women. However, disparities between regions persist, with the GDI ranging from 0.628 (Central region) to 0.401 (Arid/Semi-Arid Lands). 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 continue to be reported in urban areas, particularly in the informal settlements.

2.2 Progress in Overall Health Status

2.2.1 Status of key health indicators

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

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

Specific interventions were also introduced to address the high burden due to specific diseases such as HIV/AIDS, Tuberculosis (TB) and Malaria. Notably, HIV/AIDS control and management showed progress, with evidence of declining incidence, prevalence and mortality. However, differences in coverage of interventions with regard to age, sex, and geographical location persist. Although efforts to control TB were hampered by the HIV epidemic, there was some improvements on some key indicators such as Case Notification, Case Detection, and Treatment Successes. However, the emergence of drug resistant TB since 2005, particularly in males, is a key challenge. There was also evidence of reduction in malaria-related mortality attributed to the scaling up of effective interventions, such as Insecticide Treated Nets (ITN); Intermittent Prophylaxis Treatment; (IPTp) and Inside Residual Spraying (IRS). High coverage of interventions addressing Neglected Tropical Diseases has also been achieved, although they still exist among different populations in the country.
Non-communicable conditions represent an increasingly significant burden of ill health and death in the country and include cardiovascular diseases, cancers, respiratory diseases, digestive diseases, psychiatric conditions, congenital anomalies, amongst others. They represented 50 – 70% of all hospital admissions during the previous policy period and up to half of all inpatient mortality. There is no evidence of reductions in these trends. Finally, injuries and violence were high, mainly affecting the productive and young population, with their mortality levels increasing over the years.

### 2.2.2 Risk factors to health

Risk factors to good health in Kenya include unsafe sex⁴, suboptimal breastfeeding, alcohol and tobacco use, obesity and physical inactivity, amongst others, as illustrated in the Table 2:

#### Table 2: Leading risk factors and contribution to mortality and morbidity, 2009

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

Available evidence suggests that there have been reductions in unsafe sexual practices, with people increasingly embracing safer sex, which can be attributed to steady improvements in knowledge and attitudes regarding sexually transmitted infections and conditions. Breastfeeding practices have also improved, with exclusive breastfeeding for up to five (5) months showing significant improvement. Tobacco use remains high, particularly among the productive populations in urban areas and among males. Evidence shows that one in five males between 18 – 29 years and one in two males between 40 – 49 years use tobacco products. The same pattern is seen in the use of alcohol products, especially the impure alcohol products mainly found in the rural areas and urban slums. Cases of alcohol poisoning were reported during the previous policy period, and over 2% of all deaths in the country were attributed to alcohol use. Other health problems that appear to be gaining ground include obesity. It is estimated that 25% of all persons in Kenya are overweight or obese, with the prevalence being highest among women in their mid to late 40s and in urban areas.

### 2.2.3 Social determinants of health

Other health determinants include maternal education, nutrition, safe water, adequate sanitation and proper housing among others. Maternal education has a strong correlation with a child’s health and survival. In Kenya, there have been improvements in maternal education over the years, with declines in the numbers of women with no education and increases in those with secondary or higher education. However, progress towards improved child nutrition has stagnated. Even though there have been improvements in acute nutrition deficiencies, such as underweight indicators in children under five (5), not much improvement has seen in the prevalence of more chronic under-nutrition variables, such as stunting and wasting. Additionally, undernourished children, both acute and chronic, are seen more in urban compared rural areas in the country.

The nutrition status of women has also shown stagnating patterns, and up to 1%, and 12% of adult women are stunted and having unacceptably low body mass index (BMI) respectively. While under-nutrition is higher amongst women aged 15 – 19 years and in rural areas of the country, obesity is higher in urban areas, currently affecting half of all women in Nairobi. There were improvements in

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⁴Unsafe sex leads to many conditions affecting Health, such as HIV, reproductive tract cancers / conditions and other Sexually Transmitted Infections, unwanted pregnancies, psychosocial conditions, amongst others.
availability of safe water sources and sanitation facilities particularly in rural areas, although some regions such as arid and semi-arid areas still have poor services. Housing conditions have been improving, with a notable increase in households using permanent roofing, and a decrease in households using earth floors. The proportion of population in active employment has stagnated / reduced, and there has been an associated increase in the proportion of inactive population. Finally, migration from rural to urban areas, most noted among people aged 20 – 34 years, has contributed to an increase in urban population, fueling an increase in urban informal settlements in the country, and their associated health risks.

2.3 Health investments

Overall health system expenditure has significantly increased in nominal terms, from 17 US$ per capita, to an estimated 40US$ per capita over the implementation period of the previous policy. This increase was primarily driven by increases in government and donor resources. The proportion of household expenditures (out of pocket) reduced from 51% of the total health expenditure in 2001/02 to 36% in 2009/10. However, there was no significant increase in health system resources. Health expenditures as a proportion of GDP, and public expenditures as a proportion of general government expenditures remained stagnant during the period. There was evidence of improving fairness in financing of health care, with higher contributions recorded amongst the better off individuals, and about 17% of the total population had financial risk protection by the end of the policy period.

Figure 2: Overall health expenditure trends: 2001-2010

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

In terms of actual expenditures, there was a limited real improvement in human resources for health and infrastructure during the previous policy period. While the actual numbers of these investments improved, the numbers per person stagnated or reduced, reflecting the stagnation of real resources for health. Improvements in real terms are only notable in the last two (2) years of the policy period (2009 and 2010).

