Government of Kenya

Reversing the trends

The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

ROADMAP for Acceleration of Implementation of Interventions to ACHIEVE OBJECTIVES of NHSSP II

Ministry of Health
December 2007

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Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya – Roadmap for Acceleration of Implementation of Interventions to Achieve Objectives of NHSSP II

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List of Abbreviations

AIDS	Acquired immune deficiency syndrome
AOP	Annual operational plan
BEOC	Basic essential obstetric care
CDF	Constituency Development Fund
CEOC	Comprehensive essential obstetric care
CE	Chief Economist
CFO	Chief Finance Officer
CHEW	Community Health Extension Worker
CHW	Community Health Worker
COC	Code of Conduct
CU	Community Unit
DANIDA	Danish Development Agency
DHMT	District Health management Team
DHRM	Department of Human Resource Management
DHS	Demographic and Health Survey
DMS	Director of Medical Services
DFID	Department for International Development
DP	Development partners
DRH	Division of Reproductive Health
EMS	Essential Medical Supplies
EDL	Essential drug list
GDC	German Development Cooperation
GDP	Gross domestic product
GOK	Government of Kenya
H/C&RS	Head, Curative and Rehabilitative Services
HENNET	Health Non-Governmental Organization Network
HIV	Human immuno-deficiency virus
HMIS	Health management information system
H/PPHS	Head, Preventive and Promotive Health Services
HR	Human resource
HRH	Human resource for health
HRM	Human resource management
H/SPMD	Head, Sector Planning and Monitoring Department
HSCC	Health Sector Coordinating Committee
HSSF	Health Sector Services Fund
ICC	Interagency Coordinating Committee
ICT	Information and communication technology
IDSR	Integrated Disease Surveillance and Response
IFMIS	Integrated financial management information system
IP	Implementing partner
ISO	International Standards Organization
IMR	Infant mortality rate
IPT	Intermittent presumptive treatment
ITN	Insecticide treated net
JFA	Joint Financing Agreement
JICA	Japanese International Cooperation Agency
JPWF	Joint Programme of Work and Funding
Ksh	Kenya shilling
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KHPF	Kenya Health Policy Framework
KHSWAp	Kenya Health Sector-Wide Approach
KNBS	Kenya National Bureau of Statistics
KSPA	Kenya Service Provision Assessment
MDGs	Millennium Development Goals
MEDS	Mission for Essential Drugs Supply
MMU	Ministerial Management Unit
MOH	Ministry of Health
M&E	Monitoring and evaluation
MTEF	Medium-term expenditure framework
MTCs	Medicines and Therapeutic Committees
MTR	Midterm review
NCDs	Non-communicable diseases
NGO	Non-governmental organization
NHA	National Health Accounts

NHISF	National Health Insurance Fund
NHSSP	National Health Sector Strategic Plan
NSHIF	National Social Health Insurance Fund
PAC	Principal Accounting Controller
PER	Public expenditure review
PETS	Public Expenditure Tracking Survey
PHMT	Provincial Health Management Team
PFM	Public financial management
PME	Performance-based monitoring and evaluation
PMIS	Procurement management Information system
RBM	Results based management
RH	Reproductive health
SWAp	Sector wide approach
SC	Service Charter
SOP	Standard operation procedure
TB	Tuberculosis
TCR	Treatment completion rate
TWG	Technical Working Group
UNFPA	United Nations Population Fund
US$	United States dollar
USG	United States government
WHO	World Health Organization
WB	World Bank

1: Introduction and **Background**

Recently the Government of Kenya initiated a Midterm Review (MTR)[1] of the implementation of the second National Health Sector Strategic Plan (NHSSP II – 2005–2010). The MTR report documents progress made in the implementation of NHSSP II, the outstanding challenges, constraints and recommendations for action. An independent external review team validated the MTR findings and provided a succinct set of recommendations on what needs to be done to address the current challenges in the health sector.

To take forward the MTR recommendations, the Ministry of Health and its stakeholders undertook a policy dialogue retreat in Mombasa in November 2007. The aim of the retreat was to identify and elaborate actions required to accelerate the implementation of the NHSSP II strategies based on the MTR recommendations. *The Roadmap for Acceleration of Implementation of Interventions to Achieve the Objectives of the NHSSP II* summarizes the MTR report and outlines the decisions agreed at the health sector policy dialogue. In addition it outlines the implementation matrix and the framework for monitoring the implementation of the recommended actions.

The purpose of this document is to:

- Provide an overview of the health sector performance and priority actions to be undertaken to remove the bottlenecks for attaining the NHSSP II objectives and the Millennium Development Goals related to health.
- Serve as the basis for allocation of resources in the second half of the NHSSP II implementation period.
- Provide a point of reference for monitoring the implementation of the MTR recommendations.

The five broad **policy objectives** of NHSSP II are to:

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

It should be emphasized that this document does not define the entire package of interventions that the health sector will be implementing and as such does not define the full investment for the health sector. The overall investment in the health sector will still be guided by existing sector plans (see Chapter 2).

It is also important to note that the MTR recommendations stress on processes as well as actions for accelerating implementation. The agreed implementation mechanisms focus on inclusiveness, coordination and accountability to address the challenges identified. This comes at a time of renewed international interest and commitment for better coordination, harmonization and alignment of inputs into the health sector to accelerate achievement of outcomes. Together with the Code of Conduct, this document also serves as Kenya's plan for the International Health Partnership.

[4] Ministry of Health, *NHSSP II Midterm Review Report*, 2007.

2: Synopsis of Key Documents

TheKenya Health Policy Framework (KHPF)[2] provides the overarching health policy imperatives for the country covering the period 1994–2010. These are:

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

To date two NHSSPs outlining the medium-term strategic objectives of the sector have been developed to support the implementation of the KHPF. By the end of 2004 it became clear that the implementation of NHSSP I had not led to improvements in most targets and indicators of health and socioeconomic development as expected. Health outcomes stagnated or worsened and utilization declined in an environment of decreasing per capita GOK allocation (from US$12/per person in 1990 to US$6/pp in 2002). Poverty levels went up from 47% in 1999 to 56% in 2002.

The second National Health Sector Strategic Plan II (NHSSP II)[3] covering the period 2005–2010 aimed to reverse the downward trend in health indicators by applying lessons learned and searching for innovative solutions. It is designed to re-invigorate the implementation of KHPF through:

The KEPH Life-Cycle Cohorts

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

- Increasing equitable access to health services;
- Improving service quality and responsiveness;
- Improving efficiency and effectiveness;
- Fostering partnership; and
- Improving financing of the health sector.

Implementation of NHSSP II has involved the introduction of the following three key strategies:

- ***Kenya Essential Package of Health (KEPH),***[4] with a human capital-based definition of essential packages. The KEPH constitutes a paradigm shift from the conventional "managing illness" approach to promoting healthy lifestyles. It defines the various services that need to be delivered for six different age cohorts (from birth to old age) and at each of the six levels of service delivery (Level 1: community, up to Level 6: Tertiary hospital; see Figure 2.1). It brought together the two apparently conflicting concepts of continuum of care – life cycles and service levels .

[2] Ministry of Health, 1994, *Kenya Policy Framework Paper, 1994-2010.* The policy framework paper is still valid and functional, but a new policy paper will be in place in 2010 together with NHSSP III.

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

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

[5] Ministry of Health, 2006, *Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LevelOne Services.* Four implementation tools have been developed since then and are in use.