2.4 County-specific trends in human resources and infrastructure

Trends in human resources and selected infrastructure by county at the beginning of this policy are illustrated in the following charts (source: SARAM report 2013).
Figure 3: County Health Facility density, per 10,000 populations

Figure 4: Ambulances per 100,000 population across counties

Figure 5: Total health staff per 10,000 population, by County
2.5 Progress in implementation of planned interventions
The previous policy framework included interventions under seven policy imperatives, and a comprehensive reform agenda. Overall, the progress made against the planned interventions is mixed, as detailed in the following sections.

2.5.1 Policy Imperative: Ensure equitable allocation of government resources to reduce disparities in health status
A comprehensive bottom-up planning process was instituted in the second half of the policy period. However, other systemic issues, such as actual capacity to implement priorities, affected the prioritization process. As a result, the interventions chosen did not necessarily lead to equitable access to essential curative and preventive services. Additionally, the poor information on resources available made it difficult to link the micro-economic framework with the epidemiological information for a rational planning framework. Criterion was not established for geographic allocation of resources. Nevertheless, a standard resource allocation criterion for district hospitals and rural health facilities (health centers and dispensaries) was in use, but for only operations and maintenance. The norms and standards for health service delivery, which include human resource, equipment and infrastructure, were developed but were 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 experience with the pull system that was based on special drawing rights of pharmaceuticals and medical supplies from the Kenya Medical Supplies Agency.

2.5.2 Policy Imperative: Increase the cost effectiveness and cost efficiency of resource allocation and use
Burden of disease and cost effectiveness analyses were not entirely applied to determine priority interventions, but as well 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, which was also partially taken into consideration in setting priorities. While norms and standards defining the appropriate mix of personnel and operations and maintenance inputs at all levels were in place, these were not utilized to ensure cost efficiency. Additionally, the health sector was not able to define and use unit costs for service delivery in priority setting.

2.5.3 Policy Imperative: Continue to manage population growth
Reproductive health services were strengthened across the country, and improvements achieved in availability and range of modern contraceptives available to users, resulting to gradual increase in contraceptive prevalence rates as shown in the following figure.

Figure 6: Trends in contraceptive use rate among married women

* Data from the first five sources omit several northern districts, while the 2003 and 2005-09 K DHS surveys represent the entire country.
There were improvements in maternal education and advocacy efforts, which led to improvements in services delivery. Information, education and communication (IEC) materials and strategies were developed throughout the policy period, facilitating dissemination of the family planning messages. There was also community involvement in the advocacy and dissemination of information, leading to increased access, availability and uptake of the services. This resulted in a drop in the fertility rates in most regions of the country for some time before stagnating.

Efforts were made to raise awareness on sexual and reproductive health amongst the youth and a strategy put in place to roll out youth friendly services in health facilities, aimed at reducing unwanted teenage pregnancies.

2.5.4 Policy Imperative: Enhance the regulatory role of government in all aspects of health care provision

Measures were put in place to devolve management decision making to provinces and districts and leave central level in charge of policy functions, although their impact was limited due to the lack of a legal framework and weak management capacity in the devolved units. The passing of the new Constitution in 2010 finally embedded this in law, although the Public Health Act has not been amended to reflect the stewardship role of the government in the current health delivery environment.

The national level and sub-national level regulatory boards were strengthened to improve their capacity to deliver. Gradual decentralization of the management and control of resources to lower level institutions was initiated through the Health Sector Services Fund.

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

With the formalization of the Kenya Health SWAp process in 2006, a framework for sector coordination and partnership was established. Necessary instruments were defined based on Memoranda of Understanding to guide this dialogue and collaboration. In addition, 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 seconds critical public health staff to non-state facilities in specific cases especially in underserved areas. However, the key beneficiaries of these initiatives have been faith-based health services providers, and not the private for profit providers who account for a significant proportion of health service providers. Collaboration with private for profit actors, and traditional practitioners is still weak. The government has also begun facilitating provision of health promotion and targeted disease prevention and curative services through community-based initiatives as defined in the 2007 Comprehensive Community Health Strategy (MOH 2006).

2.5.7 Policy Imperative: Increase and diversify per capita financial flows to the health sector

The health sector was not able to expand the budgetary allocations, in real terms, to healthcare. However, strategies were put in place to influence resource allocation, 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 Package (ESP) in 2009. These increases are nominal, not real, and represent a shift in total sector financing away from government and households, towards donors.

There was also a relative increase in finances for preventive and promotive healthcare, as a proportion of recurrent versus development expenditures, implying less investment in real terms for medical care (see Figure 7). The result of this weak financing means that the opportunity cost of new programs was high – with common programs having less financing. Nevertheless, the financing of health services has increasingly become progressive. The National Hospital Insurance Fund has been transformed into a state corporation aimed at improving effectiveness and efficiency in health
financing. It has expanded its benefits package to include more clinical services, and preventive and promotive services.

Provision of insurance services has also expanded, with increases in the numbers of firms and the people covered. However, insurance coverage has remained limited to urban areas and to formal sector employees. The 10/20 policy on cost-sharing introduced in 2004 reduced the contributions of users of facilities to a token amount in dispensaries and health centers. Further, exemptions for user fees was introduced for some specific health services, including treatment of children less than 5 years, maternity services in dispensaries and health centers, TB treatment in public health facilities, and immunization services. Although this has significantly improved financial access to services, it has greatly reduced the amounts of resources mobilized through user fees. Community based health financing initiatives have not been applied effectively in the country, in spite of the existence of a relatively strong community-based Savings and Credit Cooperative Organization (SACCO) system that would have acted as a backbone for community-based insurance initiatives.

2.5.8 Policy Imperative: Implementation of the reform agenda
A number of reform initiatives were undertaken in the policy period, although they achieved mixed results:

i. Strengthening the capacity of the Ministry of Health, especially 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, outreaches, or community based services, though their application has been limited to some areas and programs;

iv. Sub-national management functions have been strengthened to allow them to better facilitate and supervise service delivery, though this mandate has been exercised differently in the various provinces/regions, and districts;

v. New statutes, laws, and policies guiding different aspects of the health sector have been introduced, though done in an uncoordinated manner and no update of existing laws undertaken;

vi. The sector has made some efforts to develop a health financing strategy to guide its resource rationalization, and mobilization approaches;
vii. The human resource component has been strengthened through staff redistribution; increase in numbers and review of management structures of application of norms and standards, as well as motivation of existing staff. The sector does not also have an investment plan to guide the distribution and improvement of health infrastructure, leading to low investments for both new and existing infrastructure.

viii. HIV/AIDS and other STIs control is now coordinated through a semi-autonomous institution – the National AIDS Control Council (NACC) – and was managed through a different line ministry from the ministry responsible for health. 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 Ministry of Health.

ix. While an explicit National Drug Policy existed, its implementation during the policy period was slow and only a fraction of the steps set out were realized. Some of the notable achievements include improvement in commodity management, harmonization of centralized procurement, warehousing and distribution mechanisms through Kenya Medical Supplies Agency (KEMSA). An Essential Medicines List had been available, although adherence to its use has been poor. Attempts to introduce a demand-driven procurement system were instituted, and there is evidence that it led to better availability of the required commodities in the public health facilities.

x. Health Management and Information System architecture has improved information completeness. However, the information collected is still limited to a few conditions, and there are weaknesses in its completeness and quality. Additionally, information analysis, dissemination and use is not well entrenched in the sector. The use of information sources beyond routine health management information remains weak.

xi. Cost containment and control strategies have not been wholly applied in the sector. Cost information is missing, and expenditure review data and recommendations are not applied. Strategies to contract health services by providers were not employed as a means of cost control.

xii. There has been an increase in the amount and scope of systems, clinical and biomedical research and a number of operational decisions have been effected as a result of some of these studies. However, there is little collaboration amongst different research institutions, and poor linkage between research and policy.

xiii. The decentralization of functions of the Ministry of Health to the provinces/regions and districts has not taken place as anticipated. The central level had instead expanded, as more vertical programs were established, necessitating more program management units. However, this is expected to change with the implementation of the new constitution.

2.6 Overall performance in Country commitments

From the situation analysis, it is evident that progress towards attaining the stated health goals achieved mixed results. Notably, there has been slow progress towards attaining its commitments to Millennium Development Goals5 (MDG) 1 (eradicate extreme poverty and hunger), 4 (reduce child mortality rates) and 6 (combat HIV, malaria, and other diseases). There has been no progress towards MDG 5 (improve maternal health), and limited progress towards meeting the obligations in the African Union Maputo Plan of Action6, which aimed to reduce poverty levels.

Regarding investments in health, there has been limited increase in financing. Although the Paris Declaration on Aid Effectiveness7 was prioritized, the implementation of the principles has remained poor. In addition, limited progress has been made towards achieving commitments of the Abuja Declaration, in which countries committed to spend at least 15% of their public expenditures on health.

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5 United Nations Millennium Summit, 2000
6 African Union Commission, 2006, Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action)
7 OECD, 2005, Paris Declaration on Aid Effectiveness
PART 2:
POLICY DIRECTIONS
Chapter 3: Policy Framework

This section provides the policy directions that will guide the health sector towards the realization of better health desired by Kenyans over the long term. These policy directions declare the policy goal; list the policy objectives and spell out the appropriate policy actions areas to be applied during the policy period. The settings and the underlying policy framework to anchor these policy directions is laid out in Chapter 4.

3.1 Policy projections

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

The current total annual mortality is estimated at approximately 420,000 persons, out of which 270,000 (64%), 110,000 (26%) and 40,000 (10%) are due to communicable, non-communicable, and injury conditions respectively. As interventions to address communicable conditions reach maturity and attain sustained universal coverage, projections show that there will be reductions in this category of disease burden, although these reductions will be slow due to the high populations facilitating communicable disease transmission.

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

Figure 8: Health projections: 2011 – 2030

a) By disease domain

b) by disease condition

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8The existing policy directions and interventions that this Kenya Policy 2012-2030 aims to change
Current efforts to tackle malaria, TB and HIV should bear fruits in the short- and medium-term. Their contribution to the overall disease burden should reduce significantly. However, other dormant or emerging conditions will continue to contribute immensely to the overall disease burden, and thus cancel out any gains made through existing interventions on communicable diseases.

This Health Policy therefore intends to ensure significant reduction in the general ill health in the Kenyan population by guaranteeing reductions in deaths due to communicable diseases by at least 48%, 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% reduction in the absolute numbers of deaths in the country, as opposed to only 14% reduction. This target corresponds well with current mortality trends in middle-income countries. The WHO’s 2008 Global Burden of Disease estimates suggest a 0.68% mortality rate in a representative group of middle income countries (Argentina, Brazil, Indonesia, and Egypt) as compared to the 0.94% mortality rate for Kenya (27% difference).

This level of mortality in 2030 would represent a 50% reduction in overall deaths, per 1,000 persons, when the population estimates are taken into consideration, translating to a reduction of 62% for communicable conditions, 27% for non-communicable conditions, and 27% for violence/injuries (see Table 3).

Table 3: Absolute and relative mortality targets for Kenya, 2010-2030

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

The scenarios and outcomes anticipated above 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

Figure 6 shows the various components and elements of the Policy Framework and illustrates how they interact. Led by the Ministry of Health, the health sector will adopt the framework to address the prevailing and emerging health challenges that the country is facing. Figure 6 shows how high-priority policy investment areas (policy orientations) will operate to influence outcomes (policy objectives). It also delineates linkages among relevant contextual (environmental) factors that play a role in reaching specific policy goals.