The Community Strategy

Objective: The Community Strategy intends to improve the health status of Kenyan communities through the initiation and implementation of life-cycle focused health actions at level 1 by:

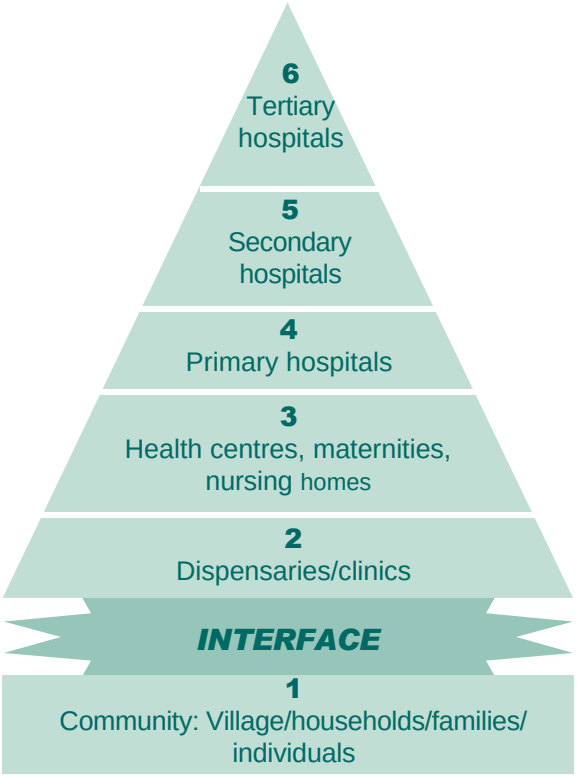
- Providing level 1 services for all cohorts and socioeconomic groups, including the "differently-abled" taking into account their needs and priorities.
- Building the capacity of Community Health Workers (CHWs) and community-owned resource persons (CORPs)to provide care at level 1.
- Strengthening health facility–community linkages through effective decentralization and partnership for the implementation of level 1 services.
- Strengthening the community to progressively realize their rights for accessible and quality care and to seek accountability from facility based health services.

Main innovations:

- Established norms for level 1services: One level 1 unit will serve 5,000 Kenyans and be manned by 50 CHWs and 2 Community Health Extension Workers (CHEWs): 1 CHW for 20–50 Households
- CHWs will work on voluntary basis with stipends paid to them.
- CHEWs will be on government payroll.
- Payment and control for both cadres will be through the health facility and village committees.
- A comprehensive message and commodity kits will be developed and used by CHWs.
- Provision of the commodity kit to manage minor illnesses.

- ***Community Health Strategy*** recognizing the community level as part of the formal health service delivery system. The MOH has developed a Community Strategy[5] to strengthen the interface between facility and community based health services and offer services at the community level (see box).

Figure 2.1: KEPH levels of care



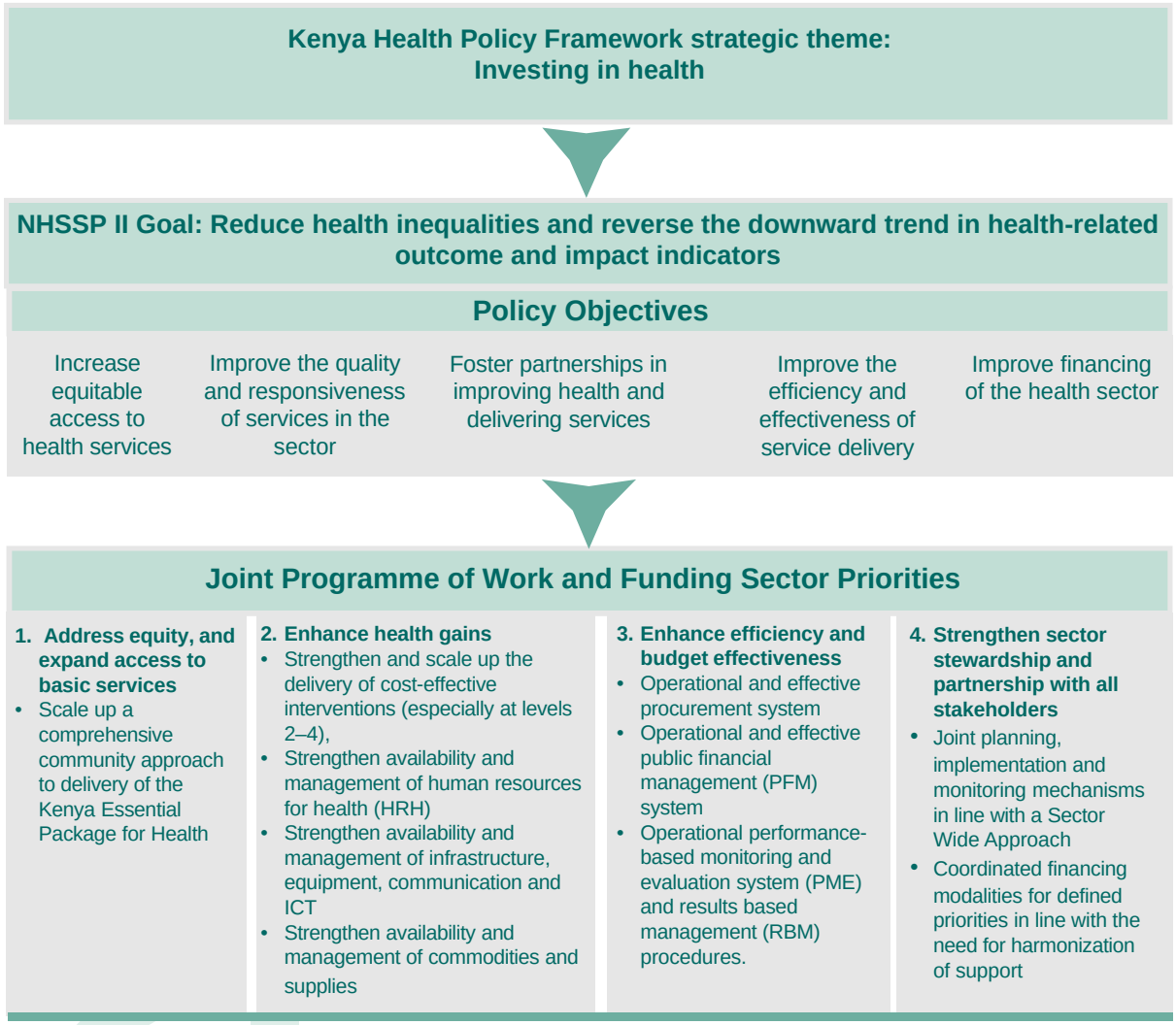
- ***Kenya Health Sector-Wide Approach (KHSWAp),*** defined as "a sustained partnership with the goal of achieving improvements in peoples' health". The emphasis in the KHSWAp is less about funding modalities and more about joint planning, monitoring and reporting. It emphasizes joint regular review of performance against jointly defined milestones and targets as defined in the Joint Programme of Work and Funding (JPWF)[5] and rolled out in Annual Operational Plans (AOPs).

The JPWF outlines the joint priority health interventions to be implemented over the period 2006–2010, their resource implications and financing situation and therefore drives the partnership of all actors in the health sector. In order to reduce transaction costs and improve effectiveness of external support, the Government and its partners designed a framework agreement for coordination, harmonization and alignments of activities in the health sector, which is also used to track the Paris Declaration on Aid Effectiveness in Kenya. This partnership framework, known as the Code of Conduct (COC), has now been signed by all the key partners in the sector.

Figure 2.2 outlines the linkages between the programme areas of the JPWF for the Kenya health sector to the development goals and objectives of NHSSP II.

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

Figure 2.2 Linkage between JPWF and development objectives and goals



3: Achievements and Challenges at Midterm

As shown in Table 1, overall progress towards achievement of key health outcomes appears to be improving. The first half of the implementation of the NHSSP II saw key improvements, particularly in child health, and disease control. Some weaknesses are still evident, particularly in relation to maternal health.

Achievements and challenges for each NHSSP II objectives are summarized below. For more detail, please refer to the NHSSP II Midterm Review Report.