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

Figure 9: Policy Framework for Health: Orientations, Principles Objectives and Goal

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

The policy objectives define the sector intent relating to the desired health outcomes needed to facilitate attainment of the overall goal. These relate to health services (both population focused public health services and person focused - medical services), risk factors and behavior change objectives, and health related sector objectives.

The policy strategies, that result to Outputs in the above diagram, are the key areas of intervention that will be focused on to attain the policy objectives. These relate to improving access, demand and quality of care. The policy principles are the parameters for consideration that will guide future sector investments.
The **policy orientations** define the sector intent relating to investments to be made, which will facilitate attainment of the policy objectives. They relate to leadership / governance, health workforce, health products, health infrastructure, health financing, and service delivery systems. Their effectiveness is measured in terms of improvements in *health outputs*, relating to better access to care, improved quality of care, and demand for care. Prioritization of investments in each policy orientation will be informed by a set of *policy principles*.

Each of the policy objectives and orientations are not mutually exclusive, and must be addressed from a synergistic viewpoint – investments in each are dependent on investments in others in order to support attainment of the policy goal.
Chapter 4: Policy Goal and Objectives

This section defines the health goal of the policy and describes the six key policy objectives that must be met to achieve that goal.

4.1 Policy goal

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

The policy aims to achieve this goal through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. It is designed to focus on the primary health care approach, which remains the most efficient and cost-effective way to organize a health system.

The target of the policy is to attain a level of health that is commensurate with that of a middle-income country. This would call for attainment of the following targets.

Table 4: Kenya Health Policy targets

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

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

(i) **Progressive realization of the right to health:** The policy aims to attain the right to health as outlined in the Constitution of Kenya 2010. To attain this, the policy seeks to employ a human rights based approach in health care delivery. This means that the policy will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programs. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all. During this policy period a basic minimum health and expandable package, Kenya Essential Health Package (KEPH), detailing what every person is entitled to will be defined and provided to all Kenyans. Other health systems investments will be strengthened to ensure progressive realization of rights to health across the country.

(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. This will be through the provision of high quality health services with a view to maintain a healthy productive population able to deliver the development agenda.

4.2 Policy objectives relating to service outcomes

The main objective of this policy is to attain universal coverage of critical services that positively contribute to the realization of the policy goal. Six policy objectives, which address the current situation, are therefore defined.

Policy Objective 1: Eliminate communicable conditions

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

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

11 Average values for Argentina, Brazil, Egypt, and Indonesia taken as representative of Middle Income Countries, to provide the target Kenya will aim to achieve
This aims to reduce the burden of communicable diseases, until they are not a major public health concern. The priority policy strategies include:

i. Attain universal access to preventive health services addressing major causes of the disease burden due to communicable conditions;
ii. Ensure quality of care in provision of the preventive and promotive services addressing major causes of the burden due to communicable conditions;
iii. Put in place interventions directly addressing marginalized and indigent populations affected by communicable conditions;
iv. Enhance comprehensive control of communicable diseases by designing and applying integrated health service provision tools, mechanisms and processes.

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

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

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

Policy Objective 3: Reduce the burden of violence and injuries

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

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

Policy Objective 4: Provide essential health care

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

i. Scale up physical access to person-centered health care by prioritizing solutions targeting hard to reach, or vulnerable populations;
ii. Ensure provision of quality health care, as defined in the norms and standards and guidelines, and by users;
iii. Ensure free access to trauma care, critical care, emergency care and disaster care services;
iv. Promote medical tourism as a means to ensure availability of high quality care in the country.

Policy Objective 5: Minimize exposure to health risk factors
This will be achieved by strengthening the health promoting interventions, which address risk factors to health, and facilitating use of products and services that lead to healthy behaviors in the population. At the beginning of the policy period, the key policy strategies that will be employed to achieve these include:

i. Reduce unsafe sexual practices, particularly amongst high risk groups;

ii. Mitigate the negative health, social and economic impact resulting from the excessive consumption and adulteration of alcoholic products;

iii. Reduce the prevalence of tobacco use and exposure to tobacco smoke and other harmful addictive substances;

iv. Institute population-based, multisectoral, multidisciplinary, and culturally relevant approaches to promoting physical activity;

v. Strengthen mechanisms for screening and management of conditions arising from health risk factors at all levels;

vi. Increase collaboration with research based organizations and institutions.

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

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

i. **Economic growth and employment**: ensure that work and stable employment and entrepreneurship opportunities are available for all people;

ii. **Security and justice**: ensure enhanced security and fair justice system important in managing access to food, water and sanitation, housing, employment opportunities, and other determinants of wellbeing;

iii. **Education and early life**: enhance education of both women and men to promote their abilities to address challenges relating to health;

iv. **Agriculture and food**: promote considerations of safety in food production systems, manufacturing, marketing and distribution;

v. **Nutrition**: ensure adequate nutrition for the whole population through promotion of proper nutrition practices;

vi. **Infrastructure, planning and transport**: encourage proper planning of roads, transport system and housing with a view to facilitate movements of people, goods and services;

vii. **Environments and sustainability**: influence population consumption patterns of natural resources in a manner that minimizes adverse impact on health;

viii. **Housing**: promote housing designs and infrastructure planning that take into account health and wellbeing;

ix. **Land and culture**: strengthen access to land and other culturally important resources by particularly women;

x. **Population**: manage population growth and urbanization implications, including rural to urban migration.
Chapter 5: Policy Principles and Orientations

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

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

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

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

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

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

5.1.6 Social accountability
This will entail reporting on performance, creation of public awareness, fostering transparency and public participations in decision making on health related matters.
5.2 Policy Orientations relating to investment areas