The Millennium Development Goals

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

Table 3.1: MDG – NHSSP I development targets, outcomes and outputs

Target	Baseline MDG 1990	Baseline NHSSP I 1999/2000	Output NHSSP I 2003	Current estimates 2007	Target MDG 2015
Kenyan Population	21.4		28.7		NS
MDG 4: Child Health					
Prevalence underweight children < 5 yrs (%)	32.5	33.1	28	11	16.2
Reduce IMR by 2/3 between 1990 and 2015	67.7	73.7	78		25
Reduce UFMR by 2/3 between 1990 and 2015	98.9	111.5	114		33
Proportion 1-year-olds immunized against measles (%)	48	76	74	80	90
Proportion of orphans due to AIDS	27,000	890,000	1.2 M		
MDG 5: Maternal, Sexual – Reproductive Health					
Reduce MMR by ¾ between 1990 and 2015	590	590	414		147
Proportion births attended by skilled health staff %	51	NA	42	37	90
Coverage of basic emergency obstetric Care (BEOC)		24			100
% WRA receiving FP commodities	—	—	10	43	70
HIV prevalence among 15–24 yr old pregnant women	5.1	13.4	10.6		NS
MDG 6: Disease Control					
Malaria Prevalence of persons five yrs and above	NA		30%		NA
Malaria In-patient case fatality rate[1]	NA		26%		NA
Pregnant women/children <5 sleeping under ITN %	NA		4 / 5		65 / 65
TB case detection rate (%)	NA		47		60
Treatment completion rate (TCR, Smear+ cases) (%)	75		80		90
MDG 7:					
Access to safe water (national) (%)	48	55	48		74
Access to good sanitation (%)	84	81	50		NS
MDG 8:					
% Population with access to essential drugs	NA		35%		NA

[1] This includes all fever cases treated as malaria. Malaria sentinel surveillance report of 2002 estimated it at less than 5%.

NHSSP II Strategy 1: Increase equitable access to health services

A three-pronged strategy to a) improve geographical access; b) improve financial access; and c) address social and cultural barriers to services.

Summary

Many achievements have been made in expanding the coverage of facilities, institutionalizing the needs of clients, and improving pro-poor financing. Challenges remain in relation to following through on policy implementation, and scaling up services.

Achievements

- 1,600 health facilities built using Constituency Development Funds (CDF). CDF-MOH planning mechanism now established.
- Inputs to strengthen referral such as mobile phones, equipment, ambulances provided. Drafting of referral strategy has begun.
- 3,649 health workers recruited and working in under served areas
- National Social Insurance Scheme (NSHIF) designed and debated.
- Reduction in user fees (20/10 policy) consolidated. Free deliveries at levels 2 and 3.
- Pro-poor resource allocation defined and in use
- Surveys suggest client satisfaction is rising. Waiting times are reduced. Annual client satisfaction review findings have informed AOPs.
- Service Charter developed, which defines rights and obligations.

Challenges/Constraints

- Coordinating investment in new facilities to ensure they are built according to priorities and commensurate with available operational resources.
- Accelerating the drafting process of the referral strategy to guide investments in other health systems.
- Inequitable distribution of health workers remains significant.
- Insufficient consultations during development of the NSHIF resulted in legislation not being passed.
- Dissemination of KEPH incomplete and implications not fully institutionalized (development partners' support not fully aligned; implementation guides not completed; staff not oriented/trained; some services not yet scaled up)
- Geographical dimension of poverty not sufficiently incorporated into resource allocation criteria.

NHSSP II Strategy 2: Improve the quality and responsiveness of services

Comprises a) improving health worker performance; and b) improving responsiveness to client needs.

Summary

Government-wide roll-out of results based management has underpinned the performance appraisal. A recent pay rise for health workers has also provided a conducive environment for reform. However, key systems and inputs such as supply chain management and transportation remain key challenges. A number of activities in Strategy 1 contribute to Strategy 2.

Achievements

- Introduction of target based performance appraisal system.
- Supervisory checklists developed and used.
- Growing use of clinical audits, including for maternal mortality (no. of MM audits year on year?)
- Availability of drugs substantially improved (extent of improvement?)

Challenges/Constraints

- Reaching targets through efficiency gains without increased resources is proving a challenge
- Transport is constraining regular supervision.
- Supply chain management has improved, but periodic stock outs continue.

NHSSP II Strategy 3: Foster partnerships in improving health and delivering services

This involves partnerships with civil society, not for profit organizations, and development partners, and improving inter-sector collaboration.

GOK recognizes effective partnership requires a results orientation, accountability, participation and transparency.

Summary

Commendable planning frameworks have been developed, and the health sector is rapidly decentralizing its planning process. Commitment has been shown on all sides to substantially strengthen partnership arrangements, but full and timely discussion and disclosure of financial decisions are yet to be realized.

Achievements

- JPWF, the medium-term expenditure framework (MTEF) and AOPs are established framework documents and processes. Decentralized planning implemented; participation steadily improved.
- Code of Conduct signed and inclusive of implementing partners (NGOs).
- Joint Financing Arrangement being developed.
- Quarterly reviews of progress initiated.

Challenges/Constraints

- Planning and budgeting processes at national level remain disjointed. Significant activity not aligned to existing plans.
- Capacity of implementing partners (IPs) to fully engage in sector is limited.
- Significant external funding still not captured in government budget. Transparency of resource allocation decisions and predictability of funding remain a challenge.
- Quarterly reviews not yet institutionalized at every level.
- MOH still not fully adapted to carry out SWAp stewardship, with structure and functions based on vertical programme approach.
- Mechanisms for IP and donor partner accountability not yet in place.

NHSSP II Strategy 4: Improve the efficiency and effectiveness of service delivery

Strategy focused on cost efficiency and cost effectiveness, planning, management and administration.

NHSSP II specified six levels of the health care system. Each level has both service delivery and management functions to ensure efficient and effective delivery of health services.

Summary

Progress is being made to enable funds to flow directly to lower level service delivery. The Health Sector Services Funds (HSSF) pilot shows that this is likely to accelerate service delivery outputs. Plans have been developed to strengthen certain health systems. However, implementation has been lacking, and plans are needed where they have not yet been developed.

Achievements

- A mechanism to direct funds to health facilities (the HSSF) was successfully piloted; national arrangements are being gazetted; roll-out is being planned.
- A shadow/functional budget exercise has been initiated to establish operational linkages between the government budget format and sector planning format.
- Harmonization of HMIS indicators was initiated.
- Plans to strengthen financial management, human resources and supply chain management (including procurement) have been developed. Annual procurement planning process has been introduced.
- Transport assessments were conducted in two provinces.
- A national communication strategy has been drafted.
- Government-wide information and communication technology (ICT(policy is being implemented by the MOH.

Challenges/Constraints

- Finalization of the JFA is experiencing delays because of GOK capacity constraints and donor partner harmonization challenges.
- Capacity at implementation level for planning and monitoring remains weak. Not all development partners follow the planning calendar.
- Data collection and use remain inefficient and sporadic. Findings from operational research not fully incorporated into decision making.

- Internal controls remain weak, and fiduciary risk is perceived to be high.
- A strategic approach to the management of infrastructure, communications and ICT is lacking.

NHSSP II Strategy 5: Improve financing of the health sector

Focus on increased funding, improving pro-poor resource allocation, achieving an appropriate balance between access and quality.

Summary

Resources have increased, and allocative efficiency has improved with more funds channelled to cost effective basic health services. Resolving bottlenecks in spending GOK funds remains a priority.

Achievements

- Increase in allocation and per capita spend on health (see Table 2)
- Increased DP funding, especially for scale up of priority public health interventions such as for malaria and HIV.
- National Hospital Insurance Fund increased benefits package to include vulnerable populations.
- Resource allocation has been reduced at higher levels and increased at lower levels of the system (15.6% 0f the MOH budget allocated to tertiary level)
- Expenditure reviews and expenditure tracking surveys conducted to rectify expenditure bottlenecks.

Table 3.2: Trends in public expenditures on health

	2004/05	2005/06	2006/07
Approved budget (Ksh million)	21,977	27,832	33,526
US$ per capita	8.7	10.8	14.5
Share of total government expenditure (%)	7.24	7.27	7.27
Share of GDP (%)	1.71	1.78	1.91
Actual expenditure (Ksh million)	19,158.40	20,636.00	23,178.00
US $ per capita	7.6	8.0	10.0
Share of total government expenditure (%)	6.31	5.39	5.02
Share of GDP (%)	1.49	1.32	1.32
$/Ksh exchange rate	77.3	77.3	68
Population projections (in millions)	32.8	33.4	34

Challenges/Constraints

- Percentage of budget spent has decreased from 87% to 69% 2004/05-2006/07.
- Difficult to make strategic resource allocation decisions with only partial knowledge of resource flows to the sector. Donor conditionality further fragments information systems.

Management and Leadership

Whilst management and leadership are subsumed within the strategies above, it is important to identify shortcomings in this area to avoid business as usual and ensure that bottlenecks really are addressed. The MTR has shown that some of the improvement plans in JPWF have not been implemented as planned. Key managerial bottlenecks around the implementation of the sector strategic approaches are:

- Lack of willing and committed champions to lead and inspire the implementation of the reform program; whenever there is willingness, the capacity for managing and leading the reform process is found quite weak.
- When such champions exist in some of areas, there is lack of adequate support in terms of resources to implement the reforms agendas;
- Some of the reforms agendas are core functions of other Ministries, where Ministry of Health cannot implement reform programs on its own. These include financial management, procurement, and human resources. Some of the actions therefore require sanction and agreement from these Ministries.
- Adequate effort was not made to make the various heads accountable for results. Though monitoring reports were produced and review meetings were held, these have not improved performance where it is needed most.
- Adequate partnership to support follow up of implementation was not fully achieved. A Health Sector Coordinating Committee was set up as part of the process of operational sing the sector's governance structure. However, Technical Committee's to coordinate partnership in specified areas of focus were not yet functional. Linkages to existing technical partnership structures such as the ICCs that were set up for Global Fund, and other specific programmes were not created.

4: Priority Recommendations

For a full list of MTR recommendations, please refer to Annex A. Here we focus on the recommendations related to:

- Priority actions to remove bottlenecks;
- Priority strategies that have experienced no/slow implementation (primarily health system strengthening); and
- Priority public health interventions that have received less support to date, but are critical to achieving NHSSP II targets (and MDGs).

Most of the recommendations are concerned with reforming the health sector, strengthening health systems, and facilitating alignment and harmonization. The priority recommendations are summarized below. For a full description, please refer to Annex B. Implementation mechanisms are described, to address management and accountability issues, followed by categorization by NHSSP II objectives.

Implementation Mechanisms

In order to address the bottlenecks identified at the end of the last chapter, the following arrangements will be initiated:

- A Team Leader for each core area of activity will be assigned from the MOH as a champion. This Team Leader is responsible and accountable for delivering the results that are outlined in this plan. The Team Leader will form a team comprising key stakeholders to fast track the implementation process. A mechanism for rewarding and sanctioning Team Leaders on the basis of their performance of the plan will be designed and implemented. Linkages will be made to existing performance contracts and the performance appraisal system.

- The improvement plans are funded from development partners and government to ensure that appropriate technical and financial support is provided. Development and implementing partners have also nominated respective leads on each area to support the Team Leader. The financial and technical support needs have been identified so that the financier is accountable to all stakeholders alongside the Team Leader.

> Most of the recommendations aim to reform the health sector, strengthen health systems, and facilitate alignment and harmonization. For example, a mechanism for rewarding and sanctioning Team Leaders on the basis of their performance of the plan will be designed and implemented.

To complete the SWAp governance structure, Technical Working Groups will be established for core areas to facilitate consultation, problem solving and coordination.

NHSSP II Objective 1: Increase equitable access to health services

Ten strategies are identified as necessary to enable achievement of this objective.. They relate to ensuring comprehensive implementation of the KEPH by level and cohort in an equitable manner.

(1) Support to ensure universal access to Maternal and neonatal health services for cohort 1, involving demand creation and supply side interventions such as free delivery, skilled attendants, effect referral and other emergency obstetric care components.
(2) Comprehensive implementation of guides and frameworks for cohorts 4 and 6.
(3) Development of a policy, strategic approach and an implementation framework for NCDs to address healthy lifestyles and provision of direct medical care for individuals in a clinical setting (all cohorts).

(4) Reduce morbidity and mortality from malaria by accelerating implementation the National Malaria Strategy that has been revised in line with NHSSP II, particularly targeting cohorts 2, 3 and 5.
(5) Strengthen implementation of existing service delivery efforts for Child health for cohorts 2 and 3, with a particular focus on coordination
(6) Accelerate implementation of TB control initiatives (cohort 5)
(7) Accelerate Community Strategy implementation (level 1), through operational sing community health worker structure, providing behaviour change communication, scaling up outreach services, etc.
(8) Accelerate KEPH dissemination throughout the sector
(9) Develop a strategy to influence the implementation of KEPH outside the health sector
(10) Strengthen public-private partnerships in delivery of services, particularly in underserved areas, through improving formal frameworks and facilitating access to the HSSF

NHSSP II Objective 2: Improve the quality and responsiveness of services

The strategies for acceleration of implementation for this objective are:
(1) Roll out service charter, to be displayed publicly containing information on services, standards, complaints, and the mechanisms to redress
(2) Develop and implement country specific hospital reforms to support and complement services at the primary care level
(3) Re-categorize and accredit health facilities in line with KEPH to guide the identification of inputs required within the context of existing KEPH Norms and Standards.
(4) Update and implementation service delivery clinical and management guidelines.
(5) Create facility-based incentives to improve quality of services such as institutionalizing processes for recognition and reward
(6) Put in place national strategy for integrated supportive supervision, involving clear definitions and implementation arrangements, and linkages to annual plans and performance appraisal, and incorporating new service delivery guidelines
(7) Fast track leadership and management capacity strengthening initiatives in accordance with the decentralization of management in the sector, including in-service training and patient centred accountability.

NHSSP II Objective 3: Foster partnerships in improving health and delivery services

The formation of Technical Working Groups, Team Leaders and DP and IP leads is described above. Other strategies to strengthen partnerships are:
(1) Strengthen sector coordination and participation structures at all levels by
- Implementong sector governance structures at all levels.
- Linking governance structures to Vision 2030 strategies.
- Establishing governance TWG.
- Developing and implementing Public Private Partnership policy

(2) Monitor adherence to COC principles and obligations, including the development of aid effectiveness indicators and targets and integrate their measurement in sector annual reviews.
(3) Build joint support and responsibility to strengthen common management arrangements and ensure use of country systems for support.
(4) Ensure partners are providing coordinated and demand driven technical assistance and cooperation.
(5) Support implementation of common monitoring tools and systems including utilization of the Joint Review Missions for review and planning of sector interventions.
(6) Develop mechanisms for generation, sharing, and use of information with implementing partners.
(7) Build the capacity of coordinating secretariats for partnership (HENNET and private sector).
(8) Endeavour to ensure that development partners are increasingly channelling funds through joint financing arrangements and using in-country systems.
(9) Establish and implement coordination mechanism for partner missions to the country.

(10) Coordinate and pool capacity development support particularly for strengthening systems.

NHSSP II Strategy 4: Improve efficiency and effectiveness

Key strategies for acceleration to improve efficiency and effectiveness are:

(1) Fast track implementation of HRH initiatives by:
- Developing recruitment and deployment policy; specifically:
  - Fill 601 existing established posts.
  - Map HRH to guide where staff will be posted.
  - Revise staff establishment for new posts.
- Finalizing and implementing HRH strategic plan, with a focus on new employment on underserved areas.
- Strengthening workforce planning and information management.
- Consolidating HRH management and development functions at national level
- Ensuring coordinated management of functions of development, determining of requirements; e.g.:
  - Employ sms technology to speed up resolution of staff problems.
  - Design appropriate incentive mechanisms for sustaining equity in distribution of HR.
  - Develop policies on retention of staff in hard to reach areas.
  - Design mechanisms for HRH support and management for non public actors.
- Decentralizing HR function.