These define ‘how’ the health sector will organize itself to facilitate attainment of the above objectives. There are seven orientations, relating to areas where investments need to be made to facilitate attainment of the policy objectives:

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, analysis, dissemination, and utilization of health related information required for provision of services;

vii. **Health Infrastructure**: Physical infrastructure, equipment, transport, and Information Communication Technology needed for provision of services

5.2.1 Policy orientation 1: Organization of Service Delivery

This relates to how the delivery of health and related services are organized to create an efficient service delivery system that maximizes health outcomes and aspires to ensure improved access, quality and demand for health services. Specific aspirations related to the three output areas are outlined below;

**Policy aspirations in relation to improving access to services:**

a) All persons shall have adequate physical access to health and related services. This is described 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 shall be minimized / removed for all persons requiring health and related services
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 aspirations in relation to improving quality of care:

a) Clients / 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 assures patient / client safety – potential harm as a result of using services should be anticipated and mitigated against
c) The health and related services provided shall be of the most effective as is feasibly possible

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

a) Clients / patients shall have adequate awareness of health actions needed to maximize their health
b) Clients / patients shall practice appropriate health seeking behaviors when there exist threats to their health

The sector shall focus and invest on the five areas shown below:

**Table 5: Areas of intervention in Organization of Service Delivery**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Description</th>
<th>Scope and focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization of the health service package</td>
<td>What the services that will be provided are, and their linkages</td>
<td>Identification, and monitoring of the health interventions to be provided</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organization of interventions by life cohorts and service areas</td>
</tr>
<tr>
<td>Organization of the health system</td>
<td>How the health system is to be structured to deliver desired services</td>
<td>Levels of care for provision of services</td>
</tr>
<tr>
<td>Organization of the community services</td>
<td>How communities are able to engage in improving their health</td>
<td>Comprehensive community strategy to build demand for services through improving community awareness and health seeking behaviours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program targeted community services to improve supply of services by taking services to the community</td>
</tr>
<tr>
<td>Organization of the facility services</td>
<td>How the facility organizes itself internally, to provide and manage care delivery.</td>
<td>Micro-planning for service delivery to reach under-served communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Epidemic preparedness &amp; planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapeutics management and monitoring</td>
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<tr>
<td></td>
<td></td>
<td>Patient safety initiatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developing long term facility master plans for long term development</td>
</tr>
<tr>
<td>Organization of emergency and referral Services</td>
<td>How services are planned, and delivered across different types of facilities. The focus is on ensuring holistic delivery of services.</td>
<td>Physical client Movement (physical referral)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient Parameters movement (e-health)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specimen movement (reverse cold chain, and reference laboratory system)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expertise movement (reverse referral)</td>
</tr>
<tr>
<td>Organization of outreach services</td>
<td>How services (preventive and curative) are supplied to communities, as per their needs.</td>
<td>Outreaches by facilities to under-served communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mobile clinics in hard to reach areas</td>
</tr>
<tr>
<td>Organization of supervision &amp; mentorship services</td>
<td>How health workers are mentored and supported to continually improve their skills and expertise in providing quality services</td>
<td>Integrated supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency supervision</td>
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<tr>
<td></td>
<td></td>
<td>Technical supervision</td>
</tr>
</tbody>
</table>

i. **Organization of the health service package**
This relates to the comprehensive description of services and their interventions that will be provided each 5 years – in line with the requirements of the bill of rights in the constitution. A service package shall be defined each 5 years, constituting the following elements:

a) The six life cycle cohorts for which services are to be provided:
   1. Pregnancy, delivery and the newborn child (up to 28 weeks of age)
   2. Early childhood (up to 5 years)
   3. Late childhood (6 to 12 years)
   4. Adolescence and youth (13 to 24 years)
   5. Adulthood (25 to 59 years)
   6. Elderly (60 years and over)

b) The program areas that will be prioritized during the given 5 years. These are 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 5 years, for each service area. Interventions are comprehensive, reflecting the broad scope required for addressing the health needs.

e) The coverage targets that need to be attained for each intervention area

**Organization of the health system**

This shall be based on a four-tier system: community, primary care, primary 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.

a) The *community services* will comprise of all community based demand creation activities organized around the Comprehensive Community Strategy defined by the Health Sector;

b) The *primary care services* will comprise all dispensaries, health centers and maternity homes of both public and private providers. Their capacity will be upgraded to ensure they can all provide appropriate demanded services;

c) The *county referral services* will include hospitals operating in, and managed by a given county. This is made up of all the former level 4 and level 5 hospitals in the county – government, and private. Together, all these hospitals in a given county form the County Referral System, with specific services shared amongst the existing County Referral facilities to form a virtual network of comprehensive services;

d) The *national referral services* will include the service units providing tertiary / highly specialized services including high level specialist medical care, laboratory support, blood product services, and research. The units include national level semi-autonomous agencies, and shall operate under a defined level of self autonomy from the National Health Ministry, allowing for self governance.

Levels of care shall be defined every 5 years, with the sector progressively moving from the six levels of care, towards four levels corresponding to the tiers of care shown on the following table.