(2) Strengthen the management and availability of commodities and supplies by:
- Delineating clearly roles and responsibilities for procurement in Health Sector, e.g.,
  - Roles and responsibilities of MOH and KEMSA.
  - Clarification of roles and responsibilities of KEMSA for non public actors.
  - Transfer of all health commodity procurement to KEMSA.
  - Role of MEDS, and other private procurement entities.
- Reviewing standard operating procedures (SOPs) for health commodity procurement and align with new procurement regulations
- Ensuring KEMSA has sufficient funding to support the supply chain management
- Accelerating implementation of procurement improvement plan
- Implementing the agreed 5% distribution cost of 5% of all commodities distributed through KEMSA.
- Reviewing health commodity procurement SOPs and building capacity at all levels.
- Finalizing revision of National Drug Policy.
- Developing/implementing Pharmaceutical Sector Strategic Plan.
- Revising Essential Drugs List (EDL).
- Developing and implementing EMS.
- Scaling up demand driven supply system/pull system.
- Decentralizing KEMSA distribution system.
- Implementing MTC at national level and in 50% of all hospitals.
- Integrating parallel commodities into the essential commodity system.
- Strengthening pharmaco-vigilance function activities.
- Introducing quality assurance (including regular audit) for commodities and supplies.
- Tracking commodity supply chain.

(3) Align infrastructure, communication and ICT strategies to ensure they effectively support service delivery by:
- Strengthening strategic framework to guide investment in infrastructure, communication, transport and ICT, e.g.,
  - Development of policies and strategic guidelines (including financing) in above areas.
  - Annual maintenance as part of procurement plan for sector.
  - Review/assessment of transport management in the health sector MOH, KEMSA, provinces, districts (procurement, maintenance, HR, etc.).
  - Development of transport guidelines.
  - ICT implementation plan to guide investment in ICT in line with overall government policy.
  - Development of guidelines for donation of medical equipment.
  - Definition of minimum specs for equipment to guide prioritization of investment.

  - Development of guidelines on investment at facilities.
  - Capacity building of managing resources at provincial and district levels.
- Strengthening information management for infrastructure, communication, transport and ICT, e.g.,
  - Guideline and manual for collating information from all stakeholders (especially from private sector).
  - Digitalization of information management.
  - Manuals for planning, management and maintenance in facilities and communities.
  - Staff training in the use of IT equipment and software.
- Developing and implementing approaches for quality assurance and audit for infrastructure, equipment maintenance and use.
- Developing and implementing approaches for quality assurance in transport maintenance and use.

(4) Strengthen public financial management system (PFM) by
- Accelerating implementation of PFM improvement plan (some parts require updating), e.g.,
  - Fast track capacity strengthening in FM at all levels.
  - Improve data capture on PFM.
  - Introduction of IFMIS at all levels
  - Annual PETS.
- Implementing HSSF.
- Reviewing the Public Health Act to take care of financial issues.
- Establising a Joint Funding Mechanism for pooled funding.

(5) Strengthen use of strategies for bottom up planning and budgeting by:
- Building capacity of planning units at all units at all levels in planning, costing and budgeting
- Strengthening linkages between sector planning and budgeting
- Rolling out the strategy to integrate gender and human rights issues in planning in collaboration with other government departments
- Exploring the role and use of medium- and longer-term planning mechanisms at sub national levels

(5) Scale up use of performance monitoring mechanism (including HMIS) by:
- Accelerating the implementation of monitoring improvement framework
  - *Coordination of PM&E, HMIS and IDSR information sources*
  - *Incorporating information from systems and other data sources of like KNBS, DHS, KAIS, etc.*
  - *Participation of all stakeholders at different levels.*
- Strengthen data management capacity (collection, analysis, computerization and use) at all levels.
- Disseminating ME findings.
- Following up implementation of MTR recommendations.
- Linking IFMIS to HMIS.
- Instituting mechanism for ensuring allocation for M&E of 5% of recurrent budgets for GOK and partner programmes.

NHSSP II Strategy 5: Improve financing of the health sector

Key strategies for acceleration of implementation are:

(1) Establish mechanisms to increase availability of resources.

(2) Improve budget management and efficient and equitable resource allocation and utilization, particularly developing costing frameworks, improving pro-poor resource allocation formulae, instituting cost effectiveness analysis to aid prioritization, availing finance/cost information to the public, and incorporating all sources for expenditure tracking.

(3) Complete and implement health care financing strategy.

(4) Implement HSSF, through more comprehensive district budgeting, finalization of guidelines, training, and ensuring fiduciary risk is low.

(5) Implement the shadow budget as a means to link planning and budgeting processes for entire sector.

(6) Improve predictability of resources by holding partners accountable to provide information on their frameworks and budgets, and quarterly disbursement data.

5: Monitoring and Evaluation

Monitoring and evaluation of progress will be done within the sector's ongoing monitoring and evaluation mechanisms. Actions needed to be implemented will be part of the respective AOPs. (Actions implemented in this financial year will be part of the current AOP 3).

Each of the main areas of focus will be monitored by its Technical Working Group. This TWG will be composed of all sector actors; government, development partners and implementing partners, that are carrying out activities, or have an interest in supporting the respective strategy. The Team Leader will coordinate the efforts of the TWG. The lead DP and lead IP will ensure adequate communication with their respective constituencies to ensure their obligations and expectations are realized.

The TWG will report on a quarterly basis to the SWAp umbrella Health Sector Coordinating Committee (HSCC) on progress against milestones, issues and challenges being met in implementation. It will also bring any issues for decision at this level.

Annual sector reviews to determine progress will be conducted as part of the AOP monitoring and review process.

The sector will review progress annually as part of the AOP monitoring and review process. The progress made against each of the areas of focus will be documented in the AOP report for each subsequent year.

Final evaluation of the sector's performance at the end of the NHSSP II will also review the contribution that these implemented strategies have made towards overall progress.

Monitoring indicators will be the same as those used to monitor the NHSSP II, and its AOPs. As highlighted in the recommendations from the Mid Term Review of the NHSSP II, monitoring of partnership and coordination will be in line with the Paris Declaration indicators (Annex B).

6: Implementation Framework

Implementation of this roadmap will be carried out in accordance with the framework presented in the following sections. The sections summarize:

- Key milestones for achievement within six months (AOP 3), the subsequent one year (AOP 4) and the final year of the NHSSP II (AOP 5);
- Responsible persons for each strategy, from government (Team Leader), development partners (Lead DP), and implementing partners (Lead IP);
- Indicators for progress towards achievement of the strategy; and
- Resource requirements to adequately implement the strategy.

These are elaborated on the basis of the respective NHSSP II objectives.

NHSSP II Strategy 1: Increase equitable access to health services

Strategies	Responsibility			Progress indicators	Targets			Budget (Ksh 000,000)		
	TL	L/DP	L/IP		6 months	AOP4	AOP5	6 mons	AOP4	AOP5
1.1 Universal access to maternal and neonatal health services										
1.1.1 Explore issues hindering utilization of maternal and neonatal services in Kenya, such as attitudes of health providers, male involvement, etc.	H/PPHS	GDC	HENNET*	Increased # of women delivering with skilled attendance	Situation analysis report disseminated and designing attitude change	Implementation	Implementation and review	1.2	TBD	TBD
1.1.2 Provide CEOC including care for newborns at all L4 facilities through functional maternities, nurseries, maternity theatres and laboratory and x-ray services		UNFPA	HENNET*	# of CEOC facilities	5	10	20	5	20	10
1.1.3 Ensure availability of family planning commodities at point of use (commodity security and distribution)		UNFPA	HENNET*	% of health facilities reporting no stock-out	70% of HFs	80%	90%		1200	1300
1.1.4 Provide BEOC including care for the newborn in all L3 facilities		UNFPA	HENNET*	# of Level 3s offering BEOC	200	300	500	30	60	120
1.1.5 Ensure availability of skilled attendants at births in the community		UNFPA	HENNET*	# of operational community midwives	120	200	500	1.2	3	4

Continued

NHSSP II Strategy 1, continued

Strategies	Responsibility			Progress indicators	Targets			Budget (Ksh 000,000)		
	TL	L/DP	L/IP		6 months	AOP4	AOP5	6 mons	AOP4	AOP5
1.1.6 Implement Referral Strategy	H/C&RS	GDC	HEN-NET*	% of facilities implementing RS	Referral strategy disseminated	Implement 25% Referral Strategy	Implement 25% Referral Strategy	2	690	690
1.1.7 Institute free deliveries in health facilities	DMS TWG	GDC	HEN-NET*	% of concept paper plan implemented	Agreed comprehensive maternal/newborn requirement concept paper	Implementation as per plan	Implementation as per plan	3	TBD	TBD
1.1.8 Institute 24-hour-a-day work hours in L3 nationwide		GDC, WORLD Bank	HEN-NET*							
1.1.9 Implement strategies to ensure financial access to comprehensive maternal health services		GDC	HEN-NET*							
1.2 Nationwide implementation of community strategy										
1.2.1 Establish functional community units	H/SPMD	UNICEF	HEN-NET*	# CUs established	150	480	960	600	1,000	1,634
1.3 Accelerated implementation of Kenya Essential Package for Health (KEPH)										
1.3.1 Implement comprehensive guides and frameworks for cohorts 4	H/PPHS	UNICEF	HEN-NET*	% schools implementing comprehensive school health package	School health strategy finalized	5%	30%	2	32	50
1.3.2 Develop a policy, strategy & comprehensive implementation plan for cohorts 4& 6		WHO	HEN-NET*	% Strategy implementation	Draft Policy/Strategy and implementation plan	Consensus & 5% Strategy implementation	15% Strategy implementation	1	10	20
1.3.4 Develop a policy, strategic approach and implementation framework for NCDs to address healthy lifestyles and provide direct medical care for individuals in a clinical setting		WHO	HEN-NET*	% of health facilities implementing guidelines	Policy/strategy and implementations plan	10% planned	30% planned	1	12	12
1.3.5 Reduce morbidity and mortality from malaria by implementing the National Malaria Strategy, revised in line with NHSSP II		WHO	HEN-NET*	% in patients admitted due to malaria	14%	14%	12%	3000	6000	6000
1.3.6 Strengthen implementation of service delivery efforts for child health		UNICEF	HEN-NET*	% reduction in under-five inpatient mortality	Baseline data, implementation plan & dissemination	15	30		400	500
1.3.7 Accelerate implementation of TB control activities		WHO	HEN-NET*	% increase in case notification	20%	20%	20%	50	3000	3000
1.3.8 Modify pre-service curricula in line with service delivery expectations	Head curative	DFID	HEN-NET*	% of institutions participating in modified training		Curricula revised	50% facilities using revised curricula		2.2	3

NHSSP II Strategy 2: Improve the quality and responsiveness of services

Strategies	Responsibility			Progress indicators	Targets			Budget (Ksh 000,000)		
	TL	L/DP	L/IP		6 months	AOP4	AOP5	6 mons	AOP4	AOP5
2.1 Improvement of facility-based services										
2.1.1 Develop and implement country specific hospital reforms	Head curative	GDC	HEN-NET*	% of facilities implementing reforms		5%	10%		10	10
2.1.2 Re-categorize health facilities in line with KEPH		GDC	HEN-NET*	% facilities categorized	Draft guideline	50% categorization of facilities	100% categorization of facilities	2	5	5
2.1.3 Roll out service charter (SC)		WB	HEN-NET*	% of facilities implementing SC	13 Intern training facilities implementing SC	25% of L4 implementing SC	50% of L4 implementing SC	1.8	3.6	3.9
2.1.4 Update and implement service delivery clinical guidelines		WHO	HENNET*	% of facilities adhering to guidelines	Guidelines disseminated	50% level 1-4 facilities adhering to guidelines	50% level 1-4 facilities adhering to guidelines	10	5	5
B1.5 Create facility-based incentives to improve quality of services		WB	HEN-NET*	% of facilities implementing agreed concepts		Agreed concept paper	10% facilities implementing		4	4
2.2 Improving service responsiveness										
2.2.1 Develop & Implement ISO-9000 Quality Management System	Head MMU			% of facilities ISO certified	Headquarters ISO 9000 certified	L5 facilities ISO certified	L4 facilities ISO certified	5	20.5	22.5
2.2.2 Put in place national strategy for integrated supportive supervision	H/C& RS	USG	HEN-NET*		Agreed supervision tool	A district per province adhering to integrated tool	50% districts per province adhering to integrated tool	1	2	3

NHSSP II Strategy 3: Foster partnerships in improving health and delivering services

Strategies	Responsibility			Progress indicators	Targets			Budget (Ksh 000,000)		
	TL	L/DP	L/IP		6 months	AOP4	AOP5	6 mons	AOP4	AOP5
3.1 Human resource for health										
3.1.1 Rationalize establishment and deployment of staff	DHRM	DFID	HEN-NET	% of additional posts filled	Draft deployment policy & revised establishment in place	Revised establishment & deployment policy & implementation plan approved	Implementation of approved revised establishment	2	1	4
3.1.2 Finalize & implement HRH strategic plan		DFID	HEN-NET	% of HRH Plan implemented	HRH Plan launched	10% plan implemented	20% plan implemented	8	34	119
3.2. Commodity supply management improvement										
3.2.1 Institutionalize the Public Proc Act & regulations	H/Proc			% of facilities with functional Committees & KEMSA increased responsibility	Comprehensive guidelines/ manuals and established Proc Committees in 50% of L4 & 100% L5	Train Proc Committees in 50% of L4 & 100% L5	Train Proc Committees in additional 50% of L4 & 50% L2&3	5	15	20
3.2.2. Establish procurement management information system (PMIS)		WB/USG	?HEN-NET	% of facilities with functional PMIS	PMIS designed	PMIS established in 50% of L4 & 100% L5	PMIS established in additional 50% of L4	3	10	10

Continued

NHSSP II Strategy 3, continued

Strategies	Responsibility			Progress indicators	Targets			Budget (Ksh 000,000)		
	TL	L/DP	L/IP		6 months	AOP4	AOP5	6 mons	AOP4	AOP5
3.3 Infrastructure, communication & ICT effectively support service delivery										
3.3.1 Strengthen strategic framework to guide investment in infrastructure, communication, transport and ICT	H/C&RS	JICA	HEN-NET	% of facilities implementing integrated policy	Draft integrated policy	5% districts implementing integrated policy	10% districts implementing integrated policy	5	15	40
3.4 Public financial management (PFM)										
3.4.1 Increase absorption capacity including 5% KEMSA distribution funds	CFO	WB	HEN-NET	% increase in development funds absorption		10% absorption increase	15% absorption increase	2	5	3
3.4.2 Introduce IFMIS at all levels	PAC	WB	HEN-NET	% of compliant districts	Integrated IFMIS (national, provincial & district)	50% district reporting on-line	50% district reporting on-line	20	40	40
3.4.3 Build capacity for HSSF	PAC	DANIDA	HEN-NET	% of facilities submitting accurate financial report	Fiduciary training of committees, facilities, district & provincial managers	50% facilities participating in HSSF	50% facilities participating in HSSF	100	75	50
3.4.4 Review Public Health Act to take care of financial issues	CE	DANIDA	HEN-NET	Revised Public Health Act	consultant contracted	-Draft amendments and cabinet memo	-Draft amendments submitted to Parliament		2	2
3.5 Information Management										
3.5.1 Incorporate information from systems, and other sources of information like KNBS, DHS, KAIS, etc.	CE	DANIDA		Annual health facts and figures	2007 health facts and figures	2008 health facts and figures	2009 health facts and figures	1.5	1.5	1.5
3.5.2 Strengthen data management capacity (collection, analysis, computerization and use) at all levels	H/SPMD	DANIDA	HEN-NET	% of districts reporting on-line on time	10% of districts in Central and Eastern provinces	25% of districts nationally	25% of districts nationally	35	43	55

NHSSP II Strategy 4: Improve the efficiency and effectiveness of service delivery

Strategies	Responsibility			Progress indicators	Targets			Budget (Ksh 000,000)		
	TL	L/DP	L/IP		6 months	AOP4	AOP5	6 mons	AOP4	AOP5
4.1 Joint sector planning strengthened										
4.1.1 Strengthen joint annual planning linked with budget & KEPH dissemination	H/SPMD	DANIDA	HEN-NET	Launched AOP by June	AOP4	AOP5	AOP1	42	44	46
4.1.2 Facilitate medium- and long-term sector planning		DANIDA	HEN-NET	Launched Policy Framework & NHSSPIII	Draft Policy Framework	Draft KHPF adopted & draft NHSSPIII	NSSPIII launched	45	40	10