**Table 6: Tiers and levels of care**

<table>
<thead>
<tr>
<th>Policy tiers of care</th>
<th>Corresponding levels of care, at beginning of policy</th>
<th>Desired levels of care, by end of policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Community</td>
<td>Level 1: Community</td>
<td>Level 1: Community</td>
</tr>
<tr>
<td>Tier 2: Primary care</td>
<td>Level 2: Dispensary / clinics Level 3: Health Centres</td>
<td>Level 2: Primary care facilities</td>
</tr>
<tr>
<td>Tier 3: Primary referral</td>
<td>Level 4: primary care hospitals Level 5: Secondary care hospitals</td>
<td>Level 3: County hospitals</td>
</tr>
<tr>
<td>Tier 4: Secondary/tertiary referral</td>
<td>Level 6: Tertiary care hospitals</td>
<td>Level 4: Regional &amp; National referral hospitals</td>
</tr>
</tbody>
</table>
iii. **Organization of community services**

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

a) Interventions focusing on building demand for existing health and related services, by improving community awareness and health seeking behaviors, &

b) Taking defined Interventions and services closer to the clients / households

iv. **Organization of the facility services**

Each health facility shall organize, and manage delivery of expected services based on its level. This constitutes the following areas:

a) Micro planning for service delivery to reach under-served communities

b) Epidemic preparedness and planning
c) Therapeutics management and monitoring
d) Long term facility development planning
e) Patient safety monitoring and initiatives

v. **Organization of emergency and referral services**
This is to ensure clients receive the benefits of care available in the health system, irrespective of where they access care 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). The referral services shall cover four elements:
   a) Physical client movement (physical referral)
   b) Patient parameters movement using e-health initiatives
   c) Specimen movement, through assuring a reverse cold chain, and reference laboratory system,
   d) Expertise movement through reverse referral

vi. **Organization of outreach services**
This relates to how health and related services are brought closer to the clients as per their needs. It shall involve two elements:
   a) How services are taken to under-served areas in the jurisdiction of a facility,
   b) Establishment and management of mobile clinics in hard to reach areas

vii. **Organization of supervision and mentorship services**
This relates to how health workers are mentored and supported to continually improve their skills and expertise in providing services. The process constitutes:
   a) Integrated supervisions
   b) Emergency supervisions
   c) Technical supervisions

5.2.2 **Policy orientation 2: Health Leadership and governance**
This relates to how the oversight of delivery of health and related services shall be provided. The policy aspiration is for a comprehensive leadership that delivers on the health agenda.
   i. The sector shall focus on six areas in which it will make its investments, as shown below.
      ii. Management systems and functions;
      iii. Partnership and coordination of health care delivery;
      iv. Governance systems and functions;
      v. Engaging of public and private services providers;
      vi. Planning and monitoring systems and services;
      vii. Health regulatory framework and services.

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

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

ii. Ensuring functional partnership and coordination mechanism at each tier of the health system.
This will be premised on the five principles of Aid Effectiveness: Ownership, Alignment, Harmonization, Mutual Accountability, and Managing for Results. This shall bring together all stakeholders in the health sector at the respective levels, representing the recognized Health Sector constituencies of:
   a. The government: Including the ministry responsible for health, and the other health related ministries functioning at the respective tiers of service delivery;
   b. Development partners supporting health, and health related interventions;
   c. Non state Implementing partners providing health services.

iii. Ensuring functional Health governance and coordination mechanism at each tier of the health system.
The structure and functioning shall be guided by a defined legal framework.

iv. Provision of oversight for implementation of functionally integrated, pluralistic health system.
This will enable optimization of equitable use of available resources and investing in comparative advantages of implementing partners in delivering this Policy’s Objectives.

v. Putting in place means for engaging with health related actors.
This aims to ensure that the health related sectors are prioritizing investments in outcomes that have an impact on health.

vi. Jointly develop operational and strategic plans and undertake review processes.
These will be linked to the overall planning and review framework of the health sector and shall apply to all entities in the health sector.

vii. Providing oversight to regulate and assess standards and quality of services.
This will ensure that a defined level of quality of care is provided to the population.

viii. Comprehensive legal and regulatory framework that guides sector actions.
The legal and regulatory framework shall bring together, in a comprehensive manner, all the health and health related legislations required to guide the implementation of the policy orientations. The ministry responsible for health will also put in place measures to regulate traditional and complementary medicines. The overall legal framework to guide health is shown in Figure 12.

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12 2005 Paris Declaration on Aid Effectiveness
5.2.3 Policy orientation 3: Adequate and equitable distribution of Health workforce

This relates to the desired health workforce, for provision of health and related services. The policy aspiration is for adequate and equitable distribution of the health workforce. The health workforce constitutes those persons recruited primarily for health and related service provision and management, who have undergone a defined formally recognized training program.

Adequacy encompasses numbers, skills mix, competence, and attitudes of the health workforce required to deliver on the health goals. The sector shall focus on four areas in which it will make its investments:

i. Reviewing and applying evidence based health workforce norms and standards for the different tiers of services delivery;

ii. Facilitation of rational capacity development of the health workforce through alignment of curricula and training to needs based on above-mentioned policy objectives. This will ensure that health personnel interact in a professional, accountable and culturally sensitive way with clients. Promotion of multi-skilling and competences of the health workforce will also be enhanced;

iii. Improving management of the existing health workforce by putting in place attraction, retention and motivational mechanisms for the workforce especially in marginalized areas;

iv. Putting in place systems to measure performance and competencies of health workforce, informed by clients/consumers of the services.

5.2.4 Policy orientation 4: Health Financing

This relates to the process of mobilizing and managing required finances to ensure provision of health and related services. The policy aspiration is for adequate finances mobilized, efficiently allocated and utilized with social and financial risk protection assured.