Continued

NHSSP II Strategy 4, continued

Strategies	Responsibility			Progress indicators	Targets			Budget (Ksh 000,000)		
	TL	L/DP	L/IP		6 months	AOP4	AOP5	6 mons	AOP4	AOP5
4.2 Use of performance monitoring mechanism scaled up										
4.2.1 Conduct joint quarterly and annual reviews	H/SPMD	?	HEN-NET	Timely adopted performance reports		Quarterly & AOP3 performance report	Quarterly & AOP4 Performance report		24.2	26.6
4.2.2 Institute an agreed mechanism for ensuring allocation for M&E of 5% of recurrent budgets for GOK and partner programmes	CE	DANIDA	HEN-NET	% allocation in annual budgets		2%	3%	Nil	Nil	Nil
4.3 Partnership & financing										
4.3.1. Annual expenditure tracking mechanisms for funds from GOK, DPs and IPs, using PETS and PER	CE	WB		PER and PET Reports	2007 PETS and 2008 PER	2008 PETS and 2009 PER	2009 PETS and 2010 PER	21.5	21.5	21.5
4.3.2 Entrench shadow budget tracking – DPs, NGOs & HH costing	CE	WB	HEN-NET	Shadow budgets	2008/09 shadow budgets	2009/10 shadow budgets	2010/11 shadow budgets		1	1
4.3.3 Complete and implement Health Care Financing Strategy including equity	CE	GDC	HEN-NET	Health care financing strategy	NHA report, costing report	Health care financing strategy, health care financing bill	Health care financing act	5	5	
4.3.4 Create sector investment plan including CDF – all levels	CE	GDC	HEN-NET	Mapping report	Pilot phase completed	Mapping Report		2.5	25	
4.4.5 Scale up strategies for harmonization & alignment to sector priorities & government systems	H/SPMD			% of partners adhering to COC	Harmonization and alignment tool designed	20% of partners adhering	50% of partners adhering	1	2	2
4.3.6 Strengthen leadership & governance structures at all levels		Development partners chair	HEN-NET	25% district managers trained in leadership and 70% facility committees established	60% Facility Committees	80% facility Committees, 480 CU structures functional	90% facility Committees, 960 CU structures functional	170	110	100

Annex A: Recommendations from the Midterm Review of NHSSP II

The MTR of the NHSSP II highlighted the key recommendations that the sector needs to implement, for it to achieve its objectives. These key recommendations are highlighted in this section. They are presented by NHSSP II objective.

Recommendations for improving equity in delivery of health services

These are highlighted in terms of strengthening the roll out and delivery of KEPH, and addressing barriers to equitable access to health services.

Recommendations for strengthening the role out and delivery of the KEPH

- Scale up implementation of the following areas of focus of the KEPH. These are safe motherhood; community strategy; malaria; tuberculosis and non-communicable diseases.
- Sustain ongoing service delivery interventions in the areas of focus that have performed well during the period under review.
- Develop implementation framework for providing services to cohorts 4 and 6.

Recommendations for addressing barriers to equitable access to health services

- Undertake a practice and policy review to develop appropriate policy framework for infrastructure, health facility plant, equipment and transport as well as for the communication and information technology including after sale maintenance policies.
- Continue dialogue with CDF Committee to ensure that the fund is supporting sector priorities and its contribution is integrated at district and national sector plans and budgets.
- Develop and implement registration guidelines, standards and regulations for operation for operational of health facilities with a clear separation of regulatory responsibilities from responsibilities of managing health facility operations or implementation of service delivery.
- Review innovative service delivery mechanisms (like the NEP nomadic clinic and others) for improvement and scaling up services to remote hard-to-reach areas
- Negotiate with Treasury to get approval of resources to fill the 9,000 approved posts. Negotiate with donors to assist the financing of these workers.
- Finalize the referral guideline, initiate the implementation of the comprehensive referral system that is guided by an ICT and transport policies and strategies.
- Institute further re-allocations of public funding towards pro-poor programmes especially rural health services in light of current poverty levels that justify more wavers of facility fees to alleviate financial constraints to health services access by the poor.
- Expedite improved direct financing of facilities to help make good of the revenue loss from exemptions, wavers and recent abolition of fees at lower levels of care
- Roll out implementation of Community Strategy in an inclusive manner by bringing on board all interested parties and resolving issue on terms of conditions of CHWs.

Recommendations for improving quality and responsiveness of service delivery

- Develop and implement HR development strategy to support KEPH.
- Establish mechanisms for performance reward as part of PAS roll-out plans including the mandate, authority, means and resources required to recognize and reward good performance as well as address and improve on specific areas of non performance.
- Develop the capacity of managers at all levels to effectively implement and manage the PAS.
- Strengthen systems and capacity for effective integrated support supervision and quality assurance programme at all levels
- Accelerate the dissemination of updated clinical standards, protocols and guidelines for the KEPH including the ministerial service charter.
- Strengthen logistics chain management for essential and public health goods in GOK and PNFP facilities.
- Develop strategies for improving provider-client relationships and accountability including development of health specific charters

Recommendations for improving efficiency and effectiveness of service delivery

Improving value for money

- Undertake further re-allocations of public funding towards pro-poor programs especially rural health services in light of current poverty levels that justify more wavers of facility fees to alleviate financial constraints to health services access by the poor.

Improving public financial management

- Accelerate the implementation of PFM improvement plan
- To reverse the declining capacity to absorb finance resources, MOH needs to conduct an urgent evaluation of its PFM system.
- Implement the HSSF
- The MOH and development partners need to enhance collaboration to reduce parallel and fragmented PFM systems in the health sector through the implementation of the JFA.
- Fast track the capacity building in financial management and Development partners should step in and help MOH build capacity, especially in PFM for the implementation of HSSF.
- To promote financial predictability, the MOH needs to develop criteria for cost sharing waivers, and provide a clear policy strategy for the health sector, to avoid disruptive decision making.
- MOH should strengthen data capture to ensure expenditure is consistent with the service delivery.
- MOH should expedite increasing of benefits by NHIF to transfer efficiency gains to the contributors.

Improving the effort to strengthen health planning

- Improve efforts for strengthening operational (district) health planning:
  - The priority is to scale-up the roll out of the training for AOP preparation at all levels with increased peer support to districts and provinces, timely circulation of planning frameworks, expenditure ceilings, formats, and/or guidelines and tools beginning with preparations for AOP4.
  - In light of the core-functions based results framework used in AOP3, the MOH technical departments should review their respective strategic approaches in line with the present policy and strategic directions. This should help in identifying gaps in delivery of their respective policy and strategic frameworks required to roll out their technical interventions in line with the implementation of the KEPH.
  - Urgently provide districts and provinces with management and planning skills training so as to take over the in-service AOP skills-sharpening training for more rapid, effective and wider coverage of the undertaking before the end of NHSSP II.
  - Enhance the administrative and logistics support available to provinces, districts and health units to conduct more inclusive annual planning with more meaningfully participation of civil society, FBO/NGOs and other partners starting in AOP4 for the AOP5 process.

- Consider and prepare for the introduction of medium term planning frameworks for districts and provinces to set the direction for sustainable decentralized operations, especially for the maintenance of capital investments in buildings, plant and equipment.

- Improve efforts for strengthening development planning by:
  - Enhancing capacity at the central level in technical planning to ensure implementation of the strategic approaches identified is maintained
  - Addressing the weakness of policy dialogue structures at sub-national level with the establishment of appropriate structures to improve engagement of civil society and partners in the planning and sector review processes.
  - Giving immediate attention to the deficit of gender and rights sensitivity in training materials and planning formats. This may require establishment of a focal area at the national level to coordinate this work.
  - Rationalizing and harmonizing the planning function, and planning cycles with budgeting cycles as soon as is practical
  - Ensuring that the restructuring of the MOH makes a succinct and clear distinction between monitoring of administrative support to technical implementation (by the MMU) and the separate, well differentiated functions of technical monitoring and evaluation of sector productivity (by the SPMD through the division of health information).
  - In the same vein, for MOH, appropriately delineating and disseminating the difference between the functions of linkage of budget management processes of MOH (and on budget donors) with the overall Government (by the planning unit), and the separate technical results based and bottom up comprehensive sector planning and budget process based on planning and monitoring sector productivity (by the SPMD).
  - Redesigning and reforming the JRM process to become bottom-up not just in terms of information generation, but also in information dissemination and linkage with other processes, particularly the quarterly monitoring review process. In addition, specific technical assessments in problem hot spot areas could be carried out during the year, to feed into the JRM process as opposed to having these all done at the JRM.

Improving monitoring

- Endorse the M&E strategic roadmap to give overall comprehensive guidance to strengthening of the M&E function in the sector.
- Develop TORs for elaboration of a development roadmap for agreeing and reassigning roles and responsibilities across the sector, staffing, system design arrangements, equipping, training and financing plan. It also includes development or updating of a national health information policy and regulations and adjust any existing guidelines to comply.
- Set up a national representative health information technical committee. This will not only to drive this work but give technical oversight to ensuring the M&E strategic framework is implemented in a comprehensive and participatory manner.
- Establish a focal point on health research as a first step towards building capacity for essential health research policy development, operations research and collaboration with research institutions for health improvements.

Improving public procurement

- Accelerate the implementation of the procurement improvement plan.
- Delineate procurement responsibilities between the ministry PU and other procurement organization including KEMSA.
- Establish the various committees currently pending (e.g., MTCs).
- Complete the new comprehensive pharmaceutical policy.
- Urgently embark on capacity building in procurement and accountability.

Strengthening commodity supply management

- Delineate roles and responsibilities of MOH and KEMSA, and define the role of KEMSA vis-à-vis non public actors like Mission for Essential Drugs Supply (MEDS).
- Demonstrate support KEMSA by articulating clear plan and schedule for transferring the balance of its EMMS procurement and eventually medical equipment to KEMSA
- Implement 5% of handling charges for all commodities procured by third parties and distributed through KEMSA.

- For KESMA, provide information to health facilities on the unspent portion of their quarterly drawing rights and roll it over to the next quarter.
- Increase the resources allocated to the procurement of commodities that go to the health facilities.
- Review the impact of the 10/20 policy on FBO and NGO facilities and consider grants to allow these facilities drawing rights from KEMSA.
- Build capacity at all levels.
- Finalize the revision of National Pharmaceutical Sector Strategic Plan.
- Revise essential medicines list.
- Scale up the demand driven supply system.
- Introduce quality assurance mechanism (including regular audit) for commodities and supplies.

Strengthening investment and maintenance

- Strengthen the strategic framework to guide investment in infrastructure, communication and transport
- Develop an ICT implementation plan to guide investment in the health sector
- Improve financing of maintenance of infrastructure, health facility plant, equipment, and transport to ensure a sound state of their operation.
- Articulate a communication and transport strategy to improve and rationalize support to referral.
- Develop the capacity for maintenance.

Recommendations for improving partnerships in the sector

- Develop a roadmap for advancing the Kenya Health SWAp and governance structures for annual planning to be agreed and HSCC mandated to monitor its progress.
- Develop some clear benchmarks to ensure adherence by all parties to the COC and ensure the SWAp is advanced.
- Develop a public-private-partnership policy framework, but priority needs to be given to addressing issues relating to private not-for-profit providers involved in direct service provision.
- Set national targets for indicators of progress on aid-effectiveness of Paris Declaration (ownership and leadership, alignment to government strategies and priorities as well as systems, mutual accountability for results and harmonization) within the NHSSPII M&E framework and to inform the KJAS results matrix.

Recommendations for improving financing for the sector

- Increase the level of health financing through improved lobbying for adherence of GOK budget projections and donor commitments.
- Improve budget management and explore mechanisms for efficient and equitable resource allocation and utilization
- Finalize and implement a long term health financing strategy.
- Review NHIF act to (a) regulate benefit ratio to a minimum of 80%, limit administrative spending and mandate expansion of benefit package to outpatient services, (b) change contribution regulation to a percentage/ratio of salary instead of fixed rates, and (c) regulate non-benefit payments/contributions to health sector.
- Include NHIF spending / income from NHIF reimbursement into financial planning of sector and health institutions.
- Plan for use of NHIF experience and capacity in contracting, payment of providers / reimbursement for delivered KEPH services and quality management.
- Transfer OBA to Ministry of Health.

Annex B: Indicators for Monitoring Progress in Strengthening of Partnerships

Indicator	Paris Declaration description	Paris Declaration target		Country target
OWNERSHIP				
1	Partners have operational development strategies — Number of countries with national development strategies (including PRSs) that have clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets.	**At least 75% of partner countries** have operational development strategies.		– (Already achieved)
ALIGNMENT				
2	Reliable country systems – Number of partner countries that have procurement and public financial management systems that either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	**(a) Public financial management – Half of partner countries** move up at least one measure (i.e., 0.5 points) on the PFM/ CPIA (Country Policy and Institutional Assessment) scale of performance.		
		(b) Procurement – One-third of partner countries move up at least one measure (i.e., from D to C, C to B or B to A) on the four-point scale used to assess performance for this indicator.		
3	Aid flows are aligned on national priorities – Percent of aid flows to the government sector that is reported on partners' national budgets.	**Halve the gap** — halve the proportion of aid flows to government sector not reported on government's budget(s) (with at least 85% reported on budget).		
4	Strengthen capacity by coordinated support — Percent of donor capacity-development support provided through coordinated programmes consistent with partners' national development strategies.	**50% of technical cooperation flows** are implemented through coordinated programmes consistent with national development strategies.		
5a	Use of country public financial management systems – Percentage of donors and of aid flows that use public financial management systems in partner countries, which either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	5+	**All donors** use partner countries' PFM systems.	
		3.5 – 4.5	**90% of donors** use partner countries' PFM systems.	
		5+	**A two-thirds reduction** in the % of aid to the public sector not using partner countries' PFM systems.	
		3.5 – 4.5	**A one-third reduction** in the % of aid to the public sector not using partner countries' PFM systems.	
5b	Use of country procurement systems – Percentage of donors and of aid flows that use partner country procurement systems which either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	5+	**All donors** use partner countries' Procurement systems.	
		3.5 – 4.5	**90% of donors** use partner countries' Procurement systems.	
		5+	**A two-thirds reduction** in the % of aid to the public sector not using partner countries' Procurement systems	
		3.5 – 4.5	**A one-third reduction** in the % of aid to the public sector not using partner countries' Procurement systems.	

Continued

Indicator	Paris Declaration description	Paris Declaration target	Country target
6	Strengthen capacity by avoiding parallel implementation structures – Number of parallel project implementation units (PIUs) per country.	**Reduce by two-thirds** the stock of parallel project implementation units (PIUs).	
7	Aid is more predictable – Percentage of aid disbursements released according to agreed schedules in annual or multiyear frameworks.	**Halve the gap —** halve the proportion of aid not disbursed within the fiscal year for which it was scheduled.	
8	Aid is untied – Percentage of bilateral aid that is untied.	**Continued progress over time.**	
HARMONIZATION			
9	Use of common arrangements or procedures – Percentage of aid provided as programme-based approaches.	**66% of aid flows** are provided in the context of programme based approaches.	
10	Encourage shared analysis – Percentage of (a) field missions and/or (b) country analytic work, including diagnostic reviews that are joint.	**(a) 40% of donor missions** to the field are joint**.**	
		(b) 66% of country analytic work is joint.	
MANAGING FOR RESULTS			
11	Results-oriented frameworks – Number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programmes.	**Reduce the gap by one-third —** Reduce the proportion of countries without transparent and monitorable performance assessment frameworks by one-third.	
MUTUAL ACCOUNTABILITY			
12	Mutual accountability – Number of partner countries that undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness including those in this Declaration.	**All partner countries** have mutual assessment reviews in place.	

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