This will be attained through ensuring equity, efficiency, transparency, and accountability in resource mobilization, allocation and use. Efforts will be made to progressively build a sustainable political,
national and community commitment with view of achieving and maintaining universal health coverage through increased and diversified domestic financing options. This will be through:

i. Establishing a national social health insurance mechanism that caters for employees, employers and the informal sector with a view to attain universal coverage;

ii. Designing harmonized and progressive resource mobilization strategies targeting all sources of funds, both domestic and international to progressively move towards a target of at least 15% of available funds allocated to health

iii. Strengthening programming of external funding of health through improved harmonization and alignment to sector priorities and improved reporting;

iv. Promoting community based health financing mechanisms;

v. Ensuring efficient allocation and utilization of resources;

vi. Progressively eliminating payment at the point of use of health services, especially by the marginalized and indigent populations;

vii. Periodically reviewing the criteria for resource allocation and purchasing mechanisms, taking into account national priorities and different sources of funds;

viii. Advocating for increased financing for health, and related sectors, to meet agreed benchmarks (national and international) and to ensure required interventions are implemented;

ix. Putting in place appropriate financing mechanisms for emergency health services;

x. Developing mechanisms that promote public private partnership in financing of health;

xi. Developing mechanisms that promote the role of private sector in financing of health.

5.2.5 Policy Orientation 5: Health Information

This relates to the process of generating, and managing information to guide evidence-based decision making in provision of health and related services. The policy aspiration is for adequate health information, for evidence-based decision making.

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

i. Harmonization of data collection, analysis, and dissemination mechanisms of state and non state actors through a legal framework;

ii. Continued strengthening of accuracy, timeliness, completeness of health information from population and health facilities;

iii. Comprehensive analysis of health information to inform decision making;

iv. Strengthening mechanisms for health information dissemination to ensure information is available where and when needed;

v. Establishing mechanisms to promote, coordinate, regulate, and ensure sustainability of health research and development;

vi. Putting in place health surveillance and response mechanisms.

5.2.6 Policy Orientation 6: Health products and technologies

This is to ensure that effective, safe, good quality, and affordable health products and technologies are available and rationally used at all times. The policy aspiration is for universal access to essential health products and technologies. This, the sector will attain through implementation of the following strategies:
i. **Defining and applying an evidence-based essential package of health products and technologies.**
   This shall be judiciously applied in the acquisition, financing and other access-enhancing interventions. It will incorporate national lists of essential medicines, health products and diagnostics; treatment protocols, and standardized equipment.

ii. **Establishing a national appraisal mechanism for health products and technologies.**
   This will provide guidance on the clinical and cost-effectiveness of new health products, technologies, clinical practices and interventional procedures.

iii. **Putting in place a harmonized national regulatory framework for health products and technologies.**
   This shall advance the quality, safety and efficacy/effectiveness based on sound science and evidence. The regulatory framework shall be autonomous in its operations and shall encompass human drugs; vaccines, blood and its products; diagnostics, medical devices and technologies; animal and veterinary drugs; food products, tobacco products, cosmetics and emerging health technologies.

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

v. **Have in place effective and reliable procurement and supply systems.**
   These shall leverage public and private investments to advance patient access to essential health products and technologies and deliver value-for-money across the system.

vi. **Promoting local production, research and innovations of essential health products and technologies.**
   This shall be in a manner that advances universal access and promotes national competitiveness.

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

5.2.7 **Policy Orientation 7: Health infrastructure**

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

i. Adopting evidence based health infrastructure investments, maintenance and replacement through utilization of norms and standards in line with government/institutions policies;

ii. Development of health infrastructure and maintenance master plans for all planning units in the sector;

iii. Investment in health infrastructure to increase access to health services;

iv. Providing the necessary logistical support, including transport, communication and IT, e-health, and medical devices to establish an appropriate and efficiently functioning referral system;

v. Promoting and increasing private sector investments in the provision of health services through infrastructure development;
vi. Development of guidelines for donations and purchase of vehicles, medical equipment and the disposal of the same;

vii. Strengthening the regulatory bodies to enforce health infrastructure standards;

viii. Development of specific policies for buildings, civil works and medical devices.

PART 3: POLICY IMPLEMENTATION
Chapter 6: Implementation Framework

Successful implementation of this policy will be dependent upon the collaborative efforts and synergies of all the stakeholders and actors through establishment of an effective partnership framework. Under the existing legal and other government policy frameworks, this policy will be implemented through health sector 5-year Health Sector Strategic Plans, multi-year National and County health Sectoral Plans and Annual Work Plans. Priority setting resource allocation and performance monitoring will be participatory. The Health Policy principles are applied here as they form the basis for defining the resource allocation criteria for the various health system investment areas. This enables a shift in the basis for prioritization of investments in diseases, to health system investment approach.

The following are the health sector actors and their respective roles in implementing this Policy:

6.1 Stakeholder roles

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

6.1.1 Clients/Consumers

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

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

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

6.1.2 Non-state actors

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

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

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

6.1.3 **State actors-including Semi-Autonomous Government Agencies**

**Inter-sectoral and inter-ministerial actors:** It is well recognized that improving the overall health status and well-being of the public depends on the synergistic functioning of the various sectors in the economy. For instance, the health status of the public would be dependent inter alia on adequate nutrition, safe drinking water, basic sanitation, a clean environment and primary education, especially for the vulnerable populations. The policies and the modes of functioning of these interdependent areas would necessarily interlink with each other to contribute to the health status of the individuals, communities and the general public. From the Policy perspective, it is therefore imperative that the independent policies of each of these inter-connected sectors be harmonized and the interface between the policies of the various sectors be smooth. To attain this, the ministry and county departments responsible for health shall take a lead role in advising, mobilizing and collaborating with other government ministries, departments and agencies.

6.2 **Institutional framework**

This Policy recognizes that coordination of service delivery in the health sector has in the previous policy period been done through a sector wide approach (SWAp), the Kenya Health SWAp (KHSWAp)\(^\text{13}\) that brings together all health stakeholders and is managed through partnership instrument, the Code of Conduct\(^\text{14}\). Governance structures and systems have also existed, through boards, at the respective service delivery levels (hospitals, and districts), including a common framework for planning and implementation.

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

i. Delivery of efficient, cost-effective and equitable health services;

ii. Devolution of health service delivery, administration and management to the community level;

iii. Stakeholder participation and accountability in health services delivery, administration and management;

iv. Operational autonomy;

v. Efficient and cost-effective monitoring, evaluation, reviewing and reporting systems;

vi. Smooth transition from the current to the proposed devolved arrangements; and

vii. Complementarity of efforts and interventions.

6.1.4 **National ministry responsible for health**

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

i. Developing national policy and legislation, standard setting and guidelines, national reporting, sector coordination and resource mobilization;

ii. Offering of National referral services

iii. Offering technical support with emphasis on planning, development and monitoring of health services and delivery standards throughout the country;


iv. Developing quality standards for provision of health services;
v. Providing policy framework on the setting of tariffs chargeable for the provisions of health services. Promoting mechanisms for improving administrative and management of health systems.

During the transition period (KHSSP 2013-2017), the national government shall support establishment of required capacities at the county level.

6.1.5 County departments responsible for health

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

i. County health facilities and pharmacies
ii. ambulance services
iii. promotion of primary health care
iv. licensing and control of undertakings that sell food to the public
v. veterinary services (excluding regulation of the health profession)
vi. Cemeteries, funeral parlors and crematoria and
vii. Refuse removal, refuse dumps and solid waste disposal.

In addition, county governments may be assigned other functions agreed upon during the intergovernmental consultative forums.

6.2.3 Technical management of health at the county level:

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

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

i. Delivering county-level health services;
ii. Licensing and accrediting non state health services providers;
iii. Financing of county level health services;
iv. Maintaining, enhancing and regulating asset development and health services providers’ operations;
v. Approving county special partnership agreements for county health services providers;
vi. In collaboration with national government, gazetting regulations for community managed health supplies to be implemented at county level;

vii. Undertaking planning, investment and asset ownership function of public health facilities;

viii. Developing an investment plan to enable fulfillment of the highest attainable right to health and document annual progress on fulfillment as required by the Constitution;

ix. Asset financing and ownership;

x. Channeling public and other funds to develop health facilities;

xi. Collecting and aggregating information at county level on implementation of projects in order to document value for money and progress in attainment of the rights;

xii. Providing a legal framework for lending arrangements to facilitate loan repayments and fees for use of assets by licensed health services providers.
Chapter 7: Monitoring and Evaluation

Fast tracking implementation of this policy is key to determining progress being made towards achievement of the policy goals. The attainment the policy goals have been disaggregated into financial and non-financial targets and indicators. These targets will reflect global commitments, health sector priorities elaborated in Vision 2030, the objectives contained in the subsequent Health Sector Strategic Plans and National and County Multi-Year Sectoral Plans. These plans will be implemented and monitored through annual work plans. The targets will be benchmarked with those of middle income countries across the globe.

7.1 Monitoring and Evaluation framework

This comprehensive Kenya Health Policy is an integral part of the overall Kenya Health Policy, Strategy and Planning Framework, as shown below in Figure 12.

Figure 13: Overarching planning and review framework for Kenya’s Health Policy

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

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

i. Medium term health and related services objectives and outcome (coverage) indicator targets for each of the six policy objectives, defined by the national government;

ii. Priority investments across the seven policy orientations required to attain the above-mentioned medium term health and related services objectives. Priority investments would be defined by the respective planning units (counties, SAGAs), to enable attainment of defined objectives and targets for the sector.

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

The program business plans reiterate these sector wide objectives around specific services (e.g. HIV, or Malaria), or systems (e.g. HRH, or health financing strategy) areas. As such, they are part of the National Health Sector Strategic Plan – their use is in laying particular emphasis on a given area. These program business plans at the national level are important in mobilizing resources for a given agenda, and as such focus efforts on accelerating its attainment.

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

i. Counties: as autonomous, decentralized management units that are able to plan and raise resources for defined services;

ii. Referral facilities: as critical service delivery units in counties and the national level (national referral facilities);

iii. Semi-Autonomous Government Agencies: as units defined to deliver specified services, with independent budgets.

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

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

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

7.2 Progress indicators

These are based on the respective domain areas. Indicators that will be used are shown in Table 7. Targets are based on the WHO statistics of the average value of four middle income countries – Argentina, Brazil, Egypt, and Indonesia.
### Table 7: Policy indicators and targets

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

*Source: Kenya Ministry of Health 2013*

Targets shall be measured in terms of absolute achievement and variation in achievement across the counties.
Chapter 8: Conclusion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Injury:** Physical damage to a person.

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

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

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

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

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

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

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

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

**Routine Health Services:** Health care services necessary to prevent and manage the damaging health effects from non emergency situations. It involves services across ALL aspects of health care services.
Trained Health professional (in the context of provision of legal termination of pregnancy): A health professional, with formal medical training at proficiency level of a Medical Officer (doctor), nurse midwife, or clinical officer who has been educated and trained to proficiency in the skills needed to manage uncomplicated abortion and post abortion care and in the identification, management and referral of abortion related complications in women and family. Such a health professional should have a valid license from the Medical and Dental practitioners Council to practice, and providing the service from a legally recognized health facility with an enabling environment consisting of the minimum human resources, infrastructure, commodities and supplies for the facility as defined in the health sector norms and standards.

Unsafe abortion: A procedure carried out by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both\textsuperscript{15}

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

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

Universal Health coverage: ensuring that everyone who needs health services is able to get them, without undue financial hardship\textsuperscript{16}


\textsuperscript{16} WORLD HEALTH ORGANIZATION (2010): The World Health Report - Health systems financing: the path to universal coverage